



# **PennState Health**

## **St. Joseph**

Reading, PA



## **Community Health Needs Assessment Implementation Plan**

**2016**

Board Approved: October 26<sup>th</sup>, 2016

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# Executive Summary

Penn State Health – St. Joseph (PSHSJ) is eager to present its Community Health Needs Assessment Implementation Plan, which outlines several of our organization’s programs and initiatives designed to address the Berks County community’s most urgent healthcare needs. With our faith-based mission, non-profit status, and locations that straddle both rural and urban underserved areas, PSHSJ’s role in addressing community need is clear. Through our implementation plan, we aim to realize our mission and to promote our four core values: reverence, integrity, compassion and excellence.

The Community Health Needs Assessment, a comprehensive evaluation of health-related concerns in Berks County, was made possible through collaboration between Penn State Health St. Joseph, Berks Community Health Center, Berks County Community Foundation, Reading Health System, and the United Way of Berks County. The data collection portion of the assessment was conducted by Holleran Community Engagement Research & Consulting and the Center for Opinion Research, two firms located in Lancaster, PA. Four main areas of need emerged at the conclusion of the survey:

- (1) increased access to care,
- (2) education and management of obesity,
- (3) improved care and management of chronic conditions, and
- (4) greater availability of behavioral & mental healthcare.

Considering these four main areas of need, PSHSJ developed the following objectives:

Objective 1: PSHSJ will aim to remove crucial barriers to care, including out of pocket expenses, language and cultural divides, transportation barriers and the complexity of navigating the healthcare system.

Objective 2: PSHSJ will implement programs to target the widespread problem of obesity in the community. Through partnerships with other organizations we will foster opportunities for education, lifestyle change, and improved health outcomes.

Objective 3: PSHSJ will offer comprehensive disease management services to aid community members in caring for chronic conditions such as diabetes and infectious diseases.

Objective 4: PSHSJ will increase the availability of behavioral and mental health services. Partnering with the Berks Counseling Center will allow for behavioral health services to be available at the Downtown Campus, a convenient location for many community members.

PSHSJ programs associated with these objectives include:

- (1) HealthOne Mobile Health Initiative, Community Health Worker Training Institute, Community Education Programming, Breast Cancer Screening for the Underserved, Dental Care for the Underserved
- (2) KidFit Children’s Metabolic Clinic, Be Bold Take Charge Initiative
- (3) Diabetes Wellness, Enhanced Patient Navigation, Infectious Disease Services
- (4) Reading Youth Violence Prevention, Youth Mental Health First Aid Training, Primary Care & Behavioral Health Integration

These initiatives were made possible through commitment from both internal champions, as well as partnerships with like-minded community organizations. Joining with other service-oriented Berks County organizations will inevitably strengthen the efficacy of PSHSJ’s efforts to improve health in the community.

Through dedication and hard work, as well as careful strategic planning, Penn State Health St. Joseph is confident that we can successfully improve health outcomes in the community and create lasting, positive change within Berks County.

# Penn State Health St. Joseph Overview

Penn State Health St. Joseph is a non-profit healthcare provider centered in Reading, Pennsylvania. Our network is comprised of a well-designed inpatient facility in Bern Township, as well as numerous outpatient primary care, diagnostic and therapeutic satellites, located across Berks County. In July of 2015, St. Joseph Medical Center and its affiliated medical group became a part of Penn State Health, a newly-created, not-for-profit entity of Penn State University.

What distinguishes PSHSJ is the commitment to embodying our mission:

*The mission of Penn State Health St. Joseph is to nurture the healing ministry of the Church supported by education and research. Fidelity to the Gospel urges us to emphasize human dignity and social justice as we create healthier communities.*

Our core values that guide our work are:

**Reverence:** A profound spirit of respect for all;

**Integrity:** Moral wholeness and honesty;

**Compassion:** Being one with others in their sorrow and dignity;

**Excellence:** Continually surpassing standards to achieve and improve quality.

Our commitment to these core values is especially evident through the work that we do at our Downtown Campus, located at the corner of 6<sup>th</sup> and Walnut Streets in the City of Reading. The Downtown Campus of PSHSJ is the largest ambulatory facility located in the city of Reading, and offers a variety of services including adult and pediatric primary care, obstetric and gynecological care, dental services, a community pharmacy, specialty clinics, imaging, laboratory, and diabetes management services. Our wide array of available services, combined with our accessible location within the city helps us position our organization as a focal point for addressing community need. More information about our Downtown Campus's role in the community can be found on the following page.

# Penn State Health St. Joseph – Downtown Campus Overview

The PSHSJ Downtown Campus is the largest ambulatory care facility in the City of Reading. Centrally located at 6th & Walnut Streets in the former Community General Hospital site, this true Community Health Center is owned and operated by St. Joseph Regional Health Network (SJRH), a subsidiary of Penn State Health. The 266,000 square-foot, two-building campus continues to undergo renovations and expansions to better serve the needs of the community. A major focus is on connecting patients with vital services in a “one stop” setting. Adult and pediatric primary care, immunizations, prevention and wellness programs, chronic disease care, obstetric/gynecological care, as well as many diagnostic and therapeutic services, can all be found within this facility.

More than 60 percent of the City of Reading’s residents are uninsured or receive Medicaid/Medicare. A majority of residents of the City of Reading are also Latino, and language and cultural barriers must be navigated skillfully along with other racial, ethnic, educational, and socio-economic-related health disparities. With a fluctuating, highly transient and predominantly poor city population of just over 80,000, Reading depends on the PSHSJ Downtown Campus to meet the complex needs of the community.

Each year, tens of thousands of patient encounters occur somewhere on the campus with 77 percent of patients served from medical assistance, self-pay or charity care. The campus provides over \$2.3 million in uncompensated care annually. Whether by connecting people with a family doctor, providing accessible specialty clinics and innovative group prenatal care, or educating future medical professionals, the PSHSJ Downtown Campus has clearly become a prototype for urban healthcare delivery.

Indeed, the PSHSJ Downtown Campus is a busy health hub with more than 20 departments, support services, and community partners. Existing primary medical and dental services at the Downtown Campus are delivered through the St. Joseph Medical Group Downtown Practice by five separate but integrated clinic pods: Family Practice, Obstetrics/Gynecology, Pediatrics, Family Practice Residency, and Dentistry. The center also works with specialty physicians in the area to get necessary services offered on-site. Other community partners important in the care of the underserved also occupy this location. These include the Migrant Farm Workers and Haven Behavioral Healthcare.

# Community Health Needs Assessment Overview

The Community Health Needs Assessment (CHNA) is a holistic evaluation of Berks County's health status, and is conducted every three years to identify the most prominent health requirements of the community. The 2016 CHNA was sponsored by Penn State Health – St. Joseph, Berks Community Health Center, Berks County Community Foundation, Reading Health System, and the United Way of Berks County. This year's CHNA was led by The Center for Opinion Research and Holleran Community Engagement Research and Consulting, two research firms located in Lancaster, Pennsylvania.

A copy of the completed CHNA is available on the organization's website. Though the overall health of Berks County residents is comparable to that of Pennsylvania residents, the 2016 CHNA highlights crucial barriers to improved health status in Berks County. These barriers disproportionately affect racial minorities, as well as those who live below the poverty line; many of these affected residents live in the City of Reading.

The four main health priorities identified by the 2016 CHNA are as follows:

## **Priority 1: Access to Care**

The Needs Assessment found that many Berks County residents due to their insurance status often face difficulty accessing essential healthcare services, including the following:

- Primary care providers
- Medical specialists
- Dentists
- Providers accepting Medicaid/Medical Assistance

Key informants who provided insight for the Needs Assessment indicated the following as some of the most significant barriers to care for County residents:

- Out of pocket expenses and co-pays
- Transportation



- Inability to navigate healthcare system
- Lack of health insurance coverage
- Language and cultural barriers

### **Priority 2: Obesity**

One component of the surveying for the Needs Assessment is a Behavioral Risk Factor Survey, which provides insight into specific health behaviors of County residents, and how those behaviors may impact health in the community. The prevalence of obesity has been rising steadily in Berks County over the past several years:

- In 2008, 63% of Berks County residents were reported as being overweight or obese. In 2015, that number has risen to 68%.
- Only 4% of Berks County residents surveyed indicated that they had consumed three servings of vegetables daily in the past year.

### **Priority 3: Chronic Illness**

Many community residents suffer from a variety of chronic conditions, as demonstrated by the following:

- 39% of surveyed participants reported having high cholesterol, and 38% report high blood pressure.
- 10% of respondents have diabetes mellitus.
- 9% report having a heart condition (heart disease, heart attack or stroke) and 8% report having a pulmonary condition (COP, emphysema or chronic bronchitis).

### **Priority 4: Behavioral & Mental Health**

Behavioral and mental health continues to be a widespread area of concern in Berks County. Many County residents suffer from a mental health condition:

- 18% of survey participants report a depressive disorder, and 19% report an anxiety disorder.
- 57% of respondents indicated one or more days with depressive symptoms in the past two weeks.
- 35% reported that mental health was not good at least one day in the past month.

# PSHSJ Implementation Plan Overview

Penn State Health – St. Joseph is excited at the opportunity to be a source of community benefit. As a long-time entity within Berks County and a strong reputation of service to the poor and underserved, our organization is fully committed to the task of implementing our outlined programs in an effort to meet the needs of the community.

As a managing partner of the Community Health Needs Assessment in Berks County, Penn State Health – St. Joseph assembled a diverse advisory group of employees who were involved throughout the time in which the Assessment was conducted. Further, this internal advisory group has committed substantial time and effort to the development of this implementation plan.

All of the community benefit pursuits outlined in this implementation plan correspond directly with the specific needs highlighted in the results from the Assessment. The specific programs that PSHSJ conducts and supports provide means to closing gaps in care for areas such as access, obesity, chronic conditions and behavioral and mental health. Each program is outlined in detail on the subsequent pages, with the following qualities emphasized:


1. Program Description
2. Objective to Be Achieved
3. Community Partners
4. Timeframe
5. Financial Commitment
6. Measure(s) of Success
7. Long-Term Sustainability
8. Executive Sponsors and Key Contacts

Though some pieces of information are unavailable at the time this document was completed, the infrastructure for each of Penn State Health – St. Joseph’s community-minded programs has been identified, and will continue develop with time.


Most importantly, our organization would be remiss if we did not thank the other community-minded organizations who have helped resource and support the programs outlined in this document. The partnerships fostered with other organizations in the community with the same dedication to service have proved invaluable and help strengthen our ability to meet the community’s needs.

# Penn State Health St. Joseph Priorities for Community Health Needs


Access to Care




Obesity



Chronic Conditions



Behavioral & Mental Health



<p>PSHSJ will aim to remove crucial barriers to care, including out of pocket expenses, language and other cultural divides, transportation barriers and the complexity of navigating the healthcare system. We are well-equipped to accomplish this task through our accessible Downtown Reading Campus location.</p>	<p>PSHSJ will implement programs to target the widespread problem of obesity in the community. Through partnerships with other organizations we will foster opportunities for education, lifestyle change, and improved health outcomes.</p>	<p>PSHSJ will offer comprehensive disease management services to aid community members in caring for chronic conditions such as diabetes and infectious diseases.</p>	<p>PSHSJ will collaborate to improve the availability of behavioral and mental health services. Partnering with behavioral health organizations will allow for services to be available at the Downtown Reading Campus, a convenient location for many members of the community.</p>
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# Penn State Health St. Joseph Priority Programs Overview

## Access to Care



## Obesity



## Chronic Conditions



## Behavioral & Mental Health



- HealthOne Mobile Health Initiative
- Community Health Worker Training Institute
- Community Education Programming
- Breast Cancer Screening for the Underserved
- Dental Care for the Underserved

- Children's Metabolic Clinic
- Be Bold, Take Charge Initiative

- Diabetes Wellness
- Enhanced Patient Navigation
- Infectious Disease Services

- Reading Youth Violence Prevention
- Youth Mental Health First Aid Training
- Primary Care & Behavioral Health Integration

# Priority 1: Access to Care

## Introduction

Access to care has been identified as a prominent community health need over the past several years in Berks County. Penn State Health St. Joseph continues to increase access throughout Berks County by providing exceptional care at convenient locations. Additionally, we promote health education and access to preventative services through our volunteer efforts and use of community health workers. Penn State Health St. Joseph will continue to broaden access to care within Berks County by developing unique ways to serve our underinsured populations. The objectives shared in this section describe the work we have done and plan to do.

## Priority Objective 1: Access to Care

### HealthOne Mobile Health Initiative

#### Program Description

PSHSJ launched a mobile health initiative to increase access to care to citizens in the community. The 32-foot mobile vehicle is completely customized for medical care featuring a full service exam space with a blood draw station, bilingual services and internet connectivity for Electronic Medical Record use. The design of the vehicle was intended to be used for wellness exams, but it still has the potential to be used for dental services.

The HealthOne initiative will be piloted with Giorgio Foods Inc. to increase access to care for the company's employees. The vehicle will be rotating through all five Giorgio worksites four days per week. Employees will be able to access the vehicle at the end of work shifts and during lunch hours. Appointments will be scheduled to reduce long wait times, but walk in care for sick-visits will also be available. Having the vehicle be accessible at a variety of times will remove the access barriers that many Giorgio employees experience, such as using time off work, limited physician office hours and long wait times.

The mobile van will be providing access to initial physical exams and preventive screenings for over 1,600 employees. The following services will be offered: Sick Visits, Urgent Care, Wellness Appointments, and Medical (Chronic Care) Appointments. The following screenings will be available to eligible employees:

- Wellness Exam
- Blood Draw and/or "Fingerstick" for Blood Sugar
- Body Mass Index
- Blood Pressure
- Blood Draw for Cholesterol
- Tobacco Utilization

The HealthOne vehicle aims to attend community events to deliver education and care to Berks County residents in need. In the short time frame that the HealthOne vehicle has been operational it was present at the Guts & Glory community event to provide free breast and colon cancer screenings. PSHSJ hopes to work with other partners in the area to remove barriers to preventative health care for all members of the community.

**Objective to Be Achieved**

PSHSJ is aiming to improve access to care to the Berks County community by removing some of the largest obstacles that residents experience such as language/cultural barriers, lack of health insurance coverage, difficulty with navigating the health care system, inability to pay out of pocket expenses and time limitations.

**Community Partners**

Giorgio Foods, Inc.

School Districts

Community Leaders

**Timeframe**

The HealthOne vehicle was launched on September 19, 2016.

**Financial Commitment**

FY'16		FY'17		FY'18	
Expense	Time (hours)	Expense	Time (hours)	Expense	Time (hours)
<b>\$54,414.50</b>	<b>116</b>	<b>TBD</b>	<b>TBD</b>	<b>TBD</b>	<b>TBD</b>

**Measure(s) of Success**

Number of visits–

Visit volume:

FY'16		FY'17		FY'18	
Actual	Budget (Yearly)	Actual	Budget (Yearly)	Actual	Budget (Yearly)
<b>38</b>	<b>3,120</b>	<b>TBD</b>	<b>TBD</b>	<b>TBD</b>	<b>TBD</b>

**\*\*As of October 31<sup>st</sup>, 2016**

**Long-Term Sustainability**

Payments from insurance; opportunities for grant funding and/or donations will continue to be sought

**Key Contacts (Executive Sponsor)**

Chris Chamberlain, RN, Program Coordinator

(Dr. Christopher Newman, VP, Medical Affairs and Chief Medical Officer)



## Priority Objective 1: Access to Care

### Community Health Worker Training Institute

#### **Program Description**

Community Health Workers (CHWs) are trusted members of the community with a gift for helping people prevent or manage disease and other physical or mental health conditions. Studies have shown that CHWs have a positive impact on patients keeping appointments, taking their medications, and reducing risk by improving access to care and assisting individuals with acute or chronic conditions. While some CHWs may have little formal training in medicine or healthcare, they tend to have an intimate knowledge of their communities and local resources. They use that wisdom and passion to help their fellow citizens overcome barriers associated with language, culture, transportation, scheduling and finances.

The Community Health Worker Training Institute at the PSHSJ Downtown Campus Langan Allied Health Academy offers a 100 hour training program designed to provide the core competencies needed for work in community-based and outpatient/inpatient settings. The training also provides comprehensive information about accessing healthcare and other human service resources specific to the particular area where the training takes place. Over 100 CHWs have been trained free of charge to date. PSHSJ has utilized CHWs effectively in several key clinical areas, including: diabetes/chronic disease management; breast cancer/oncology; maternal child health; and primary medical and dental care for the urban underserved.

Through this initiative, we were also instrumental in planning the first ever state-wide Community Health Worker Symposium - which took place May 5-6, 2015 in State College, PA - and continues to advocate for CHWs as an emerging profession in Pennsylvania.

#### **Objective to be Achieved**

To build Community Health Worker capacity in the community, improving health care access, utilization, and coordination.

#### **Community Partners**

Eastcentral PA Area Health Education Center

Literacy Council of Reading/Berks

**Timeframe**

Continue 100 hour training program (begun as a pilot in 2014) through 2018, adapting and tailoring to better meet the needs of the community.

**Financial Commitment**

The Community Health Worker Training Institute is funded through a private benefactor.

<b>Fiscal Year</b>	<b>Budget</b>	<b>Actual</b>
<b>FY2016</b>	\$25,000	To be determined
<b>FY2017</b>	\$25,000	
<b>FY2018</b>	\$25,000	

**Measure(s) of Success**

Number and percentage of students completing the program and receiving certification; number and nature of job or volunteer placements; sustainability of program and positions

**Long-Term Sustainability**

Renewal of current commitment; other grant support; possibility of modest tuition fees

**Key Contacts (Executive Sponsor)**

Laura M. Welliver, Grants & Special Projects Officer

(Mary Hahn, VP, Ambulatory Services and Business Development)

# Priority Objective 1: Access to Care

## Community Education Programming

### Program Description

Penn State Health – St. Joseph is proud to fund and host several different free educational programs both in the community, and at many of our locations. Some of the programs offered include:

- **Oncology Services:** The PSHSJ Cancer Center proudly offers several free support groups for patients who are undergoing cancer treatment.
  - *Strength for the Journey* - A free support group for all cancer patients. The group provides a lifeline to information, support and encouragement from diagnosis through survivorship.
  - *Take C.A.R.E.* – A free 3-session program that teaches survivors how to exercise safely after breast cancer surgery and treatment. All sessions are taught by a certified exercise physiologist, who will monitor the individual participant’s needs and progress.
- **Community Education at Exeter Ridge:** The new PSHSJ primary care site in Exeter Township hosts a variety of workshops and support groups.
  - *Alzheimer’s Association Caregiver Support Groups* – The Delaware Valley chapter of the Alzheimer’s Association offers a free support group for those caring for friends or family members with Alzheimer’s.
  - *Wellness Workshops* – On the second Tuesday of each month, workshops are held at the Exeter Ridge site. Workshops cover a variety of topics, including Medicare updates, meditation practices and crime prevention.
- **Guts and Glory Digestive Wellness Expo:** Penn State Health – St. Joseph annually sponsors “Guts and Glory,” a health and wellness expo presented by My Gut Instinct. The event, which is free to the community, provides a plethora of information and resources about maintaining health and wellness in a vibrant and engaging setting.

### Community Partners

Breast Cancer Support Services of Berks

Alzheimer’s Association, Delaware Valley Chapter

My Gut Instinct

American Cancer Society

**Objective to Be Achieved**

To increase opportunities for free instruction and support in the community, thus empowering patients and the public with important health and wellness information.

**Timeframe**

All of these initiatives are now underway and slated to continue.

**Financial Commitment**

Fiscal Year	Budget	Actual
FY2016	\$10,000	\$10,000
FY2017	\$10,000	
FY2018	\$10,000	

**Measure(s) of Success**

Number of attendees; program evaluation surveys

**Long-Term Sustainability**

Grants and sponsorships; incorporation into ongoing programs.

**Key Contacts (Executive Sponsor)**

Karen Wagner, MSHP, DABR, Director, Oncology Services

Monica Rush, RN, Director, Rehabilitation Services

(Sharon Strohecker, MSN, RN, VP, Clinical Services and Chief Nursing Officer)

## Priority Objective 1: Access to Care

### Breast Cancer Screening for the Underserved

#### Program Description

PSHSJ is committed to expanding breast cancer education, screening, diagnostic, treatment, and support access for un(der)insured urban, Latina, and other underserved women in our community. Reading is a majority Latino city often designated as one of the poorest in the nation. Through this special initiative, conducted in close collaboration with several local organizations, PSHSJ uses a true "promotora" approach to outreach and care coordination. We seek to reach appropriate patients with free clinical breast exams and screening mammograms. Based upon the probability of abnormal findings, we prepare to offer additional diagnostic procedures and enhanced patient navigation. Client and systems impact is tracked by our multidisciplinary breast health team.

#### Objective to Be Achieved

To reduce cultural, linguistic, socioeconomic and other barriers to improve breast health service access and utilization in the target population, serving at least 200 patients annually.

#### Community Partners

American Cancer Society

Breast Cancer Support Services

Centro Hispano Daniel Torres

El Poder del Rosado (Latina Pink Power) Group

La Belleza de Nuestra Salud (Annual Latina Health Conference) Steering Committee

#### Timeframe

Program is currently in place and on-going through FYE 2017

**Financial Commitment**

<b>Fiscal Year</b>	<b>Budget</b>	<b>Actual</b>
<b>FY2016</b>	\$85,000 (Susan G. Komen National) \$90,000 (Susan G. Komen Philadelphia Affiliate)	To be determined
<b>FY2017</b>	Applied to renew Susan G. Komen Philadelphia Affiliate	
<b>FY2018</b>		

**Measure(s) of Success**

Number and needs of patients served  
Timeliness across continuum of care  
Decrease in no-show and lost-to-care rates

**Long-Term Sustainability**

Renewal of current support, other grants and donations; new models of care integration

**Key Contacts (Executive Sponsor)**

Karen Wagner, MSHP, DABR, Director, Oncology Services  
Lisa Spencer, M.Ed., BSRT(T), CN-BI, Breast Care Patient Navigator  
Laura M. Welliver, Grants & Special Projects Officer  
(Sharon Strohecker, MSN, RN, VP, Clinical Services and Chief Nursing Officer)

## Priority Objective 1: Access to Care

### Dental Care for the Underserved

#### Program Description

Addressing lack of access to basic dental health care featured prominently in the 2013 Berks County CHNA, and certainly mirrors other recent reports on the state and national level. A county-wide Oral Health Task Force has since been established, and PSHSJ is an active participant in that process. Still, our unique Dental Services department is really the only local program of its kind, as a full time dental practice with an ability to expand and enhance services for the medical assistance and uninsured patient populations.

As PSHSJ continues to pursue a Patient Centered Medical Home model of care to improve quality, efficiency, and outcomes for all patients served by our well established Downtown Campus clinics, we have had the opportunity to increase community capacity to reach underserved patients of all ages and circumstances. Our longstanding Dental Residency Program is an important part of this process and recently received reaccreditation. Additional interventions will result in at least a 10% increase in patients and visits, thanks to recent grant support for some much needed materials, equipment, and supplies, plus the addition of a new Dental Hygienist position.

#### Objective to Be Achieved

To increase community capacity to reach underserved patients with primary, preventative, and restorative dental care

#### Community Partners

Berks County Oral Health Task Force  
Berks-Schuylkill Dental Hygienists' Association  
Keystone Farmworker Health Program

#### Timeframe

Program currently in place and slated to continue at least through FYE 2017

**Financial Commitment**

<b>Fiscal Year</b>	<b>Budget</b>	<b>Actual</b>
<b>FY2016</b>	\$100,000 (PA Dept. of Health Community Based Health Care Program) \$10,000 (Delta Dental Foundation)	To be determined
<b>FY2017</b>		
<b>FY2018</b>		

**Measure(s) of Success**

Decreased wait times and no show rates  
Increase walk-in and same day appointment availability  
Increase capacity to serve uninsured child and adult patients

**Long-Term Sustainability**

Renewal of current commitments; other grants & donations; in-kind support

**Key Contacts (Executive Sponsor)**

Dr. Christopher Kosenske, Dental Director  
Mary Moyer, Director, Downtown Campus  
(Dr. Christopher Newman, VP, Medical Affairs and Chief Medical Officer)



# Priority Objective 2: Obesity

## Introduction

When the Berks Community Health Needs Assessment results were shared publicly on April 7, 2016 at the County Healthcare Summit, obesity (along with behavioral/mental health) was selected as the key concern of all four priorities identified. Therefore, it is imperative that obesity continues to be viewed as a community-wide concern, well beyond the walls of PSHSJ. To be successful at making improvements, many organizations across the county will need to be involved. Discussions of a new task force and/or community partnership that will focus its efforts on reducing obesity are underway. Those efforts are not yet reflected in this implementation plan, but will be a strong consideration as we focus on the health needs surrounding obesity. The two objectives shared in this section reflect tangible work that is already structured and moving forward.

## Primary Objective 2: Obesity

### KidFit Children's Metabolic Clinic

#### **Program Description**

The Reading Elks Pediatric Clinic at the Downtown Campus offers a "KidFit" Metabolic Clinic for children ages 7-13. Children who are overweight or obese are enrolled in the program, and are seen with their parents in a group setting twice a month. At each session, children and parents receive education about positive behavior modification, healthy eating habits and exercise. In addition, a provider sees children one-on-one during group sessions to assess their individual health needs. A bilingual community health worker is present for the both the education and provider visit portions of the session to accommodate Spanish-speaking patients. Through interactive games and activities, information is presented in a way that both parents and children will enjoy.

#### **Objective to be Achieved**

Enroll children with Body Mass Index (BMI)  $\geq$  85th percentile, and provide them, as well as their parents, with education about maintaining a healthy lifestyle, proper nutrition and finding fun ways to exercise.

#### **Community Partner**

Reading Elks Lodge #115

Penn State University – Berks Campus

#### **Timeframe**

Group visits began in 2016. The group meets every other Thursday of each month for a total of six sessions. Children will continue to be recruited for group visits from the pediatric practice at the Downtown Campus.

**Financial Commitment**

<b>Fiscal Year</b>	<b>Budget</b>	<b>Actual</b>
<b>FY2016</b>	\$10,000	To be determined
<b>FY2017</b>	\$10,000	
<b>FY2018</b>	\$10,000	

**Measure(s) of Success**

A specific measure of success is still being developed for participants in the KidFit program, as group visits began recently in the spring of 2016. However, both weight and BMI are recorded for each participant at every visit, so the means to track each group's progress and success is readily available.

**Long-Term Sustainability**

The KidFit program is especially relevant at a time when concern grows over the local and national problem of childhood obesity. The program continues to thrive and evolve through the support and partnership with the Reading Elks.

**Key Contacts (Executive Sponsor)**

Elizabeth Hawk, RDN, CDE, Diabetes Management Services

Frieda Fisher, CRNP, Downtown Pediatric Practice

Kathy Henry, RN, Outpatient Diabetes Navigator

(Mary Hahn, VP, Ambulatory Services and Business Development)

## Priority Objective 2: Obesity

### Be Bold, Take Charge

#### Program Description

Penn State Health – St. Joseph has partnered with Penn State Berks to launch a collaborative and multifaceted social entrepreneurship initiative. Be Bold, Take Charge is an effort designed to improve health outcomes in the city of Reading through improved access to nutritious food, education about how to live healthfully, as well as promotion of physical activity. The project encompasses five main strategic areas including changing perspectives, education, reducing crime, economic development and building a grassroots movement. Many specific efforts are currently in development, including the launch of a bilingual cooking show, a website with educational material about health resources in the community and a physician-authored blog about the impressive capabilities of the human body.

Further, Penn State Berks will be occupying space in the Langan Allied Health Academy, located on the lower level of our Downtown Campus. Maintaining a presence in this space will ensure that the efforts of this initiative are located within the community that is being served to increase accessibility.

The influence of nutrition on the human body is profound, and our goal for this particular collaboration is to create positive change within the health of this community through improvement of access to this particular basic need.

#### Objective to Be Achieved

To improve overall health outcomes in the city of Reading through improving access to nutritious foods and promoting increased physical activity.

#### Community Partner

Penn State University – Berks Campus, St. Peter’s Roman Catholic Church

#### Timeframe

Thorough research and careful implementation are both necessary for this endeavor to succeed; therefore, it is expected that efforts related to this initiative will span the next several years.

**Financial Commitment**

As part of a new collaboration with Penn State University Berks Campus, Penn State Health St. Joseph has offered complimentary space in the Langan Allied Health Academy at our Downtown Campus to the University for use on various endeavors related to social entrepreneurship, including Be Bold, Take Charge. Further, select PSHSJ employees have dedicated their time to this project; the estimated value of that time spent thus far can be found in the table below:

<b>Fiscal Year</b>	<b>Budget</b>	<b>Actual</b>
<b>FY2016</b>	\$5,000	To be determined
<b>FY2017</b>	\$5,000	
<b>FY2018</b>	\$5,000	

**Measure(s) of Success**

Gradual reduction in BMI for a random sample of 300 patients from the PSHSJ Downtown Campus who reside in the city of Reading.

**Long-Term Sustainability**

Sustainability of this project over the next several years will be made possible in part through PSU Berks's receipt of a \$50,000 SEED grant to fund social entrepreneurial endeavors within the community. Further opportunities for funding will continue to be sought.

**Key Contacts (Executive Sponsor)**

Jim Shankweiler, Lecturer in Business, Penn State Berks

Lisa Weaver, Community Development Specialist, AmeriCorps VISTA

Kimberly Wolf, DO, Director of Quality Initiatives, St. Joseph Medical Group

(Mary Hahn, VP, Ambulatory Services and Business Development)

# Priority Objective 3: Chronic Conditions

## Introduction

With access to care barriers remaining so prominent in the Community Health Needs Assessment for Berks County, it may not be surprising that the effective management of chronic health conditions is also a significant challenge. Disease specific efforts and new group models of care must be continued, along with systems improvements all along the continuum of care. Enhanced patient navigation and the use of a “promotora” or community health worker approach has shown to be particularly effective in our urban and rural communities. The areas highlighted in this section reflect a desire and intention to build upon such successes and to address emerging issues.

## Priority Objective 3: Chronic Conditions

### Diabetes Wellness

#### Program Description

Since its inception in 2013, Diabetes Wellness has become a valuable part of the Family Practice clinic at the Downtown Campus. The program revolves around two main components that have been designed to improve access to diabetes care for St. Joe's patients at the Downtown Family Practice:

1. A Diabetes nurse navigator and community health worker provide culturally sensitive care coordination, referral to appropriate specialists and aid in removal of barriers to care for all diabetic patients who are seen on the 2<sup>nd</sup> floor Family Practice at the Downtown Campus.
2. Group sessions are held continuously in both English and Spanish for patients who wish to receive additional education about how to manage their diabetes. In addition, patients attending group sessions are able to see a provider one-on-one to address any needs at that time.

In addition to the above two components, the program leads have developed new ways to increase the scope of the program. Namely, the nurse navigator and community health worker have expanded their work to patients seen at the Residency clinic on the first floor of the Downtown campus, and have also recruited some of these patients for group sessions. In addition, expanding availability of group sessions to community members outside of the PSHSJ network is underway, further increasing access to appropriate diabetes care in the city of Reading.

#### Objective to be Achieved

The overarching goal of Diabetes Wellness is to provide culturally-sensitive care to patients with type II diabetes, and to promote self-management of diabetes through education about proper nutrition, exercise and health maintenance.

#### Community Partners

Since Diabetes Wellness has been effectively integrated into the delivery of primary care at the Downtown Campus, we will continue to explore ways in which we can expand services to community partners such as the YMCA of downtown Reading.

**Timeframe**

English-speaking and Spanish-speaking groups each meet bi-weekly and run concurrently for six sessions over the course of twelve weeks. Expansion of the program to Residency clinic patients began in FY2016, and extending group visits to patients outside the PSHSJ network is scheduled to begin by the end of FY2017.

**Financial Commitment**

Fiscal Year	Budget	Actual
FY2016	\$50,000	To be determined
FY2017	\$50,000	
FY2018	\$50,000	

**Measure of Success**

10% reduction in Hemoglobin A1c  $\geq 8$  for registered patients with type II diabetes at the Downtown Campus.

**Long-Term Sustainability**

Care for diabetes and other chronic conditions was again highlighted as paramount in the 2016 Community Health Needs Assessment. The Diabetes Wellness services at the PSHSJ Downtown Campus help to provide that care. Since the program's initial rollout in 2013, it has become well-integrated into the delivery of care at this campus.

**Key Contacts (Executive Sponsor)**

Patty Gaul, RN, Director of Ambulatory Clinical Services

Kathy Henry, RN, Diabetes Nurse Navigator

Elizabeth Hawk, MS, RDN, CDE, Diabetes Management Services

(Mary Hahn, VP, Ambulatory Services and Business Development)



## Priority Objective 3: Chronic Conditions

### Enhanced Patient Navigation

#### **Program Description**

Patient navigation has become an important PSHSJ priority along the continuum of care in various clinical areas. Expanding navigation support for chronic disease patients in particular is a key focus as we move further into a multidisciplinary team approach to care, expanding navigation support for chronic disease patients. From Nurse Navigators to Community Health Workers, the role of breaking down barriers while educating, empowering, connecting, and reconnecting patients and their families holds great promise for those struggling with a potentially lifelong or life-threatening illness. PSHSJ will build upon patient navigation successes in areas such as diabetes, breast cancer, primary and prenatal care to guide these efforts.

#### **Objective to Be Achieved**

To offer appropriate patient navigation support in key areas, resulting in improved chronic disease management and treatment outcomes.

#### **Community Partners**

Reading School District

American Association of

Diabetes Educators

American Cancer Society

Mary's Shelter

Centering Healthcare Institute

#### **Timeframe**

Ongoing

**Financial Commitment**

<b>Fiscal Year</b>	<b>Budget</b>	<b>Actual</b>
<b>FY2016</b>	\$600,000	To be determined
<b>FY2017</b>	\$600,000	
<b>FY2018</b>	\$600,000	

**Measure(s) of Success**

Increase in patients keeping appointments, medication and other treatment plan compliance, and satisfaction rates

Decrease in hospital admissions or readmissions

**Long-Term Sustainability**

Though new navigation efforts are often grant funded, incorporation of such functions into operations should be possible given CQI and ROI.

**Key Contacts (Executive Sponsor)**

Patty Gaul, RN, Director of Ambulatory Clinical Services

Karen Wagner, MSHP, DABR, Director, Oncology Services

(Sharon Strohecker, MSN, RN, VP, Clinical Services and Chief Nursing Officer)

## Priority Objective 3: Chronic Conditions

### Infectious Disease Services

#### **Program Description**

With the recent addition of Dr. Georgina Nasr to the medical staff, PSHSJ is reestablishing the prior Downtown Campus HIV clinic program. Centrally located in our “one-stop” community health center, the clinic offers a full range of high-quality services in a single location to people at risk for or living with HIV/AIDS. This ensures both greater convenience and confidentiality. Our providers, led by Dr. Nasr, deliver anti-HIV virus therapy and preventive care, as well as primary care services. They offer the most up-to-date comprehensive medical care available in aiming to help patients live longer, healthier lives. In addition, PSHSJ clinicians can help HIV/AIDS patients gain access to clinical trials - studies of new medications and treatments - giving them access to promising therapies. And, with other complex public health issues of concern here in recent years, including Ebola and Zika, PSHSJ will continue to assess service gaps and stands ready to respond to emerging needs in our community.

#### **Objective to Be Achieved**

To expand access to quality infectious disease care for the underserved in our community through integration of enhanced services at the PSHSJ Downtown Campus.

#### **Community Partners**

Co-County Wellness Services

Keystone Farmworker Health Program

#### **Timeframe**

Services will be in place by late 2016

**Financial Commitment**

<b>Fiscal Year</b>	<b>Budget</b>	<b>Actual</b>
<b>FY2016</b>	Not Applicable	Not Applicable
<b>FY2017</b>	To Be Determined	
<b>FY2018</b>	To Be Determined	

**Measure(s) of Success**

Number and nature of cases; clinical outcomes

**Long-Term Sustainability**

Grants and contracts; primary care integration; insurance reimbursements; reduced hospital admission and readmission rates

**Key Contacts (Executive Sponsor)**

Dr. Georgina Nasr, St. Joseph Medical Group

Mary Moyer, Director, Downtown Campus

(Dr. Christopher Newman, VP of Medical Affairs and Chief Medical Officer)

## Priority Objective 4: Behavioral & Mental Health

### **Introduction**

When behavioral/mental health (along with obesity) was again selected as the key concern of all four main priorities when the Berks Community Health Needs Assessment results were shared publicly on April 7, 2016 at the County Healthcare Summit, the magnitude and complexity of the problem had already become increasingly clear to PSHSJ. We strongly support the development of a special county wide effort to address this burgeoning crisis. All local health and human service providers, advocacy organizations, and other multi-sector stakeholders much be involved if significant progress is to be made and sustained. Meantime, PSHSJ will continue several relevant partnership projects, including the following.

## Priority Objective 4: Behavioral & Mental Health

### Reading Youth Violence Prevention Program

#### Program Description

What became the Reading Youth Violence Prevention Project (RYVP) first began in 2009-10 with a SJMC Foundation planning grant application to the Catholic Health Initiatives (CHI) Mission & Ministry Fund. St. Joe's was one of the first hospitals to undertake such an effort, helping launch what is now the ambitious CHI system-wide *United Against Violence* advocacy initiative.

RYVP took shape through an authentic community planning and coalition building process that continued for nearly two years, engaging over 150 key organizational stakeholders in creating what became the comprehensive "*Blueprint for Action*" Reading Impact Plan. A major challenge was keeping the focus on policy, practice and systems change, rather than traditional projects and programs. We worked closely with Prevention Institute, of Oakland, CA during this initial phase.

St. Joe's now coordinates RYVP as an ever evolving multi-sector collaboration with the help of a now ad-hoc stakeholder Steering Committee. In 2014-15 we completed a third year of full implementation, and a fifth year of active partnership in the growing United Against Violence network. The majority of funds received by St. Joe's have been strategically reinvested back into the community to increase youth empowerment and resiliency. We are pleased to reflect on the work of over a dozen RYVP "Impact Initiatives" totaling nearly \$250K, with literally thousands of city youth and caring adults involved. Among many notable efforts are our sub grants to:

- (1) The student-led "Project Peace" group (formed in the aftermath of a series of shootings in 2010) to ensure its further expansion to all six secondary schools in the Reading School District.
- (2) The Reading Recreation Commission and partners for the Young Women's Leadership Program – which won a state-wide award for excellence in youth programming from the Pennsylvania Parks and Recreation Society in 2014, and has since expanded to several school and community sites.

As we embark upon the on-going implementation phase of RYVP with a transitioning CHI relationship (given SJRHN's recent move to the new Penn State Health network), we look forward to re-engaging internal and external stakeholders, developing a new home base or communications hub for the broader coalition and key constituencies, and "anchoring" those pieces ready for sustainability by other community partners.

-Continued on Next Page-

**Program Description (Continued)**

Based on lessons learned thus far, we hope to focus RYVP efforts more specifically on pre to early teen age youth with plans for at least one “universal” city-wide project or strategy and emphasis on the most promising prevention programs as well as boys’/girls’ leadership and service learning type initiatives. We’ll also pursue emerging opportunities to “bridge” RYVP – literally, across the river/railroad – encouraging greater interaction between city & county youth and piloting at least one collaborative effort or group.

**Objective to Be Achieved**

To support best practice efforts that help prevent and reduce youth on youth violence and related risk factors in the City of Reading and beyond.

**Community Partners**

Numerous – see RYVP Blueprint for Action (<http://www.thefutureofhealthcare.org/assets/reading-youth-violence-prevention-project.pdf>)

**Timeframe**

Began as a planning then pilot project in 2010. Now in the ongoing implementation and sustainability phase through 2018.

**Financial Commitment**

Catholic Health Initiatives

Fiscal Year	Budget	Actual
FY2016	\$20,000	\$19,000
FY2017	\$20,000	
FY2018	\$20,000	

**Measure(s) of Success**

Comparison to previously set baseline and destination metrics – see RYVP Blueprint for Action

Outcomes from RYVP Impact Initiatives – five year report forthcoming

**Long-Term Sustainability**

RYVP and the “Blueprint for Action” have also been leveraged effectively to help local agencies and organizations secure nearly three million dollars in new and renewal funds for related initiatives to date.

**Key Contacts (Executive Sponsor)**

Laura M. Welliver, Grants & Special Projects Officer

(Mary Hahn, VP, Ambulatory Services and Business Development)



## Priority Objective 4: Behavioral & Mental Health

### Youth Mental Health First Aid Training

#### **Program Description**

The Mental Health First Aid model is a best practice approach aimed at empowering laypersons and professionals to handle known or suspected crisis situations. It has several program variations for particular audiences and applications, all of which we hope to eventually make more readily available in Reading & Berks County.

Youth Mental Health First Aid is an 8-hour certification course that introduces participants to the unique risk factors and warning signs of mental health problems in adolescents, and helps build an understanding of the importance of early intervention. The program teaches how to help an adolescent who is in crisis or experiencing a potential mental health or substance use challenge.

The course teaches participants the risk factors and warning signs of a variety of mental health challenges common among adolescents, including anxiety, depression, psychosis, eating disorders, AD/HD, disruptive behavior disorders, and substance use disorder. Participants do not learn to diagnose, nor how to provide any therapy or counseling – rather, they learn a core five-step action plan to support an adolescent developing signs and symptoms of mental illness or in an emotional crisis.

Youth Mental Health First Aid uses role-playing and simulations to demonstrate how to assess a mental health crisis, select interventions, provide initial help, and connect young people to professional, peer, and self-help care. Youth Mental Health First Aid is listed in SAMHSA's National Registry of Evidenced Based Programs and Practices and is approved as one of the curriculums that meet the professional development requirement of Act 71. Professionals and educators may thus be eligible for CEU's.

#### **Objective to be Achieved**

To build community capacity to proactively recognize and appropriately intervene in various crisis scenarios.

**Community Partners**

AmeriCorps VISTA

Eastcentral Pennsylvania Area Health Education Center (ECPAHEC)

Literacy Council of Reading-Berks (LCRB)

**Timeframe**

This program was initially piloted (and remains) as part of PSHSJ's Community Health Worker (CHW) Training Institute since 2014, but is now also available to professionals and the public as a free or low cost stand-alone training.

**Financial Commitment**

BCCF Community General Hospital Fund - \$6K for public sessions and training of trainers through 2016

<b>Fiscal Year</b>	<b>Budget</b>	<b>Actual</b>
<b>FY2016</b>	\$6,000	To be determined
<b>FY2017</b>		
<b>FY2018</b>		

**Measure(s) of Success**

Number of trainers, professionals, and laypeople trained.

Interest in and demand for YMHFA and other model variations.

Level of acceptance and integration of the mental health first aid model into local policies, practices, systems, and organizations.

**Long-Term Sustainability**

Continued integration into other training programs, such as CHW; additional grants and partnerships; modest registration fees

**Key Contacts (Executive Sponsor)**

Laura M. Welliver, Grants & Special Projects Officer

Debra Youngfelt, B.S., MCHES, CTTS, Health Educator/Planner, ECPAHEC

Cathy Martin, Instructor/Coordinator, LCRB

(Mary Hahn, VP, Ambulatory Services and Business Development)

## Priority Objective 4: Behavioral & Mental Health

### Primary Care & Behavioral Health Integration

#### Program Description

Penn State Health St. Joseph is coordinating and co-locating with Berks Counseling Center ('BCC'), a state designated Community Mental Health Center, for the integration of primary care and behavioral health in a medical home model of care.

#### Objective to be Achieved

PSHSJ will also work closely with BCC to ensure effective outreach and recruitment, information, training, and referral, care coordination, health promotion and prevention programming, chronic disease management and to address other emerging needs.

#### Community Partner

Berks Counseling Center

#### Timeframe

Tentative start – January 2017

#### Financial Commitment

Fiscal Year	Budget	Actual
FY2016	Not Applicable	Not Applicable
FY2017	To Be Determined	
FY2018		

#### Measure(s) of Success

Number and nature of needs addressed for shared patient population.

**Long-Term Sustainability**

Pending new payment models integrating primary care and behavioral health services and billable services options for care management.

**Key Contacts (Executive Sponsor)**

Mary Moyer, Director, Downtown Campus

(Mary Hahn, Vice President, Ambulatory Services and Business Development)

# Summary and Board Approval

## Summary

Penn State Health St. Joseph (PSHSJ) continues to add value and improve community health needs through its programs focusing on care for the underserved. Aligning the results from the Community Health Needs Assessment with prioritized health concerns in Berks County, our organization has identified key initiatives that work toward addressing these needs through this implementation plan. PSHSJ continues our efforts with community partners who are also sensitive to the cultural and linguistic barriers associated with providing care to the underserved in order to pool limited resources and make an impact in the community. By identifying four objectives focusing on access to care, obesity, chronic conditions and behavioral and mental health, PSHSJ is able to execute tangible programs that will make a difference. We look forward to continued efforts of improving the health of Berks County.

## Board Approval

The St. Joseph Regional Health Network Board of Directors (the local governing body of Penn State Health St. Joseph) has been informed of the Community Health Needs Assessment process and requirements. The Board understands its commitment to this federal mandate through the Patient Protection and Affordable Care Act, as tax-exempt hospitals must perform this assessment once every three years. A publically available report must include a needs assessment, as well as an implementation strategy. The assessment and implementation plan need to be reported on the organization's IRS Form 990 (for FY16). Non-compliance may result in the organization facing a \$50,000 fine per hospital per year, including a potential revocation of tax-exempt status. Both the assessment and implementation plan are available on the organization's website: [www.thefutureofhealthcare.org](http://www.thefutureofhealthcare.org).

St. Joseph Regional Health Network Board of Directors Approval: October 26<sup>th</sup>, 2016