Tamaqua Area Community Partnership (TACP) Community Health Strategic Plan

The Community Health Strategic Plan for the Borough of Tamaqua and surrounding communities lays a clear foundation for the future development of Community Health in this area. It has been developed to prioritize community health services needs identified in the Tamaqua Area Health Needs Assessment completed in 2010. The initiatives contained within the strategic plan will be a major contributor to achieving the vision of a healthy community in Tamaqua and the surrounding area.

The Community Health Committee actively engaged a variety of stakeholders in the development of the Community Health Strategic Plan, including community members, local hospital and community health staff, local government and non-government organizations and general practitioners. The issues raised by these stakeholders and the Tamaqua Area Health Needs Assessment formed the basis for the overall direction of this Plan. Growth in demand for community health services is anticipated in Tamaqua and the surrounding communities over the next three years and beyond. As a result, community health capacity will need to expand to be responsive to the increased need in the community. Much of the anticipated demand is a directly related to the high unemployment rates, increasing rates of chronic disease, an aging community and unhealthy lifestyle behaviors leading to obesity and chronic disease.

Implementation of this Plan involves some changes to models of care and to service delivery, along with improvements in coordination of community services. These improvements can be made within existing resources although new resources will be required over time to expand the capacity of Community Health, both in terms of infrastructure and service capacity.

To assist in ensuring that the proposed Community Health Strategic Plan is being implemented and that all community health services are effective in meeting population needs, it is recommended that a Community Health Partnership continues to meet after this Plan has been accepted by the TACP Board of Directors and the St. Luke's Miner Memorial Board of Directors. The Partnership, modeled after the St. Luke's Hospital Bethlehem Partnership, can be an extension of TACP or newly formed under St. Luke's Miners Memorial Hospital. This committee will review the Community Health Strategic Plan annually in order to be responsive to changing circumstances, as well as being active participants in community wide service and asset planning, highlighting the need for ongoing provision of community-based services to the existing community. Consistent with this is also the need to constantly review the outcomes of community health services to ensure the provision of high quality, effective services.

The framework for the development of the Community Health Partnership along with the mission, vision, values and strategic direction for Community Health are outlined in the following pages. Members of the Community Health Committee are listed in Appendix A.

Mission
The Community Health Committee established the following mission statement:

The Community Health Committee is dedicated to working with and supporting existing community organizations and individual community members to improve the quality of health for all residents of Tamaqua and surrounding communities through improved health services, efficient utilization of health resources and community empowerment.

Vision
Our vision is that all residents are empowered to improve their own quality of life through access to healthcare, education and community programs focusing on healthy lifestyles, community safety and clean, sustainable environments.

Core Values
All residents have the right to good health to lead productive lives.
The power of collaboration is the key to our communities' success.
We can accomplish our goals by empowering other organizations and individuals.
All residents should feel safe in their neighborhoods.
All residents should live in a clean, healthy environment.
Well established community programs and services should be consistently marketed to increase visibility and awareness to residents.

The Plan
In order to develop a successful Strategic Plan, the Community Health Committee held a series of working meetings to solicit input for the Plan. The Community Health Committee determined that the following were the top health priorities that needed to be addressed in the Borough of Tamaqua and surrounding communities:

1. Community Outreach
2. Chronic Disease Prevention (focus on obesity, physical activity and tobacco; acknowledging the link to chronic diseases)
3. Chronic Disease Management (focus on diabetes and asthma)
4. Access to Care
5. Substance Abuse
6. Mental Health

The priority areas were chosen based on data collected from the Tamaqua Area Health Needs Assessment, secondary local and state data and anecdotal information reported by community members.

The following goals and objectives are part of a three year strategic plan to guide TACP, St. Luke's Miners Memorial Hospital and the community in addressing these issues.

1. Community Outreach

A. Community Outreach and Education

Our purpose is to clearly articulate and raise awareness of community health and human service programs in Tamaqua and the surrounding area. We want to aid the community in making health-promoting choices through prevention education, health policy and environmental changes that will increase opportunities for better health. There are valuable programs and services that benefit all community members regardless of race, education or economic status yet they are not apparent to the community they serve. Despite the presence of community events, prevention and health education campaigns, health committees and service organizations, these programs and services are generally misunderstood, invisible and not well attended. Anecdotally, services, programs and resources available to the community are perceived to be for the poor or underprivileged and often carry a stigma. The perceived link to public health program impact on the prevention and management of disease and the promotion of the community's well being is weak. The challenge of this focus area is to develop long-term partnerships to address the emerging health issues rather than making it the responsibility of a single entity.

Baseline Data for Determining Goal:

1. Residents of the TASD (42%) are more likely to have physical, mental or emotional limitations as compared to respondents to the state (19%) and national (19%) BRFSS.
2. 63% of respondents reported participating in physical activity in the past six months and 44% reported exercising 2-3 times per week.
3. Seventeen percent of respondents reported physical health and 20% reported emotional health interferes with normal social activities all or most of the time.
4. The following are the five most prevalent conditions reported by survey respondents: Hypertension - 43%, Diabetes - 23%, Mental Health Problems - 17%.
5. 47% of respondents have a BMI indicating obesity. This rate is much higher than state (28%) and national (27%) 2009 BRFSS data.
6. A top five identified barrier for accessing health care is that the community does not practice healthy lifestyles.
7. Focus group participants reported that there is a stigma associated with being a medical assistance patient.
8. Focus group participants reported that there are high rates of undiagnosed or untreated mental health problems.

Goal: To empower residents to achieve improved health through the awareness and understanding of and participation in, the services, programs and partnerships

provided by local hospitals, health and human service organizations and community-based organizations.

Objectives:

1. Increase the publics' awareness of the programs, services and resources available at local hospitals, health and human service organizations and community-based organizations.

2. Provide multiple channels for the community to access information regarding participation in programs and services.

3. Increase the medical and human services community (medical providers, executive directors, etc.) awareness of the programs and services that would complement their practice and benefit their clients.

4. Positively promote community health programs as a value-added benefit of the community's infrastructure and an essential partner for a healthier/successful community.

5. Actively partner and build relationships with community-based organizations/initiatives that share our mission and vision for a healthy community.

6. Develop a comprehensive awareness campaign that highlights the relationship between public health and the quality of life for local residents focusing on obesity, physical activity, tobacco use and mental health.

Outcomes:

1. Increased awareness and understanding of local hospitals, health and human service organizations and community-based organization's community role and value-added benefits of their services and programs.
2. Improved utilization of services.
3. Continued collaborative partnerships with community organizations and individuals.
4. Increase in appropriate referrals to and from local medical providers and human service organizations.

Implementation Strategies:

1. Dedicate a staff person to serve as a Community Health Manager.
2. Develop a comprehensive plan of outreach, education and communication for emerging health issues that outlines priority populations and priority messages.
3. Develop a tool to survey all current community health programs and initiatives to develop a clearinghouse to promote such programs.

4. Integrate community participation in program planning and service delivery models.
5. Establish a Community Health Partnership, including community members, to provide regular input to the governing Board of Directors and to assist in the implementation of the Strategic Plan.
6. Create community-wide, multi-media campaigns that address priority health messages and current programs, services and initiatives.
7. Create a media/public information page for priority health issues or partner with another source who already maintains such a media page.
8. Create tools that outline the value-added benefits public health brings to the community- displays/exhibits, educational materials, web pages, fact sheets, etc.
9. Establish a Speaker's Bureau to address emerging health issues and other needed health information and actively participate in speaking engagements at schools, organizations, church meetings, etc.

Resources:

1. Funding for a Community Health Manager, supplies, materials, printing, media campaign, etc.
2. Dedicated office space for Community Health Manager and staff.
3. Representatives from local hospitals, health and human service organizations and community-based organization to serve on a public health advisory group.
4. Partner who can help manage web page content.
5. Student interns who can develop and conduct public opinion poll and clearinghouse of local programs, services and initiatives.
6. Partner who can help develop a marketing campaign.

2. Chronic Disease Prevention

A. Obesity

There are many conditions that are associated with being overweight or obese, such as Type 2 diabetes, elevated cholesterol levels (hyperlipidemia) and hypertension. These conditions are independent risk factors for coronary artery disease. Being overweight or obese also increased the risk of gall bladder disease, sleep apnea, respiratory problems and some types of cancers.

A measure of body mass index (BMI) is often used to determine desirable weights. People with a BMI of 25 to 29.9 are considered overweight and people with a BMI of 30 or above are considered obese. Obesity is considered by the CDC to be at epidemic levels.

With obesity increasing in the community, especially in children, there is a need for programs on multiple levels to combat the problem among all ages. The most difficult challenge is changing the sedentary lifestyle habits of the community. Programs must be offered that will appeal to all community members, including low income, as well as be affordable and easily accessible.

Baseline Data for Determining Goal:

1. 25% of children grades K through 6 are obese in the Tamaqua Area School District (TASD) compared to 21% in Schuylkill County.
2. 47% of adults in Tamaqua are obese based on their calculated BMI.

Goal: Increase the awareness of obesity as a major public health problem to prevent premature morbidity and mortality.

Objectives:

1. Reduce the proportion of children who are obese.
   Baseline: 25% in grades K through 6 in TASD
   Target: Decrease obesity in children by 3% to 22%

2. Reduce the proportion of adults who are obese.
   Baseline: 47% of adults in Tamaqua
   Target: Decrease obesity in Tamaqua and surrounding area by 4% to 43%.

3. Increase the proportion of persons who know the health risks (hypertension, hyperlipidemia, insulin resistance, etc.) and diseases (i.e., diabetes, cardiovascular disease, cancer, asthma, etc.) associated with obesity.

4. Increase the availability and accessibility of affordable, healthy foods and beverages.

5. Increase healthcare providers who routinely monitor, track and inform patients and/or parents of weight gain or growth by measuring BMI.

Outcomes:

1. Healthy behavioral and lifestyle choices.
2. Decreased unnecessary morbidity and mortality.
3. Improved quality of life.

Implementation Strategies:

1. Collaborate with local produce growers and community organizations to increase the availability and affordability of fruits and vegetables to children and their families.
2. Partner with local communities to explore the concept of community gardens and feasibility of implementation.
3. Develop a tool to survey health care providers to determine baseline percentage who present and discuss the health risks associated with obesity to their patients and partner with them to implement this strategy.
4. Work with healthcare providers to increase the use of evidence-based

counseling and guidance to patients and parents about promoting a healthy weight and preventing obesity by healthy eating and physical activity.
5. Increase understanding and use of BMI by the general population.
6. Partner with local communities and organizations to develop community-based nutrition programs serving both children and adults.
7. Support business initiatives that address nutrition and obesity.

Resources:

1. Funding for a Community Health Manager.
2. Partnerships with schools, local hospitals, businesses and community organizations for best practice childhood obesity prevention programs and weight management programs.
3. Tool to survey health care providers.
4. Funding for community gardens.
5. Property to develop community gardens.
6. Means to increase availability and marketing of locally grown produce.
7. Partnerships with local farmers and Penn State Cooperative Extension.
8. Develop a comprehensive plan of outreach, education and communication which includes BMI and obesity as priority messages.

B. Physical Activity

Being physically active is one of the most important steps that people of all ages can take to improve their health. Regular physical activity improves overall health and fitness, as well as helps prevent premature morbidity and mortality. Many conditions affected by physical activity occur with increasing age, such as heart disease and cancer. Reducing risk of these conditions may require years of participation in regular physical activity. However, other benefits, such as increased cardio-respiratory fitness, increased muscular strength, and decreased depressive symptoms and blood pressure, require only a few weeks or months of participation in physical activity. Most health benefits occur with at least 150 minutes a week of moderate-intensity physical activity, such as brisk walking. Further physical activity guidelines for children, adults and older adults can be found in the *Physical Activity Guidelines for Americans* developed by the U.S. Department of Health and Human Services.

Baseline Data for Determining Goal:

1. 36% of respondents reported participating in physical activity other than their regular job during the past month as compared to 74% in the state and 76% nationally.
2. 44% reported exercising 2-3 times per week.
3. 25% of children grades K through 6 are obese in the Tamaqua Area School District (TASD) compared to 21% in Schuylkill County.
4. 47% of adults in Tamaqua are obese based on their calculated BMI.

Goal: Improve health, fitness and quality of life through daily physical activity.
Objectives:

1. Reduce the proportion of adults who engage in no leisure-time physical activity.
   Baseline: 64% reported not participating in physical activity other than their regular job.
   Target: Decrease no leisure-time physical activity in adults by 5% to 59%.

2. Increase the proportion of adults who are aware of the *Physical Activity Guidelines for Americans.*

3. Increase the proportion of physician visits made by all child and adult patients that include brief counseling about exercise.

Outcomes:

1. Healthy behavioral and lifestyle choices.
2. Decreased unnecessary morbidity and mortality.
3. Improved quality of life.

Implementation Strategies:

1. Integrate physical activity awareness into the community-wide, multi-media outreach campaign to increase education about the *Physical Activity Guidelines for Americans* and the benefits of physical activity.
2. Develop a tool to survey health care providers to determine baseline percentage who educate patients about physical activity and partner with them to implement this strategy.
3. Work with healthcare providers to increase the use of evidence-based counseling and guidance to patients and parents about physical activity to promote a health weight.
4. Partner with local communities and organizations to develop or incorporate physical activity into programs serving both children and adults.
5. Support business initiatives that address physical activity.
6. Partner with local community organizations to offer discounted physical activity programs, gym memberships and registration fees for sport activities.

Resources:

1. Funding for a Community Health Manager.
2. Partnerships with schools, local hospitals, businesses and community organizations for best practice physical activity programs and discounted physical activity programs, gym memberships and registration fees for sport activities.
3. Tool to survey health care providers.

4. Develop a comprehensive plan of outreach, education and communication which includes *Physical Activity Guidelines for Americans* and the benefits of physical activity.
5. Funding to help subsidize discounted physical activity programs, gym memberships and registration fees for sport activities.

C. Tobacco Use

Tobacco use has significant health consequences including heart disease, cancers of the lung, larynx, esophagus, pharynx, mouth and bladder, as well as chronic lung disease. Tobacco also contributes to cancer of the pancreas, kidney and cervix. Consequneces of smoking during pregnancy include spontaneous abortions, low birth weight babies and sudden infant death syndrome. Smokeless tobacco causes a number of serious oral health problems including cancer of the mouth, gum disease and tooth loss. Additionally, second hand smoke exposure can cause heart disease and lung cancer among adults and lower respiratory tract infections and ear infections among children.

Baseline Data for Determining Goal:

1. 34% of respondents smoke cigarettes, which is higher compared to the state (20%) and national (18%) 2009 BRFSS data.
2. 54% of respondents reported smoking greater than 10 cigarettes per day.

Goal: Reduce illness, disability, and death related to tobacco use and secondhand smoke exposure.

Objectives:

1. Reduce tobacco use by adults.
   Baseline: 34% reported smoking cigarettes.
   Target: Decrease tobacco use by 5% to 29%.

2. Increase smoking cessation attempts by adult smokers.

3. Reduce the proportion of nonsmokers exposed to secondhand smoke.

Outcomes:

1. Health behavioral and lifestyle choices.
2. Decreased unnecessary morbidity and mortality.
3. Improved quality of life.

Implementation Strategies:

1. Promote the St. Luke's Hospital Tobacco Cessation Treatment Center to increase patient and worksite referrals.
2. Ensure tobacco-use assessments of patients are occurring in local medical and dental practices.

3. Provide brief counseling training to medical and dental practices to assess smoking status; thereby making appropriate referrals to the St. Luke's Hospital Tobacco Cessation Treatment Center.
4. Promote smoke-free policies of local businesses, organizations, day-care centers, churches, public parks, etc.

Resources:

1. St. Luke's Hospital tobacco cessation counselors to provide cessation counseling and training.
2. Partnerships with local businesses, medical and dental providers, community organizations, worksites, day-care centers, churches, etc. to promote cessation services and smoke-free policies.

3. Chronic Disease Management

A. Diabetes

Diabetes rates in Tamaqua are higher than compared to state and national rates. Many factors contribute to the onset of diabetes, including family history of the disease, obesity and lack of physical activity. Difficulties in managing the disease include poor living conditions, limited access to health care, a lack of economic resources and a lack of education about the disease. Nationally, the rate of Type 2 diabetes has been rising dramatically, especially among adolescents as problems of obesity have increased. In aging populations, as in Tamaqua and the surrounding area, diabetes can become costly and financially burdensome to the community unless education is provided to the community about how to prevention diabetes. Healthcare providers and community health workers should focus efforts towards educating the community about the importance of weight control, exercise, nutritious food choices and checking blood glucose levels when they have certain risks factors. Additionally, prevention of obesity in children, which, in turn, results in higher rates of childhood onset of diabetes, presents a challenge to educators and medical providers.

Baseline Data for Determining Goal:

1. The prevalence rate of diabetes in Tamaqua is higher (23%) as compared to state (9%) and national (8%) rates.
2. 47% of respondents have a BMI indicating obesity. This rate is much higher than state (28%) and national (27%) 2009 BRFSS data.
3. 63% of respondents reported participating in physical activity in the past six months and 44% reported exercising 2-3 times per week.

Goal: Prevent premature morbidity and mortality due to diabetes.

Objectives:

1. Increase the proportion of adults with diabetes who actively manage their disease through clinical and laboratory methods:

a. Increase the proportion of diabetic adults who have glycosylated hemoglobin (A1C) measurements at least once per year.
   Baseline: Preliminary data shows 48% of St. Luke's Rural Health Center patients receiving an annual glycosylated hemoglobin (A1C).
   Target: Increase the number of adults who receive an annual glycosylated hemoglobin (A1C) by 10%.
b. Increase the proportion of older adults with diabetes who have dilated eye examinations annually.
   Baseline: Preliminary data shows 8% of St. Luke's Rural Health Center patients receiving a dilated eye examination annually.
   Target: Increase the number of adults who receive a dilated eye examination annually by 10%.
c. Increase the proportion of older adults with diabetes who have annual foot exams.
   Baseline: Preliminary data shows 13% of St. Luke's Rural Health Center patients receiving an annual foot exam.
   Target: Increase the number of adults who receive an annual foot exam by 10%.

2. Increase the proportion of adults who attend diabetes self management classes.

Outcomes:

1. Healthy behavioral and lifestyle choices.
2. Decreased unnecessary morbidity/mortality.
3. Decreased disparities in health outcomes.
4. Improved quality of life.

Implementation Strategies:

1. Partner with community agencies and medical providers to expand diabetes programming for people with diabetes, those who are at-risk and their families to encompass all aspects of diabetes self-management including screening, blood glucose control, nutrition and physical activity.
2. Market the St. Luke's Miners Memorial Diabetes Self Management program to local medical providers to increase referral base.
3. Promote compliance with the American Diabetes Association Clinical Guidelines with local medical providers to improve overall patient outcomes.

Resources:

1. St. Luke's Miners Memorial Diabetes Self Management program to conduct community diabetes self management classes.

2. Partnerships with local medical providers and community agencies who can promote the diabetes self management classes and be potential sites to host the program.
3. Partnerships with local medical providers to increase referral base to the diabetes self management program.
4. American Diabetes Association Clinical Guidelines.

B. Asthma

Higher rates of asthma were reported in Tamaqua as compared to state and national rates. Additionally, in the Tamaqua Area Health Needs Assessment, the most prevalent chronic condition reported for children living in an adult household was asthma.

Asthma is a common, chronic disease of the airways that is complex, with variable and persistent symptoms, airflow and airway obstruction, bronchial hyper-responsiveness, and an underlying inflammation of the lining of the lungs. Asthma is characterized by various triggers with levels of severity and evolving treatment options. Asthma symptoms can be triggered by exposure to allergens or irritants, viral respiratory infections or exercise. Asthma cannot be cured, but it can be controlled so that people are able to lead active and healthy lives. Asthma control can usually be achieved through adherence to an effective medical management plan, treatment of coexisting medical conditions and avoidance of environmental and occupational triggers. Missed school days, lost work days, ED visits, hospitalizations, and deaths can be prevented when asthma is controlled resulting in an improved quality of life for individuals affected by asthma.

To fully understand the burden of asthma in Tamaqua and the surrounding area and to meet the below objectives, it is recommended that an Asthma Partnership/Coalition be formed. The partnership should include members of local hospitals, schools, child care centers, community organizations who are identified as potential stakeholders in the asthma initiative. This partnership should focus on creating an asthma surveillance system to collect data on asthma prevalence, symptoms, disease management, health care access and utilization, and mortality. Surveillance and evaluation data will be used to better define the burden of asthma, guide policy and program planning, and assess the impact of strategic plan activities.

Baseline Data for Determining Goal:

1. The prevalence rate of asthma in Tamaqua is higher (21%) as compared to state (13%) and national (13%) rates.
2. The most prevalent condition reported for children living in an adult household was asthma (8%).

Goal: Decrease asthma disparities and morbidity.

Objectives:

1. Improve asthma management by ensuring that health care providers treating individuals with asthma utilize the current National Heart, Lung and Blood Institute Clinical Guidelines for asthma.

2. Improve asthma management among members of child care organizations and schools including children, their care givers and all individuals with whom they interact.

Outcomes:

1. Healthy behavioral and lifestyle choices.
2. Decreased unnecessary morbidity/mortality.
3. Decreased disparities in health outcomes.
4. Improved quality of life.

Implementation Strategies:

1. Create an Asthma Partnership to monitor and identify asthma trends and disparities.
2. Promote the use of the National Heart Lung Blood Institute (NHLBI) asthma guidelines and asthma educational materials in medical practices.
3. Collaborate with local asthma champions to coordinate and provide annual asthma education to local medical providers.
4. Provide school nurses, school personnel (administrators, teachers, maintenance), and child care providers, with access to education and resources necessary to prevent and manage asthma in child care and school (after-school and before-school) settings.

Resources:

1. NHLBI Asthma Guidelines.
2. Partnership with local medical providers, schools, child care centers and community agencies.
3. Asthma expert to conduct asthma education to local medical providers.
4. Medical staff meeting to educate providers on NHLBI asthma guidelines.
5. Meeting location for Asthma Partnership/Coalition.
6. Asthma nurse to partner with school nurses, child care providers and families to conduct asthma education/in-services.
7. Community Health Manager to develop the Asthma Partnership/Coalition.
8. Grant funding for future asthma screening and management program based on outcomes of surveillance data.

4. Access to Medical and Dental Care

Access to quality health care in rural communities has been a long standing issue. The challenges of providing appropriate access to health care in these communities stem from multiple factors: geographic remoteness, long distances, less availability of specialty providers and limited transportation, to name a few. Despite having three local rural health centers in close proximity to Tamaqua, they are inaccessible to many who live in the Tamaqua Borough. Additionally, there are no local dentists who accept medical assistance. Children can access dental care on the Carbon County Dental Van but adults must travel up to one hour to access a dentist who accepts medical assistance so they often forgo dental care.

Co-location and/or consolidation of medical and dental services would improve and increase access to needed services for an underserved population (uninsured or low income adults, seniors and children). For a community in need, providing preventive care, primary care and dental care in the same location would increase access to quality care for uninsured, low income and Medicaid patients; reduce the fragmented care they are currently receiving; strengthen the safety net for these vulnerable populations; as well as serve as a medical home for a traditionally underserved population. Additionally, implementing a patient navigator model at the rural health centers would be beneficial to patients. A patient navigator is a member of the healthcare team who helps patients "navigate" the healthcare system and get timely care. Navigators work with patients to identify their barriers to healthcare and connect them to the resources they may need such as financial assistance, counseling, transportation and additional medical appointments and/or testing. This model has been proven to improve overall patient outcomes.

Baseline Data for Determining Goal:

1. 46% of respondents reported having a dental exam in the past year.
2. 15% of respondents reported having no health insurance.
3. Focus group members reported the following statements:
    a. Local primary care providers are at their capacity for medical assistance patients.
    b. The St. Luke’s Hospital Rural Health Centers are inaccessible or are not known to many who live in the Tamaqua Borough.
    c. Dentists who accept medical assistance are scarce so many residents often have to cross county lines to receive dental care.
    d. There is a stigma associated with being a medical assistance patient.
4. 45% of families reported needing dental services in the past year, but only 35% reported having received them.
5. 40% reported needing health-related services, but only 34% received that health care.

Goal: Ensure increased access to high quality medical and dental services to decrease health disparities.

Objectives:

1. Increase access to quality preventive, primary and dental health care for uninsured, low-income and Medicaid populations (children, adults and seniors) through co-location of services at the rural health centers.

2. Implement a patient navigator model to improve overall patient outcomes.

Outcomes:

1. Decreased fragmented care; increase comprehensive services.
2. Increase the availability of and access to preventive, primary and dental health care services for uninsured, low-income and Medicaid populations.
3. Decrease unnecessary morbidity and mortality.
4. Decrease health disparities.

Implementation Strategies:

1. With community partners, conduct feasibility study to open a rural health center in Tamaqua including preventive, primary and dental health care services.
2. Collaborate with local community programs to offer dental services at the rural health centers.
3. Train rural health center staff on the patient navigator model.
4. Identify staff to work as a patient navigator.
5. Market availability of services to the community.

Resources:

1. Feasibility study for a Tamaqua rural health center.
2. Staff to lead the feasibility study.
3. Partnership with a local community dental program to provide services at the rural health centers.
4. Funding/strategic planning to implement a patient navigator model and dental services at the rural health centers.
5. Patient navigator training course.
6. Identified staff to act as patient navigators.
7. Means to market the rural health center patient navigator model and dental services to the community.
8. Partnerships with local community organizations and schools.

5. Substance Abuse

Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative

behavioral and health outcomes. The substances the community was most concerned about in the Tamaqua area were prescription drugs, alcohol, heroin and tobacco. The effects of substance abuse significantly contribute to social, physical, mental and public health problems including domestic violence, child abuse, teenage pregnancy, crime, etc. Substance abuse prevention and treatment services have proven to work in reducing some of the overall human and economic impacts of substance abuse. Best practice communities have piloted a health care delivery system designed to increase access and quality of behavioral health care services while maintaining cost effectiveness. This approach ensures consistent performance measures across providers and increases accountability, decreases administrative overhead, and emphasizes best practices.

Beyond maintaining a continuum of care, communities must ensure that persons with substance abuse problems have their basic needs addressed. For example, people need jobs, housing, transportation, child care, education, and insurance that covers mental and physical services to support and stabilize their lives. This can only be realized through continued collaboration among private and public partners; consumers and family members; and other community stakeholders working in the areas of substance abuse, health, public safety, education, workforce development, mental health, etc.

Baseline Data for Determining Goal:

1. Based on the percent of participants reporting a TASD community issue as "very serious" or "serious", the following were listed in the top ten concerns as identified in the Community Needs Survey: Alcohol abuse, illegal drug use, crime, youth violence and domestic violence.
2. Agency key informants identified the following health conditions and behaviors as very important issues in the community: teenage pregnancy, alcoholism, drug abuse and tobacco use.

Goal: Increase community awareness of current substance abuse service delivery systems and best practice models to address substance abuse.

Objectives:

1. Integrate services, connecting existing substance abuse service delivery with primary care, emergency care, mental health, and social service and community agencies to ensure limited resources are available for the community.

2. Adopt two best practice strategies to address substance abuse prevention, treatment, aftercare and/or data collection in collaboration with law enforcement agencies, local safety initiative groups, drug and alcohol organizations, health care providers, schools and community agencies.

Outcomes:

1. Decreased fragmented care; increase comprehensive services.
2. Increase the availability of and access to substance abuse treatment services.
3. Implementation of two best practice substance abuse prevention, treatment and/or aftercare models.
4. Decrease health disparities.
5. Increased community-wide education and awareness about substance use and abuse.

Implementation Strategies:

1. Collaborate with local substance abuse treatment programs to market services to primary care, emergency care and substance abuse providers, as well as social service and community agencies.
2. Create strong linkages among providers and disseminate information so that at-risk and underserved populations have the knowledge and skills to access services, thereby ensuring availability of readily accessible, equitable and comprehensive services to the community.
3. Research best practices and identify effective models of service delivery to address substance abuse in the community.
4. Discuss feasibility of implementing best practice models with primary care, emergency care and mental health providers and other stakeholders.
5. Identify and invite qualified professionals to conduct community training regarding best practices.
6. Create common standards for quality of care, outcomes measurement, and data collection to better assess the impact of substance abuse in the community.

Resources:

1. Partnerships with primary care, emergency care and substance abuse providers.
2. Partnerships with local social services community agencies, schools, law enforcement agencies and drug and alcohol providers.
3. Staff to research, present and implement best practice models.
4. Qualified professionals to train stakeholders on best practice models.
5. Staff to assess current data collection pertaining to substance abuse.
6. Staff to implement a quantitative data collection model and to conduct outcome evaluation on best practice implementation and current impact of substance abuse in the community.

7. Mental Health

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental health is essential

to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society. It also plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.

Allowing mental health illness to become a chronic and complex problem is no benefit to the patient and places an additional burden on already-scarce services. Evidence points to the positive impact of early intervention in reducing personal, occupational and financial burdens. To begin addressing mental health illness in the community, success lies with enhanced collaboration between medical providers, community organizations, schools, social service organizations and mental health treatment services.

Baseline Data for Determining Goal:

1. The prevalence rate of mental health illness in Tamaqua is 17%.
2. The mental illness rate reported for adults living in the survey respondents household was 7%.
3. The mental illness rate reported for children living in an adult household was 4%.
4. Focus group respondents reported that there are high rates of undiagnosed or untreated mental health problems and few mental health providers in the Tamaqua area.

Goal: Increase utilization of mental health treatment services.

Objectives:

1. Integrate services, connecting existing mental health treatment services with primary care, emergency care, schools and social service and community agencies to ensure limited resources are available for the community and improving the safety net of services.

2. Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral.

3. Increase the proportion of children with mental health problems who receive treatment.

Outcomes:

1. Decreased fragmented care; increase comprehensive services.
2. Increase the availability of and access to mental health treatment services.
3. Decrease health disparities.
4. Increased community-wide education and awareness about mental health disorders and need for treatment.

Implementation Strategies:

1. Collaborate with local mental health providers to market services to primary care, emergency care and mental health providers, as well as social service and community agencies.
2. Create strong linkages among providers and disseminate information so that at-risk and underserved populations have the knowledge and skills to access services, thereby ensuring availability of readily accessible, equitable and comprehensive services to the community.
3. Collaborate with local mental health providers and medical providers to assess feasibility of providing on site mental health services.
4. Collaborate with schools and pediatric providers to ensure a system is in place to screen adolescents (12-18 years of age) for mental health disorders and referral appropriately.

Resources:

1. Partnerships with primary care, emergency care and mental health providers.
2. Partnerships with local social services community agencies and schools.
3. Staff to assess feasibility of onsite mental health services, especially at the St. Luke's Hospital Rural Health Centers.
4. Staff to partner with schools to address screening for mental health disorders in adolescents.

Again, it is recommended to create a Community Health Partnership as either an extension of TACP or a newly formed Partnership of St. Luke's Miners Memorial Hospital to evaluate the progress of the three year strategic plan.

For more information about the Community Health Strategic Plan, please contact:

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Community Health
St. Luke's Hospital
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Appendix A: Community Health Committee Members

1. Larissa Verta, Lehigh Carbon Community College
2. Linda Cara, Tamaqua Area School District
3. Florence Janis, Community Member
4. Dina Depos, Tamaqua Salvation Army
5. Mary Louise Zimmerman, St. Luke's Miners Memorial Hospital, Homecare
6. Hollie Gibbons, St. Luke's Hospital

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