State Health Improvement Plan

Pennsylvania Department of Health
2023 - 2028

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DEPARTMENT OF HEALTH

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March 2023

Greetings Pennsylvanians:

I am excited to present Pennsylvania's 2023-2028 State Health Improvement Plan (SHIP), which outlines the steps and partnerships needed over the next five years to achieve our vision of a healthy Pennsylvania for all. With over nine months of hard work, our steering committee and work groups have ensured the plan has achievable and measurable goals and objectives to improve the health of all Pennsylvanians. Focusing on health equity, chronic disease prevention, and whole person care, the SHIP is a call to action for policymakers, healthcare providers, nonprofits, and residents to work at all levels of government and community to promote and support health improvements throughout the Commonwealth. It builds on existing partnerships and encourages new collaborations throughout Pennsylvania to help ensure the strategies are implemented.

The COVID-19 pandemic exposed long-existing health disparities in many health metrics. To be most impactful, the SHIP focuses on eliminating health disparities, especially in underserved communities and those hardest hit by the pandemic.

We look forward to working with the myriad of partners who are committed to implement the strategies set forth in the SHIP over the next five years and tracking the impact of the work. Together, we will work tirelessly, and with the flexibility needed to adapt to the times, to make healthy choices the easy choices.

Thank you for working to making a healthy Pennsylvania for all not just a vision, but a reality.

Sincerely,

Debra L. Bogen MD

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

Executive Summary

The Pennsylvania State Health Improvement Plan (SHIP) is a multi-year strategic plan developed by the Pennsylvania Department of Health in collaboration with the Healthy Pennsylvania Partnership (HPP), a multi- sector partnership of stakeholders and collaborators. The SHIP identifies health priorities, goals, measurable objectives, and strategies for the next five years. The SHIP is a plan to bring together communities, organizations, and individuals to work toward common ends to advance public health in Pennsylvania.

Implementing the SHIP

Three Work Groups will address challenges presented in this report: Health Equity (HE), Chronic Disease Prevention (CDP), and Whole Person Care (WPC). Each work group has two to four goals to be achieved and objectives that will be used to measure progress on this five-year plan.

Within each work group, there are two to four **goals**, which are statements of what will be achieved. Each work group also defines **objectives**, which will be used to measure progress on this five-year plan.

- Health Equity workgroup will focus on improving health equity by addressing social determinants of health. The three goals are 1) Increase financial well-being, food security, and safe affordable housing, 2) Increase community safety by reducing the number of violent incidences that occur due to racism, discrimination, or domestic disputes, and 3) Improve environmental health, focusing on environmental justice communities. This HE workgroup will monitor nine objectives.

- Chronic Diseases Prevention will focus on reducing chronic disease risk factors and societal impact. The two goals are 1) Increase the population at a healthy weight through increasing availability and accessibility of physical activity and affordable nutritious food and 2) reduce the impact of tobacco and nicotine use. The CPD workgroup will monitor eight objectives.

- Whole person care workgroup will focus on increasing access to culturally humble whole person care through the lifespan. The four goals are 1) Increase access to medical and oral health care, 2) Improve mental health and substance use outcomes through improved mental health services, trauma informed trainings, and substance use interventions, 3) Improve health outcomes through improved chronic diseases management, and 4) Improve maternal and infant health outcomes by improving prenatal, perinatal, and postnatal care. The WPC workgroup will monitor 14 objectives.

Meetings for each goal area will be held regularly to facilitate collaboration, and strategies described in the annual plan will be conducted by partners in those work groups. The meetings will describe progress to partners and requests for support.

Yearly, the partnership will develop a report describing progress toward goals, and adjust the plan as needed, while producing the next year's work plan.

In addition to the active engagement with partners that participate in meetings, the plan is expected to support communities across Pennsylvania with evidence-based strategies to address the most pressing health issues in those communities.

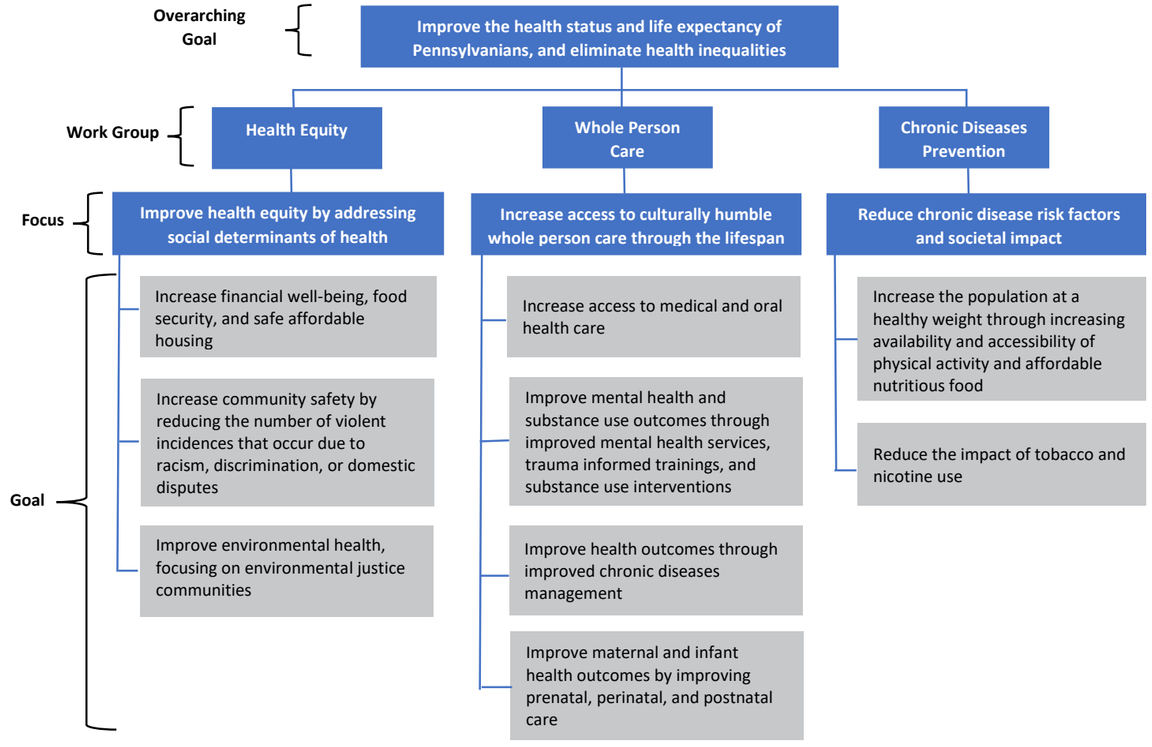


FIGURE 1. SHIP ORGANIZATIONAL CHART

Addressing these and other key health issues in this plan, especially by focusing on populations who are most at risk for poorer health outcomes, will give all Pennsylvanians a better path to good health.

How was the SHIP developed?

Developing the SHIP was a multi-step process which used the Mobilizing for Action with Programs and Partners (MAPP) framework.[1] Throughout the process, the HPP members on the steering committee and the work groups participated in the process. There are six phases in MAPP that include:

- Phase 1, organizing for success & partnership development: A steering committee and work groups were formed.

- Phase 2, visioning: The visioning was completed during the State Health Assessment (SHA) development and shared with the newly formed teams.

- Phase 3, the four assessments: Included, a Themes and Strengths assessment, a Forces of Change assessment, a State Public Health System assessment, and the SHA.

- Phase 4, identify priority issues: Using data from the assessments, 12 priority issues were identified. Those 12 priority issues were discussed with the work groups and further categorized into three priority categories namely Health Equity, Whole Person Care and Chronic Diseases Prevention.

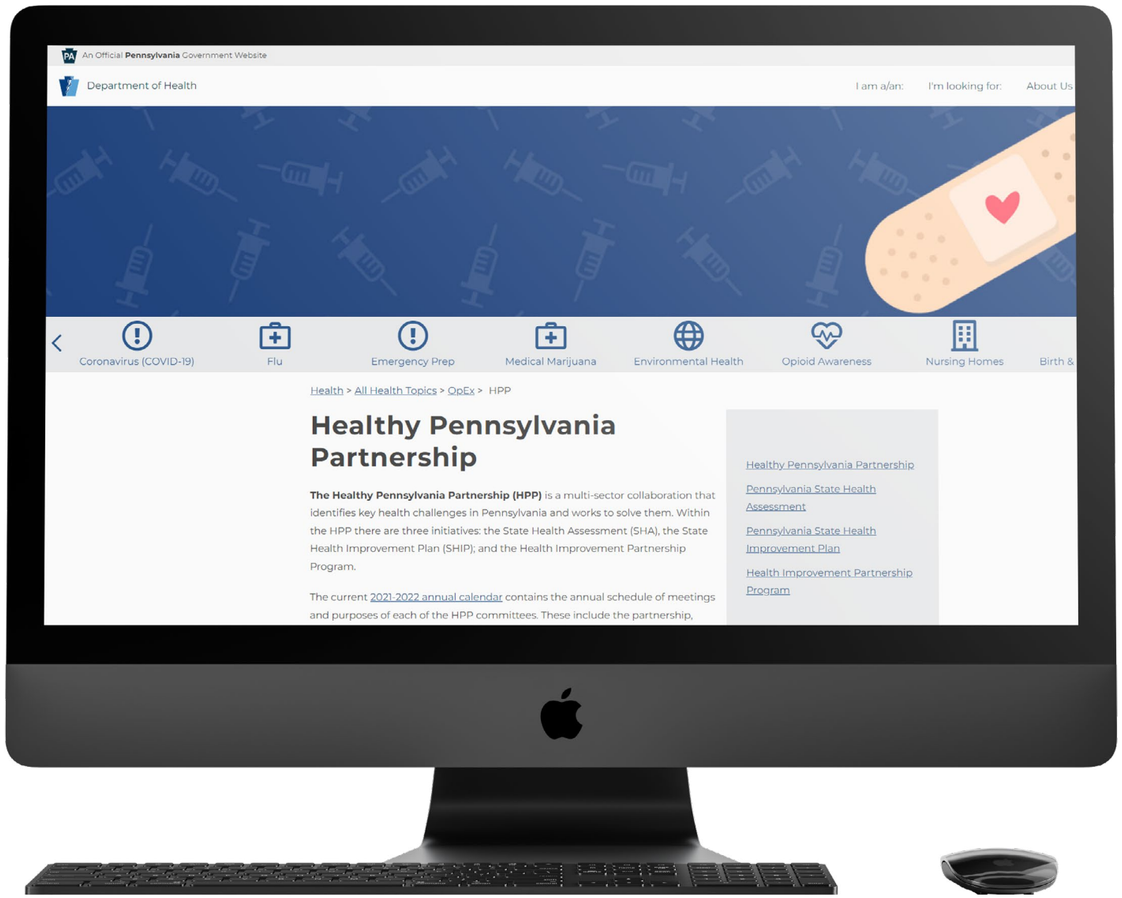
- Phase 5, formulate goals, objectives, & strategies: During this phase goals were defined, SMART objectives were identified, and strategies and assets were proposed and refined.

- Phase 6, action cycle: This phase begins with the publication of the plan, and will be monitored and updated yearly, for successes and needs for modifications.

How to Get Involved

The success of the SHIP depends largely on the collaborative efforts of the HPP and other statewide partnerships. The HPP is always looking to add new partners to the strategies set forth in the plan. If you would like to get involved in the HPP, SHA, or SHIP you can do the following:

- Visit the DOH website to read the published documents
- Contact the SHIP Coordinator or SHA Lead to get added to the appropriate mailing lists
- See how your work aligns with the HPP, SHA, and SHIP
- Partner with other organizations in your region to implement SHIP strategies



Introduction

What is the SHIP?

The Pennsylvania State Health Improvement Plan (SHIP) is a multi-year strategic plan developed by the Pennsylvania Department of Health (PA DOH) in collaboration with the Healthy Pennsylvania Partnership (HPP), a multi-sector partnership of stakeholders and collaborators. The SHIP identifies health priorities, goals, measurable objectives, and strategies to address the health issues for the next five years.

Healthy Pennsylvania Partnership

The following vision, mission, and guiding principles describe the HPP as defined during development of the State Health Assessment (SHA) in 2020. The members of the HPP include health care professionals, associations, health systems, health and human services organizations, community collaborations, local public health agencies, government agencies, and others.

- Vision: Pennsylvania is a place where all people can achieve their full physical, mental, and social well-being in a safe environment, free of inequities.
- Mission: To protect and improve the health of all Pennsylvanians by engaging stakeholders across multiple sectors to understand and respond to the health needs of Pennsylvanians through holistic, evidence-based, and data-informed intervention and prevention efforts.
- Guiding Principles: Leadership, Inclusion, Collaboration, Accessibility, Accountability, and Equity

The State Health Assessment

The SHA is a statistical report on the health status of Pennsylvanians. It uses the combined knowledge and expertise of the HPP to identify key health indicators to assess the overall health status of Pennsylvanians. The data presented in the SHA informs the priorities and indicators used in the SHIP as it highlights where Pennsylvania can make the greatest impact in improving health.

Why is the SHIP important?

Public health is “the science and art of preventing disease, prolonging life, and promoting health through the organized efforts and informed choices of society, organizations, public and private communities, and individuals”. [2] The SHIP is a plan to bring together organizations, communities, and individuals to work together toward common ends. In this way, this plan can play a vital role in advancing public health in Pennsylvania. Some of the challenges Pennsylvania faces to achieve the HPP vision include:

- Pennsylvanian’s average life expectancy at birth declined from 78.1 in 2018 to 76.8 in 2020.[3] While this decline may have been caused in large part by the COVID-19 pandemic, it also exacerbated long-existing challenges.
- The age-adjusted death rate in 2019 per 100,000 was 24.4% higher for Black Pennsylvanians than for whites. Addressing discrimination and racism directly will be needed to reduce such disparities. [4]
- In 2020, in Pennsylvania, age-adjusted drug overdoses deaths were 42.4 per 100,000, which is higher than the rate of the nation at large (28.3 per 100,000). [5] Reducing drug overdose deaths is a complex set of challenges that will take many strategies to address.
- In 2019, about a third of high school students felt sad or hopeless every day for 2 or more weeks in a year with higher rates among lesbian, gay or bisexual (62%).[6]

A Focus on Equity

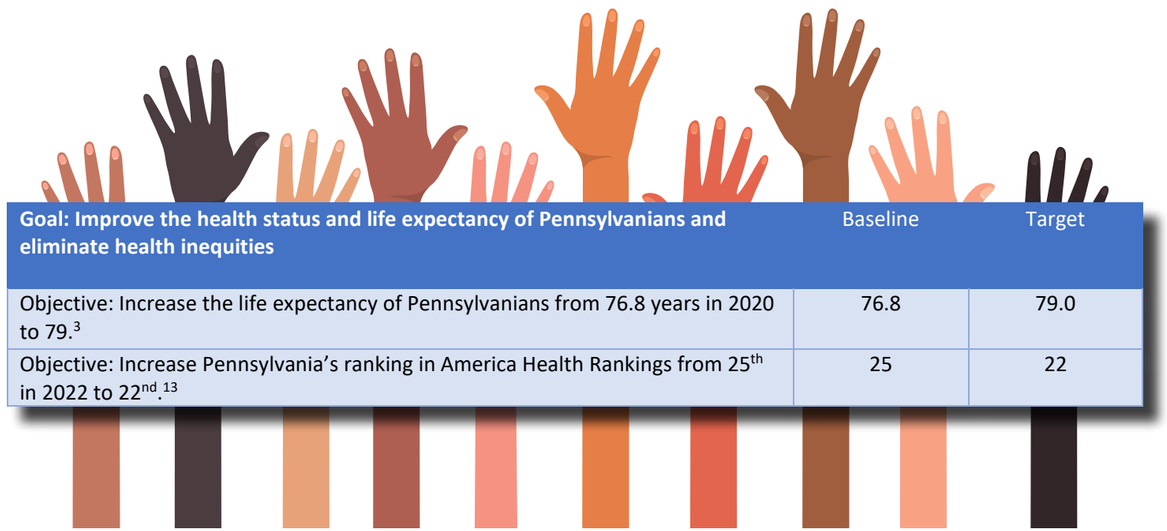
PA DOH defines health equity as providing everyone a fair opportunity to attain their full health potential and that no one is disadvantaged from achieving this potential. It implies the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, geographically or by other means of stratification. Achieving health equity requires valuing all individuals and populations, recognizing, and rectifying historical injustice and providing resources according to need.[7,8]

Health disparities are differences in the incidence and prevalence of health conditions and health status among groups of people. Most health disparities are due to certain conditions or result from discrimination based on socioeconomic status, age, race or ethnicity, sexual orientation, gender, gender identity, disability status, geographic location, or some combination of these.[9] Some health disparities addressed in the SHIP are as follows:

- People with less than a high school education are twice as likely to experience poverty.[10]
- Adults with income less than $15,000 are more than three times as likely to be current smokers compared to adults with income ≥$75,000.[11]
- Black individuals are nearly 3 times more likely to experience diabetes-related hospitalization than their white counterparts and 15 times more likely to be victims of homicide.[4,12]

The COVID-19 pandemic exacerbated existing health disparities in Pennsylvania. For example, while the age-adjusted death rate in 2019 was 21% higher in Black Pennsylvanians than whites, in 2020 that disparity grew to 39% with Black Pennsylvanians experiencing COVID-19 -related deaths at twice the rate of whites.[4] Underserved communities living in poorer rural and urban areas were some of the most vulnerable to transmission, infection, hospitalization, and mortality due to the disease. The pandemic highlighted the inequities experienced throughout Pennsylvania communities long before COVID-19 was declared a public health emergency, and these inequities were at the center of the conversations around prioritizing goals, objectives, and strategies for the SHIP.

The SHIP breaks down objectives by various populations to ensure the populations experiencing the greatest health disparities are the focus of interventions. While setting targets, the HPP acknowledged that it is not acceptable for one population to have poorer outcomes than the overall population so all targets for populations of focus have been set to match the overall targets, no matter how difficult it may feel to obtain. It is the only acceptable approach to eliminate health disparities. Additionally, the SHIP has set an overarching goal to improve the health status and life expectancy of Pennsylvanians and eliminate health inequities so that all strategies implemented over the next 5 years work to “close the gap”.



Goal: Improve the health status and life expectancy of Pennsylvanians and eliminate health inequities	Baseline	Target
Objective: Increase the life expectancy of Pennsylvanians from 76.8 years in 2020 to 79.[3]	76.8	79.0
Objective: Increase Pennsylvania’s ranking in America Health Rankings from 25th in 2022 to 22nd.[13]	25	22

SHIP Framework and Definitions

The HPP utilized the County Health Rankings model[14] and the socioecological model[15] as guides to develop the framework of the 2023- 2028 Pennsylvania SHIP. The SHIP considers the impact of organizations, community, and public policy on social determinants of health and therefore on health outcomes.

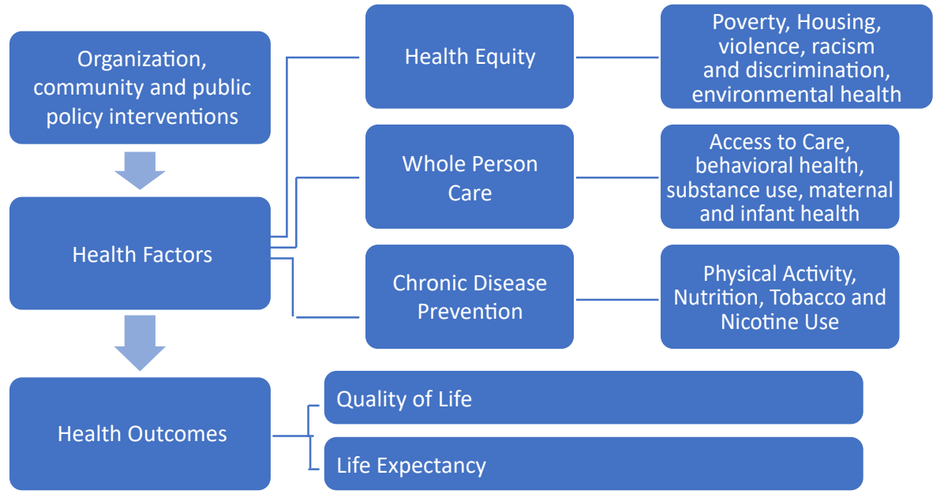


FIGURE 2. SHIP FRAMEWORK

The SHIP uses the Association of State and Territorial Health Officials (ASTHO) Guide to Developing a State Health Improvement Plan[16] to help define the priorities, goals, objectives, and strategies throughout the plan. The following definitions were used to guide the discussions among the HPP:

- Priority – health topic that is important to focus on over the next five years to improve the health of Pennsylvanians
- Goal – broad statement of what the partnership hopes to accomplish related to the priority and may include the approach or “by or through” phrase
- Objective – target for achievements through interventions. SMARTIE objectives should be Specific, Measurable, Attainable, Relevant, Time-bound, Inclusive, Equitable
- Strategy – a plan of action to achieve goals, and identifies activities that must be planned, by whom and for whom

Data Limitations

The objectives selected throughout the SHIP are selected because of their data availability. The SHIP implementation team is limited by data that is available at the state level and collected consistently and acknowledges that, in some cases it might not be the absolute best measure for the goal. Additionally, the team recognizes that individuals with disabilities and other people at increased risk are a priority within the work groups. Though the data does not allow for these populations to be called out specifically within each objective, the populations’ needs will be addressed through individual strategies within each goal.

Acknowledgments

The Pennsylvania SHIP is the result of more than a year of collaboration among community partners and state agencies. We thank those individuals, agencies, and organizations that contributed their time and expertise to the development of this plan. Appendix E has a list of the individuals and organizations that participated in the planning and development of the health priorities, goals, objectives, and strategies for the plan.

This publication was supported by the Cooperative Agreement Number #5U58CD001297 from the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC.

SHIP Process and Stakeholder Engagement

The SHIP was developed by the collaborative efforts of PA DOH, HPP, community members and Harrisburg University of Science and Technology (HU) in alignment with Public Health Accreditation Board (PHAB) standards. The HPP is a multi-sectoral collaboration of partners that identifies key health challenges in the commonwealth and works to solve them. There are three initiatives within the HPP: SHA, SHIP, and the Health Improvement Partnership Program.

Initially a leadership group was created including PA DOH and HU members. The role of this group was to coordinate the SHIP development activities and lead the process. A steering committee existed from the previous SHIP work and was expanded for this effort primarily to enhance the focus on equity. The steering committee had 26 members from key public and private sectors. The role of this committee was to lead and advise the SHIP development and implementation process. In addition to this, four work groups were formed to inform the process based on the Population Health framework from County Health Rankings and Roadmaps. These work groups included Health Behaviors, Clinical Care, Social and Economic Factors, and Physical Environment. Members of these work groups include experts from each of their respective fields. The roles of each committee are described in Figure 3.

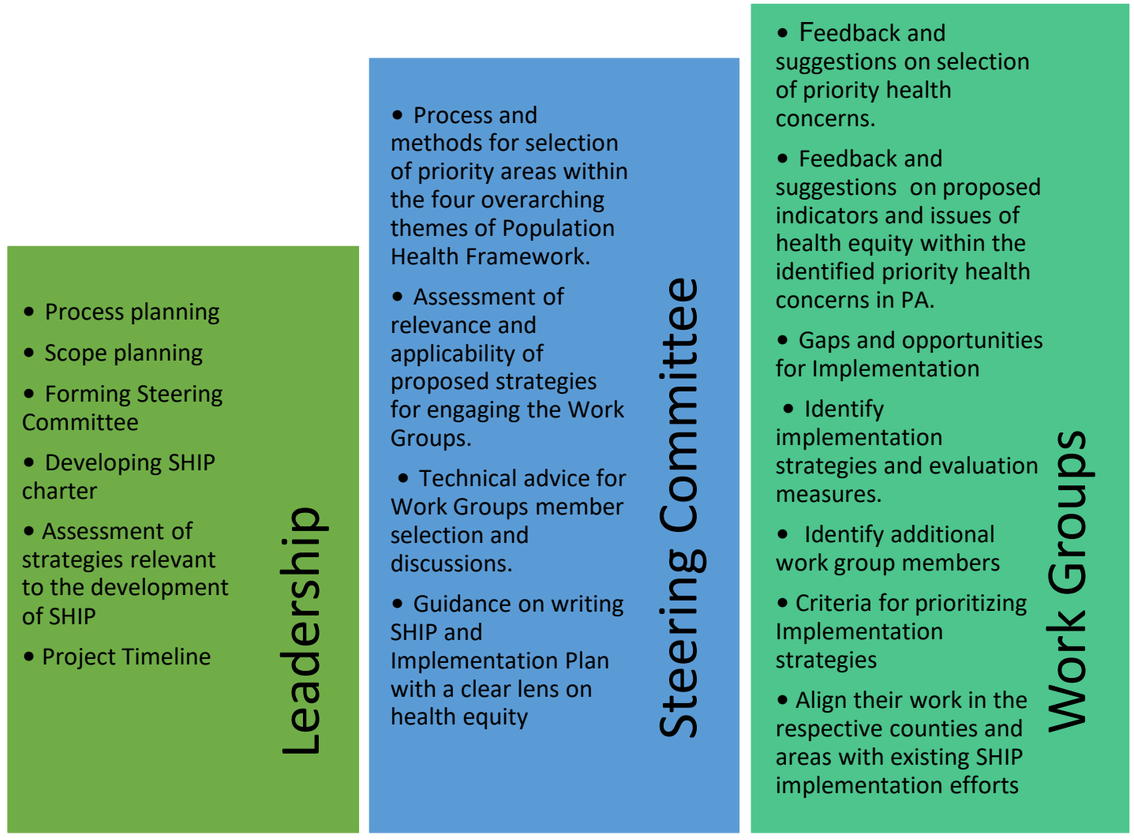


FIGURE 3. STAKEHOLDER ENGAGEMENT LEVELS

Members of the steering committee and work groups conducted regular meetings between May 2022 to December 2022 to develop the SHIP (Figure 4).

FIGURE 4. STAKEHOLDER INPUT AND PARTICIPATION ON SHIP ACTIVITIES AND PROCESSES

The SHIP development involved several activities including team building, discussions, MAPP assessments, reviewing Community Health Needs Assessments (CHNA), health topic prioritization, goal and objective setting, asset identification, strategy identification and writing the plan. Quantitative and qualitative data was used to inform the SHIP development process. All qualitative data from discussions were recorded and transcribed and later analyzed using MAX Qualitative Data Analysis (MAXQDA) software.

Mobilizing for Action through Planning and Partnership Model

The Mobilizing for Action through Planning and Partnership (MAPP) model guided the approach for the development of the SHIP. MAPP is a community-driven planning tool for improving public health designed by the National Association of County and City Health Officials (NACCHO). MAPP helps communities prioritize their public health issues, identify resources for addressing them, and implement strategies relevant to their unique community context. There are four assessments as part of the MAPP process (Figure 5):

- State Health Status assessment
- State Forces of Change assessment
- State Themes and Strengths assessment
- State Public Health System assessment

These four assessments, shown in the outer arrows of the MAPP model, were used to inform the SHIP development.

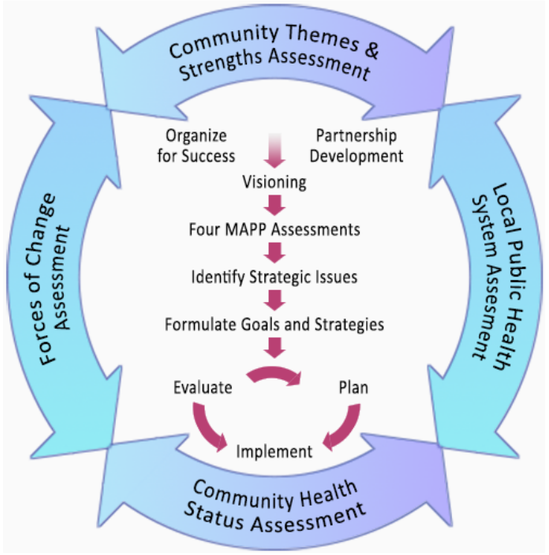


FIGURE 5. MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIP

State Health Status Assessment

The Pennsylvania SHA was conducted in 2020 and updated in 2021.17 The SHA was developed collaboratively with the HPP. The process of developing the report included a systematic collection and analysis of qualitative and quantitative data from a wide range of sources with the active involvement of the HPP. Qualitative data that identified priorities, populations at risk and factors contributing to those risks were collected from stakeholder meetings, focus groups, and a public poll. Quantitative data for most selected indicators were collected from state and national sources.

The SHA highlighted major health issues facing Pennsylvanians, identified disproportionately impacted populations, explored contributing factors to higher health risks or poorer health outcomes, and identified community assets available to improve the health status.

In addition to an overarching framework of social determinants of health and equity, the SHA highlighted eight health issues affecting Pennsylvanians. These are:

- Access to Care
- Mental Health
- Substance Use
- Chronic Diseases
- Infectious Diseases
- Maternal and Infant Health
- Injury and Violence
- Environmental Health

Finding from the SHA were used as a primary resource for the development of the SHIP.

State Forces of Change Assessment

The Forces of Change assessment is designed to collect data on factors, trends, and events that shape the public health system. The assessment is an integral part of the MAPP process. There are eight categories in the Forces of Change Assessment – social, economic, political, technological, environmental, scientific, legal, and ethical.

To conduct the Forces of Change assessment, the SHIP Steering Committee was convened on August 5, 2022. Steering committee members were asked to consider the factors, trends, and events for the eight assessment categories. They were also asked to contribute their insight into the threats and opportunities relative to each of the eight assessment categories.

This assessment identified that the top five threats facing Pennsylvanians are transportation issues which lead to social health disparities, the health impacts resulting from climate change, the rising of health issues related to natural resource extractions, and the escalating costs of medicines necessary to treat chronic diseases. Data collected suggests that the Commonwealth has opportunities to integrate health and social services, including acceptance of social determinants of health as a human right, expanding the fundamental concept of health equity, and establishing policies that improve affordable housing.

Exploring the trends, events, and factors data reveals several additional insights. Specifically, there is concern that disparities persist in the allocation of mental healthcare. Events across the state have led to the perception that violence, particularly domestic violence, is a major concern. In terms of trends, there will continue to be an escalating emphasis on health equity principles and the need to capture data on sexual orientation and gender identification. Also, the availability of affordable housing, particularly in urban areas, will continue to decline.

Additional themes gathered from the Forces of Change data include several concerns. Changes in federal and state level administration and legislation may result in changes that disrupt availability of equitable health services and may increase population density in areas of the state that are considered climate favorable. There also remains concern for continued inequitable health care delivery particularly in the transgender and reproductive health services.

The table below details factors, trends, and events, and associated threats and opportunities that were identified by the steering committee.

Forces, trends, and events	Threats posed	Opportunities created
• Disparities in mental healthcare • Decreasing availability of affordable housing • Change in administration • Displacement of communities due to climate change • Increase in domestic violence incidents • Increasing need to capture sexual orientation data • Increasing restrictions on tobacco sales • Emphasis on health equity	• Natural resource extraction resulting in rising health issues • Cost of medicines necessary to treat chronic diseases becomes an economic issue • Legislative changes that disrupt equitable availability to health services • Health impacts resulting from climate change • Increased population density in climate favorable areas • Reduced ability to analyze health care outcomes data • Reduced ability to lower rates of chronic diseases • Inequitable care particularly in the transgender community and reproductive health services	• Better integration of health and social services • Acceptance of social determinants of health as a human right • Establish policies that improve housing • Acceptance that safe housing is a human right • Expand peoples' understanding of health equity

TABLE 1. FORCES OF CHANGE ASSESSMENT SUMMARY

State Community Themes and Strengths Assessment

The Community Themes and Strengths Assessment was conducted to provide a deep understanding of issues the community members' feel are important. In August and September 2022, a series of five virtual listening sessions was conducted to gather perceptions, thoughts, opinions, and concerns regarding the quality of life within the Commonwealth. Participants of the listening session were organizations that advocate to improve or provide health or social services for vulnerable groups in the different regions (Western, Central, and Eastern) of the Commonwealth. The listening sessions included an initial two-hour session followed by a one-hour verification session held two weeks later.

Participants were asked to discuss the following topics:

- Why or why don't you view your community as a place where you or your community members would like to raise children or age in place?
- What do you perceive to be the most prominent health concerns in your community?
- What strengths do you believe your community uses to improve health?

The major themes identified were telehealth, access to transportation resources, access to mental health services, and affordability of housing. The Commonwealth heavily relied on telehealth to provide health care services during the COVID-19 pandemic. Though virtual delivery of services provided a reasonable alternative, particularly at the height of the COVID-19 pandemic, there is a significant portion of the population who do not have access to virtual care due to a lack of access to electronic (cellphone or computer) or web-based equipment and have inadequate transportation resources, especially in rural areas of the state. Additionally, access to mental health services was severely strained. Several listening group members voiced concerns that prevalence of mental health illness is rising in the state and access to services is significantly limited, independent of the COVID-19 pandemic.

Housing, specifically in the urban areas, was also raised as an issue. Listening group members indicated that long waiting lists are common and that many residents simply cannot afford basic housing. The lack of stable housing arrangements compounds other health-related issues such as chronic stress and mental health, violence prevention, and support for children. Participants suggested increasing mental health support services to first responders, increasing the viability of telehealth, and supporting legislative initiatives to address the housing crisis, which could improve the healthcare system.

Emergence of collaborations and coalitions among healthcare providers across the state was mentioned as one of the strengths. Resource limitations encouraged the emergence of partnerships in the Commonwealth's health systems, particularly at the local level. Though taxing the health delivery system, collaboration and partnerships have strengthened the ability of the commonwealth to optimize available resources while providing integrated health delivery. Multiple coalitions have formed across the state to address mental health, obesity, and nutrition.

Another strength identified was the increased use of telehealth as a viable alternative for access to many healthcare services. Though some portions of the population have not benefited from the emergence of telehealth as a viable alternative for access, technology has improved access to many in the commonwealth. For example, telehealth medicine facilitated administering health services to individuals who would previously be unable to travel due to disabilities.

State Public Health System Assessment

The State Public Health System Assessment (PHSA) is another component of the MAPP assessments and provides a framework to assess capacity and performance of the state public health system. This assessment can help to identify partners and strengthen partnerships, improve communications within the public health system, and identify strengths, weaknesses, and opportunities within the health system.

The PHSA included assessment of the ten Essential Services. Evaluation of each Essential Service is organized into four areas known as model standards. These are planning and implementation, state-local relationships, performance management and quality improvement, and public health capacity and resources. The 10 Essential Public Health Services are:[18]

1. Monitor health status to identify and solve community health problems
2. Diagnose and investigate health problems and health hazards in the community
3. Inform, educate, and empower people about health issues
4. Mobilize community partnerships and action to identify and solve health problems
5. Develop policies and plans that support individual and community health efforts
6. Enforce laws and regulations that protect health and ensure safety
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable
8. Assure competent public and personal health care workforce
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services
10. Research for new insights and innovative solutions to health problems

The Pennsylvania PHSA was conducted in July 2022. Information collection was done through a survey using the National Public Health Performance Standards - Version 3.0 guide.[19] The survey was distributed to all work group members and there was a total of 67 responses.

Under each model standard, there are assessment questions (referenced as items) which serve as measures of performance. Each item was scored based on the level of activity categorized as 0% (no activity), 25% (minimal activity), 50% (moderate activity), 75% (significant activity) and 100% (optimal activity).

Individual item scores were obtained by averaging the responses from all participants who scored the question. The score for each model standard was obtained by dividing the sum of the scores of the items included in that model standard by the number of questions. Score for each Essential Service was obtained by averaging the scores of the four models and the overall score was obtained by averaging the scores of all Essential Services (Figure 6).

Individual item scores ranged from lowest with score of 28 (Coordinate efforts to conduct research) to the highest with score of 61 (Establish and maintain a statewide health insurance exchange to assure access to insurance coverage) (see supplemental data for the score of each individual item). The average scores of each of the 10 Essential Services are shown in Figure 6. The overall performance score was 42. The highest score was for Essential Service 7, "Link people to needed personal health services and assure the provision of health care when otherwise unavailable." The lowest score was for Essential Service 10, "Research for new insights, and innovative solutions to health problems" (Table 2).

Overall, the assessment showed strength in planning and implementation for many of the essential public health services and weakness in state-local relationships (Figure 7). Moreover, several strengths, weaknesses and opportunities were identified for each Essential Service.

High scoring essential services	Low scoring essential services
Essential Service 7: Link people to needed personal health services and assure the provision of health care when otherwise unavailable	Essential Service 10: Research for new insights and innovative solutions to health problems
Essential Service 3: Inform, educate, and empower people about health issues	Essential Service 6: Enforce laws and regulations that protect health and ensure safety
Essential Service 2: Diagnose and investigate health problems and health hazards in the community	Essential Service 8: Assure a competent public and personal health care workforce

TABLE 2. HIGHEST SCORING AND LOWEST SCORING ESSENTIAL SERVICES

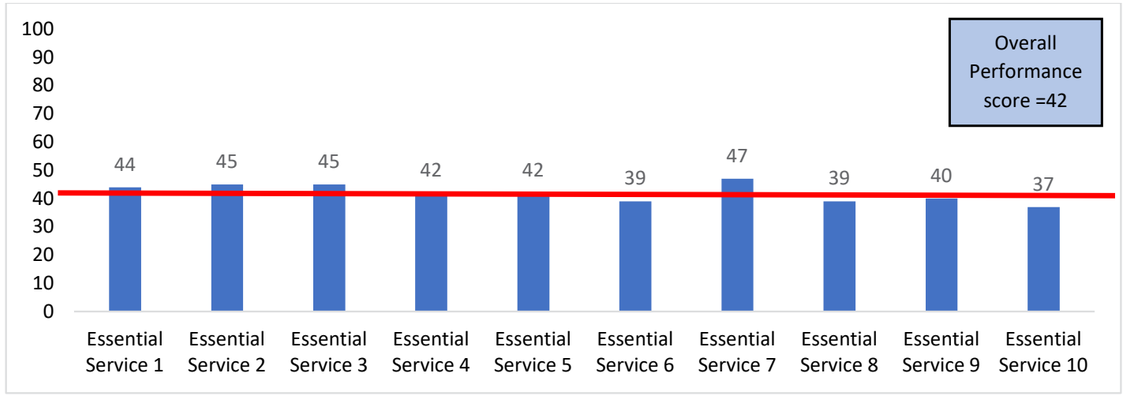


FIGURE 6. AVERAGE SCORE OF ALL MODEL STANDARDS AMONG ALL TEN ESSENTIAL SERVICES

FIGURE 7. AVERAGE SCORE OF ALL MODEL STANDARDS AMONG ALL TEN ESSENTIAL SERVICES

Alignment of Community Health Improvement Plans and State Health Improvement Plan

To assess alignment of local health improvement plans and the SHIP, Community Health Improvement Plans (CHIPs) and Community Health Needs Assessments (CHNAs) from across the state were reviewed. These CHIPs and CHNAs were published between 2018 and 2022 and identified health priorities specific to their respective communities. The CHNAs/CHIPs were reviewed for duplication, and the priorities were extracted and later categorized into similar categories. Below is a table summarizing the frequency of health priorities identified by the CHNAs/CHIPs.

Health Issue	Frequency the health issue was identified as priority in CHNAs	Identified as a SHIP priority through the stakeholder engagement process
Access	93	Yes
Chronic Diseases	92	Yes
Mental health	66	Yes
Substance use	58	Yes
Health equity	25	Yes
Food insecurity	9	Yes
Transportation	9	Yes
Public health infrastructure	7	No
Housing	4	Yes
Maternal health	4	Yes
Infectious diseases	4	No
Child abuse, Parental support for children and youth	2	No
Environmental health	2	Yes
Racism and discrimination	2	Yes
Violence	2	Yes

Table 3. Alignment of State and Local Priorities

Prioritization of Health Issues

Based on the review of the SHA, Forces of Change assessment, Themes and Strengths assessment, Public Health System assessment, and Community Health Needs assessments, a list of health topics was developed. Health topics were organized in groups, and state, national, and population data were provided.

The Hanlon prioritization technique was used to identify the top health issues in the state. The Hanlon method uses three components to determine the priority score of the health issue. These are size of the problem, seriousness of the problem and availability of intervention. The priority scores were calculated using the formula:

$$D = [A + (2xB) \times C]$$

Where **D**=Priority score

A= Size of the problem

B= Seriousness of the problem

C= Availability of intervention

All the components of the Hanlon method were scored using the scale of one to ten. To get the scores for A (size of the problem), the health issues were ranked by three scorers on the scale of 1 to 10 and then averaged. To get score for B (seriousness) and C (availability of intervention), a survey was sent to all SHIP members. Seriousness was evaluated using five questions: 1) Does the health issue require immediate attention? 2) Are there socioeconomic consequences related to the health problem? 3) Is there an impact on the quality of life? 4) Does the problem have a high death or hospitalization rate? And 5) Is there an existing disparity in death and hospitalization rate among marginalized groups? Availability of intervention was evaluated by responding to the questions “Are there evidence-based interventions or promising practices to prevent or control this health problem? Can these interventions or practices be implemented easily?"

Initially, a total of 154 indicators categorized into 21 health topics were considered. Based on the computed priority score and follow-up discussions, a total of 12 issues were ranked as high importance. These health issues were discussed with the workgroups and further organized into three priority categories namely Health Equity, Whole Person Care and Chronic Diseases Prevention.

Setting Goals, Objectives, and Strategies

The workgroups were reorganized to reflect the newly prioritized health topics. Consecutive meetings were conducted to set goals, objectives, and strategies. Goals and objectives were selected based on the workgroup discussions and follow-up surveys. Evidence based strategies were identified from a literature review and workgroup members using a survey. Moreover, the strategies were refined by consulting with departments and statewide programs to align with what they have prioritized.

Targets for the objectives were calculated based on the percent Improvement tool (ten percent or up to five percentage points improvement),[20] exponential smoothing model, adopting already existing objectives or based on consensus among the steering committee members. Further, target populations and counties were identified if their estimate was more than 10% that of the overall population estimate. The process of SHIP development is summarized in the figure below (figure 8).

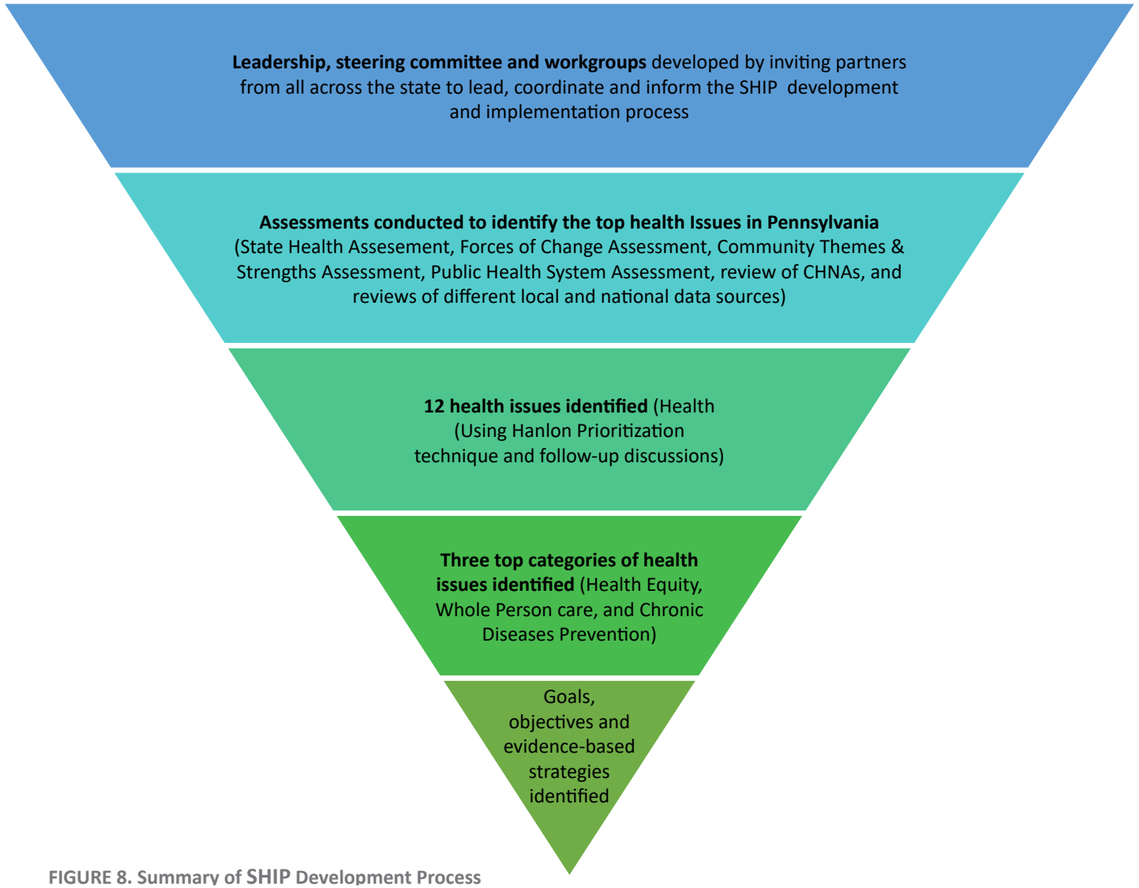


FIGURE 8. Summary of SHIP Development Process

Goals, Objectives, Strategies

Health Equity

With the focus of improving health equity by addressing social determinants of health, this section prioritizes poverty, housing, violence, food insecurity and environmental health. The three health equity goals are:

- Increase financial well-being, food security, and safe affordable housing
- Increase community safety by reducing the number of violent incidences that occur due to racism, discrimination, or domestic disputes
- Improve environmental health, focusing on environmental justice communities

Goal 1.1: Increase financial well-being, food security, and safe affordable housing

Individuals and families living in poverty are less likely to have access to safe and affordable housing, nutritious foods, opportunities for physical activity, and health care. In Pennsylvania, about 1 in 8 individuals are currently living in poverty with substantial disparities among the Black, Hispanic, and Less than High School Education populations.[10] Poverty, housing, and nutrition are so inter-related that by improving one indicator we can ultimately improve the others. For example, an individual with stable housing has a higher probability of finding and retaining employment, and a steady income results in an increased likelihood of accessing nutritious foods. Therefore, the Health Equity Work Group will work on improving the following 4 objectives in parallel.

Objective 1.1.1	Priority	Baseline (Percent)	Target (Percent)
Decrease the percent of the population living in poverty from 12.1% in 2021 to 9.0% (ACS)[10]	Overall	12.1	9.0
	Black	24.8	9.0
	Hispanic	22.5	9.0
	Less than high school education	25.1	9.0

Objective 1.1.2	Priority	Baseline (Count)	Target (Count)
Reduce the number of people experiencing homelessness from 13,375 in 2020 to 12,037 (Housing and Urban Development data)[21]	Overall	13,375	12,037
	Black	6,793	6,114
	Severely mentally ill	3,212	2,891
	Chronic substance use	2,393	2,158

Objective 1.1.3	Priority	Baseline (Percent)	Target (Percent)
Reduce the percent of the population spending 30% or more of their income on rent by from 47% in 2021 to 42% (CHR) [2]	Overall	47.0	42.0
	Centre	58.0	42.0
	Pike	57.0	42.0
	Lawrence	52.0	42.0
	Philadelphia	52.0	42.0
	Monroe	52.0	42.0

Objective 1.1.4	Priority	Baseline (Percent)	Target (Percent)
Reduce food insecurity from 8.9% in 2020 to 6.3% (Map the Meal Gap)[22]	Overall	8.9	6.3
	Black	22.0	6.3
	Hispanic	21.0	6.3
	Age<18	13.1	6.3

The following strategies, assets and partners will be essential to the success of improving the above objectives.

Goal 1.1 Featured Strategies

- Increase targeted employment programs
- Improve childcare access
- Increase awareness of housing support initiatives
- Make use of Housing First programs to impact behavioral health services for vulnerable populations
- Expand co-housing and multi-generational housing options
- Pursue health in all policies, both statewide and locally
- Connect veterans to housing navigators
- Expand policies that make housing more affordable
- Implement tenant-based housing vouchers
- Increase eligibility, awareness, uptake, and utilization of benefits such as SNAP, CACFP, WIC and others
- Strengthen local food systems
- Expand PA Healthy Pantry Initiative
- Expand participation in the Community Eligibility Provision (Free & Reduced School Lunch Program – 100% free school lunch & Breakfast)
- Extend recovery home stays so that patients have more than 90 days to find housing, a job, outpatient services, etc.

Goal 1.1 Assets

- Medical Assistance Transportation Program (MATP)
- Traveler's Aid
- Low Income Home Energy Assistance Program (LIHEAP)
- Client Assistance Program (CAP)
- Child Care Works Subsidized Child Care Program
- Section 8, low-income housing voucher programs
- Transitional and 3/4 housing
- Faith-based institutions who provide temporary funding for rent
- Pennsylvania Department of Transportation (PennDOT)
- Philabundance
- Greater Pittsburgh Community Food Bank
- Second Harvest NWPA (Erie)
- Second Harvest Lehigh Valley
- Mercer County Food Bank
- Westmoreland County Food Bank
- Helping Harvest
- Weinberg Regional Food Bank
- Philadelphia Hunger Coalition
- Pennsylvania Hunger Action Center
- Thriving PA
- WIC Stakeholders Collaborative
- Medical Assistance
- Local food banks and faith-based institutions
- Affordable housing
- Workforce development initiatives
- Allegheny Links
- Volunteers of America
- Coordinated Investment Planning Council
- Habitat For Humanity
- House Bill 581, Expanding Affordable Housing in Pennsylvania
- Community Health Organizers (CHOs)
- PA DOH, Pennsylvania Healthy Pantry Initiative
- WIC; SNAP; SNAP-Ed
- Governor's Food Security Partnership
- CACFP Story Map
- Pennsylvania Food Bank
- Central Pennsylvania Food Bank
- Governor’s Office College Food Insecurity Initiative
- Erie Food Policy Advisory Council (FPAC)
- Regional Accountable Health Council (RAHC)
- National school lunch programs
- Drexel University Student Group
- Food Policy Advisory Council
- Meals on Wheels
- Greater Erie Community Action Committee
- Office of Child Development and Early Learning
- Early Learning Resource Center
- PA Career Link

Goal 1.1 Partners

- Access Services
- Allegheny County Health Department, Chronic Disease & Injury Prevention
- City of York, Bureau of Health
- Council on Chemical Abuse
- Duquesne University, School of Health Sciences
- Feeding Pennsylvania
- Greater Pittsburgh Foodbank
- Healthy Community Lifespaces
- Housing Alliance of Pennsylvania
- Kings College/Main Line Health Center for Population Health Research
- Libraries
- Mission Effectiveness, Diversity, Equity & Inclusion
- Pennsylvania Department of Aging
- Pennsylvania Department of Education
- PA DOH, Office of Health Equity
- PA DOH, Office of Operational Excellence
- Pennsylvania Area Health Education Center
- Pennsylvania Association of Community Health Centers
- Pennsylvania Department of Human Services (PA DHS)
- Pennsylvania Downtown Center, Healthy Communities Program
- Pennsylvania Office of Rural Health (PORH)
- Schuylkill County's VISION
- University of Pennsylvania

Goal 1.2: Increase community safety by reducing the number of violent incidences that occur due to racism, discrimination, or domestic disputes.

In Pennsylvania, there are disparities in violent incidences data that are a result of racism, discrimination, and domestic disputes. For example, the rate of homicides among Black males is nearly nine times higher than that of the overall rate.[4] Additionally, reports of elder abuse are on the rise.[23] A person’s interactions with the places they live, work, learn, play, and worship and their relationships with family, friends, co-workers, community members and institutions are essential to creating a strong foundation for positive health outcomes. When those relationships become influenced by violence, racism, and discrimination, the layers of health and social inequities become compounded resulting in decreased quality of life, lasting emotional, physical, and financial impacts, and possible premature death. Though the following three objectives do not comprehensively reflect the work that will be done under this goal, their improvement will demonstrate success in impacting violence within Pennsylvania.

Objective 1.2.1	Priority	Baseline (age adjusted rate per 100,000)	Target (age adjusted rate per 100,000)
Reduce the number of homicides from 8.3/100,000 in 2020 to 7.5/100,000 (Death certificates)[4]	Overall	8.3	7.5
	Black	39.4	7.5
	Males	14	7.5
	Age 15-34	18.4	7.5

Objective 1.2.2	**Priority**	**Baseline (Count)**	**Target (Count)**
Decrease the total reports of need for older adult protective services received due to caregiver or self-neglect from 58.3% to 53.3% (PA Department of Aging) [23]	Overall	58.3	53.3

Below are the list of strategies, assets and partners that will be involved to achieve the above objectives.

Goal 1.2 Featured Strategies

- Improve community partnerships including with police departments
- Work with coalitions to promote positive community relations among various groups to prevent tension through education
- Educate the community regarding hate crimes, hateful incidents, and how to report hate crimes
- Pursue stronger legislation for hate crimes against groups that have been marginalized and those with disabilities
- Address social isolation and loneliness by making resources available when an older individual has known risk factors.

Goal 1.2 Assets

- Medical Assistance Transportation Program (MATP)
- Pennsylvania Human Relations Commission
- Federal Bureau of Investigation
- Local Police Departments
- CDC Cure
- Medical Assistance
- Cure Violence Global

Goal 1.2 Partners

- Allegheny County Department of Human Services
- Allegheny County Health Department, Chronic Disease & Injury Prevention
- Bradbury-Sullivan LGBT Community Center
- Council on Chemical Abuse
- Duquesne University, School of Health Sciences
- Mission Effectiveness, Diversity, Equity, & Inclusion
- PA DOH, Bureau of Health Promotion and Risk Reduction
- PA DOH, Office of Health Equity
- Pennsylvania Area Health Education Center
- Pennsylvania Coalition Against Domestic Violence
- Pennsylvania Downtown Center
- Pennsylvania Office of Rural Health

Goal 1.3: Improve environmental health, focusing on environmental justice communities.

The built environment plays a large role in one's health; a person's zip code can be connected to negative health outcomes.[24] Currently, over one quarter of Pennsylvanians are living in environmental justice areas (communities with low-income and high minority populations) and are disproportionately affected by adverse climate events and poor environmental health conditions.[10] According to the World Health Organization, climate change is the single biggest health threat facing humanity as it impacts both social and environmental social determinants of health such as clean air, safe drinking water, food quality and quantity, and safe housing. While working to improve environmental health throughout the state, it is important to focus on those communities that are disproportionately impacted. The HPP will work to improve environmental health, consequently improving health outcomes for those living in environmental justice areas.

Objective 1.3.1	Priority	Baseline (percent)	Target (percent)
Increase population living in counties meeting the National Ambient Air Quality Standard (NAAQS) for PM 2.5 from 61.2% in 2019 to 66.0% (DEP/EPA via EDDIE)[25]	Overall	61.2	66.0

Objective 1.3.2	Priority	Baseline (Count)	Target (Count)
Reduce number of heat-related hospitalizations from 206 in 2020 to 185 (Pennsylvania Environmental Public Health Tracking Program)	Overall	206	185

Objective 1.3.3	Priority	Baseline (Count)	Target (Count)
Increase the number of 0-71-month-olds tested for lead from 148,432 in 2020 to 163,275 (Childhood Lead Surveillance Report)[26]	Overall	148,432	163,275

Below are the list of strategies, assets and partners that will be involved to achieve the above objectives.

Goal 1.3 Featured Strategies

- Engage in activities included in the Pennsylvania Climate Action Plan
- Educate healthcare professionals on climate-related health risks
- Collaborate with business entities affecting air and water quality to establish a better living environment for all Pennsylvanians.
- Collaborate with business entities to develop worker safety plans to protect workers from extreme heat.
- Increase awareness through education and public information campaigns
- Work with the Pennsylvania Department of Conservation and Natural Resources (PA DCNR) to ensure tree planting is occurring to improve air quality and reduce temperatures
- Eradicate lead paint hazards from older homes of children from low-income families.
- Train WIC staff working at clinics on lead prevention.
- Increase lead testing rates in WIC Clinics.
- Increase provider lead testing rates for providers who test at 1 year and/or 2 years.
- Expand home-based educational intervention programs to address environmental risk factors such as lead exposure, pest remediation, air pollution, etc. to prevent lead poisoning, asthma, and other diseases.

Goal 1.3 Assets

- Pennsylvania Department of Conservation and Natural Resources
- PA Regional Center for Children's Environmental Health
- Pennsylvania Department of Human Services
- Pennsylvania Environment Resource Center
- Penn State Sustainability Institute
- Citizen Scientists
- Pennsylvania Department of Environmental Protection
- Pennsylvania Department of Education
- The Community Grocer

Goal 1.3 Partners

- Congestion Mitigation Air Quality (CMAQ)
- Pennsylvania Department of Environmental Protection
- PA DOH, Office of Health Equity
- Pennsylvania Downtown Center
- Pennsylvania Office of Rural Health
- Safe Routes to School
- WalkWorks
- PA DCNR

Chronic Disease Prevention

Poor nutrition, physical inactivity and tobacco use are highly associated with chronic diseases development. This section focuses on obesity, physical activity, nutrition, and tobacco use as prevention measures for the following goals:

- Increase the population at a healthy weight through increasing availability and accessibility of physical activity and affordable nutritious food
- Reduce the impact of tobacco and nicotine use

GOAL 2.1: Increase the population at a healthy weight through increasing availability and accessibility of physical activity and affordable nutritious food

Chronic diseases include but are not limited to obesity, coronary heart diseases, diabetes, cancer, COPD, asthma, and cardiovascular diseases. These non-communicable diseases represent a burden on public health and health care systems. For example, 47% of Pennsylvania adults in 2020 lived with one or more chronic diseases, with higher rates among 65 years and older.[17] Some risk factors for chronic diseases are physical inactivity and poor nutrition. Access to nutritious food and physical activity can result in a positive impact on the health status of a person. Therefore, the CDP work group will work on the following seven objectives with the intent of helping to make physical activity and nutritious food more accessible. Making the healthy choice should be the easy choice for our population, which will result in a healthier Pennsylvania for all.

Objective 2.1.1	Priority	Baseline (Percent)	Target (Percent)
Increase the percentage of adult who participated in 150 minutes (or vigorous equivalent) of physical activity per week from 51% in 2019 to 56% (BRFSS)[11]	Overall	51	56
	Black, non-Hispanic	44	56
	Hispanic	44	56
	Less than high school education	41	56

Objective 2.1.2	Priority	Baseline (Percent)	Target (Percent)
Increase the percent of high school students who participate in at least 60 minutes of physical activity on at least 1 day during a week from 87.4% in 2019 to 90.5% (YRBS).[6]	Overall	87.4	90.5
	Black	75.5	90.5
	Hispanic	80.7	90.5
	Asian/PI	81.1	90.5
	Lesbian, gay or bisexual	78.3	90.5

Objective 2.1.3	Priority	Baseline (Percent)	Target (Percent)
Increase the percentage adults who consume at least five servings of fruits and/or vegetables every day from 14% in 2021 to 18% (BRFSS)[11]	Overall	14	18

Objective 2.1.4	Priority	Baseline (Percent)	Target (Percent)
Increase the percent of high school students who eat vegetables during a week from 92.1% in 2019 to 94.6% (YRBS)[6]	Overall	92.1	94.6
	Black	81.9	94.6

Objective 2.1.5	Priority	Baseline (Percent)	Target (Percent)
Reduce adult obesity from 33% in 2021 to 28% (BRFSS)[11]	Overall	33	28
	Black, non-Hispanic	45	28

Objective 2.1.6	Priority	Baseline (Percent)	Target (Percent)
Reduce childhood obesity from 18.1% in 2017-2018 to 14.4% (Growth Screening Index)[27]	Overall	18.1	14.4

Below are the list of strategies, assets and partners that will be involved to achieve the above objectives.

Goal 2.1 Featured Strategies

- Increase access to school facilities or community programs to increase physical activity
- Combine physical activity opportunities and social support to build, strengthen, and maintain social networks that encourage positive behavior change
- Increase access to safe and free/low-cost physical activity opportunities
- Primary care provider prescriptions for exercise
- Increase active transportation options
- Increased adherence to State model student wellness plans
- Encourage walkability, walking, and bicycling for transportation and recreation through programs and improvements in the built environment, including equipment such as Bike Share, Safe Routes to School, trails within 10 minutes of every Pennsylvanian
- Develop training programs to increase capacity of communities to achieve this bicycle and pedestrian friendly designations or policies
- Assist communities in creating Active Transportation Plans, Complete Street Policies, and Vision Zero Plans
- Increase access to healthy, nutritious foods and beverages, including food pantries, community gardens, and farm markets
- Increase the use of easy-to-read food labels around schools, hospitals, common community areas
- Increase number of participants in the school free and reduced-price meal plans
- Educate on healthy food habits
- Provide affordable and accessible opportunities to be physically active, such as parks, trails, fitness events and recreational facilities, particularly in under-resourced communities. Increase access to obesity treatment – pharmacotherapies, bariatric surgery
- Increase access to safe physical activity and active transportation
- Implement food service guidelines in worksites and community settings
- Implement high-impact obesity prevention standards in early care and education state systems and systems support
- Provide school support via assessment, training and technical assistance on school health policies, and wellness practices and programs
- Promote family-centered healthy weight programs, like healthy weight and your child
- Promote usage of SNAP and WIC benefits for purchasing healthy food (e.g. double up food bucks)
- Implement mobile markets in under-resourced communities.
- Increase the number of communities with bicycle and pedestrian friendly designations and/or policies.

Goal 2.1 Assets	
• Active Transportation Advisory Committees • AARP/Indoor large malls open for adults to walk • Afterschool programs • Central Pennsylvania Food Bank • CDC School Health Guidelines to Promote Healthy Eating and Physical Activity • Corridor Safe Routes to Parks accelerator program • Comprehensive School Physical Activity Programs (CSPAP) • Pennsylvania Department of Community and Economic Development plans • Erie Food Police Advisory Council • Farmers Markets • Free technical assistance from Safe Routes to School Partnership through SPAN grant • Food Trust • Giant/Martins hosts a healthy food stand for events/ • Good Food, Healthy Hospitals Program • Healthy Harrisburg • Healthy Pantry Initiative • Keystone Kids Go workgroup • League of American Bicyclist • Lehigh Valley Food Policy Council • Local communities with walking programs, bike racks placed around a community • North-West Regional Accountable Health Council • Pennsylvania Department of Education, Division of Food and Nutrition PA Academy of Nutrition and Dietetics,	• ParksRx involving arts and culture in walking and/or biking routes • Parks and Rec: Schools are open during winter • Pennsylvania Nutrition and Physical Activity Self-Assessment for Child Care (PA NAPSACC) • Free access to GO NAPSACC for any childcare provider/program in Pennsylvania • Recycle Bicycles • Safe Routes to School • School Wellness Grant Programs • SNAP • SHARE • Slippery Rock University's School Wellness Education Program • Trainings the Department of Education is doing with Health/Physical Education teachers throughout the state • Walkworks • Whole School, Whole Community, Whole Child (WSCC) • Walk with a Doc • Weight management Program UPMC Central PA, • We Walk PHL • Wellness policies for schools (including Safe Routes to School) • Walk Friendly Community Assessment • WIC • Philabundance

Goal 2.1 Partners	
• Active Transportation Resource Center • Bello, Reilley, McGrory & DiPippo Attorneys at Law • Buhl Regional Health Foundation • Community Hero Action Group • Duquesne University Center for Integrative Health • Early Alert • Feeding Pennsylvania • Pennsylvania Academy of Nutrition and Dietetics • Harrisburg Area YMCA • Healthy Community Life spaces • Pennsylvania Academy of Family Physicians • Pennsylvania Association of Community Health Centers • PA DOH, Bureau of Epidemiology • PA DOH, Bureau of Community Health Systems • PA DOH, Office of Policy	• Pennsylvania Office of Rural Health • PA DOH, Bureau of Health Promotion & Risk Reduction • Penn State Health • PA DCNR • Pennsylvania Department of Education, Bureau of Curriculum and Assessment • Pennsylvania Downtown Center • Pennsylvania Housing Finance Agency • Pennsylvania Occupational Therapy Association • Pennsylvania School Board Association • Schuylkill County's VISION • The Arc of Pennsylvania • PA DOH, Office of Health Equity

Goal 2.2: Reduce the impact of tobacco and nicotine use

Smoking is a risk factor for chronic diseases such as heart disease, stroke, lung disease, cancer, and others. In 2021, in Pennsylvania, the rate of tobacco use was higher among those populations with household income under $15,000 (27%) compared to those with household income above $75,000 (8%).[11] Also, the increasing exposure of the population to nicotine products other than conventional cigarettes is a concerning public health issue among high school students.[6] Although federal and state taxes on cigarettes have increased, it is still an issue among groups that have been marginalized, including Black Pennsylvanians and people with lower income and education levels. Therefore, the Chronic Disease Prevention Work Group will be working on the following two objectives towards this goal.

Objective 2.2.1	Priority	Baseline (Percent)	Target (Percent)
Reduce current tobacco use (smokes every day or some days) among adults from 14% in 2021 to 11% (BRFSS)[11]	Overall	14	11
	Black, non-Hispanic	16	11
	Age 30-44	18	11
	Age 45-64	18	11
	Less than high school education	24	11
	Income <15k	27	11
	Income 15k-25k	24	11

Objective 2.2.2	Priority	Baseline (Percent)	Target (Percent)
Reduce current vaping among high school students from 24.4% in 2019 to 20.2% (YRBS)[6]	Overall	24.4	20.2

Below are the list of strategies, assets and partners that will be involved to achieve the above objectives.

Goal 2.2 Featured Strategies	
• Promote referrals to 1-800 Quit-Now • Increase the number of providers practicing the AAC (Ask, Advise, Connect)	• Mandate that all health and dental insurance plans in Pennsylvania include a smoking cessation benefit in their plan • Increase training to medical and dental care providers

Goal 2.2 Assets	
• Organizations who have received tobacco control funds from the state • YMCA Center for Healthy Living • Tobacco Prevention Control Program Strategic plan	• Pennsylvania Alliance to Control Tobacco • Regional Primary Contractors • Medicaid to Support quit Line

Goal 2.2 Partners	
• American Lung Association • Clinton County Healthy Communities & PSU Extension • Community Care Behavioral Health • Harrisburg Area YMCA • PA DOH, Office of Health Equity • Pennsylvania Coalition for Oral Health • Pennsylvania Association of Community Health Centers	• Pennsylvania Housing Finance Agency • Philadelphia Department of Public Health • Pennsylvania Statewide Tobacco-Free Recovery Initiative • Pennsylvania Medical Society • Public Health Management Corporation

Whole Person Care

The Whole Person Care Work Group will focus its efforts to increase access to culturally humble whole person care through the lifespan. Improving access to whole person care empowers individuals, families, and communities to improve their health in various physical, behavioral, environmental, social, and medical life domains. Whole person care focuses on restoring health, promoting resilience, and preventing diseases across a lifespan.[28] There are four goals in this section to achieve the overall focus in whole person care:

- Increase access to medical and oral health care
- Improve mental health and substance use outcomes through improved mental health services, trauma informed trainings, and substance use interventions
- Improve health outcomes through improved chronic diseases management
- Improve maternal and infant health outcomes by improving prenatal, perinatal, and postnatal care

Goal 3.1: Increase access to medical and oral health care

Access to adequate and quality medical and oral health care is important as it allows Pennsylvanians who need these services with the opportunities to gain access to care providers to receive them. Healthy People 2030 focuses on improving health by helping people get timely, high-quality health care services. Sometimes people do not get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care will be explored by the work group. In 2020, about 68% of all adults in Pennsylvania visited a dentist with disproportionately lower dentist visits among low income and low educational status residents.[11] Oral health is integral to overall health and access to dental services is essential to promoting and maintaining good oral health. Yet those who need dental care the most are often the least likely to receive it.[29] Working to increase the number of people who access and receive oral health care and the number of people with personal health care provider will be a primary for this work group. Under this goal, the Whole Person Care Work Group will be responsible for working on the following two objectives:

Objective 3.1.1	Priority	Baseline (Percent)	Target (Percent)
Reduce the number of people who do not have a personal health care provider from 11% in 2021 to 8% (BRFSS)[11]	Overall	11	8
	Males	15	8
	Hispanic	21	8
	Asian, non-Hispanic	21	8
	Less than high school education	17	8
	Age 18-29	21	8
	Age 30-44	17	8
	Lesbian, gay or bisexual	13	8
	No primary source of health insurance	52	8

Objective 3.1.2	Priority	Baseline (Percent)	Target (Percent)
Increase people who visited a dentist in the last year from 68% in 2020 to 73% (BRFSS)[11]	Overall	68	73
	Less than high school	47	73
	Income <15k	46	73
	Income 15k-25k	54	73
	Black, non-Hispanic	58	73
	No Health Insurance	46	73

Below are the list of strategies, assets and partners that will be involved to achieve the above objectives.

Goal 3.1 Featured Strategies

- Increase access to health services through flexible healthcare delivery methods (e.g telehealth/telemedicine, mobile healthcare, school-based, in-office)
- Increase affordable access to mobile phones, internet, and appropriate technologies to all PA citizens with medical and behavioral health service needs
- Integrate behavioral health and oral health into primary care practice, including integrating patient navigators and community health workers
- Improve telehealth/telemedicine-friendly legislation, policies, and financial support
- Integrate health and transportation planning
- Support regulations that require MCOs to report on reimbursements of mental health and substance use services
- Reduce medication costs
- Promote meaningful transparency on price and cost sharing
- Increase the workforce
- Increase the percentage of certified community health workers who offer oral health information and dental referrals to their clients
- Track the number of individuals and organizations that are requesting and using oral health education materials
- Increase affordable access to oral/dental healthcare
- Increase carpool, rideshare, and car share programs

Goal 3.1 Assets

- Federally Qualified Health Centers (FQHCs)
- School-based health clinics run by FQHCs
- Behavioral Health commission funding
- Nurse navigators
- Community Pharmacies
- Pennsylvania Health Insurance Exchange Authority, dba/ Pennie
- Community Health Workers
- FindHelp.org
- Free clinics

Goal 3.1 Partners

- Access Services
- Harrisburg Area YMCA-Healthy Living
- Mission Effectiveness, Diversity, Equity, & Inclusion
- Nursing Foundation of PA
- Pennsylvania Association of Community Health Centers
- Pennsylvania Coalition for Oral Health
- PA DOH Oral Health Program
- Pennsylvania Academy of Family Physicians
- Pennsylvania Office of Rural Health
- Rehabilitation and Community Providers Association (RCPA)
- The Arc of Pennsylvania
- The Hospital & Health System Association of PA-Population Health & Clinical Affairs
- PennDOT

Goal 3.2: Improve mental health and substance use outcomes through improved mental health services, trauma informed trainings, and substance use interventions

Mental health includes our emotional, psychological, and social well-being and affects how we think, feel, and act.[30] It also helps determine how we handle stress, relate to others, make healthy choices, and is important at every Pennsylvanian's stage of life. Approximately one in seven Pennsylvania adults reported their mental health was not good for 14 or more days in a month, with higher rates among lesbian, gay or bisexual and low-income adults. Moreover, about a third of high school students felt sad or hopeless every day for two or more weeks in a year with higher rates among lesbian, gay or bisexual (62%).[6] Drug overdoses continue to plague Pennsylvanians, specifically among male adults, those 35-55 years of age, and Black adults.[31] The intersectionality among mental health, trauma, and substance use has been highlighted by the COVID-19 pandemic and the demand for these services contributes to provider overwhelm, burnout and

large provider to client ratios.[32] Implementing universal trainings that create trauma-informed approaches to care will be explored by this work group. Under this goal, the Whole Person Care work group work collaboratively on the following four objectives:

Objective 3.2.1	Priority	Baseline (Percent)	Target (Percent)
Decrease adults who report their mental health not good for 14 or more days in the past month from 14% in 2021 to 11% (BRFSS)[11]	Overall	14	11
	Black, non-Hispanic	16	11
	Hispanic	17	11
	Age 18-29	21	11
	Age 30-44	17	11
	Less than high school	17	11
	Income <15k	27	11
	Income 15k-25k	23	11
	Lesbian, gay or bisexual	35	11

Objective 3.2.2	Priority	Baseline (age-adjusted rate per 100,000)	Target (age-adjusted rate per 100,000)
Reduce suicide rates from 14.0/100,000 in 2019 to 10.7/100,000 (Death certificate)[4]	Overall	14.0	10.7

Objective 3.2.3	Priority	Baseline (Percent)	Target (Percent)
Decrease high school students who felt sad or hopeless from 34.5% in 2019 to 29.8% (YRBS)[6]	Overall	34.5	29.8
	Hispanic	41.9	29.8
	Male	45.1	29.8
	Lesbian, gay or bisexual	62	29.8

Objective 3.2.4	Priority	Baseline (Rate per 10,000)	Target (Rate per 10,000)
Reduce drug overdose deaths from 4.2/10,000 in 2021 to 3.8/10,000 (Pennsylvania Drug Overdose Surveillance Interactive Data Report)[31]	Overall	4.2	3.8
	Black	6.9	3.8
	Age 35-44	9.6	3.8
	Males	6	3.8
	Montour	11	3.8
	Philadelphia	8.1	3.8
	Cambria	7.3	3.8
	Fayette	6.3	3.8
	Lawrence	6.2	3.8
	Luzerne	6.1	3.8
	Allegheny	5.9	3.8
	Mercer	5.8	3.8
	Carbon	5.8	3.8
	Armstrong	5.3	3.8
	Lackawanna	5.1	3.8
	Lehigh	5	3.8
	Washington	4.8	3.8
	Westmoreland	4.7	3.8
	Tioga	4.7	3.8

Objective 3.2.5	Priority	Baseline (Provider to population ratio)	Target (Provider to population ratio)
Increase mental health provider to population ratio from 420:1 in 2021 to 378:1 (CHR)[33]	Overall	420:1	378:1
	Juniata	6,155:1	378:1
	Sullivan	5,913:1	378:1
	Cameron	4,330:1	378:1
	Potter	4,113:1	378:1
	Perry	2,718:1	378:1
	Forest	2,322:1	378:1
	Northumberland	2,149:1	378:1
	Fulton	2,072:1	378:1
	Wyoming	1,562:1	378:1
	Snyder	1,493:1	378:1

Below are the list of strategies, assets and partners that will be involved to achieve the above objectives.

Goal 3.2 Featured Strategies

- Increase trauma sensitive trainings to the public, workplaces, and social service organizations on identifying and supporting children, teens, and adults
- Increase the number and availability of school-based mental health services and support
- Increase and promote access to standardized screening across the community
- Reduce barriers to community-based mental health services and resources
- Increase awareness of available mental health services
- Reduce stigma regarding mental health services through providing community support groups throughout Pennsylvania
- Increase advertising for 211 and the suicide prevention hotline
- Increase behavioral health treatment for substance use disorder
- Prescription Drug Monitoring Program: Help health care providers safely prescribe controlled substances, and patients get the treatment they need
- Utilize the Patient Advocacy Program to connect with patients
- Promote the First Responder Addiction and Connection to Treatment Program to ensure first responders, public safety professionals and their agencies have the tools necessary to respond and fight the opioid epidemic
- Increase access to naloxone
- Increase access to Medication Assisted Treatment
- Expand harm reduction services including fentanyl testing strips, drug checking, syringe services programs, overdose prevention sites

Goal 3.2 Assets	
• County level Suicide Prevention Task Force committees • Several organizations offer Mental Health First Aid training in Pennsylvania: Penn State Extension, National Alliance on Mental Illness, PA Area Health Education Center • Community Health Workers • State Suicide Taskforce • County crisis centers • 988 Suicide and Crisis Lifeline • Zero Suicide Initiative (QPR) • PA School Board Association • Local school boards • ECHO Programs • Crisis Text Line • Veterans Crisis Line • PA DOH First Responder Toolkit • Deaf and Hard of Hearing • Pennsylvania Department of State, Bureau of Occupational Licenses • Pennsylvania Pharmacists Association • Health Choices groups • School-based health clinics • School Peer Specialists • Certified Recovery Specialists • Pennsylvania Medical Society Opioids Resource Page	• Prescription Take Back Events • Naloxone training and availability to everyone • Fixed site medication return boxes • Penn State Addiction Center for Translation • Primary care physicians • Providing community Medications for Opioid Use Disorder (MOUD) services • PA DHS Centers of Excellence • Community Care • Regional EMS Councils • Department of Drug and Alcohol Prevention's Get Help Now • Local American Society of Addiction Medicine (ASAM) Chapter • SAMHSA hotline • PA 211 • FindHelp.org • Telephonic Psychiatric Consultation Service Program (Telephonic Psychiatric Consultation Service Program) • Pennsylvania Coordinated Medication Assisted Treatment (PacMAT) programs • Mail order naloxone program

Goal 3.2 Partners	
• Community Care Behavioral Health Organization • Pennsylvania Area Health Education Center • Pennsylvania Academy of Family Physicians • Penn Medicine Lancaster General Health • Health Choices groups • Department of Advocacy and Reform • Access Services • Pennsylvania Office of Rural Health • Pennsylvania Coalition Against Domestic Violence	• Bucks County Health Improvement Partnership • Tioga County Partnership for Community Health • Bethlehem Health Bureau • Duquesne University, School of Health Sciences • PA DOH, Office of Drug Surveillance and Misuse Prevention (ODSMP) • Pennsylvania Department of Drug and Alcohol Programs

Goal 3.3: Improve health outcomes through improved chronic diseases management.

Chronic disease management's integrated care approach to managing illness includes screenings, check-ups, monitoring and coordinating treatment, and patient education.[34] It can improve an individual's quality of life while reducing their health care costs by preventing or minimizing the effects of a disease. Overall, 47% of Pennsylvania adults live with one or more chronic diseases (e.g., cancer, cardiovascular disease, arthritis, asthma, Chronic Obstructive Pulmonary Diseases (COPD), and diabetes) with higher rates among age 65 and older (78%).[17]

People with chronic conditions generally use more health care services, including physician visits, hospital care, and prescription drugs. Many disease management programs have been successful at improving self-care practices and reducing use of various health care services, including hospital admissions and emergency room visits. The focus of this goal is to reduce hospitalizations and deaths related to heart disease, cancer, diabetes, COPD, and Alzheimer's disease. The work group will collaborate to explore ways to implement strategies that address the whole person, while still focusing on disease management and the individual's specific condition(s). Under this goal, the Whole Person Care Work Group will be responsible for working on the following five objectives:

Objective 3.3.1	Priority	Baseline (age adjusted rate per 100,000)	Target (age adjusted rate per 100,000)
Decrease heart disease related hospitalizations from 926.8/100,000 in 2019 to 543.5/100,000 (PHC4)[12]	Overall	926.8	543.5
	Age >55	3397.8	543.5
	Black	1332.9	543.5
	Philadelphia	1157.8	543.5
	Blair	1138.3	543.5
	Schuylkill	1111.7	543.5
	Cambria	1109.2	543.5
	Fayette	1104.6	543.5
	Bradford	1103.6	543.5
	Carbon	1067.6	543.5
	Mercer	1063.1	543.5
	Clearfield	1057.4	543.5
	Cameron	1052.8	543.5
	Westmoreland	1051.9	543.5
	Northampton	1036	543.5
	Jefferson	1029.1	543.5
	Huntingdon	1,026.5	543.5

*2019 data was used as a baseline because COVID-19 has affected hospitalization patterns in 2020.

Objective 3.3.2	Priority	Baseline (age adjusted rate per 100,000)	Target (age adjusted rate per 100,000)
Reduce the overall cancer death rate from 152.7/100,000 in 2019 to 140.95/100,000 (Death certificate)[4]	Overall	152.7	140.9
	Age >60	722.2	140.9
	Black	173.9	140.9
	Sullivan	221	140.9
	Potter	202.2	140.9
	Mifflin	201.8	140.9
	Schuylkill	193.7	140.9
	Greene	191.2	140.9
	Perry	191.2	140.9
	Elk	183.6	140.9
	Lycoming	178.2	140.9
	Washington	175	140.9
	Forest	174	140.9
	Northumberland	173.2	140.9
	Fayette	172.5	140.9
	Tioga	171.5	140.9
	Jefferson	168.9	140.9

*2019 data was used as a baseline because COVID-19 has affected hospitalization patterns in 2020.

Objective 3.3.3	Priority	Baseline (age adjusted rate per 100,000)	Target (age adjusted rate per 100,000)
Decrease diabetes related hospitalizations from 197.7/100,000 in 2019 to 180.0/100,000 (PHC4) [12]	Overall	197.7	180
	Age >50	392.3	180
	Black	442.6	180
	Philadelphia	331.4	180
	Venango	325	180
	Fayette	281.2	180
	Schuylkill	271.5	180
	Mercer	256	180
	Luzerne	243.4	180
	Dauphin	240.3	180
	Northampton	235.9	180
	Monroe	234.1	180
	Lawrence	231.4	180
	Beaver	228.8	180
	Fulton	228.4	180
	Carbon	219.3	180
	Northumberland	218.7	180

*2019 data was used as a baseline because COVID-19 has affected hospitalization patterns in 2020.

Objective 3.3.4	Priority	Baseline (age adjusted rate per 100,000)	Target (age adjusted rate per 100,000)
Decrease COPD related hospitalization from 136.9/100,000 in 2019 to 69.0/100,000 (PHC4) [12]	Overall	136.9	69.0
	Age>55	473.0	69.0
	Black	243.6	69.0
	McKean	386.5	69.0
	Cameron	352.0	69.0
	Potter	279.4	69.0
	Elk	246.1	69.0
	Philadelphia	231.5	69.0
	Bradford	231.1	69.0
	Fayette	218.1	69.0
	Susquehanna	200.2	69.0
	Clearfield	191.6	69.0
	Greene	191.6	69.0
	Mercer	176.5	69.0
	Monroe	170.7	69.0
	Blair	167.0	69.0
	Huntingdon	165.2	69.0

*2019 data was used as a baseline because COVID-19 has affected hospitalization patterns in 2020.

Objective 3.3.5	Priority	Baseline (age adjusted rate per 100,000)	Target (age adjusted rate per 100,000)
Decrease Alzheimer's related hospitalization from 7.3/100,000 in 2019 to 2.5/100,000 (PHC4) [12]	Overall	7.3	2.5
	Age>65	54.4	2.5
	Hispanic	9	2.5
	Jefferson	48.7	2.5
	Clearfield	31.7	2.5
	Somerset	31	2.5
	Cambria	17.5	2.5
	Monroe	13.1	2.5
	York	12.5	2.5
	Northampton	12.2	2.5
	Lehigh	11.6	2.5
	Bucks	11.2	2.5
	Schuylkill	9	2.5

*2019 data was used as a baseline because COVID-19 has affected hospitalization patterns in 2020.

Below are the list of strategies, assets and partners that will be involved to achieve the above objectives.

Goal 3.3 Featured Strategies

- Implement educational programs, improve health literacy to result in better heart disease management
- Increase heart disease screenings, referrals for positive screenings, and follow-up
- Increase access to nutrition education
- Participate in the Pennsylvania Cancer Coalition
- Report progress to SHIP from the Pennsylvania Cancer Coalition
- Implement educational programs promoting healthy eating and active living, improve health literacy to result in better diabetes management
- Increase diabetes screenings, referrals for positive screenings, and follow-up
- Promote and increase access to dietitian-delivered nutrition therapy for people with diabetes
- Support the Diabetes Action Network and diabetes support groups
- Reduce the cost of diabetes medications and supplies, including the removal of copays and fees for lifesaving medications
- Increase access to remote monitoring systems through increasing insurance reimbursement and provider/patient awareness
- Collaborate with professional health organizations to communicate current standards of diagnosis, including spirometry use, and treatment options for COPD
- Promote increasing physical activity, eating a healthy diet, and quitting cigarette smoking and excessive drinking in Alzheimer's patients
- Promote social connections and intellectual activity
- Mobilize partnerships across entire communities for prevention and care of Alzheimer's disease and all-related dementias
- Promote cognitive screens as part of physicals
- Improve caregivers' education and comfort in caring for and supporting those with Alzheimer's disease and all related dementias

Goal 3.3 Assets	
• Public Health Service Grant • Early Alert Program • Pennsylvania Medical Society-Diabetes Prevention Program grant • Expand medication formularies across MCOs • Regional Tobacco Cessation task force • Alzheimer's Association education and support services • Pennsylvania Department of Aging workgroups • Pennsylvania Cancer Coalition Strategic Plan • PA DOH - Division of Cancer Prevention and Control	• Alzheimer's Disease Research Centers (ADRCs: Penn and Pitt) • Project ECHO Primary Care • Jewish Health Foundation (PAPQC) • Dementia Friends PA • Act 9 of 2022- the Early Detection and Diagnosis of Alzheimer's or A Related Disorder Act • Alzheimer's Disease & Related Disorders: Aging publications • Accion Comunal Latino Americano de Montgomery County (ACLAMO)

Goal 3.3 Partners	
• Access Services • Allegheny County Health Department, Chronic Disease & Injury Prevention • Allentown Health Bureau • Alzheimer's Association • American Heart Association • American Lung Association • Bradbury-Sullivan LGBT Community Center • Clinton County Healthy Communities • Clinton County PSU Extension • Community Care Behavioral Health Organization • Department of Drug and Alcohol Prevention • Duquesne University Center for Integrative Health • Geisinger Kistler Family Medicine • Harrisburg Area YMCA • Healthy Communities Program • Healthy Community Lifespaces • PA DOH, Division of Injury Prevention, Heart Disease and Stroke Program, Division of Injury Prevention • Mission Effectiveness, Diversity, Equity, & Inclusion • NEPA-Volunteers of America of Pennsylvania	• Pennsylvania Academy of Family Physicians • Pennsylvania Association of Community Health Centers • Pennsylvania Chapter American College of Cardiology • Pennsylvania Medical Society • Penn State Health • Pennsylvania Area Health Education Center • Pennsylvania Downtown Center • Pennsylvania Downtown Center, Healthy Community Program • Pennsylvania Office of Rural Health • Pennsylvania State Nurses Association • Physician representation • Public Health Management Corporation • Quality Insights • The Arc of Pennsylvania • The Hospital & Health System Association of Pennsylvania-Population Health & Clinical Affairs • University of Pennsylvania, Diabetes Education Department

Goal 3.4: Improve maternal and infant health outcomes by improving prenatal, perinatal, and postnatal care.

Before pregnancy, the health and wellness of a person is critical to achieving safe outcomes for the individual and their baby. Access to care is vital during this period because it allows providers to identify, treat, and stabilize chronic conditions; address behavioral health needs; and plan for a healthy pregnancy. Prenatal care can reduce the risk of pregnancy complications for both the pregnant person and child. After pregnancy, an individual is advised to establish or reestablish their well-person care.

Racial disparities in adverse maternal health outcomes persist in Pennsylvania. Black women and infants are nearly three times as likely to die compared their white counterparts. While there may be multiple factors associated with individual deaths during pregnancy, racial disparities in birth outcomes are known to originate from the detrimental effects of institutional and interpersonal racism, implicit bias among providers and social determinants of health. Additionally, accidental poisoning accounted for 50% of pregnancy associated deaths.[15]

The work group aims to improve the quality of essential, routine prenatal, perinatal, and postnatal care for women and newborns with the goal of improving maternal and newborn health and well-being. The Whole Person Care Work Group will be responsible for working on the following two objectives.

Objective 3.4.1	Priority	Baseline (Percent)	Target (Percent)
Reduce the rate of infant mortality from 5.6/1,000 in 2020 to 4.0/1,000 (Death certificate)[4]	Overall	5.6	4.0
	Black	10.9	4.0

Objective 3.4.2	Priority	Baseline **(rate per 1000)**	Target **(rate per 1000)**
Reduce severe maternal morbidity from 92.4/10,000 in 2020 to 83.2/100,000 (HCUP)[35]	Overall	92.4	83.2
	Black	148	83.2
	Hispanic	103	83.2
	Age 35-55	137.6	83.2

Goal 3.4 Featured Strategies	
• Vaccinate newborns at age-appropriate times • Improve early and adequate prenatal care visits • Increase behavioral health services during prenatal, perinatal, and postnatal care	• Annually provide breastfeeding education and community outreach to improve breastfeeding initiation and duration rates • Increase access to prenatal and postnatal care

Goal 3.4 Assets	
• Nurse Family Partnership (NFP) programs • County and Municipal Health Department's Maternal Child Health Programs • Plans of Safe Care teams in the counties • Jewish Health Foundation (JHF) • Pennsylvania Perinatal Quality Collaborative (PAPQC) • Nurse led coalitions and Community Health Workers • Dementia Friends Pennsylvania • Pennsylvania Immunization Coalition • PennDOT • Local Early Intervention Program	• Interventions to Minimize Preterm and Low birth weight Infants using Continuous Quality Improvement Techniques (IMPLICIT) Network • Telephonic Psychiatric Consultation Service Program (Telephonic Psychiatric Consultation Service Program) • Children's Health Insurance Program • Transit in Washington County • Pocono Pony in Monroe County • Rabbit Transit/Transfer in Northeast Pennsylvania • County Children, Youth and Families

Goal 3.4 Partners	
• Allegheny County Health Department, Chronic Disease & Injury Prevention • Chester County Health Department, Maternal and Child Health Program • CMHDs Maternal Child Health Programs • Pennsylvania Department of Drug and Alcohol Programs, Prevention Unit • Geisinger Kistler Family Medicine • Harrisburg Area YMCA • Healthy Communities Program • Healthy Start Pittsburgh • Maternal and Family Health Services, Inc. • Mission Effectiveness, Diversity, Equity, & Inclusion • Nursing Foundation PA • Pennsylvania Academy of Family Physicians • Pennsylvania Association of Community Health Centers	• PA DOH, Breastfeeding Program • Pennsylvania Immunization Coalition through PA Chapter of American Academy of Pediatrics • PA DOH, Bureau of Family Health • PennDOT, Policy Office • Pennsylvania Area Health Education Center • Pennsylvania Downtown Center • Pennsylvania Health Insurance Exchange Authority, d/b/a Pennsylvania Health Insurance Exchange Authority, d/b/a Pennie • Pennsylvania Office of Rural Health • The Arc of Pennsylvania • The Pennsylvania Perinatal Quality Collaborative (PA PQC)

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Appendix A. Populations of Focus by Objective, PA-SHIP 2023-2028

This table summarizes the populations who are at higher risk for poor health outcomes by objectives. Populations and counties were identified when the data showed a disparity greater than 10% of the overall population. The grayed cells indicate there is no data available for that population or the difference in the data was less than 10% that of the overall population estimate.

Objectives	Sex	Age	Race and ethnicity	Income and education	Sexual orientation	Other populations	County
Health Equity							
Poverty			Blacks, Hispanic	Less than high school education			
Homelessness			Black			Individuals with severe mental illness, Individuals with chronic substance use	
Spending 30% of income on rent							Centre, Pike, Lawrence, Philadelphia, Monroe
Food insecurity		<18	Black, Hispanic				
Homicides	Males	Age 15-34	Black				
Elder abuse		Elder population					
Air quality							
Heat-related hospitalizations							
Lead among children							
Chronic Diseases Prevention							
Physical activity among adults			Hispanic, Black, Asian/PI	Less than High School education			
Physical activity among high school students		Grade 9-12	Blacks, Hispanic Asian/PI		Lesbian, gay or bisexual		
Communities with bicycle and pedestrian friendly designations and/or policies							

Objectives	Sex	Age	Race and ethnicity	Income and education	Sexual orientation	Other populations	County
Fruits and or vegetables consumption among adults							
Vegetable's consumption		Grade 9-12	Black				
Adult obesity			Black				
Childhood obesity		K-12					Clinton, Columbia, Lycoming, Northumberland, Tioga, Susquehanna, Wyoming, Jefferson, Venango, Fulton, Huntingdon, Juniata, Greene
Tobacco use		30-64	Black	Income <25K, less than High School education			
Vaping		Grade 9-12	White				
Whole Person care							
People who do not have personal health care provider	Males	18-44	Hispanic, Asian	Less than High School education	Lesbian, gay or bisexual	People with no primary source of insurance	
Dentist visits			Black	Income <25K, less than High School education		People with no primary source of insurance	
Mental health provider to population ratio							Juniata, Sullivan, Cameron, Potter, Perry, Forest, Northumberland, Fulton, Wyoming, Snyder
Suicide	Males						
Poor mental health days		18-44	Hispanic, Black	Income <25K, less than High School education	Lesbian, gay or bisexual		
Felling sad or hopeless	Female	Grade 9-12	Hispanic		Lesbian, gay or bisexual		

Objectives	Sex	Age	Race and ethnicity	Income and education	Sexual orientation	Other populations	County
Drug overdose deaths	Males	35-44	Black				Montour, Philadelphia, Cambria, Fayette, Lawrence, Luzerne, Allegheny, Mercer, Carbon, Armstrong, Lackawanna, Lehigh, Washington, Westmoreland, Tioga
Heart disease related hospitalizations		Age>55	Black				Philadelphia, Blair, Schuylkill, Cambria, Fayette, Bradford, Carbon, Mercer, Clearfield, Cameron, Westmoreland, Northampton, Jefferson, Huntingdon
Overall cancer death		Age>60	Black				Sullivan, Potter, Mifflin, Schuylkill, Greene, Perry, Elk, Lycoming, Washington, Forest, Northumberland, Fayette, Tioga, Jefferson
Diabetes related hospitalizations		Age>50	Black				Philadelphia, Venango, Fayette, Schuylkill, Mercer, Luzerne, Dauphin, Northampton, Monroe, Lawrence, Beaver, Fulton, Carbon, Northumberland
COPD related hospitalization		Age>55	Black				McKean; Cameron; Potter; Elk; Philadelphia; Bradford; Fayette; Susquehanna; Clearfield; Greene; Mercer; Monroe; Blair; Huntingdon
Alzheimer's related hospitalization		Age>65	Hispanic				Jefferson, Clearfield, Somerset, Cambria, Monroe, York,
							Northampton, Lehigh, Bucks, Schuylkill
Infant mortality			Black				
Severe maternal morbidity		35-55	Black Hispanic				

Appendix B. SHIP Goals and Objective Summary

This table is a summary of all the goals and objectives included in the 2023-2028 Pennsylvania SHIP. Each objective includes a baseline and target.

	Goals and Objectives	Baseline	Target
Overall Goals			
	Increase Pennsylvania's ranking in America Health Rankings from 25th in 2022 to 22[1]	25	22
	Increase the life expectancy of Pennsylvanians from 76.3 years in 2020 to 79[1]	76.8	79.0
1. Health Equity			
Goal 1.1: Increase financial well-being, food security, and safe affordable housing			
1.1.1	Decrease the percent of the population living in poverty from 12.1% in 2021 to 9.0% (ACS)[2]	12.1%	9.0%
1.1.2	Reduce the number of people experiencing homelessness from 13,375 in 2020 to 12,037 (Housing and Urban Development data)[2]	13,375	12,037
1.1.3	Reduce the percent of the population spending 30% or more of their income on rent by from 47% in 2021 to 42% (CHR)[2]	47%	42%
1.1.4	Reduce food insecurity in Pennsylvania from 8.9% in 2020 to 6.3% (Map the Meal Gap)[2]	8.9%	6.3%
Goal 1.2: Increase community safety by reducing the number of violent incidences that occur due to racism, discrimination, or domestic disputes			
1.2.1	Reduce the number of homicides from 8.3/100,000 in 2019 to 7.5/100,000 (Death certificates) [2]	8.3	7.5
1.2.2	Decrease the total reports of need for older adult protective services received due to caregiver or self-neglect from 58.3% to 53.3% (PA Department of Aging)[23]	58.3%	53.3%
Goal 1.3: Improve environmental health, focusing on environmental justice communities			
1.3.1	Increase population living in counties meeting the National Ambient Air Quality Standard (NAAQS) for PM 2.5 from 61.2% in 2019 to 66% (DEP/EPA via EDDIE)[2]	61.2%	66%
1.3.2	Reduce number of heat-related hospitalizations from 206 in 2020 to 185 (Environmental Public Health Tracking)[2]	206	185
1.3.3	Increase the number of 0–71-month-olds tested for lead from 148,432 in 2020 to 163,275 (Childhood Lead Surveillance Report)[2]	148,432	163,275
2. Chronic Diseases Prevention			
Goal 2.1: Increase the population at a healthy weight through increasing availability and accessibility of physical activity and affordable nutritious food			
2.1.2	Increase the percentage of adult who participated in 150 minutes (or vigorous equivalent) of physical activity per week from 51% in 2019 to 56% (BRFSS)[2]	51%	56%
2.1.2	Increase high school students who participate in at least 60 minutes of physical activity on at least 1 day during a week from 87.4% in 2019 to 90.5 (YRBS)[2]	87.4%	90.5%
2.1.3	Increase the percentage of Pennsylvania adults who consume at least five servings of fruits and/or vegetables every day from 14% in 2021 to 18% (BRFSS)[2]	14%	18%
2.1.4	Increase high school students who eat vegetables during a week from 92.1% in 2019 to 94.6% (YRBS, 2028)[2]	92.1%	94.6%
2.1.5	Reduce adult obesity by from 33% in 2021 to 28% (BRFSS)[2]	33%	28%
2.1.6	Reduce childhood obesity from 18.1% in 2017-2018 to 14.4% (Growth Screening Index)[2]	18.1%	14.4%
Goal 2.2: Reduce the impact of tobacco and nicotine use			
2.2.1	Reduce current tobacco use (smokes every day or some days) among adults from 14% in 2021 to 11% (BRFSS)[2]	14%	11%
2.2.2	Reduce current vaping among high school students from 24.4% in 2019 to 20.2% (YRBS)[2]	24.4%	20.2%
3. Whole Person Care			
Goal 3.1: Increase access to medical and oral health care			
3.1.1	Reduce people who do not have personal health care provider from 11% in 2021 to 8% (BRFSS)[2]	11%	8%
3.1.2	Increase people who visited a dentist in the last year from 68% in 2020 to 73% (BRFSS)[2]	68%	73%
Goal 3.2: Improve mental health and substance use outcomes through improved mental health services, trauma informed trainings, and substance use interventions			
3.2.1	Reduce suicide rates from 14.0/100,000 in 2019 to 10.7/100,000 (Death certificate)[2]	14.0	10.7
3.2.2	Decrease adults who report their mental health not good 14 or more days in the past month from 14% in 2020 to 11% (BRFSS)[2]	14%	11%
3.2.3	Decrease high school students who felt sad or hopeless from 34.5% in 2019 to 29.8% (YRBS)[2]	34.5%	29.8%
3.2.4	Reduce drug overdose deaths from 4.2/10,000 in 2021 to 3.8/10,000 (PA Drug Overdose Surveillance Interactive Data Report)[2]	4.2	3.8
3.2.5	Increase mental health provider to population ratio from 420:1 in 2021 to 378:1 (CHR)[2]	420:1	378:1
Goal 3.3 Improve health outcomes through improved chronic diseases management			
3.3.1	Decrease heart disease related hospitalizations from 926.8/100,000 in 2019 to 543.5/100,000 (PHC4) [3]	926.8	543.5
3.3.2	Reduce the overall cancer death rate from 152.7/100,000 in 2019 to 140.9/100,000 (Death certificate)[4]	152.7	140.9
3.3.3	Decrease diabetes related hospitalizations from 197.7/100,000 in 2019 to 180/100,000 (PHC4)[2]	197.7	180
3.3.4	Decrease COPD related hospitalization from 136.9/100,000 in 2019 to 69.0/100,000 (PHC4)[3]	136.9	69.0
3.3.5	Decrease Alzheimer's related hospitalization from 7.3/100,000 in 2019 to 2.5/100,000 (PHC4)[3]	7.3	2.5
Goal 3.4: Improve maternal and infant health outcomes by improving prenatal, perinatal, and postnatal care			
3.4.1	Reduce the rate of infant mortality from 5.6/1,000 in 2020 to 4.0/1,000 (Death certificate)[3]	5.6	4.0
3.4.2	Reduce severe maternal morbidity from 92.4/10,000 in 2020 to 83.2/100,000 (HCUP)[2]	92.4	83.2

1. Target was set based consensus among the Steering Committee members.
2. Target was calculated using Percent Improvement tool (Ten percent or up to five percentage points improvement). Available at: https://www.cdc.gov/nchs/healthy_people/hp2030/hp2030-target-setting.htm.
3. Target was adopted based on already existing objectives.
4. Target was calculated based on Exponential Smoothing Model.

Note: Decimal point is included if it is reported in the data source and omitted if not reported

Appendix C. Additional Strategies

This is a compilation of additional strategies that do not have leads or teams within each work-group (Health Equity, Chronic Disease Prevention and Whole Person Care). When a team is formed, the additional strategies can be included in annual implementation plans.

Health Equity Work Group	
GOAL 1.1: Increase financial well-being, food security, and safe affordable housing	
• School-based employees be paid a living wage • Decrease the annual unemployment rate among the working age population • Increase minimum wage • Pursue legislation and partnerships between public and private organizations to reduce housing-related discrimination • Pursue legislation to restrict evictions • Promote zoning reform (zoning to allow for multiple occupants in homes) • Encourage development of accessible dwelling units and missing middle housing typologies	• Pursue legislation that requires a certain ratio of affordable housing based on development • Assess local ordinances aimed at housing quality • Increase WIC Farmers' Market Nutrition Program redemption rate • Increase agriculture surplus system for distribution to charitable food systems -PACT • Education for preschool staff in nutrition security • Increase home-delivered and congregate meal services for older adults
GOAL 1.2: Increase community safety by reducing the number of violent incidences that occur due to racism, discrimination, or domestic disputes	
• Enhance hate crime data collection and analysis • Social-emotional learning programs for youth, including education on domestic violence prevention • Healthy relationship programs for couples of all sexual orientations and gender identities • Support survivors to increase safety and lessen harms • Disrupt the developmental pathways toward partner violence including Parenting skill and family relationship programs Treatment for at-risk children, youth, and families • Develop interdisciplinary task force to examine incidences of substantiated abuse in facilities and identify prevention strategies • Raise long-term care resident awareness and increase visibility of the federally required State Office of the Long-Term Care Ombudsman, its purpose, and how to access	• Firearm restrictions for domestic violence offenders (Lautenberg Amendment Act) • Safe housing support for victims including safe and affirming housing for LGBTQ+ victims and survivors • Promote, educate (including cultural competency training), and empower stakeholders that are working with DV victims to understand the impacts of DV • Educate healthcare providers, including emergency personnel and primary care providers, on how to ask all patients about safety at home using trauma-informed and identity-affirming techniques • Develop a system to make universities, trade schools, and other institutions that educate students in clinical professions, allied health professions & direct care workforce aware of training opportunities available for their students on the topics of elder abuse, violence, injury, neglect, and exploitation, and connect them to those resources
GOAL 1.3: Improve environmental health, focusing on environmental justice communities	
• None	•

Chronic Disease Prevention Work Group	
GOAL 2.1: Increase the population at a healthy weight through increasing availability and accessibility of physical activity and affordable nutritious food	
• Promote land use policies to support physical activity • Engage Chambers of Commerce about adding bike or pedestrian friendly infrastructure • Implement a statewide, comprehensive student wellness recognition program • Activity programs for older adults	• Assist communities with bicycle friendly community designations from the League of American Bicyclists and walk friendly community designations from The University of North Carolina Highway Safety Research Center • Get Transit organizations to add health facilities to their focus areas
GOAL 2.2: Reduce the impact of tobacco and nicotine use.	
• Increase the tax on tobacco and nicotine products • Reduce tobacco and flavoring vaping sales to individuals under the age of 21 • Ensure alignment with PA Tobacco Prevention and Control Strategic Plan	• Support state and federal level tobacco control policy • Participate in the Pennsylvania Alliance to Control Tobacco (PACT)
Whole Person Care Work Group	
GOAL 3.1: Increase access to medical and oral health care	
• Promote use of FQHCs and health centers that work on a sliding scale payment system to ensure that all people can be seen by providers.	• Increase access to oral health services • Reduce or eliminate copays and/or deductibles for the insured population
GOAL 3.2: Improve mental health and substance use outcomes through improved mental health services, trauma informed trainings, and substance use interventions	
• Reduce intentional overdose deaths • Implement a statewide, comprehensive diverse worksite trauma-informed and wellness recognition program • Increase the number and reach (using telephonic) of psychiatrists • Improve mental health among middle school students • Increase education on overdose prevention • Create community medication take-back initiatives to recover large amounts of opioids and other drugs	• Reduce the stigma around substance use • Expand Prescriber Education program • Provides grant funding to Local Health Department's to support overdose prevention • Increase Public Awareness Campaigns • Warm hand-off from ED to treatment provider • Access to treatment beds for all status of insurance • Include Overdose prevention sites as one more part of mitigating overdose risk and to be included a form of harm reduction.
Goal 3.3: Improve health outcomes through improved chronic diseases management	
• Reduce the cost of heart disease medications, including the removal of copays and fees for lifesaving medications • Support state legislation to reduce the amount of salt allowed in Pennsylvania foods • Increase access to cardiac care and rehab	• Support or promote legislation to tax sugary drinks sold in Pennsylvania. • Implement the Cognitive Decline and Caregiver Modules of the BRFSS

Goal 3.4: Improve maternal and infant health outcomes by improving prenatal, perinatal, and postnatal care	
• Counseling about nutrition • Annually provide breastfeeding education and community outreach to improve breastfeeding initiation and duration rates • Title V Action Plan: Facilitate the adoption and implementation of the World Health Organization's ten evidenced based 'steps' for breastfeeding within PA birthing facilities • Counseling against use of tobacco, alcohol, and illicit drugs • Expand breastfeeding-support groups within local communities: Title V action Plan: Collaborate with the Safe Sleep Program to promote and support breastfeeding within each program; Annually provide breastfeeding education, and community outreach to improve breastfeeding initiation and duration rates • Educate parents about safe sleep, secondhand smoke, car seat safety, and exposure to harmful substances • Increase the number of community-based doulas providing services in targeted neighborhoods	• Screen women for health risks and pre-existing chronic conditions such as diabetes, hypertension, SUD, and sexually transmitted diseases • Improve reproductive education and life-planning • Counseling against use of tobacco, alcohol, and illicit drugs • Counseling about nutrition and physical exercise • Educate women about the early signs of pregnancy-related problems • Increase the percent of women who successfully complete evidence-based or informed home visiting programs • Participate in the PA DOH Family Health action planning process • Establish or expand transportation services and subsidy programs for areas with low population densities and underserved communities • Use data, as determined by the 6-step Perinatal Periods of Risk (PPOR) process, to implement prevention initiatives or interventions in the selected communities

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Appendix E. List of Acronyms

AAMC: American Association of Medical Colleges
ACO: Accountable Care Organization
AHA: American Hospital Association
AHRQ: Agency for Healthcare Research and Quality
APA: American Psychological Association
APN: Advanced Practice Nurse
APRN: Advanced Practice Registered Nurse
BCBS: Blue Cross and Blue Shield
BMI: Body Mass Index
BON: Board of Nursing
BRFSS: Behavioral Risk Factor Surveillance System
CDC: Centers for Disease Control and Prevention
CDP: Chronic Disease Prevention
CHAS: Community Health Advisory Survey
CHIP: Children's Health Insurance Program
CHR: County Health Rankings and Roadmaps
CHS: Center for Health Statistics
CHW: Community Health Worker
CMHP: Core Mental Health Provider
CMS: Centers for Medicare and Medicaid Services
CNM: Certified Nurse Midwife
CNS: Clinical Nurse Specialist
CPS: Certified Peer Specialist
CRNA: Certified Registered Nurse Anesthetist
DCNR: Pennsylvania Department of Conservation and Natural Resources
DOH: Department of Health
EHR: Electronic Health Record
ER: Emergency Room
FPL: Federal Poverty Level
FTE: Full-Time Equivalent
GDP: Gross Domestic Product
GME: Graduate Medical Education
HCUP: Healthcare Cost and Utilization Project
HE: Health Equity
HHS: Health and Human Services
HIT: Health Information Technology
HMO: Health Maintenance Organization
HRSA: Health Resources and Services Administration
ICU: Intensive Care Unit
IOM: Institute of Medicine
IT: Information Technology
LCSW: Licensed Clinical Social Worker
LPC: Licensed Professional Counselor
LSSP: Licensed Specialist in School Psychology
MA: Medical Assistant
MCO: Managed Care Organization
MFT: Marriage and Family Therapist
MTM: Medication Therapy Management
NAAL: National Assessment of Adult Literacy
NAIP: Network Access Improvement Program
NCQA: National Committee for Quality Assurance
NHSC: National Health Service Corps
NP: Nurse Practitioner
OB/GYN: Obstetrics/Gynecology
OT: Occupational Therapist
PA: Physician Assistant
PCAL: Patient Care Activity Level
PCMH: Patient-Centered Medical Home
PCP: Primary Care Practitioner
PHC4: Pennsylvania Health Care Cost Containment Council
PPACA: Patient Protection and Affordable Care Act
PsyD: Doctor of Psychology
PT: Physical Therapist
PTSD: Post-Traumatic Stress Disorder
RN: Registered Nurse
SES: Socio-Economic Status
SHA: State Health Assessment
SHIP: State Health Improvement Plan
SLP: Speech Language Pathologist
U.S.: United States
VA: US Department of Veterans Affairs
WHO: World Health Organization
WPC: Whole Person Care
YRBSS: Youth Risk Behavior Surveillance System

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