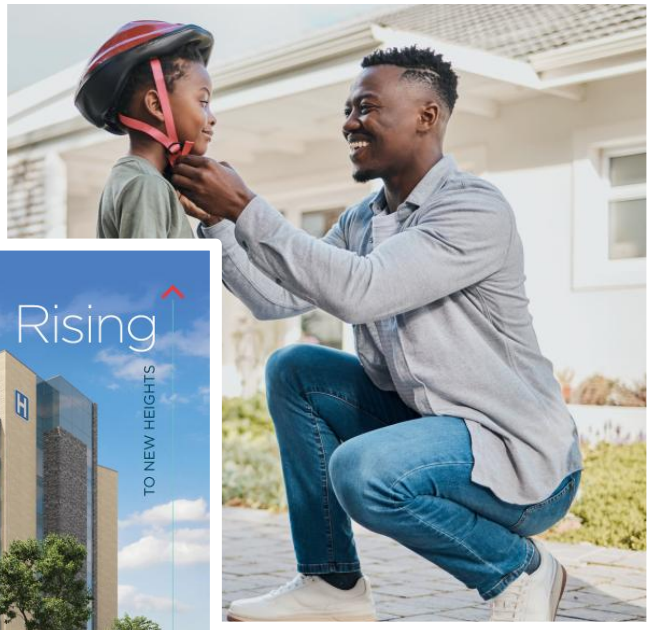
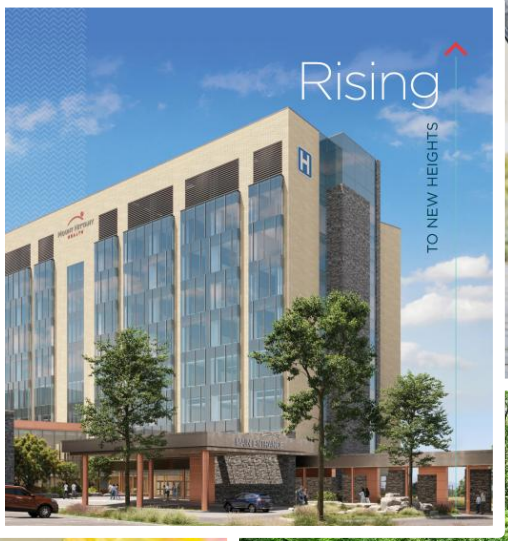
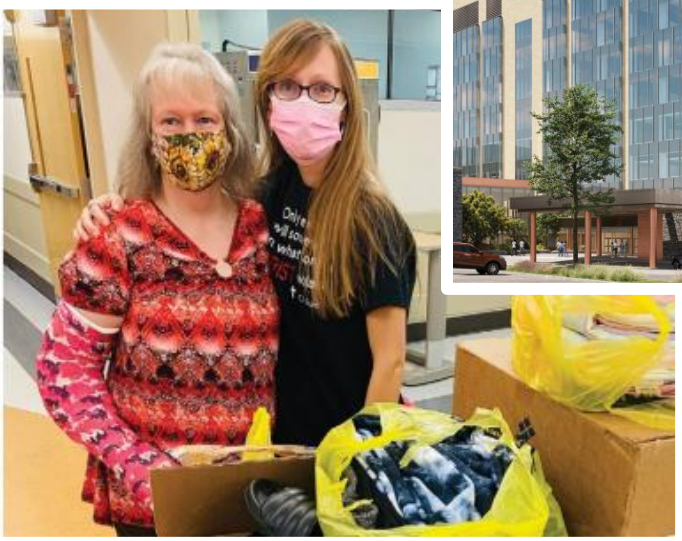
2025 Community Health Implementation Plan

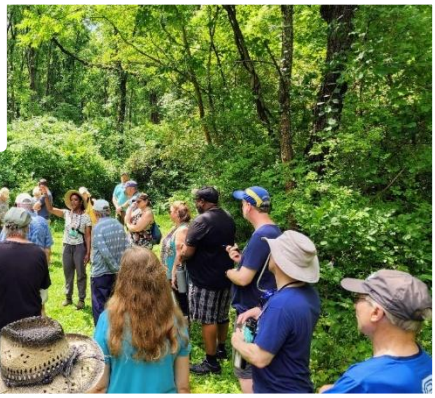
September 2025

MOUNT NITTANY® HEALTH









About Mount Nittany Health and the 2025 CHNA & CHIP

As a trusted local healthcare leader, Mount Nittany Health (MNH) is dedicated to understanding and addressing the most pressing health and wellness concerns of our community. Mount Nittany Health conducts a Community Health Needs Assessment (CHNA) every three years to monitor the health of community members and the myriad social and environmental factors that influence health and well-being. The CHNA informs the development of our Community Health Implementation Plan (CHIP) to address identified priority needs and align community health investments with the highest needs in our community.

The goal of the CHNA and CHIP is to help facilitate a healthy and thriving Centre County for all residents and to foster a collaborative approach for community health improvement.

CHNA and CHIP Objectives:

- Compile a comprehensive profile of the factors that impact health and well-being in Centre County
- Compare community health indicators with previous CHNAs to document trends and changes
- Demonstrate the impact of Social Drivers of Health; document disparities experienced by populations and communities
- Strengthen stakeholder engagement and partnerships; engage residents in the study process
- Define three-year priority areas and develop action planning
- Develop a community resource to monitor the progress of community health initiatives

We thank you for partnering with us in this effort. We invite our community partners to learn more about the CHNA and CHIP and opportunities for collaboration to address identified health needs. Please visit our website or contact Mount Nittany Health Communications at Communications@mountnittany.org.

2025-28 Community Health Implementation Plan

What is a Community Health Implementation Plan (CHIP)?

A CHIP helps organizations move from data to action to address priority health needs identified in the CHNA. The CHIP serves as a guide for strategic planning and a tool by which to measure impact by detailing goals, objectives, and strategies over the three-year reporting timeframe. Anchoring initiatives and community benefit activities to measurable objectives, the CHIP creates a framework for determining the impact of collective action towards community health.

Community Input

Like the CHNA, the CHIP reflects input from diverse stakeholders and helps to foster collaboration among community-based organizations. Health and human service professionals from across Centre County provided input to define and recommend solutions to the historical and day-to-day challenges in our community. Together this input provided diverse perspectives on health trends, helped us better understand lived experiences among at risk and underserved populations, and provided insights into the gaps that contribute to health disparities and inequities.

Determining Community Health Priorities

To improve community health, it is imperative to prioritize resources and activities toward the most pressing and cross-cutting health needs. In determining health priorities on which to focus its efforts over the next three-year cycle, MNH leadership reviewed findings from the CHNA and sought to align with its health improvement programs and population health management strategies.

Based on the CHNA findings, MNH will focus on the following priority areas and cross-cutting strategies for the 2025-2028 reporting cycle:

We will continue to monitor and share our progress toward these efforts during the 2025-2028 reporting cycle.

1. CROSS CUTTING STRATEGIES

Community Partnerships & Collaboration

OBJECTIVES:

- Increase community awareness, understanding, and collective impact in addressing social determinants of health
- 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 communities and at-risk populations.

Actions/tactics	Anticipated impact	MNH Resources	Potential Collaborations
1a. Foster opportunities for collective community conversation and impact by hosting an annual community health forum	Enhanced community partnership to collectively address identified health needs	Professional Development, Education, Brand & Community Engagement and Planning & Program Development	County Agencies and Programs, Local Non-profit Organizations, Community Health Care Partners, Local Businesses, School Districts, Universities/ Colleges, Faith Community Representation
1b. Develop a process to assist and encourage ongoing discussion around community health issues and initiatives	Enhanced community engagement presence	Brand & Community Engagement, and Planning & Program Development	
1c. Provide leadership and advocacy for community services that support health and wellbeing	Enhanced and improved coordination of community services	MNH leadership, MNH providers, Brand & Community Engagement, and Planning & Program Development	

2. Social Determinants of Health (SDoH) and Rising Costs of Living

OBJECTIVES:

- Create data collection infrastructure to understand and quantify social determinants of health that affect patient health and well being
- Advance local initiatives to address social determinants of health barriers.

Actions/tactics	Anticipated impact	MNH Resources	Potential Collaborations
2a. Develop ability and capacity to capture and quantify a robust portfolio of patient SDoH through the implementation of Epic in June 2026	Enhanced quantification of SDoH need within Centre County	MNH Epic Data Analytics and Data Governance committees, internal Population Health, Case Management and Primary Care representatives	Local Non-profit Organizations, Community Health Care Partners
2b. Assess development and implementation of evidence-based SDoH screenings and a warm handoff program	Assessment of potential program opportunities and related impact		
2c. Continue with Transitions of Care program to support transitions of care and outcomes for high-risk populations	Ongoing ambulatory case management efforts to provide support to patients with SDoH barriers	Case Management, Population Health, Primary Care	
2d. Support innovative and collaborative opportunities that align with CHNA identified priorities and cross- cutting strategies	Ongoing community support	Brand & Community Engagement, and Planning & Program Development	

3. Care of Marginalized and Vulnerable Communities

OBJECTIVE:

- Advance local initiatives to address social determinants of health barriers, as well as provide care to at risk populations

Actions/tactics	Anticipated impact	MNH Resources	Potential Collaborations
3a. Provide financial, technical, and operational support to community partners serving at risk populations	Targeted financial support that aligns with CHNA identified priorities and cross cutting strategies	Brand & Community Engagement, and Planning & Program Development	Local Non-profit Organizations, Community Health Care Partners, Universities/Colleges
3b. Support and sponsor free or low-cost healthy lifestyle programs, activities, and education opportunities, targeting at risk populations.			
3c. Support innovative and collaborative opportunities that align with CHNA identified priorities and cross cutting strategies			
3d. Support and expand MNH Centre County Children's Advocacy Center	Increased and enhanced spaces for the care of children of child abuse	MNH CAC; MNH Pediatrics, Facilities, Health System Transformation	Law Enforcement, Community Agencies, Community Healthcare Partners
3e. Continue to provide staff education that develop competencies in caring for diverse populations	Enhanced patient experience	MNH Professional & Organizational Development, MNH staff and providers	Community Health Care Partners

PRIORITY ISSUES

4. Access to Care

GOAL: Improve primary care and specialty care access across the county

OBJECTIVE: Increase primary care access

Actions/tactics	Anticipated impact	MNH Resources	Potential Collaborations
4a. Grow the number of total net new primary care providers by 3.0 FTEs by June 2028	Improved access to primary care providers	Primary Care, Population Health Staff and Programs, Brand & Community Engagement, Human Resources, Talent Acquisition and Physician Recruitment	Payers, County Agencies and programs. State agencies and programs; local and regional non-profits
4b. Continued execution on *Express*CARE strategy for expanded access to unscheduled care	Expanded hours, additional access	Primary Care, Health System Transformation, Facilities	Payers, County Agencies and programs. State agencies and programs; local and regional non-profits

OBJECTIVE: Increase targeted service line and specialty care access

Actions/tactics	Anticipated impact	MNH Resources	Potential Collaborations
4c. Grow the number of total net new service line and/or specialty care providers by 3.0 FTEs by June 2028	Improved access to service line and specialty care providers	Specialty care practices, Service Line Directors, Population Health Staff and Programs, Brand & Community Engagement, Human Resources, Talent Acquisition and Physician Recruitment	Payers, County Agencies, Community Healthcare Partners
4d. Increase specialty care at MNH Huntingdon practice location	Improved specialty care access within Southern Centre County	Specialty Care practices, Facilities, Population Health Staff and Programs, Brand & Community Engagement	Partner with community FQHC; Huntingdon community

OBJECTIVE: Promote/develop healthcare workforce pipeline

Actions/tactics	Anticipated impact	MNH Resources	Potential Collaborations
4e. Explore education partnerships with local schools and universities/colleges	Increased awareness relating to healthcare jobs and related opportunities	Human Resources, Talent Acquisition and Physician Recruitment	Community Healthcare Partners, School Districts, Universities/Colleges

5. Behavioral Health

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

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

Actions/tactics	Anticipated impact	MNH Resources	Potential Collaborations
5a. Support community initiatives to increase awareness of behavioral health and substance use disorder signs and symptoms and reduce stigma	Decrease stigma relating to behavioral health disorders and increase community awareness and support	Behavioral Health Staff and Programs, Primary Care, Brand & Community Engagement, Emergency Department, Case Management, Planning & Program Development, MNH Foundation	County Agencies and programs. State agencies and programs; school districts, local and regional non-profits, school districts, Universities/Colleges
5b. Partner with community organizations to develop messaging and programs that promote integrated physical and behavioral well-being, and address prevention and self-management	Increased awareness and promotion of healthy lifestyles for adults, youth and student populations		
5c. Support innovative and collaborative opportunities that align with CHNA identified priorities and cross cutting strategies	Ongoing community support		
5d. Participate in grant opportunities that align with CHNA identified priorities and cross cutting strategies as appropriate	Support for identified services		

OBJECTIVE: Increase access to behavioral health services and improve care coordination for patients with a behavioral health disorder.

Actions/tactics	Anticipated impact	MNH Resources	Potential Collaborations
5e. Develop an intensive outpatient program/partial hospitalization program to provide continuum of care offerings to patients with behavioral health care needs pre- and/or post-discharge or as an alternative to an inpatient stay	Improved access along the continuum of care relating to behavioral health needs	Behavioral Health Staff and Programs, Primary Care, Brand & Community Engagement, Human Resources, Talent Acquisition, Physician Recruitment, Emergency Department, Health System Transformation, Case Management and Facilities	Payers, County Agencies and programs. State agencies and programs; Local and Regional Non-profits
5f. Increase number of behavioral health care providers by June 2028	Improved access to care		
5g. Pilot telehealth and in-person therapy offerings embedded in primary care	Improve access along the continuum of care relating to behavioral health needs, increase primary care access		
5h. Continue to provide case management services for patients seeking behavioral health care in the Emergency Department	Ongoing continuity of care		
5i. In conjunction with completed master facility plan, evaluate need for increased inpatient bed capacity	Completion of IP BH bed configuration and design as appropriate		

6. PRIORITY ISSUE: Chronic Healthcare and Preventative Care

GOAL: Reduce risk factors for chronic disease and improve management of chronic disease conditions – specifically cardiovascular disease, obesity, breast, lung & colorectal cancer, diabetes and dental care

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

Actions/tactics	Anticipated impact	MNH Resources	Potential Collaborations
6a. Provide MNH providers as subject matter experts to provide chronic disease community education	Increased awareness and education relating to prevention of chronic disease and promotion of healthy lifestyles for adults and youth	MNH Providers, Brand & Community Engagement, and Planning & Program Development	Community Health Partners, School Districts, Universities/Colleges
6b. Continue use and expansion of digital communication tools to increase awareness and provide education relating to chronic disease and preventive care			
6c. Support innovative and collaborative opportunities that align with CHNA identified priorities and cross cutting strategies	Increased access to preventative care, increased participation in wellness programs	Brand & Community Engagement, and Planning & Program Development	Local and Regional Non-profits, Community Health Partners

OBJECTIVE: Improve care coordination for individuals diagnosed with a chronic condition – specifically obesity, diabetes, cardiovascular care and cancer care.

Actions/tactics	Anticipated impact	MNH Resources	Potential Collaborations
6d. Expand palliative care services for individuals with chronic illness, focused on improved quality of life for patients and their family	Improved patient care along the continuum of care for chronic care patients	Palliative Medicine staff and program, Case Management, Chronic Care specialty staff and programs	Community Health Care Partners
6e. Continue the Ambulatory Case Management program services as Epic SDoH Electronic Medical Record (EMR) measures become available	Ongoing care of primary care patients relating to SDoH needs, enhanced quantification of SDoH	Case Management, Population Health, Weight Management, Diabetes, Primary Care	
6f. Continue the Diabetes Care program targeting high-risk patients with diabetes	Ongoing improvement of participant average A1c scores	Case Management, Population Health, Weight Management, Diabetes, Primary Care	
6g. Continue to expand cardiovascular service line strategy	Enhanced continuity of patient care across the cardiovascular continuum	Planning & Program Development, Health System Transformation, Human Resources, Talent Acquisition, and Physician Recruitment, Cardiology practice and providers	
6h. Redesign and implement navigation processes for cancer patients	Consistent and improved coordination for solid tumor patients	Cancer Service Line Director, Medical Oncology Program, Radiation Oncology Program, Navigation Program	

OBJECTIVE: Promote, provide and/or sponsor access to preventive health services

Actions/tactics	Anticipated impact	MNH Resources	Potential Collaborations
6i. Support the delivery of preventive services in partnership with community agencies	Increased access to care within County and targeted rural communities	Cancer Care Service Line programs, Primary Care, MNH Foundation, Planning & Program Development, Health System Transformation, Brand & Community Engagement	Payers, County Agencies and programs, State agencies and programs, Local and Regional Non-profits, Community Health Partners
6j. Increase breast and lung screening capacity	Increased access to preventative screenings within Centre County	Cancer Care Service Line programs	
6k. Partner/support community partners to support the promotion of ***preventative dental care screenings***	Increased access to preventative dental care screenings within Centre County amongst vulnerable populations	Brand & Community Engagement, and Planning & Program Development	

Next Steps

Mount Nittany Health is committed to advancing initiatives and community collaboration to support the issues identified through the CHNA. The 2025 CHNA report was presented to the MNH Board of Directors and approved in June 2025. The corresponding three-year CHIP was presented to the MNH Board of Directors and approved in September 2025.

Mount Nittany Health welcomes your partnership to meet the health and medical needs of our community. We know we cannot do this work alone and that sustained, meaningful health improvement will require collaboration to bring the best that each of our community organizations has to offer. Together, we can make our communities better places to live, work, learn, and play.