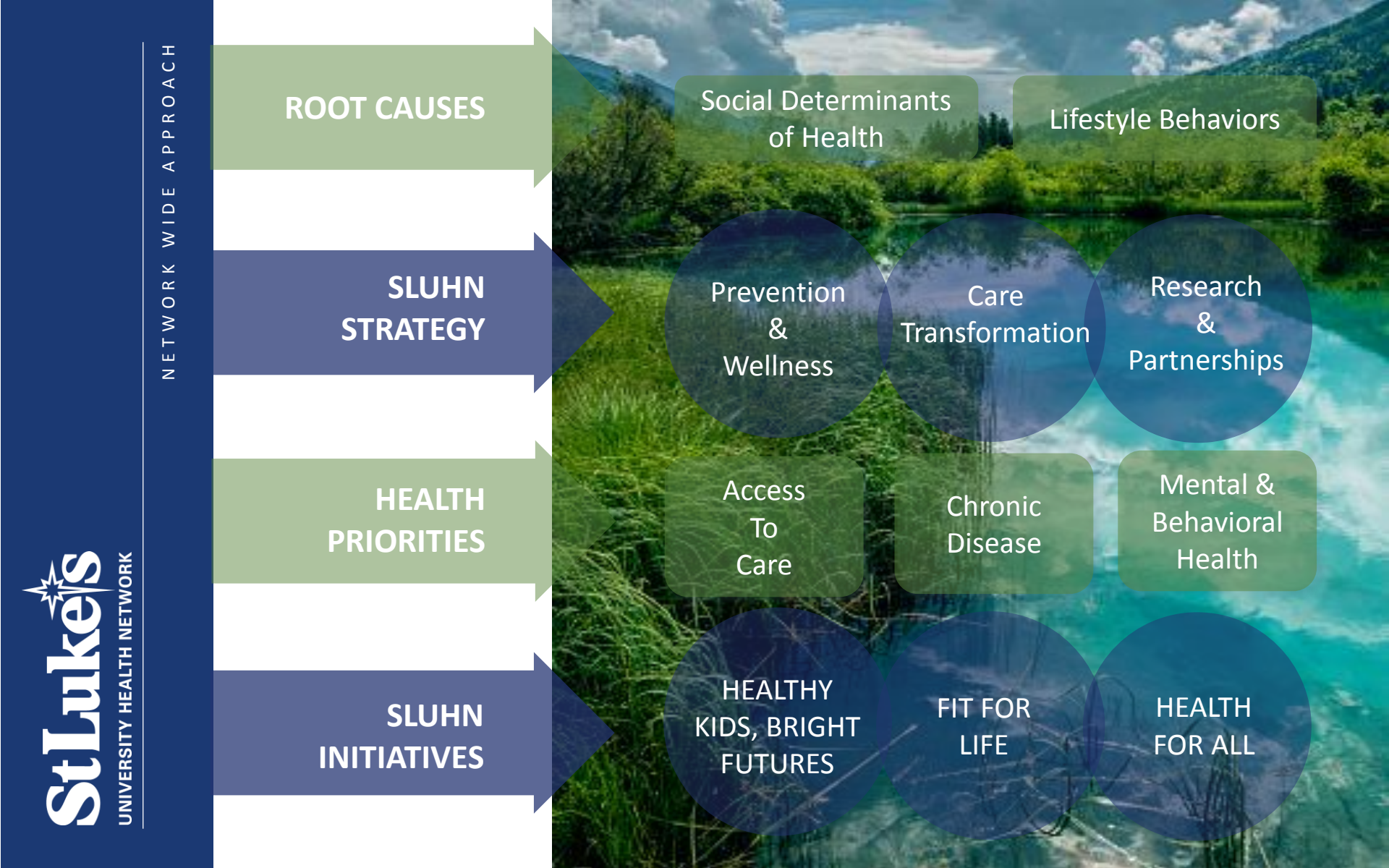
NETWORK WIDE APPROACH

St. Luke's University Health Network Implementation Strategy Overview

St Luke's UNIVERSITY HEALTH NETWORK


NETWORK WIDE APPROACH
StLuke's
UNIVERSITY HEALTH NETWORK
ROOT CAUSES
Social Determinants of Health
Lifestyle Behaviors
SLUHN STRATEGY
Prevention & Wellness
Care Transformation
Research & Partnerships
HEALTH PRIORITIES
Access To Care
Chronic Disease
Mental & Behavioral Health
SLUHN INITIATIVES
HEALTHY KIDS, BRIGHT FUTURES
FIT FOR LIFE
HEALTH FOR ALL

NETWORK WIDE APPROACH

St Luke's UNIVERSITY HEALTH NETWORK

St. Luke's University Health Network
Implementation Strategy Overview

Our Community Health Needs Assessment (CHNA) as mandated by the Affordable Care Act, is comprised of both primary and secondary data. The primary data was collected through campus specific key informant interviews and key stakeholder focus groups, as well as community health surveys, where approximately 10,234 surveys were conducted throughout the eleven campus St. Luke's University Health Network (SLUHN) geographic region. The needs identified using the primary data were supplemented by secondary data (hospital, zip-code, county, state and national level data) to provide a more comprehensive picture of the needs in the community and factors affecting the community's health for the 2019-2022 CHNA cycle. Data revealed that the priority health categories include improving access to care/reducing health disparities, promoting healthy lifestyles/preventing chronic disease, and improving mental/behavioral health. These three categories were seen as priorities across the network. The root causes of these three health priorities are largely related to social determinants of health such as housing and job readiness, as well as lifestyle behaviors, such as smoking, poor diet, lack of exercise, and substance use.

Improving Access to Care and Reducing Health Disparities: Data continue to show the need for primary care, mental health and dental providers in our region, especially in our more rural counties. Uninsured rates have dropped to 8%, but Hispanic populations are nearly twice as likely to be uninsured. Income-related disparities are significant, with Medicaid, low income and rural populations reporting higher rates of chronic disease, lower rates of preventive screenings and healthy behaviors, and more frequent late stage cancers at diagnosis. Affordable housing, food security and transportation were consistently cited as barriers to care and well-being across network communities.

SLUHN initiatives related to Improving Access to Care and Reducing Health Disparities include: primary care access, care coordination, oral health services, maternal and child health, Adopt a School, cancer screening programs using health equity funds, adolescent career mentoring, REACH and parish nursing.

Additionally we continue working with partners and grow collaborations with community agencies and organizations to effectively address needs more comprehensively and have a greater impact within our service areas. Partners for this priority area include but are not limited to school districts, food pantries, soup kitchens and the Hispanic Center of the Lehigh Valley.

Promoting Healthy Lifestyles and Preventing Chronic Disease: Seventy-five percent of our service area is overweight or obese, compared to 71% nationwide. Moreover, only 15% of survey respondents reported exercising 30 minutes or more five or more times a week and only 10% reported eating five or more servings of fruits and vegetables a day. Eighty percent of respondents forty-five years and older reported one or more chronic diseases. These data have not shifted since the last assessment. Data demonstrate that unhealthy behaviors are paralleled by disease outcomes and correlate with income levels, with lower income individuals having less healthy behaviors and more disease.

SLUHN initiatives related to Promoting Healthy Lifestyles and Preventing Chronic Disease include: Adopt a School Gardens, Tail on the Trail, Walk with a Doc, diabetes initiatives, smoking cessation and employee wellness.

Additionally we continue working with partners and grow collaborations with community agencies and organizations to effectively address needs more comprehensively and have a greater impact within our service areas. Partners for this priority area include but are not limited to local area small farms, school districts, Kellyn Foundation and the D&L Trail System.

NETWORK WIDE APPROACH

St Luke's UNIVERSITY HEALTH NETWORK

Improving Mental and Behavioral Health: Mental and behavioral health are growing concerns in our communities, with 37% of our service area reporting they experienced one or more poor mental health days in a 30-day period. According to the 2017 Pennsylvania Youth Survey, 38% of all students felt sad or depressed on most days in a 12-month period and approximately 18% attempted suicide. The most alarming data show dramatic increases in synthetic opioid (largely fentanyl) deaths in our service area, with the largest increases reported in Schuylkill and Warren counties.

SLUHN initiatives related to Improving Mental and Behavioral Health include: integrated mental health in practices and schools, mindfulness, trauma informed practices and initiatives to address the opioid epidemic from a network and community perspective.

Additionally we continue working with partners and grow collaborations with community agencies and organizations to effectively address needs more comprehensively and have a greater impact within our service areas. Partners for this priority area include but are not limited to local area yoga and mindful bases practices, Treatment Centers, County Drug and Alcohol and County Health Departments.

The Community Health and Preventive Medicine Department emphasizes community engagement through local, state and national partnerships to drive the implementation, as well as integration and evaluation of our programs to improve targeted health outcomes. We will work collaboratively in partnership with our community and network partners to create a more equitable community with better health outcomes, especially among our most vulnerable populations such as our homeless, Hispanic communities, seniors, women and children. Overall, the counties that SLUHN serves are not very healthy when compared to other counties in the country for a common set of health-related outcomes; our service area achieved the 90th percentile for only 9% of metrics. The intent is to shift these indicators to ensure that the whole community is moving toward optimal health.