



CENTRE COUNTY

2019 Community Health Needs Implementation Plan

Executive Summary

As a trusted local healthcare leader, Mount Nittany Health is committed to understanding and addressing the most pressing health and wellness concerns for our community. Therefore, every three years Mount Nittany Health conducts a Community Health Needs Assessment (CHNA) and creates a corresponding implementation plan to address the health priorities identified by the CHNA.

Mount Nittany Health has conducted the 2019 CHNA in partnership with Centre Foundation, Centre County United Way, and Centre County Partnership for Community Health. The 2019 CHNA will be used as a tool for informing strategy, funding, and action plans to improve the health and wellness of our community.

Research from our most recent CHNA (completed in 2019) shows us that our community, Centre County, is a healthy community. Centre County meets 12 Healthy People 2020 goals and ranks 2nd among all 67 Pennsylvania counties for health outcomes.

However, there are still health issues and areas of health disparity in our community that exist. The 2019 CHNA identified three priority areas based on the scope and severity of the issue affecting Centre County residents. This plan, which was developed in collaboration with key community organizations and has been adopted by the Mount Nittany Health board of directors, outlines each priority area along with their respective challenges, goals, objectives and strategies.

The identified health priority areas of behavioral health, substance abuse and chronic disease are complex issues affected by a multitude of factors requiring a community wide coordinated approach to identify and implement impactful solutions. Mount Nittany Health looks forward to potentially partnering with a host of community organizations, coalitions and interested individuals to positively impact these priority areas.

PRIORITY ISSUE: Behavioral Health and Substance Use Disorders

GOAL: Improve overall well-being of residents by increasing access to care and encouraging resiliency, wellness, and self-management of behavioral health and/or substance use disorders.

OBJECTIVE 1: Increase awareness of behavioral health and substance use disorders and promote evidence-based prevention and management strategies.

TACTICS:

- Support community initiatives to provide education to increase awareness of behavioral health and substance use disorder signs and symptoms and reduce stigma.
- Support community initiatives to promote available behavioral health and substance use disorder services across Centre County.
- Partner with community organizations to develop messaging and programs that promote integrated physical and behavioral well-being, and address prevention and self-management.
- Provide continuing education opportunities for healthcare professionals to increase awareness of behavioral health and substance use disorders and available treatment services in the community.
- Initiate early stage interventions for youth at high risk of substance use, targeting alcohol and e-cigarette use.

OBJECTIVE 2: Increase access to behavioral health services and improve care coordination for patients with a behavioral health and/or substance use disorder.

TACTICS:

- Promote evidence-based practices for patient-centered behavioral health and/or substance use disorder care and treatment.
- Collaborate with the Centre County Mental Health Task Force to identify and implement improvements in the delivery of crisis services and transitions of care.
- Provide case management services for patients seeking behavioral health and/or substance use disorder care in the Emergency Department.
- Assess implementation of evidence-based screenings and a warm handoff program for behavioral health and substance use disorders at MNH primary care practices.
- Develop and implement MNH behavioral health services, including expanded inpatient and outpatient offerings and integrated behavioral health and primary care services.
- Expand MNMC inpatient behavioral health unit capacity to increase local access to care

PRIORITY ISSUE: Chronic Disease

GOAL: Reduce risk factors for chronic disease and improve management of chronic disease conditions.

OBJECTIVE 1: Increase access and participation in prevention and education programs that encourage healthy lifestyles for adults and youth.

TACTICS:

- Provide financial, technical and operational support to local organizations dedicated to serving at-risk populations and engaging residents in their improving their health status.
- Support and sponsor free or low-cost healthy lifestyle programs, activities, and education opportunities, targeting at-risk communities and populations.
- Provide MNH providers as subject matter experts to provide chronic disease community education.
- Support the delivery of mobile preventive and educational services in partnership with community agencies.

OBJECTIVE 2: Advance local initiatives to address social determinants of health barriers.

TACTICS:

- Provide continuing education opportunities for healthcare professionals to increase awareness of social determinants of health and available support services.
- Partner with community organizations to increase awareness of available social support services, and reduce barriers to connecting individuals with services.
- Pursue innovative funding and collaboration models to reduce social determinants of health barriers, with an emphasis on rural, at-risk communities.

OBJECTIVE 1: Improve care coordination for individuals diagnosed with a chronic condition.

- Provide a Mount Nittany Physician Group Care Coordinator Program for high-risk primary care patients and patients seen in the inpatient setting for a respiratory illness and/or chronic disease.
- Expand palliative care services for individuals with serious illness, focused on improved quality of life for patients and their family.
- Provide integrated care models to improve outcomes for patients with chronic disease, targeting cancer, congestive heart failure, and diabetes.
- Explore and pilot a Community Health Worker program to provide case management and social service assistance, targeting high-risk patients with diabetes and obesity.
- Assess implementation of evidence-based social determinants of health screenings and a warm handoff program at MNH primary care practices.