

Health Care Council of the Lehigh Valley
Action Plan for Allentown Community Benefit Service Area*
2013-2016

GOAL – Focus on the Allentown Community Benefit Service Area, improve the mortality and morbidity rates for the leading causes of death and illness in the Lehigh Valley while lowering health care costs and improving patient experience.

Leading Causes of Death and Illness in the Lehigh Valley

- 1) Heart Disease
- 2) Cancer
- 3) Stroke
- 4) Lung Disease
- 5) Injury/Violence
- 6) Complications Related to Diabetes

PRIORITY AREAS

- 1) Improve Access to Care
- 2) Enhance the Collection and Dissemination of Health Information
- 3) Address Social Determinants of Health and Health Disparities
- 4) Promote Healthy Lifestyles and Behaviors

STRATEGIES

- 1) Improve Access to Care
 - a) Physical Health (including primary care and post-acute care)
 - i) Increase access to wellness, preventive, screening and testing services
 - ii) Improve chronic disease management
 - iii) Reduce the need for more intrusive, costlier health care
 - iv) Coordinate fragmented intra- and inter-hospital primary care efforts
 - v) Provide accessible, easy to follow information so community members can access physical health care that meet their cultural and medical needs and are accessible during appropriate times
 - b) Mental/Behavioral Health
 - i) Integrate behavioral health support into physical health care that
 - (1) Promotes positive mental health
 - (2) Prevents mental health-related problems from occurring
 - (3) Provides good physical health care for patients experiencing mental health problems
 - (a) Includes links and referrals to appropriate mental/behavioral health services
 - (4) Incorporates approaches that promote recovery for people who have experienced mental health problems
 - c) Oral Health
 - i) Promote good oral health and its connection with good physical health
 - ii) Increase access to preventive and restorative dental services

- 2) Enhance the Collection and Dissemination of Health Information
 - a) Collection of health data needed for improved population management
 - i) Capture health care utilization data at a more granular (neighborhood) level
 - ii) Collect health risk factors at a more granular level
 - iii) Use Community Based Participatory Research (CBPR) and other qualitative research techniques to collect important health related information
 - b) Dissemination of health data needed for improved population management
 - i) Utilize shared data platforms to share data with other stakeholders
 - ii) Continue to develop methods to improve health education at the community level
 - iii) Use CBPR and other community engagement strategies to disseminate useful health information
 - iv) Improve health literacy

- 3) Address Social Determinants of Health and Health Disparities
 - a) Promote Healthy Neighborhoods in Community Benefits Service Areas
 - b) Enhance stakeholder partnerships to identify health-related needs, services and support
 - c) Continue to develop effective community engagement models that help identify:
 - i) Factors that contribute to health
 - ii) Approaches to effectively address disparities
 - d) Demonstrably apply strategies learned from Enhancing Health Information

- 4) Promote Healthy Lifestyles and Behaviors
 - a) Support Local Public Health Departments' efforts to:
 - i) Reduce tobacco use
 - ii) Increase access to healthy foods
 - iii) Increase physical activities
 - iv) Reduce excessive alcohol and other drug use
 - b) Integrate healthy lifestyle efforts into physical health clinical setting
 - c) Create community-based health leadership and shared responsibility to improve health

ACTION STEPS FOR 2013-14

PRIORITY AREA #1 – IMPROVE ACCESS TO CARE

1 a – Access to Care – Physical Health

- (1) Continue to make primary care and post-acute care available through
 - a) School-based health centers
 - b) Telehealth services
 - c) Parish Nursing
 - d) Health Networks' primary care community health facilities
 - e) Mobile medical units
- (2) Support and assist the newly formed federally qualified health centers at Neighborhood Health Centers of the Lehigh Valley (NHCLV)
 - a) Include NHCLV as Health Care Council (HCC) member
 - b) Assist with improving capacity
- (3) Continue and expand efforts that remove barriers to care, including
 - a) Assistance with Medicaid applications
 - b) Assistance with transportation to and from care
 - c) Interpreter services

- d) Flexible office hours
- (4) Under the oversight of the Health Care Council, analyze and coordinate physical health services among HCC members and NHCLV to maximize the availability and access to primary care in the Community Benefit Service Area
 - a) Use all efficiencies saved through coordination to expand and enhance primary care services
 - b) Use information gained from analysis to advocate for further expansion of primary care services
 - c) Include community representation to enhance, confirm and/or dispute efforts to expand and improve access to primary care
- (5) Continue to encourage and train health professionals to enhance listening and patient engagement skills
- (6) Engage consortiums similar to the Partnership for a Disability Friendly Community to learn more about and become better at addressing health care for people with disabilities
- (7) Use community-based health professionals (community health workers, promotoras, community based patient navigators, visiting nurses, home health professionals) to assist community members with accessing and navigating primary health care

1 b – Access to Care – Mental/Behavioral Health

- (1) Continue to promote mental health awareness
- (2) Develop a comprehensive inventory of behavioral health resources in the Lehigh Valley
- (3) Engage key Lehigh Valley players (including primary care and specialty medical providers, county and state administrators, legislators, payers, people living with mental illness and other essential partners)
- (4) Review successful national and state models of primary care approaches for
 - a) front line depression and addictions screenings
 - b) promoting positive mental health
 - c) preventing mental health problems from occurring
 - d) incorporating/expanding a recovery model of mental health treatment
- (5) Assess workforce development needs
- (6) Develop a comprehensive plan for next steps
- (7) Implement plan

1 c – Access to Care – Oral Health

- (1) Continue to make oral health services available through
 - a) School based sealant programs
 - b) Dental vans
 - c) Clinics
- (2) Support and assist the newly formed federally qualified health centers at NHCLV as they develop and expand oral health services
- (3) Under the oversight of the Health Care Council, analyze and coordinate oral health services among HCC members and NHCLV to maximize the availability and access to oral health care in the Community Benefit Service Area

PRIORITY AREA #2 – ENHANCE THE COLLECTION AND DISSEMINATION OF HEALTH INFORMATION

2 a – Health Information – Collection of Health Data Needed for Improve Population Health Management

- (1) Under the oversight of the Health Care Council, expand the quality and quantity of data available for coordinated health care planning
 - a) Create and implement a data-sharing agreement document for Health Care Council organizations
 - b) Coordinate shared hospital registry data for
 - (1) Cancer
 - (2) Stroke
 - (3) Diabetes
 - (4) Trauma
 - c) Use “hotspotting” techniques to identify clusters of
 - i) Disease/illness concentration
 - ii) ‘Super-utilizers’ of health care services
 - d) Analyze data on disparities by race, gender, age and geography
 - e) Conduct a behavioral risk factor assessment of the Community Benefit Service Area, with an emphasis on adolescent health
 - f) Continue to use Community-Based Participatory Research techniques to collect important qualitative data regarding health
 - g) Follow up on 2009 and 2011 Public Opinion Survey work

2 b – Health Information – Dissemination of Health Data Needed for Improved Population Health Management

- (1) Ensure that data collected in 2a is available to clinical departments within HCC institutions, as well as residents of the Community Benefits Service Area
- (2) Address health literacy deficiencies through
 - a) Adaptations in clinical settings (e.g., interpreter services, easy to read written information, “talkback” training for clinicians)
 - b) Health literacy improvement trainings
- (3) Increase the number of trained Community Health Workers with an active presence in the Community Benefits Service Area
- (4) Use Community Health Workers to disseminate important data and conduct regular community-based trainings/classes on topics such as nutrition, cooking, exercise, etc.
- (5) Provide on-line support services and health information
- (6) Improve coordination of data base platforms used by health care organizations (CIM, Community Platform, CHNA.org)
- (7) Continue to participate in Community Dialogues
- (8) Continue to use CBPR techniques to disseminate important data regarding health

PRIORITY AREA #3 – ADDRESS SOCIAL DETERMINANTS OF HEALTH AND HEALTH DISPARITIES

3 a – Social Determinants/Health Disparities – Healthy Neighborhoods

- (1) Continue community health programs that address
 - a) Heart disease
 - b) Cancer
 - c) Stroke
 - d) Lung Disease
 - e) Injury/Violence
 - f) Diabetes

- (2) Actively participate in Neighborhood/Community Groups negatively impacted by health disparities – Allentown Promise Neighborhood, Partnership for a Disability Friendly Community and Jordan Heights
- (3) Use Community Health Workers, Nurse Family Partnerships and other community outreach professionals in neighborhoods negatively impacted by health disparities
- (4) Teach health related classes, workshops and trainings identified by community members to improve the overall health of the neighborhood/community
- (5) Conduct neighborhood level health assessments in areas negatively impacted by health disparities
- (6) Incorporate concepts like Healthy Homes and home visitation programs to address health disparities such as pediatric asthma and early childhood development
- (7) Use health utilization data from Priority Area #2 to identify new communities with clusters of illnesses

3 b – Social Determinants/Health Disparities – Stakeholder Partnerships

- (1) Continue to develop and expand stakeholder partnerships with
 - a) Health Care Council of the Lehigh Valley
 - i) Develop a universal charity care application form
 - ii) Formalize the structure and governance of the HCC
 - iii) Establish a data sharing agreement
 - b) Allentown School District
 - i) School-based health care services
 - ii) Childhood obesity
 - iii) Maternal-Child programs (including teen pregnancy and early childhood development)
 - iv) Community School model
 - c) Municipal and County Government, including public health and human services
 - i) Maternal-Child programs
 - ii) Behavioral Health
 - iii) Exercise (walking/bike trails, parks)
 - iv) Lifestyles and behaviors (see Priority Area #4a)
 - d) Non-profit organizations
 - i) Community School model
 - e) Faith-based organizations
 - i) Community Engagement
 - ii) Lifestyle and Behaviors
 - f) Local businesses
 - i) Community Engagement
 - ii) Lifestyle and Behaviors
 - g) Funders
- (2) Engage community groups, school districts, elected officials in discussions through forums like “Friends of St. Luke’s Allentown”

3 c – Social Determinants/Health Disparities – Community Engagement

- (1) Continue to develop Community-Based Participatory Research capacity
- (2) Continue and expand Community Dialogues in Allentown, including dialogues about racial and ethnic disparities
- (3) Train community health workers and other community-based health professionals in community engagement practices

- (4) Connect community engagement strategies with community-based health leadership efforts described in 4c

3 d – Social Determinants/Health Disparities – New Strategies

- Demonstrate how new information identified in Priority Area #2 is leading to new efforts, strategies and partnerships

PRIORITY AREA #4 – PROMOTE HEALTHY LIFESTYLES AND BEHAVIORS

4 a – Promote Healthy Lifestyles and Behaviors – Support Local Public Health Department efforts

- (1) Invite Public Health representatives to join the Health Care Council
- (2) Support community based activities that reach residents in a more accessible manner with less transportation and financial barriers (e.g., vaccinations, STD services, healthy eating, etc.)
- (3) Include Residents and Interns in Allentown Health Bureau initiatives
- (4) Coordinate and expand pre-natal, health baby and maternal child services

4 b – Promote Healthy Lifestyles and Behaviors – Integrate healthy lifestyle efforts into physical health clinical setting

- (1) Link community health workers and other community based health professionals with primary care practices
- (2) Integrate home accessibility and injury prevention recommendations, especially for elderly and post-acute care patients
- (3) Develop support teams, like Community Care Teams, to provide important links and resources for patients
- (4) Offer dietary and nutritional consultations for patients with weight issues that impact health
- (5) Offer cessation support for patients trying to quit using tobacco products
- (6) Continue efforts to integrate behavioral health services into health care settings

4 c – Promote Healthy Lifestyles and Behaviors – Create community-based health leadership and shared responsibility to improve health

- (1) Continue to support and expand Community Leadership Training like those offered in the Stanford Chronic Disease Management model and Citizen Health Care Project
- (2) Develop Advisory Councils and other forums to bring community issues “to the table”
- (3) Continue and expand Youth Engagement/Development strategies like:
 - a) Career mentoring
 - b) School-to-Work programs
 - c) Health career exploration
- (4) Support strategies like Community Exchange that encourage residents to have support systems and friendships

* Goals, Priority Areas, Strategies and Action Steps have been developed based on information from:

- *The Road to Health: Community Health Profile 2012*
- *Lehigh Valley Community Health Forums (November-December 2012) Report of Findings*
- *Summary and Findings of the Social Reconnaissance 2012*
- *St. Luke’s Community Health Needs Study Survey Findings December 2011*
- *Allentown Community Health Partnership Allentown Community Health Opinion Survey October 2010*
- *The Triple Aim: Care, Health and Cost; Berwick D., Nolan T, Whittington J, Health Affairs: May 2008*