

April 2019



# A FIVE-COUNTY REGIONAL COMMUNITY HEALTH NEEDS ASSESSTMENT IMPLEMENTATION STRATEGY

Cumberland, Dauphin, Lebanon, Perry, and York Counties

## UPMC Pinnacle



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## COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)

### Introduction

The Patient Protection and Affordable Care Act (PPACA), which went into effect on March 23, 2010, requires tax-exempt hospitals to conduct community health needs assessments (CHNA) and implementation strategies in order to improve the health and well-being of residents within the communities served by the hospitals.

The CHNA process undertaken by UPMC Pinnacle, with project management and consultation by Tripp Umbach, included input from representatives who represent the broad interests of the community served by the hospital facilities, including those with special knowledge of public health issues, data related to underserved, hard-to-reach, vulnerable populations, and representatives of vulnerable populations served by each hospital. Tripp Umbach worked closely with members of UPMC Pinnacle to oversee and accomplish the assessment and its goals. This report fulfills the requirements of the Internal Revenue Code 501(r)(3), established within the Patient Protection and Affordable Care Act (PPACA) requiring that nonprofit hospitals conduct CHNAs every three years.

Data from government and social agencies provides a strong framework and a comprehensive piece to the overall CHNA. The information collected is a snapshot of the health of residents in central Pennsylvania, which encompassed socioeconomic information, health statistics, demographics, children's health, and mental health issues, etc. The CHNA report is a summary of primary and secondary data collected for UPMC Pinnacle hospitals.

## Community Partnerships

The Pennsylvania Psychiatric Institute (PPI), UPMC Pinnacle, UPMC Pinnacle Carlisle, Community Osteopathic, Harrisburg, and West Shore hospitals worked closely to develop an implementation strategy plan to address the needs identified by the community in the CHNA in a sustainable and accessible manner in order to better serve the needs of the five-county region of Pennsylvania.

UPMC Pinnacle, UPMC Pinnacle Carlisle, and PPI worked closely to identify gaps in services to address access to care, behavioral health, and social determinants of health. The working group worked to identify ways to expand the health care outreach to rural and homebound populations within the five-county geography. Functioning collectively as a team, the group also focused to improve behavioral health illnesses by providing access to quality mental health and substance use disorder programs and education to address the individual. It was also important to the working group to increase the knowledge and opportunities of residents to attain and improve lifestyle choices within the UPMC Pinnacle rural communities and underserved populations.

### The Pennsylvania Psychiatric Institute (PPI)

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

## UPMC Pinnacle

UPMC Pinnacle is a not-for-profit health care system dedicated to providing and improving the health and quality of life for the people of central Pennsylvania since 1873. A proven leader in medical innovation, UPMC Pinnacle offers a wide range of services from primary care to complex surgeries. The health care network includes seven campuses as well as medical services such as family practice, imaging, outpatient surgery, and oncology at multiple locations throughout the region.

UPMC Pinnacle is a nationally recognized leader in providing high-quality, patient-centered health care services in central Pennsylvania and surrounding rural communities. Its medical staff of more than 2,900 physicians and allied health professionals and approximately 11,000 employees serve a 10-county area at outpatient facilities and seven acute care hospitals with 1,161 licensed beds: Carlisle, Community Osteopathic, Hanover, Harrisburg, Lititz, Memorial, and West Shore. The not-for-profit system anticipates caring for more than 1.2 million area residents in CY 2019.

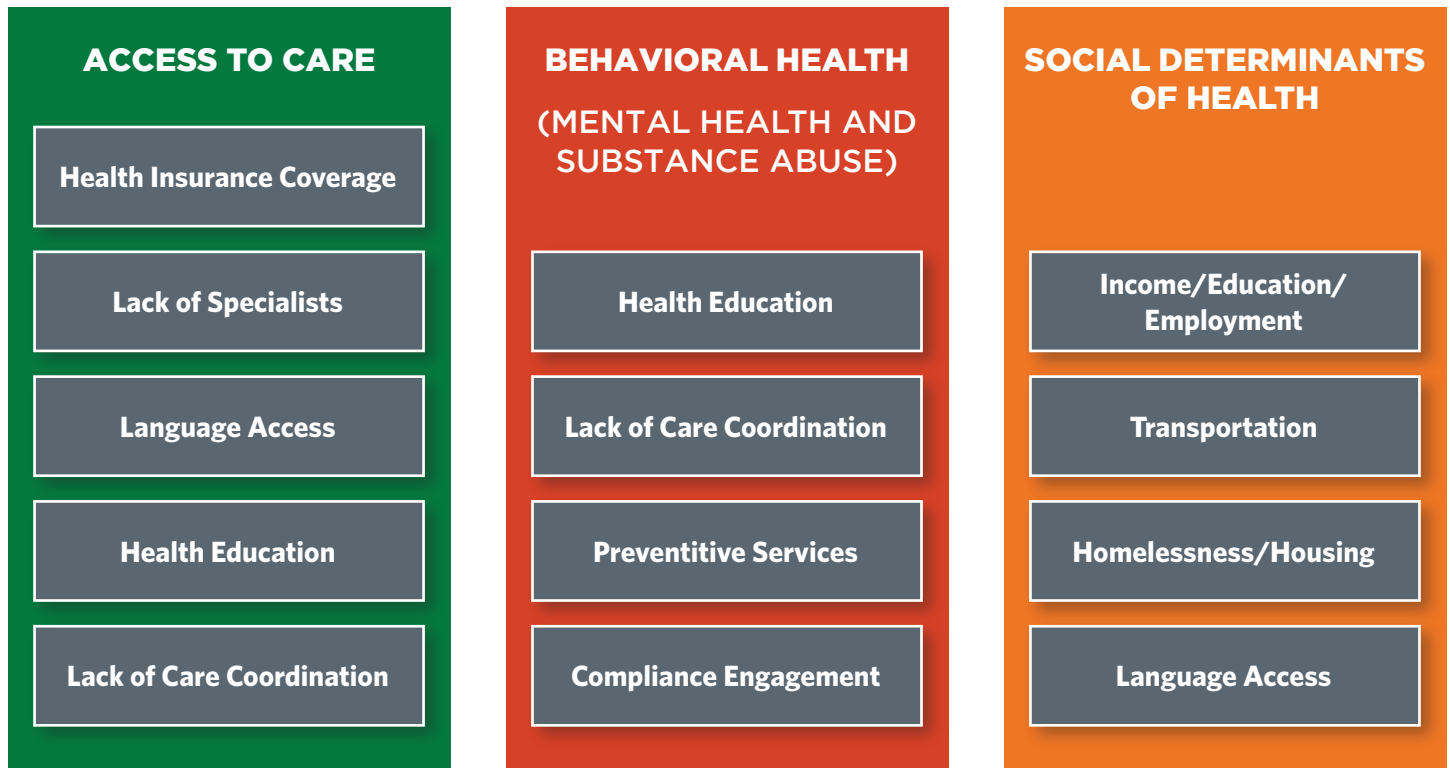
As a community hospital, UPMC Pinnacle maintains a focus on the needs of the local communities and strategies that address the unique health care needs of the diverse populations being served.



## 2019-2022

### COMMUNITY HEALTH REGIONAL PRIORITIES

In the spring of 2018, key need areas were identified during the CHNA process through the gathering of primary and secondary data, community stakeholder interviews, hand-distributed surveys, a community forum, and a health provider inventory, which highlighted organizations and agencies that serve the community. The three identified needs were:



Cooperative structures and regional partnerships are essential in order to capitalize on the counties strengths, stretching resources when the region has been faced with financial limits and budget restrictions. UPMC Pinnacle, UPMC Pinnacle Carlisle, and PPI participate in coalitions such as the Hospital and Healthsystem Association of Pennsylvania (HAP), South Central Pennsylvania CHNA Collaborative, the Dauphin County Health Improvement Partnership (DCHIP), the Capital Area Coalition on Homelessness, The Pennsylvania Office of Rural Health, and The Pennsylvania Department of Health Office of Health Equity Advisory Committee. By crafting new partnerships and securing existing community-based relationships, the CHNA plan can accomplish more and produce more outcomes which positively affect residents. Closing the health disparities gaps and improving the quality of life for community residents are two of the goals that members of the working group and their organizations are accomplishing.



## PRIORITY 1: ACCESS TO CARE

Health disparities regarding access to care continue to be a challenge for health systems across the nation despite the implementation of the Patient Protection and Affordable Care Act (PPACA) in 2010. Even with the availability of the government sponsored insurance plans and enrollment processes, the key reasons for access to care disparities continues to be affordability and the lack of health insurance coverage. 2018 CHNA findings note a slight increase with 85.5% of respondents reporting that they have insurance coverage as compared to 80.0% in 2015.

Health disparities, as it relates to quality health care, is directly connected to the lack of primary care physicians, specialty care, and dental care providers as noted by both the 2015 and the 2018 CHNAs. However, when asked “Do you have a primary care provider” a slight increase of primary care physicians is noted by respondents in the 2018 study (79.4%) as compared to 2015 (76.7%).

Language barriers negatively impact the patient’s and family’s ability to access appropriate services and use health services effectively.

**GOAL:** Expand the health care reach to rural and homebound populations.

**ANTICIPATED IMPACT:** Rural and homebound populations have increased access to health care services.

## **Strategy 1: Strengthen access to specialty provider-based services and supportive services, and increase utilization of health care services by community members.**

### **Provide Insurance Enrollment Specialists and Financial Aid Counselors to enroll uninsured adults and children in appropriate insurance plans.**

Health insurance is a critical component in one's ability to access affordable health care services. Access to health care is the ability to obtain needed primary care services, health care specialists, and emergency treatment. Having health care coverage does not ensure accessibility to all health services. It is noted that some providers continue to refuse particular health insurance plans and deny vulnerable patients much needed health services. UPMC Pinnacle continues to provide trained insurance enrollment specialists and financial aid counselors who have established 10 monthly appointment days at community-based sites to enroll uninsured patients into MA and appropriate health plans.

### **Optimize the patient-centered medical home: UPMC Pinnacle created a partnership and network with local community health centers in 2009.**

Using technology for information exchange between UPMC Pinnacle and the community health centers and clinics, patients are tracked and connected to health care services. Health information sharing is critical to improve access to care and to optimize the delivery of quality patient care services. The benefits of appropriate sharing of health information among patients, physicians, payors, and others in the health care delivery system is well documented and necessary to reduce inappropriate emergency department visits, readmissions, and to ensure proper utilization of available health services.

### **Collaborate with community health center staff to review cases of high utilization and acuity.**

In collaboration with the community health centers and clinics, UPMC Pinnacle continues to provide diagnostic services to identified and eligible at-risk patients at no cost to the patients. The Community Health Team navigates care for at-risk populations and conducts monthly visits with community clinics and centers to provide safer, timelier, and more efficient patient-centered medical home care. UPMC Pinnacle will continue to provide home visits to high risk populations, providing free diagnostic services to clinic patients.

### **Continue partnership with community health centers and clinics to coordinate care to uninsured, underinsured, and diverse populations.**

Community health navigation staff will continue to conduct free clinics visits to identify social determinants of health and enroll the uninsured into appropriate health plans.

**Improve adult diabetic care.** The American Diabetes Association reports 30 million people have diabetes. That is one in 10 adults age 20 and older. For seniors (65 years and older), that figure rises to more than one in four. In Pennsylvania, 1,374,000 people, or 12% of the adult population, have diabetes. At a regional level, in the 2018 survey, nearly 20% of respondents reported having diabetes.

UPMC Pinnacle physicians and providers continue to provide services and education to enhance awareness, encourage patient and family involvement in their care, and to prevent the occurrence of diabetes.

## **Strategy 2: Strengthen access to dental provider-based services, supportive services, and utilization of dental services by community members.**

### **Increase utilization of the SMILES program to minimize dental care as a barrier to overall health status improvement and coordinate care of urgent dental needs in the Emergency Department.**

The Dental SMILES Program was deployed in 2010 to address the dental needs of low-income families and those with limited dental coverage. For many underserved and under-insured populations within the community, dental insurance is typically not provided and/or obtainable. The SMILES Program is a collaboration with dental providers in the community who serve to bridge the gap for those seeking dental services as they provide free or low-cost dental care as well as preventive oral screenings.

The SMILES program serves over 120 underserved and uninsured patients annually who do not have the ability to pay for preventive health services and dental care emergencies.

### **Strategy 3: Strengthen access to provider-based services and supportive services by increasing number of patients with health insurance coverage.**

UPMC Pinnacle Carlisle is committed to making health care more accessible for the patients it serves by offering community resources to those who have barriers to health insurance coverage. Although Cumberland County's Community Needs Index (CNI) rating is 2.4, Carlisle, which is the county seat of Cumberland County, has a CNI rating of 3.0 (17013). Cumberland County is a large county with some rural populations and limited access to public transportation. The county assistance office is set outside the borough of Carlisle making it difficult for certain populations directly within the city to obtain access. UPMC Pinnacle Carlisle has not had enrollment specialists aiding in enrollments for community members since the hospital was purchased from Community Health System (CHS) in 2017. Healthcare Receivables Specialist Inc. (HRSI) is only contracted for the Emergency Department (ED) and Inpatient and does not have a representative onsite full-time. These FQHC locations are the only other site where individuals can go to connect with insurance and they only have limited availability for non-patients. There is a large population that routinely uses the Emergency Department in Carlisle as their PCP, so there is a great need to help individuals get insurance and establish a PCP.

**Increase insurance access in the community and catchment area for Carlisle.** Lack of health insurance serves as a barrier to accessing provider-based care and services in the Carlisle area. Many uninsured and underinsured residents cannot afford health insurance and may postpone or fail to seek medical care and treatment until necessary. This delay in care often results in unnecessary ED visits, as well as health complications and poor outcomes.

### **Develop work plan to expand coverage to Carlisle.**

There are significant financial implications of not having coverage, both to the health system and the patient. A work plan to address the need for expanded insurance coverage to the Carlisle area will examine the characteristics of the uninsured and underinsured populations and delineate actions for improving access to care.

**Assess needs and improve access to specialty providers in Carlisle:** Efforts to improve access to specialty providers is necessary to meet the complex needs of patient and families across the region. A lack of specialty providers in the Carlisle areas are noted:

- Nephology
- Endocrinology
- Dermatology
- Oral Health
- Ophthalmology

### **Explore telehealth to improve access to specialty care.**

Telehealth is the delivery of health-related services and information via telecommunications technologies. Telehealth services have proven to be effective in improving access to specialty care for patients and families residing in rural and underserved areas. Telehealth is demonstrated as two health professionals view and discuss care over the telephone and/or remote cameras existing between the patient, facilities, and different sites.



#### **Strategy 4: Provide patient access to health care resources in their language.**

**Expand interpretation services to patients.** Limited and non-English-speaking populations are more likely to face barriers to accessing care resulting in higher rates of certain health conditions as compared to English-speaking populations. It has been widely documented that patients better understand their care when language does not serve as a barrier. When patients who speak little or no English have someone at their provider's office or the inpatient and/or outpatient settings who speaks their preferred language, barriers to accessing care are minimized

Each year, UPMC Pinnacle provides services to more than a half million patients of diverse nationalities, ethnic backgrounds, and cultures. In addition, the employees of the organization reflect the multiracial, cultural, and ethnic communities we serve. Continued efforts to improve access to care through language and translation services is paramount. Implementation actions include the following:

- Finalize approved policy
- Develop a language service line to arrange 24-hour coverage
- Market language services to the entire system
- Expand the interpreter pool (78 currently)
- Add interpretation on 24-hour nurse line

#### **Expand translation of medical documents to patients.**

To meet the cultural and linguistic needs of patients, expanded translation activities will include the discharge summary and CyraCom translation from Epic, UPMC Pinnacle's electronic health record.

#### **Strategy 5: Increase access to evidence-based smoking cessation and prevention programs.**

**Continue tobacco cessation and smoking prevention programs.** According to the American Cancer Society, each year more than 480,000 people in the United States, or one in five, die from illnesses related to tobacco use.

Tobacco usage is linked to several chronic illnesses including cancer, heart disease, chronic lung illnesses, and skin conditions. In Pennsylvania, over 18% of the population reports that they smoke. Tobacco usage along with lower rates of perception of risks of smoking seems to be more prevalent in the Cumberland (23%) and Perry (30%) areas of the region. A very slight decrease of 1% was noted in the 2018 study (38.5%) as compared to the 2015 study (39.5%). Continuing smoking prevention and cessation programs is a key action for improving the health of the community.

#### **Strategy 6: Increase number of patients receiving care coordination services.**

##### **Explore payor options for payment programs.**

UPMC Pinnacle care navigators connect patients and families to needed health services, programs, and community resources and in partnership with personal care facilities, senior living communities, faith-based communities, community clinics, and the correctional system. Care navigators provide individuals and groups with access to UPMC Pinnacle's resources, expertise, and create links between community partners, the health care system, and other community resources to promote health and healing.

Care navigators tap into community assets and resources to assist with chronic disease management, empower individuals to take charge of their health, and help community members access and navigate the health system. Payor involvement is essential to explore payment programs and to assist the education of staff and providers in meeting payor and Medicare criteria.

**Explore chronic care management billing.** This action includes efforts to educate staff and PCPs on Medicare criteria, working with PCPs to develop patient care goals and care plans and to ensure annual wellness visits for Medicare patients.



## **PRIORITY 2: BEHAVIORAL HEALTH** (MENTAL HEALTH AND SUBSTANCE ABUSE)

Since January 2016, the Department of Drug & Alcohol Programs (DDAP) has worked with stakeholders to ensure a seamless transition for opioid overdose survivors from emergency medical care to specialty substance use disorder (SUD) treatment, thus improving the prospect of recovery. This concept is referred to as warm hand-off. DDAP incorporated contractual changes with the Single County Authorities (SCAs) in its 2015-2020 grant agreement that establishes the overdose survivor as a priority population and requires each SCA to create a warm hand-off policy. Perry and Dauphin counties have the highest rate (86.3%) of residents seeking drug and alcohol treatment.

According to data related to child and adolescent services reported in a 2012-2013, York County has the highest rate of children and teens with ADHD (9.25%). This rate is higher than the statewide average (5.23%). The percentage of individuals with any mental illness or a serious mental illness has increased in the state of Pennsylvania.

**GOAL:** Improve Behavioral Health illnesses by providing access to quality mental health and substance use programs and education that address the whole person.

**ANTICIPATED IMPACT:** Prevention, Education, and Treatment.

The community need to implement measures to prevent suicide is evident as the 2018 CHNA Report documented that, excluding Cumberland, all counties (Dauphin, Perry, Lebanon, and York) (2012-2016) saw an increase in the numbers of deaths attributed to suicide, with York County having the largest increase at 73 deaths. Most suicides are attributed to mental health disorders such as depression, schizophrenia, personality conditions, and bipolar illnesses. Other causes and risk factors include substance abuse, alcoholism, and drug usage.

### **Strategy 1: Conduct mental health screening to reduce occurrence of suicide.**

**PPI and UPMC Pinnacle will partner with local organizations to provide mental health screenings for youth in schools and other high-need community areas.** Suicide is often linked with socio-economic factors, including financial difficulties, poor relationships, job loss, and other life challenges. Among adolescents, bullying has been identified as a possible risk factor for suicide. The implementation of effective suicide prevention efforts among adults and youth such as mental health screenings is critical to this five-county region.

**Hamilton Health will screen (using Patient Health Questionnaire 9- PHQ9) all patients age 12 and older during every primary care visit.** Hamilton Health will provide essential screening of adolescents and adults. Information sharing among partnering community organizations is essential in meeting the behavioral health needs of patients and families across the service areas.

### **Strategy 2: Provide mental health training to law enforcement officers.**

**Give police officers access to mental health education to do their job safely and effectively.** Law enforcement officers are often called upon and play a key role in addressing the needs of individuals and families during a mental health crisis. Without sufficient training in mental health crisis intervention, law enforcement is not adequately prepared to determine and differentiate when a person's behavior is related to a mental health disability or a physical condition. Law enforcement officers need appropriate training to employ effective crisis intervention and de-escalation techniques during a mental health crisis.

**A lack of training increases the likelihood of injury to both officers and individuals with mental health illness.** In collaboration, PPI, and the Pennsylvania State Police Academy will provide mental health crisis intervention training to 300 officers over the next three years.

### **Strategy 3: Implement an integrated care model for behavioral health.**

**Pinnacle Health Psychological Association (PHPA) has implemented counseling services with Medical Group (PHMG) practices.** Primary care settings have become a gateway for many individuals with behavioral health and primary care needs. To address these dual needs, many primary care providers are integrating behavioral health care services into their clinical settings and training medical professionals.

Integrated Care Models have emerged to include the use of care managers, behavioral health consultants, behavioralists, and others working together to plan and provide comprehensive behavioral health care. The Center for Integrated Health Solutions (CIHS) monitors activities and models around the country in order to share best practices with the primary and behavioral health care professionals.

**Engage patients on-site through mental health professionals to enhance continuity in services and integration of mental and physical health.** The UPMC Pinnacle/PHMG Integrated Behavioral Health-collaborative care is a model of integrated behavioral health care and incorporates caseload focused psychiatric consultation support by a behavioral health care manager. This Integrated Care approach will be integrated into Kline Health Center and the UPMC Pinnacle Medical Group.

**Expand patient health care team to include the behavioral health care manager (BHCM) and psychiatric consultant (PC).** The behavioral health care manager (BHCM) performs the following key roles:

- BCHP supports patient's engagement, self-management, assessment, and relapse prevention
- BCHP provides warm handoffs, close follow-up, and validates measures and treatment planning.

#### **Strategy 4: Provide early engagement and support for psychosis.**

**Provide comprehensive treatment and support for young adults ages 16-30 experiencing early psychosis in the area.** Half of mental health conditions begin by age 14, and 75% of mental health conditions develop by age 24. The normal personality and behavior changes of adolescence may mimic or mask symptoms of a mental health condition. Early engagement and support are crucial to improving outcomes and increasing the promise of recovery. An increase from 35.9% (2015) to 39.3% (2018) of survey respondents reported having been told by a medical professional that they have a mental health concern.

**Increase access to comprehensive treatment and support to young adults.** Efforts to strengthen access to comprehensive mental health treatment and community-based supportive services promote early engagement and intervention, and prevent mental health complications among young adults.

**Offer diversionary pipelines from community in various settings for non-suicidal presentations of psychosis.** Awareness and education of available behavioral health services and alternative community settings can be offered as options to non-suicidal patients.

#### **Strategy 5: Implement Trauma Informed Care (TIC) to meet needs of the whole person.**

**Recruit and retain Trauma Informed Care (TIC) staff who can support long-term TIC clinical programming.**

Trauma Informed Care means treating a whole person and taking into account past trauma and the resulting coping mechanisms when attempting to understand behaviors and treat the patient. Education, prevention, early identification and intervention, and effective trauma treatment are all necessary to break the cycle of violence.

**Increase clinical quality through development of evidence-based treatment modalities for individuals impacted by trauma.** To ensure quality of care, patient safety and treatment of trauma impacted patients, it is vitally important to research best practices, applicable knowledge, and evidence-based treatment modalities that have proven to be specifically effective in caring for trauma impacted patients. Evidence-based treatment modalities are based on a conscientious knowledge of mental health practices and incorporates the best evidence from well-designed studies, patient outcomes, values, and preferences. Mental health clinicians and counselors provide expertise in making appropriate decisions relative to trauma informed care.

**Develop Steering Committee.** The Trauma Informed Care (TIC) Steering Committee was created to support the translation of TIC theory gained through the Substance Abuse and Mental Health Services Administration (SAMHSA) technical assistance grant and to put those theories into practice. The Steering Committee met to set the following priorities: Select a TIC Chair from a pool of PPI's talented master clinicians. The TIC Chair will oversee three TIC Subcommittees: 1) TIC Education Subcommittee; 2) the TIC Mentor Subcommittee that provide experiential supervision to the units and sites; and 3) the TIC Subcommittee of Debriefers for both patients and staff. The Debriefers work with trauma patients after significant events to prevent re-traumatization from occurring and complex trauma from developing.

### **Strategy 6: Improve access to health care through a medical home.**

**Deploy Community Health Workers (CHWs) to help consumers navigate their way to services.** A medical home is a team-based health care delivery model led by a health care provider to provide comprehensive and continuous medical care to patients. Improving access to a medical home helps the patient achieve optimal health outcomes. The medical home approach has been deployed in many communities to provide comprehensive primary care for children, youth, and adults.

The Contact to Care Program is an initiative that is helping to improve access to health care in Harrisburg. United Way of the Capital Region (UWCR) worked together with a group of community health care experts to look at ways to impact health for the Capital Region. The Contact to Care Program is based on research showing that having a primary medical home for care improves health outcomes overall. Community Health Workers are trained community residents who serve their community and assist them in accessing the following health services:

- Behavioral Health
- Dental Care
- Health Care
- Vision Care
- Transportation

### **Strategy 7: Provide direct access for those experiencing a mental health crisis.**

**Use assessment, screenings, and placement methods to determine and refer to level of care required for emergent care needs in outpatient facilities and schools.** A direct admission program provides individuals experiencing a mental health crisis in a physician office, therapy office, or outpatient facility direct access to a psychiatric facility and increased access to inpatient, partial hospitalization, and outpatient services. Once assessed and screened, an appropriate level of care and disposition can be provided.

### **Strategy 8: Improve access to mental health care through telepsychiatry.**

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

### **Strategy 9: Improve behavioral health of children and adolescents.**

**Develop an Intensive Outpatient Program as next component of continuum of service line.** According to the 2012-2013 report, York County has the highest rate of children and teens with ADHD (9.25%). This rate is higher than the statewide average (5.23%).

**Create specialized group programs to address specific needs of adolescents.** For a diversity of children and adolescents, specialized programs are necessary to meet their behavioral health, cultural, social, and emotional needs. These programs include: Social Skills: "building strong relationships through effective communication," Crisis Management: "Keeping your cool," Problem Solving: "The facts of life," emotional regulation, LGBTQ, parenting processing group, and others.

## **Strategy 10: Improve access to Medicated Assisted Treatment (MAT).**

**Medicated Assisted Treatment (MAT) is the use of medications in conjunction with counseling to provide a patient-centered approach to the treatment of substance use disorders.** In MAT, approved medications, in combination with counseling and behavioral therapies are provided with a “whole-patient” approach to the treatment of substance use disorders. For opiate dependence, approved medications include Methadone, Buprenorphine (with and without naloxone), and Naltrexone.

**Hamilton Health will conduct (annual and PRN) screenings for substance use ages 10 and older.** Our community partner Hamilton Health has the tools to provide annual and as needed substance use disorder screenings to youth and adults as they present to the center for care.

### **Develop a medical legal partnership with Dickinson Law school to provide free legal services.**

Underserved, low-income patients and families may experience the need to access legal services and advice. Through a medical-legal partnership, these services can be offered at no cost to the eligible patient.

**New mobile unit for the Center for Addiction Recovery to service the rural areas in our footprint.** The Center for Addiction Recovery applies a proven, multifaceted treatment approach that helps individuals and families climb out of addiction into long-term recovery. The center provides intensive and customized outpatient treatment to meet the individual’s need, facilitates interventions in a supportive environment, and provides prevention education for families, employers, and schools. A new mobile unit for the Center for Addiction Recovery will be procured to improve access to critical behavioral health services and programs and to provide much needed outreach to rural and underserved populations. The mobile unit will be equipped with program materials and special supplies to meet the needs of underserved behavioral health communities.

## **Strategy 11: Provide Steps to Recovery for pregnant women facing addiction.**

**Provide assessment and plan for Medication Assisted Therapy during pregnancy.** As identified and assessed, pregnant women with addiction issues will receive Medicated Assisted Treatment (MAT) through the use of approved medications in conjunction with counseling services to provide a patient-centered approach to the treatment of substance use disorders.

**Support prenatal care and education using the Centering Pregnancy model.** Centering group prenatal care follows the recommended schedule of 10 prenatal visits, but each visit is 90 minutes to two hours long, resulting in more time with their prenatal provider. Moms engage in their care by taking their own weight and blood pressure and recording their own health data with private time with their provider for belly checks. Particularly important for women with addiction issues, centering materials help moms and providers ensure that everything from nutrition, common discomforts, stress management, labor and delivery, breastfeeding, and infant care are covered addressed.

**Transition women to the center for addiction recovery after birth of the baby, if continuing with medication assisted therapy.** This action is critical to ensure the health, safety, and recovery of both the mom and the baby.

**Provide care coordination with hospital and community resources for mom and baby.** Centering groups are comprised of women of different ages, races, and socio-economic backgrounds as they share the common experience of pregnancy, birth, and family care. Continuity and coordination of care is provided through a family-centered approach throughout the first two years of parenting.

## **Strategy 12: Partner with Center for Addiction Recovery Actions.**

**Provide warm handoff process in EDs.** Since January 2016, the Department of Drug & Alcohol Programs (DDAP) has worked with stakeholders to ensure a seamless transition for opioid overdose survivors from emergency medical care to specialty substance use disorder (SUD) treatment, thus improving the prospect of recovery. This concept is referred to as warm hand-off. DDAP incorporated contractual changes with the Single County Authorities (SCAs) in its 2015-2020 grant agreement that establishes the overdose survivor as a priority population and requires each SCA to create a warm hand-off policy.

**Provide X Waiver training sessions.** Based on the Drug Addiction Treatment Act of 2000, this expands the clinical context of medication-assisted opioid dependency treatment. Qualified physicians are permitted to dispense or prescribe specifically approved Schedule III, IV, and V narcotic medications (medications that have a lower risk for abuse, such as buprenorphine) in settings other than an opioid treatment program (OTP).



## PRIORITY 3: SOCIAL DETERMINANTS OF HEALTH

As defined by the World Health Organization (WHO), social determinants of health (SDOH) are the economic and social conditions that influence individual and group differences in health status. The economic and social conditions under which people and groups live are often called “societal risk conditions,” rather than individual risk factors that either increase or decrease the risk for a health condition or disease.

Portions of the Healthy People 2020 Social Determinants Overview states “Health starts in our homes, schools, workplaces, neighborhoods, and communities. Our health is also determined in part by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships. The conditions in which we live explain in part why some Americans are healthier than others and why Americans more generally are not as healthy as they could be.”

Healthy People 2020 delineates five key social determinants of health that affect our quality of life and well-being:

- Economic Stability
- Education
- Social and Community Context
- Health and Health Care
- Neighborhood and Built Environment

**GOAL:** Increase knowledge of access and opportunity to UPMC Pinnacle resources in rural communities and underserved populations.

**ANTICIPATED IMPACT:** Five identified community organizations develop a relationship with UPMC Pinnacle within 12 months.

UPMC Pinnacle has made great strides in adopting culturally and linguistically appropriate health care practices throughout the system and continually enhancing sensitivity and responsiveness to the clinical and cultural interests, needs and expectations of patients, families, and the workforce. In 2016-2017, the health system provided diversity and inclusion education to the senior leadership, faculty, medical staff, students, and community members. Social determinants of health (SDOH) was categorized as a new finding in the 2018 Community Health Needs Assessment (CHNA) report. It was noted that those findings were embedded in the narrative within the 2016 goals. Economic factors such as household income and employment opportunities within the community impact the affordability of health insurance, thereby, limiting access to health services.



**Strategy 1: Address income, education, and employment determinants of health that negatively impact a healthy and diverse workforce and preventive care.**

**Collaborate with community businesses and higher education institutions to improve knowledge about available resources through UPMC Pinnacle.** Education plays a vital role in helping individuals make informed health decisions and to effectively navigate today's complex health care delivery system. Addressing social determinants of health through community education and awareness of available resources at community-based diversity events and outreach are planned to affect the health status of individuals, families, and disparate communities.

**Collaborate with area school districts to provide job opportunities through established career fairs.** Career fairs are designed to improve access to job opportunities and job training. In partnership with area school districts, career development efforts expose our youth to various health care and other professions and help them explore future job aspirations.

**Establish a Workforce Development pilot program that connects to community partners to improve employment opportunities for the unemployed and career-track seekers.** The Workforce Development pilot program will be designed to improve the economic well-being of the populations and region served by UPMC Pinnacle. It has been well documented that economic status has direct relationship to health status and quality of life. This initiative is supported through the following actions:

- Support School District career development programs by collaborating with UPMC Pinnacle HR recruitment staff.
- Connect with partner Human Resources (HR) departments regarding their efforts around recruitment with higher education.
- Establish "senior mentors" to support students exploring career tracks.

**Investigate possible domains in Epic (electronic health record) to capture data regarding diversity (race, religion, socioeconomic status, etc.).** UPMC Pinnacle has made cultural competence a strategic priority and the uniqueness of all races, ethnicities, colors, religions, beliefs, abilities, appearances, genders, and sexual orientation are understood, respected, and welcomed. To ensure the delivery of culturally competent and individualized patient care, it is essential to capture critical data and patient demographics.

**Strategy 2: Address transportation barriers to reduce missed appointments due to unreliable or no transportation, which negatively impacts preventive care and increased ED visits.**

**Provide transportation to patients who have difficulty with private transportation by connecting them to programs and services available in the five-county region.** Many low-income and vulnerable people, especially in the Carlisle and rural areas, face challenges in regard to the lack of transportation or unreliable transportation. Inappropriate usage of the ED often results. Other effects of missed doctor and other appointments are poor health management, lack of preventive care, and poor health outcomes. To address the lack of transportation or unreliable transportation, the following actions will be taken:

- Establish partnership with Capital Area Transit (CAT) to provide transportation to health care
- Engage and roll-out Uber Health pilot program
- Partner with established clinics for outreach to the demographics of highly missed appointments

### **Strategy 3: Assist homeless recipients within the UPMC Pinnacle “footprint” from the streets and into structured, long-term care through collaboration with community partners.**

**Track admission and discharge patients through the HMIS System.** Homelessness continues to be a community health issue across the region. Tracking efforts to connect them to health care services and to assist their living conditions toward appropriate long-term housing are on-going and in partnerships with a plethora of community and housing organizations.

- Extract participants of UPMC Pinnacle from HMIS System to obtain participants with a homeless or temporary living status

**Structure data and information used to track progress, collaborate with local shelters, hospitals, and Pennsylvania Psychiatric Institute to improve prevention efforts.** A review of best practices and programs assist efforts to improve the quality of life for homeless residents across the UPMC Pinnacle footprint:

- Review benchmark data and experience from Cleveland Health with Uber Health
- Review the Santa Rosa Cancer Center project
- Review the Single Point of Entry Project (Cumberland County)

**Develop a mechanism with community partners to share information, as appropriate.** The sharing of information among community partners regarding programs and services to assist the homeless informs and effects change. Information sharing is key to facilitating the implementation of strategies to improve the health and well-being of the homeless.

- Introduce the Homeless Assistance Program to the community for them to initiate the project (Pay for Success)
- Schedule a meeting with community partners to discover their tracking
- Review common metrics of Eastern Continuum of Care
- Obtain benchmark data from Blueprint to End Homelessness - Capital Area Coalition on Homelessness (CACH)

**Reach those living in unstable housing situations through the Central PA Partnership Investment Opportunities (Pay for Success) - Win future RFPs.** Environmental conditions and quality of housing are key social determinants of health. “It takes a community” to meet the needs of the homeless and the sharing of information enables community partners to work towards a common goal to effectively address the quality of life and living conditions of the homeless.

- Review and research real estate market with the Pennsylvania Housing Finance Agency (PHFA)

#### **Strategy 4: Improve language access given through the development and promotion of culturally and linguistically appropriate services.**

**Provide effective communication and language assistance services to culturally and linguistically diverse individuals receiving care and services.** Continuing to provide effective communication and language assistance to linguistically diverse individuals, UPMC Pinnacle will take the following steps:

- Poll hospitals and agencies regarding the tools and practices used to meet cultural and linguistic needs
- Implement SDOH Epic Build and collect data
- Complete UPMC Pinnacle service line for Language Access
- Assess language access among community partners

**Evaluate and assess the language services workforce for language access barriers.** Similar to our patients and the community, the workforce represents a diversity of cultures and languages and may experience language barriers as well. An evaluation of those needs served as the foundation to address the cultural and linguistic needs of the workforce.

**Develop a process to assess bilingual providers to discover gaps of language access.** UPMC Pinnacle continues to expand diversity and inclusion education and promotes efforts to explore the language needs of bilingual providers. A better understanding of the needs, barriers, and/or gaps that bilingual providers experience leads to action and initiatives to improve language access.

**Implementation of UPMC Pinnacle Cultural Health Care Program:** UPMC Pinnacle continues to provide Bridging the Gap Medical Interpreter Training sessions and the promotion of the utilization of CyraCom (phone, video, and My Accessible Real-Time Translation Interpreter - (MARTTI)) to enhance, expand and improve language access across the organization and the community.

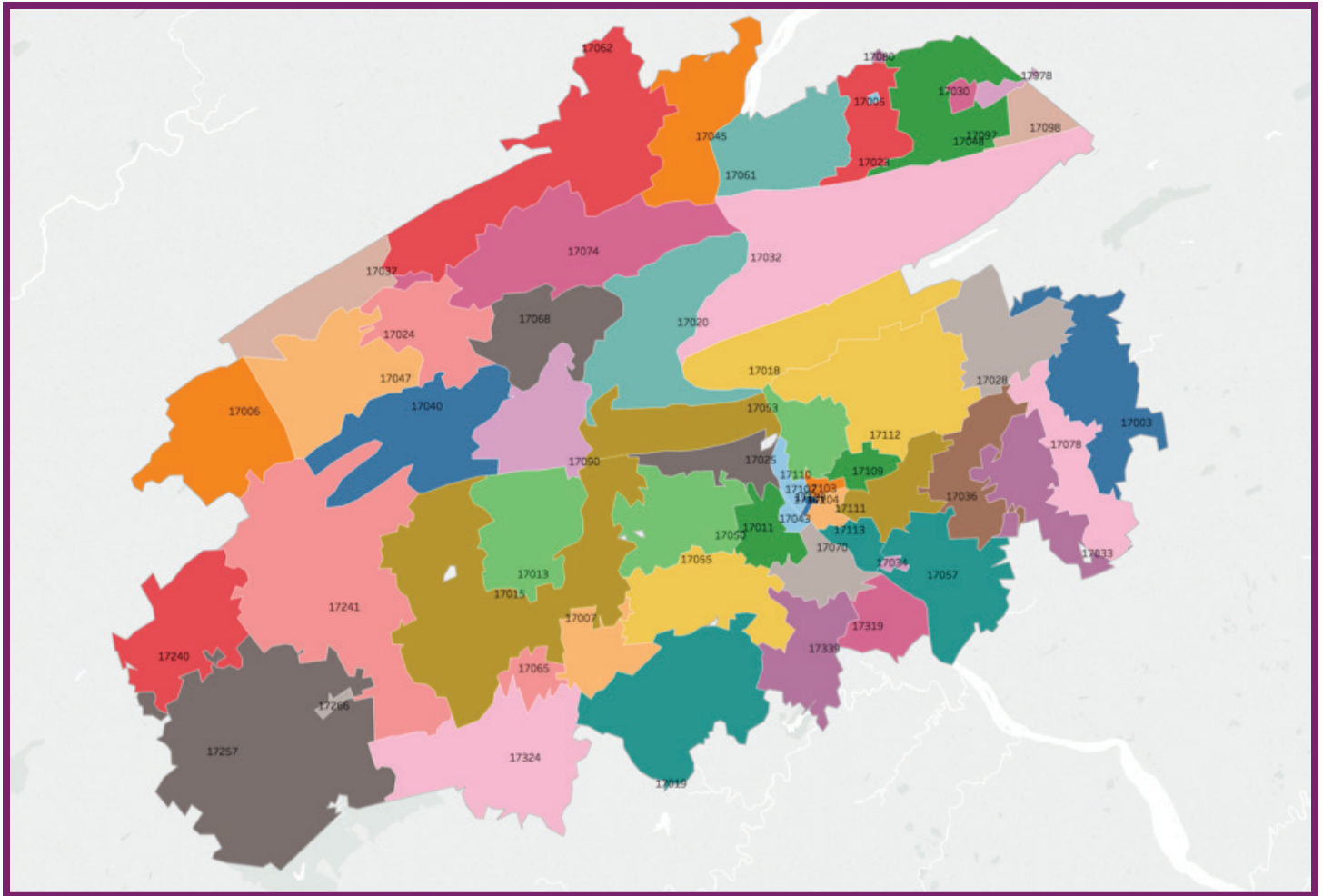
**Explore Telemedical Support Services for culturally and linguistically diverse populations.** Telemedicine has great application for eliminating language barriers as it improves access to culturally competent health care. In settings such as critical care and the ED, telemedicine technology can assist to provide life-saving information for linguistically diverse patients and families.

## APPENDIX A: STUDY AREA

ZIP CODE	CITY	COUNTY
17007	Boiling Springs	Cumberland
17011	Camp Hill	Cumberland
17013	Carlisle	Cumberland
17015	Carlisle	Cumberland
17025	Enola	Cumberland
17043	Lemoyne	Cumberland
17050	Mechanicsburg	Cumberland
17055	Mechanicsburg	Cumberland
17065	Mount Holly Springs	Cumberland
17070	New Cumberland	Cumberland
17240	Newburg	Cumberland
17241	Newville	Cumberland
17257	Shippensburg	Cumberland
17266	Walnut Bottom	Cumberland
17324	Gardners	Cumberland
17005	Berrysburg	Dauphin
17018	Dauphin	Dauphin
17023	Elizabethville	Dauphin
17028	Grantville	Dauphin
17030	Gratz	Dauphin
17032	Halifax	Dauphin
17033	Hershey	Dauphin
17034	Highspire	Dauphin
17036	Hummelstown	Dauphin
17048	Lykens	Dauphin
17057	Middletown	Dauphin
17061	Millersburg	Dauphin
17080	Pillow	Dauphin
17097	Wiconisco	Dauphin

ZIP CODE	CITY	COUNTY
17098	Williamstown	Dauphin
17101	Harrisburg	Dauphin
17102	Harrisburg	Dauphin
17103	Harrisburg	Dauphin
17104	Harrisburg	Dauphin
17109	Harrisburg	Dauphin
17110	Harrisburg	Dauphin
17111	Harrisburg	Dauphin
17112	Harrisburg	Dauphin
17113	Harrisburg	Dauphin
17978	Spring Glen	Dauphin
17003	Annaville	Lebanon
17078	Palmyra	Lebanon
17006	Blain	Perry
17020	Duncannon	Perry
17024	Elliottsburg	Perry
17037	Ickesburg	Perry
17040	Landisburg	Perry
17045	Liverpool	Perry
17047	Loysville	Perry
17053	Marysville	Perry
17062	Millerstown	Perry
17068	New Bloomfield	Perry
17074	Newport	Perry
17090	Shermans Dale	Perry
17019	Dillsburg	York
17319	Etters	York
17339	Lewisberry	York

## APPENDIX B: MAP OF STUDY AREA



## APPENDIX C: PINNACLEHEALTH PSYCHOLOGICAL ASSOCIATES, UPMC PINNACLE

PinnacleHealth Psychological Associates (PHPA) is a service of UPMC Pinnacle and is supported by UPMC Pinnacle's many resources. PHPA offers caring, qualified professionals using the latest therapies and treatment methods to help community residents. Patients will receive comprehensive psychological care at PHPA through range of programs and specialties.

PHPA staff consists of licensed: psychiatrists, psychologists, professional counselors, and clinical social workers. PHPA offers individual cognitive-behavioral psychotherapy, supportive psychotherapy, and psychiatric services that include consultation, evaluation and medication management.

PHPA's goal is to assist residents in finding positive, productive solutions to patients' concerns. Therapist will assess patients with a tailored, comprehensive treatment plan ultimately helping patients reach their goals. Listed below are PHPA's strategic goals and initiatives for the next coming years.

### Existing Services

- **Outpatient Services - PHPA - HH Brady Hall 5th Floor and West Shore Bent Creek Locations**
  - Outpatient Psychotherapy - individual, family, couples, and group.
  - Employee Counseling Service (ECS)
  - Critical Incident Stress Management (CISM)
  - Family Information and Support Center (FISC) – support for Mass Casualty Incidents
  - 24/7 on-call clinician for mental health emergencies of any type
  - Medical Group/Hospital Floor Support – assist with assessment and disposition of patient behavioral health concerns
  - Education (Resident education, Lunch & Learn on request for any entity, Wellness Presentations, Training on all behavioral health topics)
- **Consult Liaison**
  - Locations: PHPA - Harrisburg Hospital, West Shore Hospital, and Community Osteopathic
  - Emergency Department and Medical/Surgical Floors
  - Telepsych Consult Liaison at Hanover; Specialists-On-Call (SOC)
  - Active Development
- **Outpatient Services**
  - UPMC/PHPA Community Behavioral Health Services for Harrisburg
  - Purchasing practice in York, Psychological Associates of Pennsylvania
- **Consult Liaison**
  - Specialists-On-Call (SOC) for Carlisle Hospital, Lititz Hospital, and Memorial Hospital
  - Emergency Department and Medical/Surgical Floors
  - Projected Development
- **Outpatient Services**
  - PHPA Model - Psychotherapy, Psychiatry, and Behavioral services in all UPMC Pinnacle communities
  - UPMC/PHPA Community Behavioral Health Service for York
  - UPMC/PHPA Community Behavioral Health Service for Lancaster
  - UPMC/PHPA Community Behavioral Health Service for Carlisle
- **Telepsych Consult Liaison as needed for all UPMC/UPMC Pinnacle Hospitals**
- **PHPA Outpatient and Inpatient Consult Liaisons (Psychiatrist and PCRNP) to cover all 7 hospitals**
- **Collaborative Care/Integrated Care Model across all hospital communities**

## APPENDIX D: REGIONAL STAKEHOLDERS

- Alder Health Services
- Aurora Social Rehabilitation Services
- Bethesda Mission
- Brethren Housing Association
- Camp Curtin YMCA
- Capital Area Head Start
- Capital Area Head Start - Keystone Human Services
- Carlisle C.A.R.E.S.
- Carlisle County Crisis Intervention
- Catholic Charities
- Catholic Charities of Harrisburg
- Central Pennsylvania Food Bank
- Christ Lutheran Church
- Community Check-Up Center
- Community Health Navigation Network (CHNN)
- Contact Helpline
- Cumberland and Perry Mental Health Intellectual & Developmental Disabilities (MH.IDD)
- Cumberland County Department of Aging and Community Services
- Cumberland County Drug & Alcohol
- Cumberland County Housing and Redevelopment Authority
- Dauphin County Area Agency on Aging
- Dauphin County Case Management Unit
- Dauphin County Commissioner
- Dauphin County Human Services
- Domestic Violence Services of Cumberland and Perry Counties
- Downtown Daily Bread
- Faith United Church of Christ
- Gaudenzia
- Grantville Food Pantry
- Hamilton Health Center Inc.
- Harrisburg Area Dental Society
- Harrisburg Housing Authority
- Harrisburg School District
- Help Ministries
- Holy Spirit Medical Outreach
- Holy Spirit Medical Outreach Service
- Hope Within Ministries
- International Service Center
- Join Hands Ministry
- Joshua Group
- Latino Hispanic American Community Center
- Lebanon Rescue Mission
- Mazzitti & Sullivan Counseling
- MidPenn Legal
- New Hope Ministries
- New Visions Inc.: Shippensburg Empowerment Dock Drop in Center
- Northern Dauphin Human Services Center
- Partnership for Better Health
- Pennsylvania Counseling Services Inc.
- Pennsylvania Psychiatric Institute (PPI)
- Pennsylvania State Representative
- Perry County Commissioner
- Perry County Food Bank
- Perry County Office for the Aging
- Perry Human Services
- Pressley Ridge
- Redevelopment Authority of Harrisburg
- Salvation Army
- STAR (Stevens Center Steps Towards Advocacy and Recovery (S.T.A.R.) Program)
- Steelton Food Pantry
- T.W. Ponessa and Associates Counseling Services Inc.
- The Community Check-Up Center
- The Northern Dauphin Human Services Center
- Tri-County Community Action
- United Way of the Capital Region
- UPMC Pinnacle
- UPMC Pinnacle Children and Teen Center
- UPMC Pinnacle Kline Health Center
- UPMC Pinnacle Resource Education and Comprehensive Care for HIV (REACCH) Program
- Wesley Union Church
- YMCA