Community Health Improvement Plan

Serving the needs of our Central Pennsylvania neighbors

WellSpan Medical Group
WellSpan Ephrata Community Hospital
WellSpan Gettysburg Hospital
WellSpan Good Samaritan Hospital
WellSpan York Hospital
WellSpan Surgery & Rehabilitation Hospital
WellSpan Philhaven
WellSpan VNA Home Care
*Summit Health

*This plan does not include the community health improvement strategies of Summit Health, which joined WellSpan Health on November 1, 2018.

WellSpan's Mission

Working as one to improve health through exceptional care for all, lifelong wellness and healthy communities.

For nearly 140 years, WellSpan has been caring for the communities of central Pennsylvania.

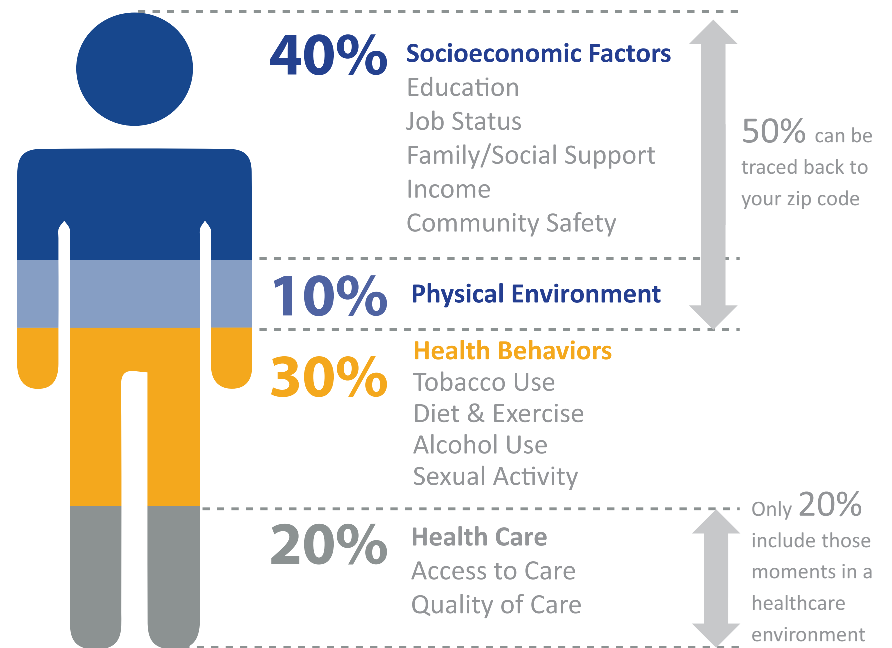
As our region's most comprehensive health system, we are humbled that our friends in Adams, Franklin, Lancaster, Lebanon and York counties entrust their good health – and that of their families – to us. We are committed to our mission of improving health, promoting lifelong wellness and fostering healthy communities. But, we know we can't do this alone. That's why we work together with our friends and neighbors throughout the region to identify community health needs and develop and implement strategies to address them.

WellSpan's journey in community health improvement spans decades. What began in the early 1990s has evolved into a central element of the health system's vision. Evidence of this commitment can be seen in the health system's mission, governance, planning strategies, processes, and organizational structure. Board members, community members, leaders and physicians are engaged in the community health needs assessment, identification of priority needs, development of initiatives to address needs and monitoring progress.

Leaders ensure that interventions are impactful, integrated and sustainable via continuous improvement, investment, partnerships and long-term development. This commitment has been championed by the system's Board of Directors, which holds management accountable, allocates resources and ensures system-wide integration.

WellSpan understands that good health is more than exceptional healthcare. It starts with the communities in which we live, work and play. WellSpan aims to be a catalyst for community change and collaborates with partners to address the social, demographic, behavioral and economic issues facing our neighbors and communities. A person's health is influenced by education, income, employment, physical environment and personal health behaviors (Figure 1). WellSpan strives to not only take care of people when they are ill but to help them stay healthy. This approach means addressing health factors beyond the walls of our facilities and embracing a model of community health that has a social determinants of health focus.

FIGURE 1



Adapted from ProMedica National Social Determinants of Health Institute. Source: Institute for Clinical Systems Improvement. Going Clinical Walls: Solving Complex Problems (October 2014)

WellSpan Community Health Framework

MISSION

Working as one to improve health through exceptional care for all, lifelong wellness and healthy communities.

OBJECTIVES

Be a catalyst and leader in health equity – collaborating with community partners to address the social, demographic, behavioral and economic/poverty issues facing our neighbors and communities, to positively impact healthy community indicators and to reshape our care models to understand and develop interventions to support cultural, social and behavioral issues which impact health.

Maintain and fulfill WellSpan's mission as a charitable, nonprofit organization by providing necessary care for all, regardless of ability to pay; sponsoring services which are difficult to sustain financially but necessary to the health and well-being of the community and identifying unmet community health needs and developing approaches to meet them.

Infrastructure for Improving Community Health

Infrastructure Priorities

Develop a new collective impact health model focusing on process integration and community advocacy.

- Optimize data analysis and collaborative processes to guide priorities, planning and outcome measurement, capacity building and advocacy.
- Build and strengthen WellSpan as a reliable and steadfast partner.

Organizational Engagement and Shared Responsibility

- WSH Planning Committee, Boards
- WSH Administrative Council
- WSH Annual Plans
- System –wide CHI Department
- Regional Health Coalitions
- Program Champions/Leaders

Ongoing Needs Assessment

- Community Health Assessments (3 yrs)

Reporting and Accountability

- Community Benefit Database
- Community Benefit Report
  - Charity (free care) at cost
  - Unpaid cost of public programs (MA)
  - Subsidized healthcare services
  - Community health outreach
  - Financial and in-kind contributions
- Communication Plan

Community Health Strategies and Priorities (FY20-22)

CARE FOR ALL

Ensure access and quality of care for patients by identifying and reducing disparities and barriers to care.

FY20-FY22 Priorities

Care for All:

Develop and maintain a strong safety net of services that maintain and improve access and quality of care for vulnerable populations.

- Addressing access and financial barriers to care.
- Developing health equity outcome measures, aligning Community Health Needs Assessment Data with Project One data.

BEHAVIORAL HEALTH AND LIFELONG WELLNESS

Support personal wellbeing and whole-person health by making it is easier for people to recognize and get support for mental health issues, and to adopt positive health behaviors.

FY20-FY22 Priorities

- **Behavioral Health:** Increasing behavioral health education and early intervention activities that build mental wellness (ACE, Trauma Informed Care, Suicide Prevention, Mental Health First Aid), and continue the integration of physical and behavioral health.
- **Opioid Abuse:** Reduce the prevalence of opioid-heroin overdose and deaths by focusing on safe prescribing, medication assisted treatment, and partnerships with the community for prevention and support.
- **Children:** Complete an assessment of needs of young children in our communities ensuring a healthy start.

HEALTHY COMMUNITIES AND SOCIAL DETERMINANTS OF HEALTH (SDOH)

Develop and implement collective impact strategies to align WellSpan healthcare providers and community based organizations to address social and economic issues which impact health.

FY20-FY22 Priorities

- Adopt "Hunger and Food Insecurity" and "Transitional Housing for Patients" as system-wide health issues for WellSpan to address in collaboration with the community.
- Begin to collect and understand patient's Social Determinants of Health.
- Establish new approaches to working with community organizations – including joint advocacy, better systems for integrated care and referrals and collective impact models.

CORE PRINCIPLES

Adoption of a broad population health definition
Integration of cultural competency and health literacy tenets
Emphasis on vulnerable populations and addressing unmet health-related needs
Collaboration with diverse populations and stakeholders
Focus on prevention and primary care
Establishment of connections between health system, family and community
Ongoing collection of data, feedback and evidence-based practice to inform decision-making

Community Health Needs Assessment (CHNA) Methodology

History of the Community Health Needs Assessment

Conducting a Community Health Needs Assessment (CHNA) every three years has been instrumental to WellSpan's community health and benefit strategy since the early 1990s. Through collaborations with local health coalitions and community partners, WellSpan Health acquires diverse information from community members pertaining to health, lifestyle behaviors, finances, access to health services, and other related topics. The development of the 2018 CHNA and subsequent reports build on processes that were standardized with prior assessments.

Previous CHNAs were conducted as follows:

- **Adams and York counties** – Healthy Adams County and the Healthy York County Coalition, both supported financially by WellSpan Health, have led the county-specific CHNA collaboratively for more than 10 years. These local coalitions have assembled a workgroup to plan for the assessment, which is conducted by Franklin and Marshall College's Center for Opinion Research and includes primary and secondary data sources.
- **Northern Lancaster County** – WellSpan Ephrata Community Hospital has partnered with Lancaster General Health to provide an interactive web portal that makes secondary data available to community members online. The partnership also conducts a county-wide assessment. WellSpan Ephrata Community Hospital continues to engage in this partnership, though an additional local CHNA is also conducted by Franklin & Marshall College for the northern Lancaster County population served by WellSpan.
- **Lebanon County** – In 2015, WellSpan Good Samaritan Hospital transitioned to a CHNA model that relies on primary and secondary data collection, conducted by Franklin & Marshall College. Prior to 2015, WellSpan Good Samaritan Hospital engaged community leaders and stakeholders in interviews related to secondary data, community resources and potential priorities to provide insight on the community health needs of the county.

WellSpan Health has recently expanded its ability to reach community members in south central Pennsylvania by affiliating with an additional healthcare organization, Summit Health. Summit Health's CHNA and priorities of focus are cross-referenced in this report and a full copy of Summit's report is available at www.summithealth.org.

Planning for the 2018 CHNA

WellSpan embraces the uniqueness of each of the respective communities served and has initiated multiple research studies and engaged numerous local community stakeholders in a series of conversations to understand the needs of Adams, northern Lancaster, Lebanon and York counties. The needs assessment process includes a modified, telephonic Behavioral Health Risk Factor Surveillance Survey (BRFSS) and the

TABLE 1 - Community Sectors Engaged in CHNA Process.

	Adams County	Lebanon County	Northern Lancaster County	York County
Behavioral Health	X	X	X	X
College / University	X	X	X	X
County/ Municipal Government	X	X	X	X
Faith-based Community		X	X	
Federally Qualified Health Center (FQHC)	X	X	X	X
Health Coalition / Partner	X	X	X	X
Healthcare Providers	X	X	X	X
Philanthropic Organization	X	X		X
Recreation Centers (YMCA/YWCA)	X	X	X	X
Schools (Elementary-High)	X	X	X	
United Way	X	X	X	X

engagement of stakeholders orchestrated by the local health coalitions in each of the counties. Additionally, WellSpan Ephrata Community Hospital continues to engage in a Lancaster county-wide assessment in partnership with Penn Medicine's Lancaster General Health and UPMC Pinnacle.

Input from diverse stakeholders and a commitment to the overall process is vital when conducting a community-wide CHNA. Numerous stakeholders from the four communities in which the CHNA was conducted participated in the planning and data review process, and represented the community sectors in Table 1, on page 5.

Data Collection and Analysis

Data collection for the 2018 CHNA was facilitated by the Center for Opinion Research at Franklin and Marshall College. The 2018 process mirrored that of the 2015 CHNA process. Berwood Yost, director of the Center and project consultant for the 2018 CHNA, has an extensive background conducting and analyzing community and corporate surveys. Community stakeholders collectively determined the battery of survey questions; discussed data collection methodology, including sample size and method of obtaining data; reviewed the raw data and supporting charts and graphs; and identified the priority setting process to be utilized in community forums.

Much like the 2015 CHNA in each of the respective counties, core questions from the Behavioral Risk Factor Surveillance System (BRFSS) were supplemented by additional questions in key focus areas (e.g., end of life care, nutrition, physical activity). These questions were validated and utilized by the Centers for Disease Control and Prevention (CDC) in national and state-wide survey instruments. Selected questions were organized into four key areas– access, health behaviors, health conditions, and prevention behaviors – as determined by the CHNA planning committee. The survey included additional questions to understand emerging health issues, for example, high deductible health plans and chronic pain.

The CHNA data included primary collection through a telephonic survey as well as secondary data. A representative sample of adult, non-institutionalized residents were interviewed to generate statistically significant results in survey indicators, many of which were identical questions from 2015 and therefore allow trending of local data. Interviews were conducted over several months, as demonstrated in Table 2.

Supplemental data were compiled to expand upon the data collected from the telephonic survey and enabled the development of a comprehensive CHNA. Examples of additional data collected include demographic information from the U.S. Census Bureau; trending data related to lifestyle and health derived from the Pennsylvania Department of Health (DOH); and vital statistics related to birth and death rates, also from the Pennsylvania DOH. Much of the comparative health data utilized the Robert Wood Johnson Foundation's County Health Rankings, annual rankings which demonstrate the performance of each Pennsylvania county in comparison to one another. These rankings provide information on health factors and health outcomes specifically.

CHNA data was presented to the WellSpan Health Board of Directors Planning Committee, and the Boards at Ephrata Community Hospital, Gettysburg Hospital, Good Samaritan Hospital, Philhaven and York Hospital. Each respective entity was engaged in discussion and provided feedback. Prior to selecting health priorities, key findings were disseminated to community stakeholders in various formats for feedback as well. The CHNA reports are available publicly on the WellSpan Health website (https://www.wellspan.org/about-wellspan/wellspan-in-the-community/).

TABLE 2	Adults Interviewed	Dates Interviewed
Adams County	461	December 4, 2017- February 25, 2018
Lebanon County	470	March 26, 2018- May 13, 2018
Northern Lancaster County	500	March 26, 2018- May 13, 2018
York County	799	December 4, 2017- February 25, 2018

Summary of Community Health Needs Assessment Data

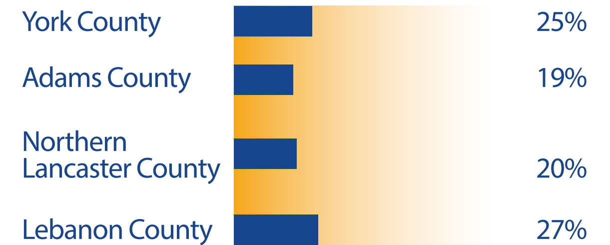
The Community Health Needs Assessment aims to paint a picture of the health of the community, identifies concerning trends across the region, and compares the counties that WellSpan Health serves with others throughout the state. The health indicators measured by the CHNA have remained mostly stable over time, but there were some notable, troublesome trends.

Access Indicators

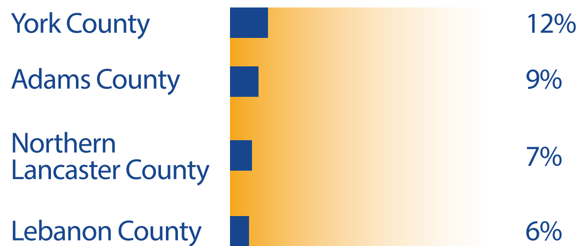
Access indicators in Adams, Lebanon, northern Lancaster and York counties were generally good, with most residents reporting they have health care coverage and a personal physician. Still, many residents in each county had some economic hardships and too many skip medical treatment due to cost. Around one in four residents of each county reports having a high-deductible health plan, which may drive down health care access and use. Many residents also believe that mental health services are unaffordable.

HAS HEALTH CARE COVERAGE

HAS A HIGH DEDUCTIBLE HEALTH PLAN



DID NOT RECEIVE HEALTH CARE IN PAST YEAR BECAUSE OF COST



Summary of Community Health Needs Assessment Data *continued*

FIGURE 2– Age-Adjusted Drug Induced Death Rate

(Source: https://www.phaim1.health.pa.gov/EDD/WebForms/DeathCntySt.aspx)

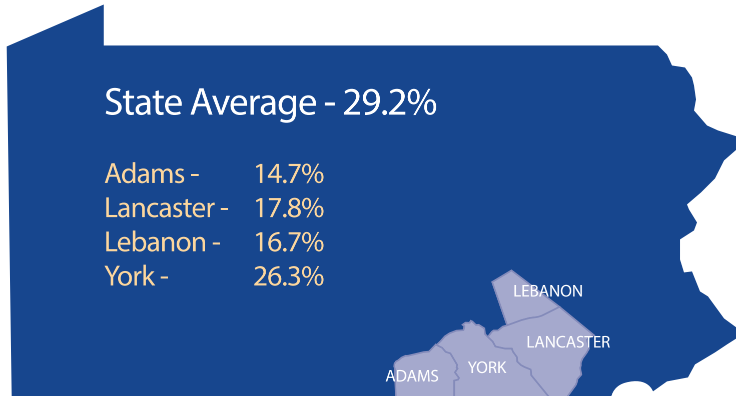
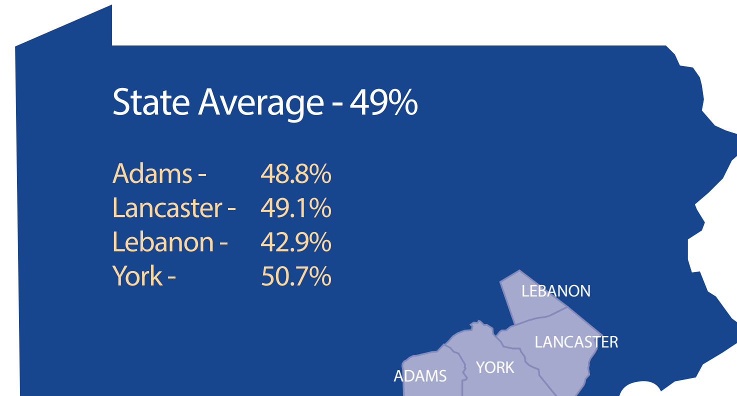


FIGURE 3 – Percent of Households Spending 30% or more of Household Income on Rent.

(Source: DPO4 Selected housing characteristics, 2013-2017 American Community Survey 5-year estimates)

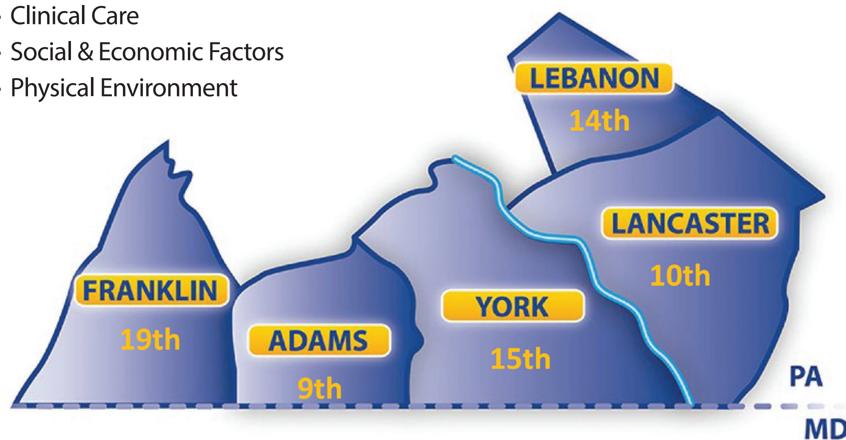


COUNTY HEALTH RANKINGS

(Source: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute

Health Factors

- Health Behaviors
- Clinical Care
- Social & Economic Factors
- Physical Environment



Summary of Community Health Needs Assessment Data *continued*

Behavioral Health and Lifelong Wellness

Rates of health conditions such as diabetes, heart disease, breathing ailments and cancer are not abnormally high compared to other parts of Pennsylvania, but a plurality of residents are overweight or obese and have high blood pressure and elevated cholesterol. Mental health diagnoses continue to rise with more than one in five having been diagnosed with either an anxiety or depressive disorder. More than a third of adults report at least one poor mental health day in the last month. About two in five residents in these counties experience chronic pain, which is one of the top five causes of disability in the United States.

BEHAVIORAL HEALTH/ SUBSTANCE USE AND LIFELONG HEALTH INDICATORS	York County	Adams County	Northern Lancaster County	Lebanon County
Has a depressive disorder	25%	22%	21%	23%
Has an anxiety disorder	23%	22%	24%	21%
At least one day mental health was not good in past month	40%	34%	35%	35%
Exercised 30 minutes on five days in past week	16%	19%	15%	17%
Consumed three servings of vegetables daily	3%	4%	3%	4%

Healthy Communities and Social Determinants of Health (SDOH)

The CHNA data found notable and persistent health disparities within all of the Central Pennsylvania counties served by WellSpan. These disparities are largely attributable to a set of social determinant factors. Analysis of secondary data shows that all counties have identifiable social problems that contribute to the persistent health disparities evident in the CHNA data. For example, as shown in Figure 3, central Pennsylvania counties tend to have many rental households that struggle with housing affordability issues.

SOCIAL DETERMINANTS HEALTH INDICATORS	York County	Adams County	Northern Lancaster County	Lebanon County
Share of households with food stamp benefits	10.8%	7.8%	9.3%	11.1%
Poverty - All families	7.5%	6.3%	7.2%	7.9%

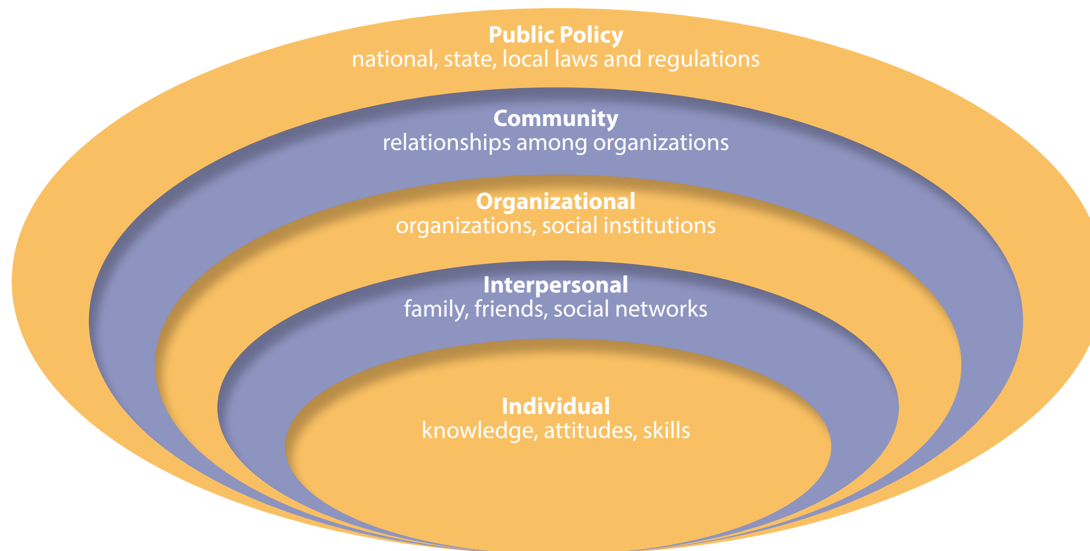
Source: Census Bureau American Survey 5-year estimates, 2012-16

Setting Community Health Priorities

The analysis of the CHNA data helps provide recommendations that are theoretically justifiable, practical, understandable, and a good fit for the community by considering:

- the scope of the problem in terms of how many residents are affected, trends, and comparisons to other communities.
- the community-level effects attributed to the problem by thinking specifically about wasted dollars, reduced quality of life, and lives lost.
- the community resources available to implement change.
- the alignment of these problems with local health systems' goals, missions, and resources.[1]

FIGURE 2 – SOCIO-ECOLOGICAL MODEL



Prevention of lifestyle diseases for too long has just focused on trying to change individual behavior and choices. A focus at the individual level does not reflect research demonstrating the influence of physical and social surroundings on a person's decision-making processes which impact their health. Similarly, individual level focus negates the impact of health inequity on specific populations' well-being. Research suggests designing environments and policies, including both public laws and organizational practices, to promote healthy behaviors may reverse the increase of lifestyle diseases.[2] Addressing the multiple barriers to health improvement is necessary for improving a community's health. For example, efforts to educate people on the importance of exercise will do little to change behaviors if people lack safe, affordable, and accessible places to exercise. This concept is represented in the Socio-Ecological Model (Figure 2).

To address the root causes of chronic conditions and health behaviors, WellSpan will evolve its community health framework by focusing on the inclusion of social determinants of health and emphasizing health equity. Public health researchers frequently attribute persistent patterns of health disparities, i.e., gaps in access, conditions, or behaviors that are larger for

[1] The process described here arises from a host of questions that arise when attempting to determine need. Should we consider those problems where the community performs poorly relative to other communities, should we consider those problems that affect the most people, should we consider those problems that adversely affect some groups more than others, or should we consider those problems that contribute most to wasted lives and dollars? Unfortunately, the federal legislation that mandates these community health needs assessments provides little guidance. The legislation says that communities may, "use any criteria to prioritize the significant health needs [of a community], including but not limited to the burden, scope, severity, or urgency of the health need; the estimated feasibility and effectiveness of possible interventions; the health disparities associated with the need; or the importance the community places on addressing the need." https://www.federalregister.gov/documents/2014/12/31/2014-30525/additional-requirements-for-charitable-hospitals-community-health-needs-assessments-for-charitable#sectno-citation-%E2%80%891.501(r)-3 . The quotation appears in §1.501(r)-3(4), added to the Code by the Patient Protection and Affordable Care Act, Public Law 111-148 (124 Stat.119 (2010)).

[2] See Stulberg, Harvard Public Health Review, Vol 2, Oct 2014

some demographic groups than for others, to a set of social determinants. Social determinants thinking suggests that health is determined by access to social and economic opportunities that arise from the places where we learn, live, and work. According to the Centers for Disease Control (CDC), "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."[3] Changing the social determinants and ensuring health equity is necessary to improve community health given how much these underlying factors influence health care access, behaviors, conditions, and outcomes.

As a part of the commitment to Community Health planning, the October 2018 annual WellSpan Board Retreat had Board members, senior management and physician leaders from across the system review the CHNA and discuss possible areas of focus. The Retreat also included a community social service panel discussion which led to agreement on social determinants of health and health equity as focus areas. Additional conversations at the entity or hospital level encouraged leaders to place additional emphasis on their respective community and its challenges.

WellSpan leaders considered the following questions as they prioritized their focus areas:

- Where should WellSpan focus its attention and resources? Why?
- Should that focus be a system priority or a local community focus?
- What role does WellSpan play in addressing that priority?
- How is success defined?
- How should WellSpan leverage its leadership in a positive way to build community capacity?

Community Priority Setting

Healthy Adams County, Healthy York County Coalition and the Community Health Council of Lebanon County began conversations with key community stakeholders at health forums in 2018. Working thoughtfully through a process of dissemination, community conversation and strategic planning, each coalition identified areas of need in response to the CHNA. These areas of focus build on existing initiatives and compliment current work at the community level. In Lancaster County, both the county-wide assessment and the northern Lancaster County assessment have been used as guiding documents in several strategic conversations and forums with stakeholders who assisted WellSpan Health in its decision-making.

WellSpan Health's Community Health Framework & Priorities

The WellSpan Community Health Framework provides an overarching infrastructure for ongoing assessment and reporting of community needs along with focused priorities. The framework is consistent with WellSpan's mission of exceptional care for all, lifelong wellness and healthy communities. The leading objectives are to be a leader in health equity and fulfill the role as a charitable non-profit organization by providing care, regardless of one's ability to pay, and addressing unmet health needs for the overall well-being of the community. The infrastructure built to support this framework includes the ability to optimize data collection, analysis and accountability. The framework aligns with the WellSpan 2025 Strategic Plan and highlights WellSpan's strength in addressing health issues through partnership and finding better ways.

In addition, seven core principles are foundational to planning and will enable WellSpan to meet the identified needs. These principles are:

- Adoption of a broad population health definition
- Integration of cultural competency and health literacy tenets
- Emphasis on vulnerable populations and addressing unmet health-related needs
- Collaboration with diverse populations and stakeholders
- Focus on prevention and primary care
- Establishment of connections between health system, family and community

[3] A complete description of the Social Determinants of Health model and objectives can be found on the Healthy People 2020 website.

- Ongoing collection of data, feedback and evidence-based practice to inform decision-making

Based on CHNA results, WellSpan's three-year strategies and priorities within its Community Health Implementation Plan include:

"Care For All": Ensure equitable access and quality of care for patients by identifying and reducing disparities and barriers to care.

"Behavioral Health and Lifelong Wellness": Support personal wellbeing and whole-person health by making it easier for people to recognize and get support for mental health issues, and to adopt positive health behaviors.

"Healthy Communities and Social Determinants of Health (SDOH)": Develop and implement collective impact strategies to align WellSpan healthcare providers and community-based organizations to address social and economic issues which impact health.

Each of the respective WellSpan entities will address the following strategies and priorities (Table 3).

TABLE 3. 2020-2022 COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) PRIORITIES

	Care For All		Behavioral Health and Lifelong Wellness			Healthy Communities and Social Determinants of Health (SDOH)		
	Access	Health Equity	Behavioral Health	Substance Use and Addiction	Lifelong Wellness	Community Engagement	SDOH	Violence
Ephrata Community Hospital	X	X	X	X	X	X	X	
Gettysburg Hospital	X	X	X	X	X	X	X	
Good Samaritan Hospital	X	X	X	X	X	X	X	
Philhaven	X	X	X	X	X	X	X	
WellSpan Medical Group	X	X	X	X	X	X	X	
WellSpan Surgery & Rehab Hospital	X	X	X	X	X	X	X	
York Hospital	X	X	X	X	X	X	X	X

Care for All Strategy

PRIORITY: ACCESS

WellSpan Health values the patient-provider relationship and has worked diligently to increase access to primary care providers and specialists. According to the 2018 CHNA, between 84 percent and 87 percent of adults in the communities that WellSpan serves indicated that they had a personal physician. In addition, more than 2.2 million patient visits were made to WellSpan Medical Group primary and specialty care practices in 2018. Additional visits were made to providers within the WellSpan Provider Network. The WellSpan Medical Group is comprised of more than 1,200 employed physicians and advanced practice clinicians across the region. Promoting the patient- provider relationship extends beyond the health care system though, as WellSpan partners with local Federally Qualified Health Centers (FQHC) including Family First, Keystone Health, Lancaster Health Center and Welsh Mountain Health Centers, as well as other clinics to implement strategies that increase patient access to local providers. Important ways in which WellSpan promotes access to care include the acceptance of all payors, including Medicaid, and an expansive financial assistance policy.

In response to the changing healthcare climate nationally, WellSpan remains focused on health equity and access to care. WellSpan recognizes disparities related to high deductible health plans, high prescription costs and the significant number of community members who make challenging decisions not to receive healthcare because of the associated costs. This is why WellSpan has expanded its financial assistance policy, has restructured its Healthy Community Network charity care program, and expanded its prescription assistance program. WellSpan seeks to transform our communities to ensure quality healthcare is available to all, regardless of their ability to pay.

GOAL	OBJECTIVE	Corp.	ECH	GH	GSH	Phil	WMG	WSRH	YH
1. Develop and maintain a strong safety net of services that improve access to care among vulnerable populations.	1.1: Partner with local Federally Qualified Health Centers (e.g. Family First Health, Keystone Health, Lancaster Health Center, Welsh Mountain Health Centers) and other organizations and clinics to support the specific health needs of vulnerable populations.	X	X	X	X	X	X	X	X
	1.2: Advance Healthy Community Network as a partnership between WellSpan Health, independent physicians, and community partners to support prospective enrollment, and insurance access for patients needing healthcare.	X	X	X	X	X	X	X	X
	1.3: Identify partnerships in the community where WellSpan Health's financial assistance policy can be utilized to support access to free or discounted services for qualifying patients.	X	X	X	X	X	X	X	X
2. Understand and address gaps in care created by affordability issues (e.g. high deductible plans).	2.1: Identify, evaluate and implement strategies to address affordability and its impact on health outcomes and patient experience.	X	X	X	X	X	X	X	X
	2.2: Pilot new options that would provide support for those with high deductible health plans or affordability concerns and increase price transparency.	X	X	X	X	X	X	X	X
3. Advance a WellSpan culture of inclusion in support of the growing diversity of our patients and communities.	3.1: Advance access to culturally-appropriate care, with a focus on ensuring access to and compliance with high quality and meaningful interpretation services.	X	X	X	X	X	X	X	X
	3.2: Be a leader in health equity, actively involved in community initiatives to understand disparities and support change.	X	X	X	X	X	X	X	X

PRIORITY: HEALTH EQUITY QUALITY OUTCOMES

The core belief which guides WellSpan's Community Health Improvement Plan is that everyone should have the opportunity to achieve their full health potential. In order to advance the health of the communities served by WellSpan, the community health strategies must consider the multitude of factors that influence one's health and well-being, including social, demographic, behavioral and economic factors. WellSpan will work collaboratively to identify and address disparities in healthcare, and their influence on health. By enhancing the availability, access and utilization of healthcare services regionally- including clinical care, preventative and support services- and by focusing on the quality and equity of those services, WellSpan can foster a transformative healthcare environment.

WellSpan will employ a data-driven approach to explore disparities among patients served and will develop strategies to address these disparities in a meaningful and impactful way. Simultaneously, WellSpan will advance its culture of inclusion and will explore its strength in recruiting and retaining diverse healthcare professionals.

GOAL	OBJECTIVE	Corp.	ECH	GH	GSH	Phil	WMG	WSRH	YH
1. Develop health equity quality outcome measures, aligning Community Health Needs Assessment data with electronic health record (Epic) data.	1.1: Identify and utilize quality/safety and patient experience measures to stratify patient information by demographic and socioeconomic data points to pinpoint disparities.	X	X	X	X	X	X	X	X
	1.2: Define a system-wide quality measurement and impact approach to addressing health inequities, focusing initially on obstetric and newborn care.	X	X	X	X	X	X	X	X

Behavioral Health & Lifelong Wellness Strategy

PRIORITY: BEHAVIORAL HEALTH

In 2018, more than one in five adults across our region reported that they had been diagnosed with a depressive disorder. Similarly, nearly the same number of adults have been diagnosed with anxiety disorder and over one-third of the population reported at least one day their mental health was not good in the past month. Given the stigma often associated with these conditions, these statistics are believed to be under-represented.

Behavioral health issues impact our communities much like others across the United States. In January 2016, WellSpan Health and Philhaven, which at the time was the 13th largest provider of behavioral health services in the United States, came together to create a new behavioral health organization that operates within WellSpan's coordinated system of care. This integrated approach enhances WellSpan's ability to identify and refer those with anxiety and depression, explore and implement alternate behavioral health care models, strengthen the pipeline of behavioral health providers serving our communities, provide further education on identifying mental health emergencies, suicide prevention and stigma reduction, and expand community partnerships to address complex behavioral health issues.

GOAL	OBJECTIVE	Corp.	ECH	GH	GSH	Phil	WMG	WSRH	YH
1. Decrease the number of community members who experience poor mental health days by increasing education and early intervention.	1.1: Increase community education and early intervention efforts by expanding the number of individuals in each community who receive training in mental health first aid, suicide prevention, and/or trauma informed care.	X	X	X	X	X	X	X	X
	1.2: Expand the existing community-wide mental health initiatives to focus on supporting specific at-risk populations, reducing stigma, and increasing access to care.	X	X	X	X	X	X	X	X
2. Increase the number of patients who are screened for depression and coordinate appropriate behavioral health services.	2.1: Integrate a standardized depression screening tool (PHQ-2) for WellSpan primary care patients who are screened, and their needs addressed.	X	X	X	X	X	X	X	X
	2.2: Advance integration of behavioral health providers into patient-centered medical homes.	X	X	X	X	X	X	X	X
	2.3: Increase access to mental health outpatient services through new care models and services.	X	X	X	X	X	X	X	X

PRIORITY: SUBSTANCE ABUSE AND ADDICTION

The misuse and abuse of opioids, prescription drugs and other substances across the United States has sparked a public health concern which continues to impact our communities. Opioids, once viewed positively for their ability to effectively manage pain, are now the subject of controversy due to the potential for addiction and increased risk of overdoses and deaths. Substance misuse and addiction are not isolated to one demographic or population, but affect numerous community members throughout the region, regardless of age, education, employment, poverty, race and ethnicity. Multi-faceted strategies that assist in alternative management of chronic pain, improve the safety and management of prescription-opioid medications, enhance the understanding of addiction, provide treatment options and resources, and support community collaborations to address substance mis-use and addiction must be strengthened and ongoing.

GOAL	OBJECTIVE	Corp.	ECH	GH	GSH	Phil	WMG	WSRH	YH
1. Reduce opioids, prescription drugs and other substances misuse to prevent overdoses and deaths.	1.1: Improve prescription opioid management within WellSpan Medical Group practices, WellSpan emergency departments and inpatient units by emphasizing safety while focusing on gaps in pain management.	X	X	X	X	X	X	X	X
	1.2: Develop tools and resources to educate WellSpan providers and partner organizations to assist them in patient management, including medication assisted therapy and available addiction services.	X	X	X	X	X	X	X	X
	1.3: Support community-level coalitions & task forces developed to address substance mis-use and addiction.	X	X	X	X	X	X	X	X

PRIORITY: LIFELONG WELLNESS

WellSpan Health strives to assist community members in reaching their optimal health. The 2018 CHNA continues to point to lifestyle and health behaviors that contribute to health conditions and issues that are concerning. For example, the overweight and obesity rates across Adams, Lancaster, Lebanon and York counties' adult populations ranged between 63% and 73%. Health outcome indicators such as high blood pressure, high cholesterol and diabetes were evident in a significant portion of the population. Proper dietary and physical activity behaviors are lacking and although tobacco use rates are steady, the practice of vaping has surged among our teenagers and young adults.

WellSpan will maintain a commitment to lifelong wellness and will assist community members on their journey to good health. This work is already evident in WellSpan's success with implementing the patient-centered medical home model within WellSpan Medical Group practices, and the evolving population health approach to healthcare that focuses on quality. WellSpan will continue to encourage healthier eating, physical activity and other positive lifestyle behaviors, whether through partnerships with local employers, motivating our own employees, or engaging community groups. As we move forward, we seek to identify opportunities to engage the next generation in good health, recognizing that lifestyle behaviors are adopted at a young age. Assessing and understanding the needs of our children, decreasing the incidence of preventable injuries and encouraging healthy behaviors at a young age rounds out our commitment to promoting lifelong wellness.

GOAL	OBJECTIVE	Corp.	ECH	GH	GSH	Phil	WMG	WSRH	YH
1. Promote lifelong wellness to encourage behaviors supporting prevention and well-being.	1.1: Advance system-wide coordination and promotion of WellSpan's prevention and disease management programs / initiatives to ensure impact and support life-long wellness.	X	X	X	X	X	X	X	X
	1:2: Conduct asset inventory of WellSpan programs to identify gaps and connect the community with prevention and wellness programming.	X	X	X	X	X	X	X	X
2. Understand the needs of children in our communities and focus on initiatives that ensure a healthy start in life.	2.1: Complete a community needs assessment of young children (0 -5 years of age) and adopt key metrics to establish a baseline for evaluating trends in future CHNA.	X	X	X	X	X	X	X	X
	2.2: Decrease the incidence of preventable injuries among children in key areas: bicycle safety, child passenger safety, Cribs for Kids (safe sleep), distracted driving among adolescents, and home safety by coordinating initiatives supporting existing programs (e.g. Safe Kids) and identifying opportunities for developing new resources.	X	X	X	X	X	X	X	X

Healthy Communities and Social Determinants of Health Strategy

PRIORITY: COMMUNITY ENGAGEMENT

WellSpan Health believes that its impact on community health is strengthened by partnering with community organizations to address identified community needs. WellSpan's commitment to partnership is evident in many ways including its Community Partnership grants, sponsorships and support of local health coalitions. WellSpan provides significant funding support to Healthy Adams County, Healthy York County Coalition and the Community Health Council of Lebanon County. In addition, it provided support for the development of the Northern Lancaster Hub of social services. These entities played a strong role in disseminating the CHNA data and providing feedback to identify priority areas in need of attention. They act as a catalyst and often their task forces or sub-committees put needs into action, moving forward with solution-focused initiatives. Maintaining and strengthening partnerships, with these entities and many others, is essential to WellSpan.

Collective Impact as an Evolving Model

Community health issues are often complex, and the initiatives employed to solve them are sometimes fragmented or incomplete, resulting in isolated impact. Finding a better way should always be a mindset to facilitate continuous improvement. A model that warrants further investigation is that of collective impact. The concept of a collective impact model is that it requires a collaborative effort with a systematic approach. An agreement on a common agenda is necessary so that all the partners understand the problem, agree upon a plan and have a vision of the outcome. Collective Impact models develop a shared measurement system so that partners' efforts are aligned, and they can leverage the strength of resources of the diverse group of stakeholders with coordinated activities. Collective impact models support continuous communication among partners to establish trust and familiarity and has a backbone structure to mobilize the collective effort.[4] A reported benefit of this model is that it provides more clarity to all partners and further identifies the roles they play.

GOAL	OBJECTIVE	Corp.	ECH	GH	GSH	Phil	WMG	WSRH	YH
1. Actively support coalitions and partnerships which promote mutual goals, assume shared responsibility, and represent diverse stakeholder perspectives.	1.1: Continue to build community capacity to address health priorities through staffing and financial support, as appropriate, to county and local health coalitions, and collaborative partnerships with diverse community stakeholders.	X	X	X	X	X	X	X	X
	1.2: Establish new approaches to working with community organizations including joint advocacy, better systems for integrated care and referrals, and collective impact models.	X	X	X	X	X	X	X	X
	1.3: Collaborate with community coalitions and stakeholders to identify and better understand social determinants of health (i.e., housing, food insecurity, poverty, etc.), and opportunities to coordinate how gaps are addressed.	X	X	X	X	X	X	X	X

[4] J. Kania and M.Kramer, Stanford Social Innovation Review, Winter 2011.

PRIORITY: SOCIAL DETERMINANTS OF HEALTH (SDOH)

WellSpan's community health approach includes a focus on the social determinants of health which suggest that health is determined by access to social and economic opportunities that arise from the places where we learn, live, and work. Public health researchers frequently attribute persistent patterns of health disparities, i.e., gaps in access, conditions, or behaviors, that are larger for some demographic groups than for others, to a set of social determinants. Food insecurity, affordable housing, transportation needs, educational attainment and health care access are among the most noted social determinants. Given the impact of these root causes it is imperative to accurately assess and analyze the need, understand the reality of those affected, and implement strategies to promote good health for all.

GOAL	OBJECTIVE	Corp.	ECH	GH	GSH	Phil	WMG	WSRH	YH
1. Advance social determinants of health (SDOH) screening and data collection and develop a referral process for identified needs.	1 .1: Establish system-wide SDOH leadership structure to guide inpatient and ambulatory data collection, analysis and decision making.	X	X	X	X	X	X	X	X
	1.2: Provide staff with county-specific resources to address SDOH needs identified in screenings and create operational workflows for referrals.	X	X	X	X	X	X	X	X
	1.3: Create a shared plan with our communities to integrate specific social service referrals with our clinical and IT infrastructure.	X	X	X	X	X	X	X	X
2. Adopt "Hunger and Food Insecurity" and "Transitional Housing for Patients" as system-wide health issues for WellSpan to address in collaboration with the community.	2.1: Advance local partnerships with community organizations to address food insecurity by improving the availability of healthy foods.	X	X	X	X	X	X	X	X
	2.2: Implement strategies for identifying hospitalized and practice identified patients who are food and housing insecure, to connect them to local resources after discharge/visit with a defined warm hand over process.	X	X	X	X	X	X	X	X
	2.3: Expand innovative community collaborations that provide safe and appropriate temporary housing for patients ready for hospital discharge, who have continued recuperative care needs without a healthy housing alternative.	X	X	X	X	X	X	X	X

Past successes translate into future opportunities.

WellSpan Health's commitment to the overall health of the communities it serves is evident in the initiatives it implements and the financial resources it allocates. In 2018, WellSpan Health provided $190.3 million in community benefit, including an estimated $12.9 million on community education and outreach programs.

Examples of initiatives developed in response to the priorities identified in the previous Community Health Improvement Plan continue and are described in Table 4.

TABLE 4. COMMUNITY HEALTH PROGRESS

2016-2019 WellSpan Community Health Progress		
STRATEGIES	**ACTIVITIES**	**DESCRIPTION**
Health Equity and Access	Bridges to Health	A multi-faceted healthcare program geared toward meeting the unique needs of the community's most vulnerable patients.
	Dixon Foundation Health Center	Development of a Health Center that will improve access to primary care, behavioral health, and social services.
	Financial Assistance Policy Expansion	Expansion of the WellSpan financial assistance policy beyond its previous threshold of 300% of the federal poverty level, making discounts available for patients whose income is between 300% and 400% of the federal poverty level.
	Hoodner Dental Center Expansion	Expansion of dental center to increase dental care access for York City residents.
	Prescription for Caring	Expansion of the Healthy Community Network program that helps offset the cost of prescriptions for those in need.
	Telepsych Services	WellSpan Philhaven program expanded to enhance access to a behavioral health specialist via computerized video conference service.
	Warm Hand-Off Program	Program that connects overdose survivors with addiction recovery services so that they can gain access to treatment.
At-Risk Populations	Healthy Beginning Plus	Provides education and prenatal care to low-income women at locations throughout the WellSpan system.
	Medication-Assisted Treatment (MAT)	MAT combines the use of medications and behavioral therapy to treat people with substance use disorders.
	Transitional Housing Programs	Community collaboration that provides safe and appropriate temporary housing for patients ready for hospital discharge, who have continued recuperative care needs.

2016-2019 WellSpan Community Health Progress		
STRATEGIES	**ACTIVITIES**	**DESCRIPTION**
Community Engagement	Coalition Support	WellSpan Health continues to support the work and development of community health coalitions and hubs of social services in each of the communities served.
	Community Partnership Grants	Between 2017-2019, WellSpan provided more than $894,000 to local non-profit agencies in the form of community partnership grants. These grants are awarded based on alignment with Community Health Improvement Plan priority areas.
	YMCA- Hanover Partnership	WellSpan/Hanover-YMCA partnership program that focuses on youth fitness and weight loss through nutritional support and athletic development.
Prevention and Wellness	Behavioral Health Community Programming	Initiatives regionally aimed to enhance awareness and remove the stigma of mental illness while equipping the community with tools to address mental health. A few examples include: The Feeling Blue website, myStrength app and Mental Health First Aid training program.
	Childhood Safety and Injury Prevention	Community leader in addressing childhood safety and injury prevention by serving as the lead agency for Safe Kids York County and national leader in promotion of infant safe sleep through Cribs for Kids Program.
	Your Life, Your Wishes	Advancement of the Your Life Your Wishes (End of Life education) task force and Horizon Planning initiatives within WellSpan and throughout the community which enhance awareness for end of life planning.
	Lifestyle Prevention Programs and Initiatives	A multitude of community programs and initiatives aimed to address health behaviors and chronic conditions related to healthy eating, weight management and physical activity. A few examples include: The 10 Pound Throwdown, For Heart's Sake, Get Outdoors (GO), Good Samaritan Hospital Community Garden, Juntos de Lebanon diabetes support group, Market Bucks, Monday's Market, walking programs, Yoga in the Park.
	Sepsis Outreach	Program that provides sepsis education to caregivers and community members using a train the trainer model.
	Sexual Assault Forensic Examiner Teams	Specially-trained emergency nurses that provide care to domestic violence/child abuse victims.
	Tobacco Cessation	Array of tobacco cessation services including one-on-one counseling, worksite cessation programs, the Quitter's Circle mobile app promotion and youth prevention programs.

In 2018, WellSpan Health's commitment to caring for the uninsured and underinsured included:

- $15.2 million in free care to patients who participated in the financial assistance program.
- $12.3 million to support services that provided discounted medical, dental and pharmaceutical care to those in need.
- $149.9 million in cost greater than what was reimbursed through Medicaid.
- $269.6 million in cost greater than what was reimbursed through Medicare.
- $36.1 million in services to patients who received care for which they did not pay and were not participating in the financial assistance plan.

Further details concerning WellSpan's community commitment may be found in the WellSpan Community Benefit Report which is produced annually and posted at www.WellSpanCommunity.org/.

Health Indicators Not Addressed

Public health research recommends a root cause approach be utilized to address many chronic conditions such as cardiovascular disease, diabetes, respiratory ailments and obesity. As such, interventions that address specific chronic conditions and prevention behaviors will continue as they have in the past. We believe, however, approaches that demonstrate collective impact and address the social determinants of health allow for a broader perspective. Indicators such as high blood pressure, diabetes and high cholesterol are not called out specifically within this plan, but a root cause approach will elicit a positive impact on these indicators as well as many others.

At WellSpan, we strongly believe in partnership and understand that other agencies' efforts impacting the communities' health are tremendously valuable. These partnerships continue to influence indicators in our CHNA that we have not specifically addressed.

For example, issues related to environmental air quality were not selected by WellSpan Health as a priority that will be addressed within this plan. WellSpan maintains involvement in transportation related efforts regionally that would improve the air quality, and we carefully consider our environmental footprint and seek opportunities to be environmentally responsible. WellSpan maintains a commitment to advancing the healthcare provided to those experiencing health issues caused by and exasperated by poor environmental air quality. Additional efforts to address environmental air quality issues in our region will require a global community response.

WellSpan believes its presence as a regional healthcare system which meets the unique needs of the counties it serves and employs more than 19,000 local community members, is well positioned to impact change through partnership and collaboration for those health issues not prioritized in this plan.

Conclusion

WellSpan is a steadfast community partner with a proven commitment to the communities we serve. We are making great strides already in the communities' health- both with medical advancements and care that occur inside the walls of our hospitals, medical group practice and ancillary services and with our strong engagement and partnership within the community. As we move forward, we will engage in focused and impactful opportunities to advance the health of our communities, understanding that the health of a community is dependent upon collaboration with diverse stakeholders, coordinating efforts and implementing strategies to address the prioritized needs. We are excited to move forward with our friends and neighbors on a quest to further live out our mission: working as one to improve health through exceptional care for all, lifelong wellness and healthy communities.

Approved by the WellSpan Board of Directors June 2019.

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