



Health Status and Health System Improvement
Building a Better Continuum of Care



EXECUTIVE SUMMARY

The following strategies have been proposed by the COC Task Force and adopted by the CAHWF Board as the focus areas for system change leading to the most impact on our health care.

Capacity and Workforce

- Recruitment and Retention
- Coordination of Activities

Champion/Lead Organization

CAHWF Planning and Grants Committees
Carlisle Regional Partnership for A Healthy Comm.

Barriers to Access Points and Services

- Creating Enhanced Access
- Medicaid, CHIP and Adult Basic Enrollment
- Prescription Medication Assistance
- Health Resources, Education and Promotion Activities

Sadler Health Center
Carlisle Regional Partnership for a Healthy Comm.
Health Share
CAHWF Prevention and Education Task Force

Health Budget and Policy

- Legislative and Resource Advocacy Strategy

CAHWF Public Policy Effort

The Carlisle Regional Partnership for a Healthy Community, the Sadler Health Center, Health Share, and the Carlisle Area Health and Wellness Foundation (CAHWF) have agreed to lead and coordinate the development of these strategy areas, to meet quarterly to assure progress, and to provide an annual “health summit” for community input and information.

The Continuum of Care Task Force met over 2003 to plan ways to enhance our regional health care systems. They shared knowledge, read the current literature and listened to experts to develop these seven strategies that provided the framework for “Building a Better Continuum of Care” over the next five years. The Carlisle Area Health and Wellness Foundation wishes to commend their service and their chairperson, Patricia Carlucci.

M. Elizabeth Clever,
Executive Director
February 3, 2004

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Project History

The Carlisle Area Health and Wellness Foundation

The Carlisle Area Health and Wellness Foundation (CAHWF) was established in June of 2001 from the proceeds of the sale of the assets of Carlisle Hospital and Health Services, Inc. and the transfer of income from related endowments and trusts.

The vision of the Carlisle Area Health and Wellness Foundation is “to be a leader and catalyst to ensure continuous improvement of health in the communities it serves”. Coupled with this vision is the mission “to identify and address health care needs and policies, promote responsible health practices, and enhance access to and delivery of health services”.

The foundation has a set of goals and purposes to guide its operations:

Forge Partnerships with Providers

1. Promote and fund best practices based on research with the ultimate goal of coordinated and holistic systems.
2. Serve as an effective and efficient partner for both funding and planning.
3. Evaluate and monitor the processes and outcomes of both CAHWF and grantees.
4. Offer training and technical assistance as part of our program services.

Connect with the Public

5. Utilize ongoing community assessment to set our goals and objectives and validate the work of grantees while respecting diverse populations and seeking equity.
6. Apply an educational approach for marketing directed at the community and information provided for use by the Board and task forces.

Assure a Forward Thinking Foundation

7. Provide sound administration based on well-developed policies supported by competent staff and external expertise.
8. Practice fiscal stewardship to maximize assets to meet our mission.

Enveloping the foundation is a set of core values stated as “valuing health education and the empowerment of individuals and organizations dedicated to the improvement of health as well as the attributes of excellence, responsiveness, stewardship and openness”.

CAHWF will focus its grant making activities in the following areas:

- Oral Health
- Behavioral Health
 - Substance Abuse
 - Mental Health
- Chronic Disease
 - Cancer
 - Asthma and COPD
 - Diabetes
 - Cardiovascular Disease

Efforts to address these focus areas should concentrate on prevention and education and/or target at-risk populations (lower income, elderly or un/underinsured).

One of the Foundation’s chief activities since its creation was the completion of a regional health status assessment in 2002. With assistance provided by Community Health Development Specialists (CHDS), CAHWF used the experience and findings to identify health needs and provide guidance to the foundation for establishing priorities.

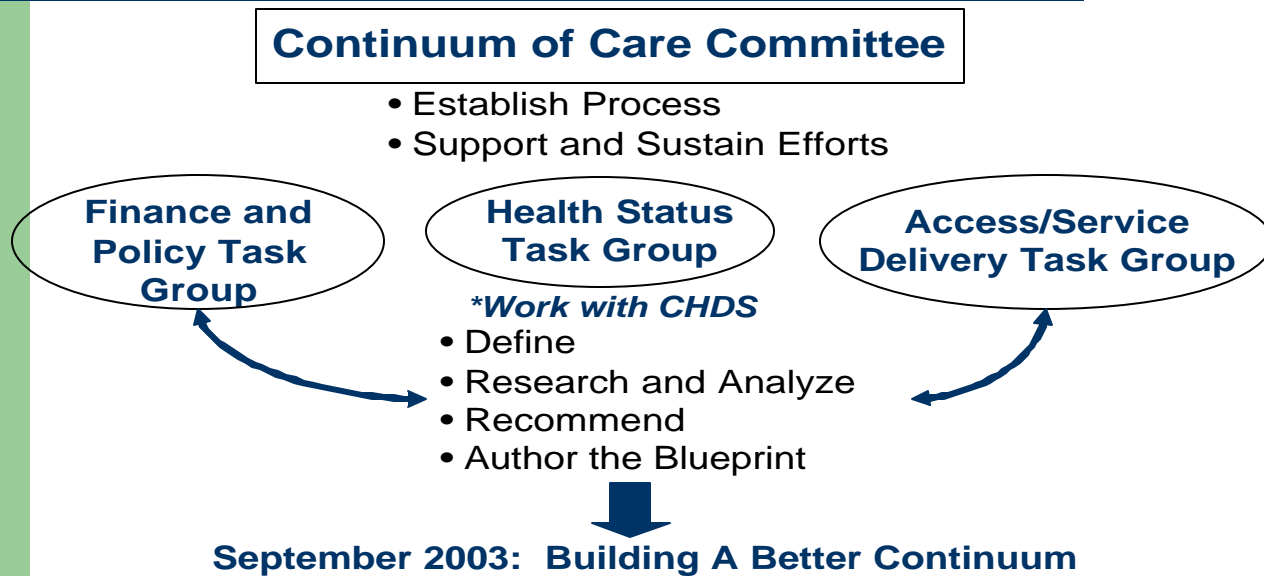
The Continuum of Care Process: A Health Systems Assessment

In order to better balance the identification of health issues and opportunities at the service level with system needs, CAHWF made a commitment to identify local health system issues and opportunities. This commitment resulted in the creation of the Continuum of Care Task Force. The COC Task Force was supported by two subgroups: (1) Access and Service Delivery; and (2) Finance and Policy. The stage has been set by CAHWF for significant and sustainable population health status and health system improvement for the Carlisle region based on these two reports.

Specifically, CAHWF was interested in a health system identification and planning process that would:

1. Define and assess the health system and its key components.
2. Identify health system issues and manageable, yet significant, health system improvement strategies, both existing or to be developed.
3. Establish a working blueprint for health system improvement, with a particular focus on the finance and delivery aspects of the health system, the continuum of care, for the Carlisle region.

Carlisle Health System Improvement Process



Since its creation in 2001 CAHWF has committed itself to creating a health system that works, is accessible and allows the tracking of patients and services. In short, CAWHF wants to facilitate a health systems process that sets the stage for health system improvement that connects, coordinates and improves health systems as the continuum of care for the Carlisle region.

Project Process

Only through the efforts of committed individuals from the Continuum of Care Task Groups (Access and Service Delivery; Finance and Policy) could this report be created. As a special note a Health Data subgroup was established to re-position key population health status and health system data for the benefit of the Access and Finance Groups. The full effort included meetings, the reading of assigned articles and additional research (data and best practices), and the convening of external experts/panelists/guest speakers.

The Carlisle health system assessment and blueprint development process was a phased approach. The four phases were:

1. Establishing the Plan and Defining the Continuum of Care: November and December 2002, and January 2003
2. Assessing the Health System: February, March, April, May and June 2003
3. Processing the Continuum of Care Task Group findings: July, August and September 2003
4. Planning and Dissemination: September and October 2003

What Have We Learned

Define and assess the health system and its key components

Using the findings from the health status assessment as a framework to operate from, the COC Task Groups established working definitions so that when discussed, Task Group members and invited participants were clear as to what was meant when geographic focus, access, primary care, or other terms were mentioned.

Both Task groups established and/or agreed to the following key definitions:

1. Geographic Focus Area: the Carlisle area, Western Cumberland County, Western Perry County, and parts of Adams and Franklin Counties. This is the same region served by the Carlisle Area Health and Wellness Foundation and our community hospital.
2. Access to Health Care Services: Access to health care is having what I need and when I need it. Please note, want and need are not synonymous terms.
3. Primary Care: The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs by developing substantial partnerships with patients in the context of family and community. Source: Institute of Medicine
4. Safety Net Primary care (medical, dental and mental), emergency care, transportation, service and referral network (to specialists) and enabling services (case management, transportation and day care).

Identify health system issues and manageable, yet significant, health system improvement strategies whether existing or to be developed.

There were three (3) recurring health system themes throughout the COC process, these themes are listed below and briefly discussed in the following paragraphs.

1. Barriers to Access Points and Services
2. Capacity and Workforce
3. Health Budget and Policy

Barriers Access Points and Services

Limited coordination of key activities like case or care management was identified as a key health system issue warranting attention. It is important to note that the COC process acknowledges that case management is taking place in the community, this issue is a matter of coordinating the case management activities in order to reduce duplication and more optimally use existing resources.

A question raised by members of the COC Task Force brought to light another issue related to access and reimbursement. The question was: “Are the individuals eligible for Medicaid and CHIP enrolled?” Other question raised that the COC Task Force could address include:

1. What is currently available (community health resources), where does access occur, when does it occur, and how are people accessing care?
2. What are the barriers to access (knowledge, awareness, eligibility, transportation, insurance, provider perspective, etc.)?
3. What role does geography and location play (perceptions, influence on behaviors, policy and finance, etc.)?
4. What are the lessons learned from providers and consumers regarding access and utilization of services? What have others tried?
5. What are the access expectations from the perspectives of providers, employers, consumers (including special populations)? What are their interests regarding access?

Access and service concerns raised as a result of the COC process included the cost of prescription medications, limited adherence of individuals to positive lifestyle and behavior changes and an acknowledgement of geographic barriers (physical or political boundaries) that limit the ability of an accessible and seamless system of care in the Carlisle region.

Other issues related to access and services focused on dental and mental health services for particularly the low-income; uninsured and underinsured; and the acknowledgement of a growing population of elderly individuals who have chronic conditions and are often heavier users of the health system. A COC member raised the question of, “Is our system ready to handle all of the baby boomers?” Recent reports also reflect the growing use of costly services by baby boomers for cardiac and other medical needs.

Capacity and Workforce

Generally COC Task Force Members noted that there is a capacity and workforce issue to address given the current modest number of providers, those providers at or near retirement, and those providers leaving Pennsylvania as a result of increased malpractice insurance premiums. Specifically, COC members noted a need for the following types of providers to be recruited and retained for the regional health system (not in priority order):

1. Dentists
2. Nurses
3. Ophthalmologists

4. Nephrologists
5. Oncologists
6. Obstetrician and Gynecologists
7. Geriatricians
8. Radiologists
9. General Surgeons

COC members also noted as an area of interest the strengthening relationship between and among Carlisle Regional Medical Center, the primary care physicians and specialists, CAHWF and the community.

Health Budget and Policy

While rising medical malpractice insurance premiums was an issue mentioned in the context of Health Budget and Policy issues (malpractice insurance is regulated at the state policy level), the most frequently mentioned issue regarding Health Budget and Policy was the current and pending state budget cuts. The COC Task Group was presented with the following data:

1. Half of Cumberland County's health care dollars from Medicaid goes to nursing home care.
2. Drug and alcohol services cut \$106 million, or about 48%. Drug and alcohol cuts will affect many other programs including foster care and other children's services and criminal justice, to name a few.
3. The Human Services Development Fund (HSDF), a block grant which counties use to fill lots of human service gaps, was cut from more than \$38 million to \$3.5 million. This will affect many different populations and close many programs. Funding burden will shift from the state to county government.
4. Cuts in Medical Assistance and Hospital Disproportionate Share will result in a number of hospital closings, particularly in urban areas and in western Pennsylvania.

Other data shared was a forecast that a number of programs will experience a 5% cut in state funds at a time when they are also losing some United Way funds, federal funds and HSDF.

Carlisle Health System Improvement Strategy

Implementation Team

Support and Sustain Efforts

- Carlisle Area Health and Wellness Foundation (CAHWF)
- Carlisle Regional Partnership for a Healthy Community (CRPHC)
- Health Share (HS)
- Sadler Health Center (SHC)

Barriers to Access Points and Services

- Enhancing Access – SHC
- Enrolment – CRPHC
- Prescription Strategies – HS
- Health Education - CAHWF

Capacity and Workforce

- Recruitment/Retention – CAHWF
- Coordination of Activities – CRPHC

Health Budget and Policy

- Advocacy - CAHWF

Plan – Develop – Implement – Monitor – Evaluate
Lead a Champion Organization



Health System Improvement

In closing, the COC process, similar to the Health Status Assessment study, can be shared with community members or used to:

- Re-convene community leaders, providers and consumers to share results and continue community dialogue;
- Build relationships between external agencies and organizations;
- Incorporate information into an already existing community health status improvement initiative;
- Organize a community coalition to address issues raised in the report; and
- Increase awareness of community health issues and community health status improvement activities.

Conclusion

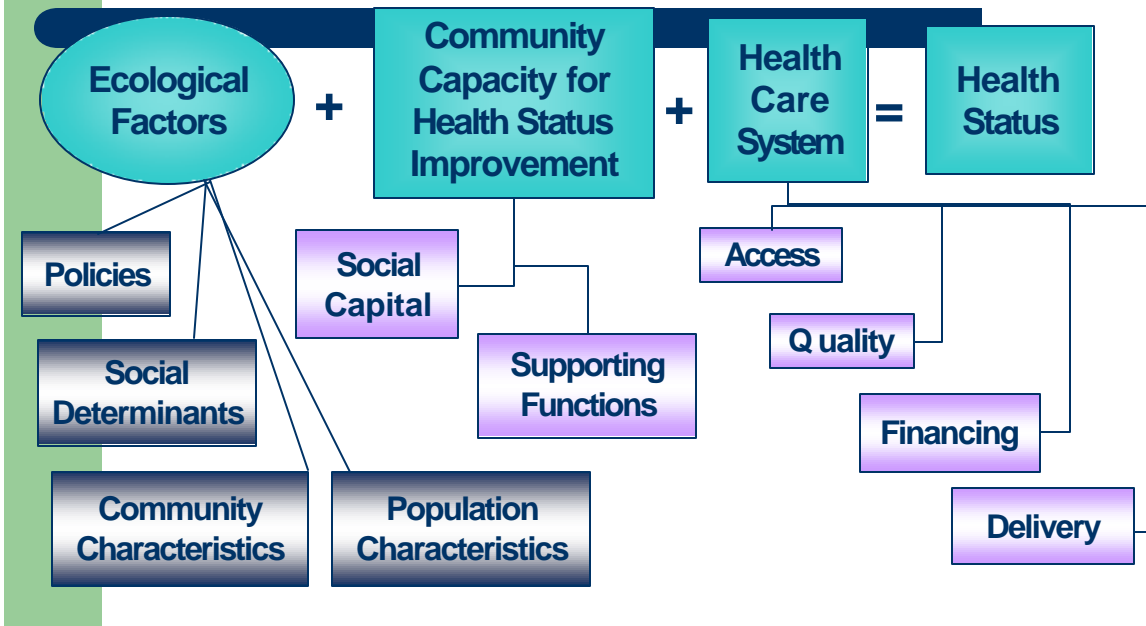
The Carlisle Continuum of Care (COC) Task Force, through its regional health system assessment (COC Process) allowed the region to define the regional health system (components), identify strengths of the regional health system, identify opportunities for health system improvement, and establish strategies to position the Carlisle region to build a better system of care.

Most important to this process is that balance is being pursued between population health status issues/opportunities and health system issue/opportunities. A focus just on the health status issues while neglecting the system to address these issues would be erroneous, as would a focus entirely on the health system while not paying attention to the system's stakeholders (individuals and institutions).

There is much work to be done over the next five years but this region offers both the resources and spirit to "Build a Better Continuum of Care".

ATTACHMENTS

Population/Community Health Status Improvement Model



CHDS recommends that the four idea/process owners continue to meet as needed and appropriate, with an emphasis on convening monthly. Also, CHDS recommends that joint strategy meetings occur not less than once a quarter to provide status reports, sharing of information, coordination of activities and the solicitation of advice and counsel. In addition, CHDS recommends that a yearly meeting (summit) be convened to look at health status and health system data, issues, opportunities and progress to date on activities (existing resources/providers and strategies, including strategies contained herein). The chart above provides an overview of the recommended strategy.

Additional Findings

All of the Task Group meetings (individual and joint) provided the opportunity for fun, engaging and productive dialogue to occur. In the following paragraphs are highlights from the meetings that elaborate and add to health system findings, with a particular focus on Primary Care.

Challenges Facing Primary Care

Task Group participants identified the following (currently exists or could exist without attention):

- The economic, workforce development and health outcomes in the community. Carlisle Regional Medical Center (CRMC) needs to be an active partner. Meeting participants were concerned that people, physicians and health care (and health care dollars) are slowly leaving the area.
- Insurance affordability, coverage and reimbursement process, in general (i.e., increasing cost to employers causes a reduction or elimination of health insurance); non-existent or inadequate coverage to pharmaceutical care, lab work, imaging, and hospitalization, especially for under and uninsured individuals and families; and the low and slow reimbursement rate process, particularly from Medicaid.
- Capacity and Workforce related to senior care, low-income populations, and the decreasing supply of primary, preventive and specialty care providers (i.e. primary care physicians, dentists and mental health providers), and specialists (i.e., a discussion participant shared that over the course of 36 months, the community went from having 6 surgeons to 1). *(At the time of this report we are at four surgeons.)*
- Operational costs associated with HIPPA, medical malpractice insurance, administration of public and private insurance claims, general costs (salary, benefits, lease, equipment, supplies, etc.).
- Focus of care (out of circumstance, not choice) has shifted from patients to paper work, forms and compliance with ever changing rules and regulations (i.e., cost and liability management not care management).
- Additional barriers to accessing health care services (other than insurance); limited transportation and day care services (children and adults).
- The limited coordination of care/case management.

Advice for Improving Primary Care

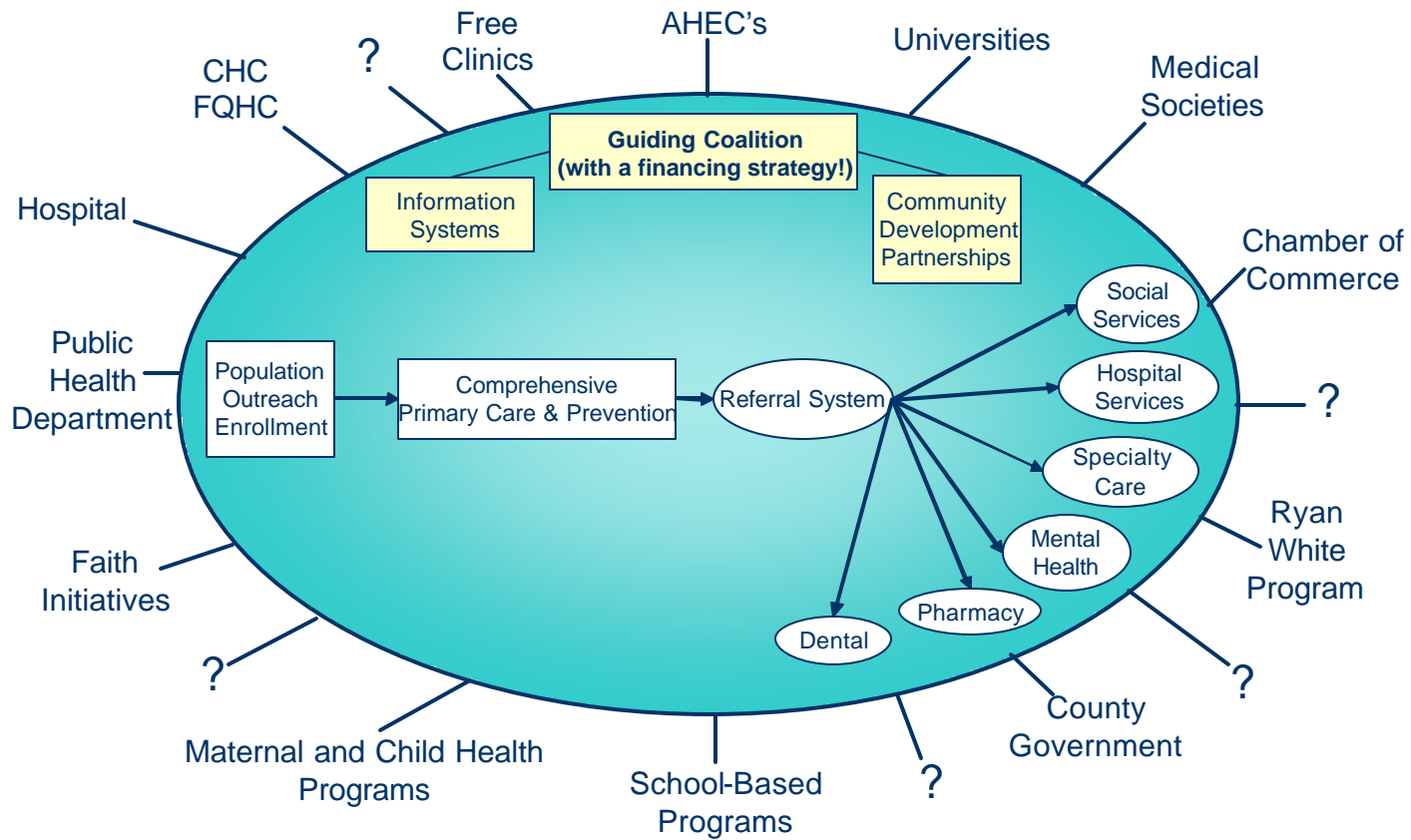
Task Groups identified opportunities for improving primary care. In response, the meeting participants identified the following (currently exists and could be enhanced or is desired to be developed):

- Convene a meeting of physicians and specialists with CRMC and HMA to discuss the issue of having a viable local health system that is accessible and focuses on positive health outcomes. This meeting and subsequent meetings can place on the table for discussion the economic, health outcomes and other impacts of having a viable and accessible health system will continue to have on the community and the institution.
- Establishing a better/different connection among and between the provider community (primary care, dental health, mental health, specialty care and supportive services); model/enhance and highlight existing local best health care practices like Health Share and C-PARC case management.
- Plan, develop and implement a coordinated recruitment and retention strategy that involves local providers, agencies, business leaders, and the community to target workforce needs, and put together a customized package to offer to prospective health care candidates (i.e., loans, homes, education, support, etc.).
- Plan, develop and implement a coordinated legislative advocacy strategy that involves local providers and agencies that targets various legislative audiences and policies (i.e., local, state and federal).
- Investigate and develop a community-wide response to HIPPA by looking at way of what information can be shared (safely) with whom, when and under what circumstances for a more coordinated flow of care.

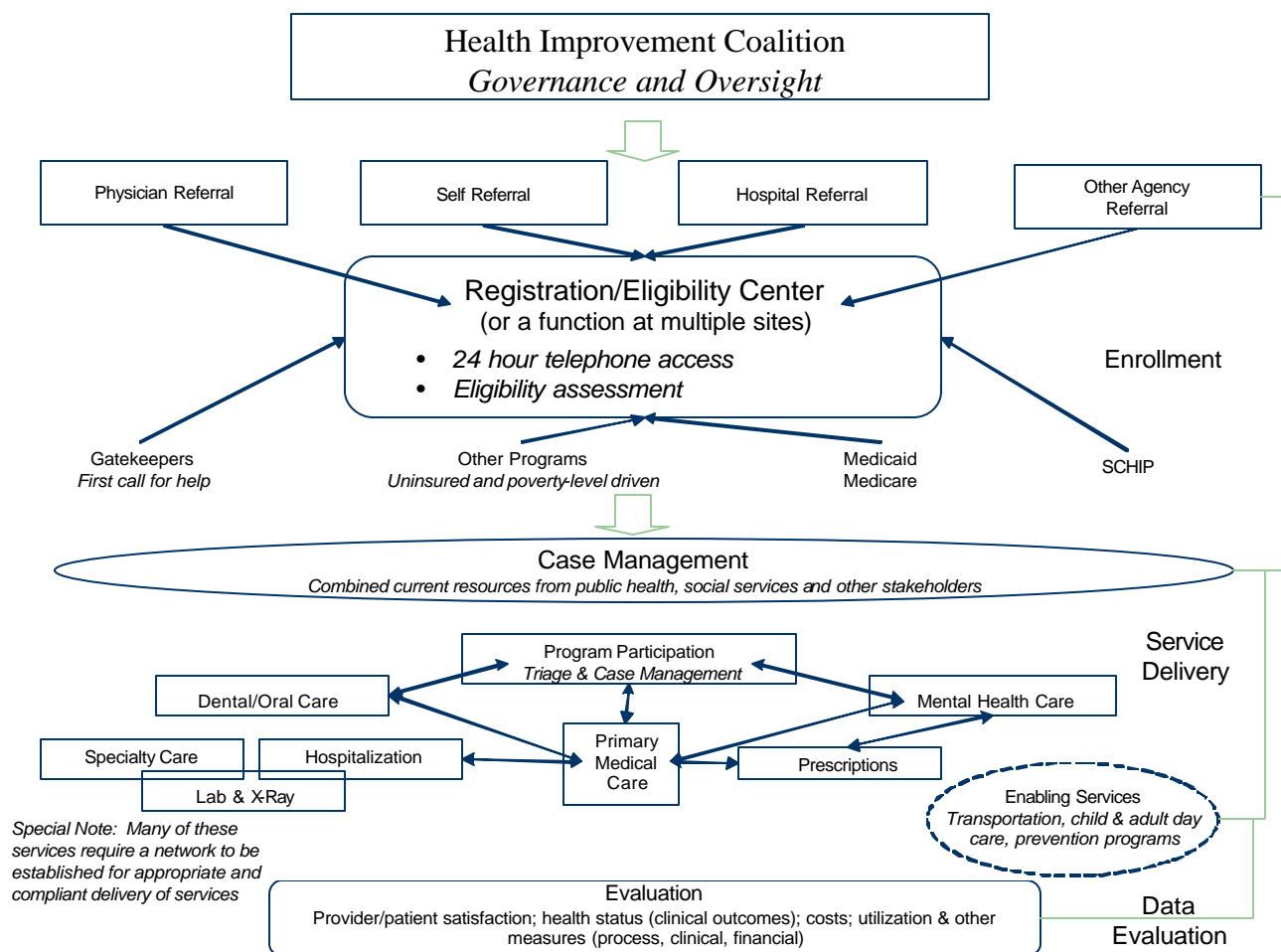
The slides on the following pages were reviewed with the Task Groups during the COC Process as various models (public and private) of viable and accessible health care systems. The COC can refer to these slides as frames of reference when discussion the components and connection of local system of care.

The Bureau of Primary Health Care (BPHC) of the Health Resources and Services Administration (HRSA) which is part of the United States Department of Health and Human Services (DHHS) developed the first slide. The purpose of the slide is to present a 100% Access System and what the components of such a system are.

Bureau of Primary Health Care (BPHC) 100% Access System



This example is from a community that developed their own model of a 100% Access System. Specific names of institutions and individuals were removed. The purpose of this slide is for the Carlisle COC to see how one community has plotted-out its ideal or 100% Access System.



Implementation Plans

Introduction

Getting from what you know to where you want to be can sometimes be a difficult, trying and time consuming task. Keeping this process simple, effective and manageable is key. The starting point in moving from information to implementation is to set priorities for issues and ideas, and then follow a strategy planning format to chart the course toward implementation.

The Process

Any process to identify opportunities and set priorities must recognize internal and external forces and factors that can impact on the potential success of those priorities. CHDS has refined a process that incorporates the most pertinent factors in a straightforward and uncomplicated process. CHDS recommend the following process:

Through one or a series of meetings established for this purpose, members of a health improvement process will need to:

1. Agree on the areas of opportunity
2. Establish specific tasks and/or recommendations
3. Rank order each area of opportunity and its tasks/recommendations - the success of the health improvement effort is largely a result of the successful balancing of success with significance. Prioritizing an opportunity that is beyond the health improvement effort's ability to impact, regardless of its significance as a health problem or community issue, is self-defeating. Similarly, choosing an insignificant strategy, regardless of how well it can be done, jeopardizes the perceived value of the health improvement effort. As a result, the following criteria are offered for consideration during the prioritization process:
 - Size of the problem: How many people are affected?
 - Seriousness of the problem: Is it life threatening, seriously debilitating, does it significantly effect quality of life?

- Effectiveness of interventions: Is there anything we can do about the problem – are existing best practices adequate?
- Community/institutional values: How closely does the issue relate to the values [mission/vision] of the community or sponsoring institution(s)?

The completed Implementation Planning Formats on the following pages often leads to finding the best current practices on which to build and identify the gaps in services. For any given idea, there are probably several efforts already in progress in the community that relate to the population or idea proposed. In order not to duplicate, a process is necessary that will uncover who is doing what around a particular issue or program idea, how it is being done, and how this relates/impacts products, services, community relations, and regional and local health status improvement activities.

The rationale for recommending a program idea was based (primarily) on:

- quantitative data (prevalence and incidence) and qualitative data (testimonies and daily exposure and experience)
- history (previous, current or planned program activities)
- internal (system or institutional) or external goals and objectives (Healthy People 2010 or CDC)
- accreditation, grant or other requirements, mandates, and obligations

The ***FIVE KEY QUESTION*** areas for implementation planning:

1. Who Do We Want To Help? (Target Population)
2. How Do We Want To Help? (Processes and Practices)
3. What To Be Mindful Of? (Considerations and Challenges)
4. Who Do We Need To Help Us Implement? (Stakeholders and Collaborators)
5. What Are Our Next Steps? (Who does what by when; and What Resources are required?)

Process Tips

CHDS offers the following process tips for the COC Committee to consider. Based on CHDS's experience, the most successful health status improvement initiatives incorporate the following:

- demonstrate the exchange of resources;
- demonstrate benefit to the entire population;
- incorporate policy level changes;
- are able to be evaluated;
- have the support of leadership;
- have community involvement;
- model mutual respect;
- impact positively on community infrastructure;
- incorporate elements of leadership development, training and education;
- increase capacity in the community for resource development;
- impact positively on racial or cultural relations; and
- incorporate local values, perceptions and advice.

The Implementation Plans

Following the five key question areas, the remaining pages contain the working ideas/implementation plans that the Carlisle Area Partnership for a Healthy Community, Sadler Health Center, Health Share and the Carlisle Area Health and Wellness Foundation (CAHWF) will continue to develop, implement, evaluate and sustain.

Access Points and Services

Coordination of Activities (i.e., case/care management and/or transportation)

Health Problem Area A health system that is not as coordinated as it could, should or ought to be; it is currently fragmented/frayed/uncoordinated

Idea Establishing a better/different connection among and between the provider community (primary care, dental health, mental health, specialty care and supportive services)

Who Do We Want To Help?	How Do We Want To Help?	What To Be Mindful Of?	Who Do We Need To Help Us Implement?	What Are Our Next Steps?
Target Population	Processes and Practices	Considerations and Challenges	Stakeholders and Collaborators	Who does what by when? (Time Frame) What Resources are required?
<ul style="list-style-type: none"> ➤ General population ➤ Providers (to help with the strategy and to benefit from the connection) ➤ Low-income/uninsured ➤ Businesses 	<ul style="list-style-type: none"> ➤ The development or enhancement of: (1) an information and service referral network (care/case management); (2) an accessible, affordable and appropriate transportation strategy ➤ Enhance exiting service referral or case/care management and transportation strategies 	<ul style="list-style-type: none"> ➤ Who is currently working on this or a similar strategy? ➤ Existing strategies ➤ Geography ➤ Standardizing processes and protocols 	<ul style="list-style-type: none"> ➤ Agencies ➤ United Way ➤ Private providers ➤ Carlisle Regional Medical Center ➤ County Health Department ➤ Health Share ➤ C-PARC ➤ Sadler Clinic 	<p>CAHWF, Health System Task Groups, and SHIP July 2003</p> <ul style="list-style-type: none"> ➤ Develop purpose statements and objectives ➤ Oversee the planning, development, implementation, support and evaluation of the ideas in this implementation plan and the other implementation plans discussed on June 2, 2003 <p>Lead: Carlisle Regional Partnership for a Healthy Community (CRPHC)</p>

Creating Enhanced Access

Health Problem Area Limited affordable, accessible, adequate, and continuous access to primary and preventive health care services for the low-income and uninsured population

Idea Enhancement and/or establishment of existing access points in and for the Carlisle region

Who Do We Want To Help?	How Do We Want To Help?	What To Be Mindful Of?	Who Do We Need To Help Us Implement?	What Are Our Next Steps?
Target Population	Processes and Practices	Considerations and Challenges	Stakeholders and Collaborators	Who does what by when? (Time Frame) What Resources are required?
<ul style="list-style-type: none"> ➤ General population ➤ Low-income and uninsured (200% of poverty) 	<ul style="list-style-type: none"> ➤ Provide access ➤ Look in to other designations, and determine what the community is eligibility for (i.e., MUA/MUP, and HPSA), and the value of receiving these designations (i.e., access to resources) ➤ Further investigate the value, benefit and opportunities for the target population, health care community and the community in general as it relates to access options (i.e.; free clinic, FQHC look-a-like, FQHC, other) ➤ Use of retired providers (i.e., in the community or at the War College) to help fill the gap 	<ul style="list-style-type: none"> ➤ The history, impact, role and relationship of existing providers who provide access to the low-income and uninsured ➤ Perceptions/mis-perceptions ➤ Information/mis-information 	<ul style="list-style-type: none"> ➤ Target population ➤ Physicians ➤ Mental Health Providers ➤ Dentists ➤ Carlisle Regional Medical Center ➤ County Health Department ➤ Project Share ➤ C-PARC ➤ Sadler Clinic ➤ Local and regional pharmacies and pharmacists 	<p style="text-align: center;">CAHWF and the Health System Task Groups July 2003</p> <ul style="list-style-type: none"> ➤ Develop purpose statements and objectives ➤ Oversee the planning, development, implementation, support and evaluation of the ideas in this implementation plan and the other implementation plans discussed on June 2, 2003 <p style="text-align: center;">Lead: Sadler Health Center (SHC)</p>

Medicaid and CHIP Enrollment

Health Problem Area Individuals that are eligible to participate in and be covered by Medicaid and CHIP may not be enrolled; those that are enrolled may not be fully aware of what/how they can access services

Idea Coordinated Medicaid/CHIP education and enrollment strategy

Who Do We Want To Help?	How Do We Want To Help?	What To Be Mindful Of?	Who Do We Need To Help Us Implement?	What Are Our Next Steps?
Target Population	Processes and Practices	Considerations and Challenges	Stakeholders and Collaborators	Who does what by when? (Time Frame) What Resources are required?
<ul style="list-style-type: none"> ➤ Poor ➤ Near Poor ➤ Uninsured ➤ Underinsured ➤ Working Poor ➤ Families ➤ Elderly ➤ Rural 	<ul style="list-style-type: none"> ➤ Identify eligible but un-enrolled populations and enroll them into their eligible insurance program ➤ Work with agencies that are currently doing this to coordinate strategies and activities ➤ Universal intake process available at multiple locations ➤ Coordinate/incorporate as part of immunizations (begin at kindergarten) 	<ul style="list-style-type: none"> ➤ Who is currently working on this or a similar strategy? ➤ Lots of time and money being spent on this ➤ HIPPA ➤ Role that comfort and trust play in enrolling and utilization ➤ Confidentiality ➤ Administratively burdensome ➤ Training and technical assistance for intake workers and volunteers 	<ul style="list-style-type: none"> ➤ Target population ➤ Physicians ➤ Mental Health Providers ➤ Dentists ➤ Carlisle Regional Medical Center ➤ County Health Department ➤ Health Share ➤ C-PARC ➤ Sadler Clinic ➤ Day Cares ➤ Head Starts ➤ WIC's ➤ Department of Public Welfare ➤ Domestic Violence 	<p>Members of the Finance and Policy Task Group July 2003</p> <ul style="list-style-type: none"> ➤ Develop purpose statements and objectives ➤ Look at local and national models and research regarding enrollment (i.e., http://www.nga.org/center/divisions/1%2C1188%2CC_ISSUE_BRIEF^D_634%2C00.html; http://www.researchforum.org/html/related_medicaid.html; and http://www.ruralhealth.hrsa.gov/pub/chip2.htm) <p>Lead: Carlisle Regional Partnership for a Healthy Community (CRPHC)</p>

Barriers to Access Points and Services

Prescription Medication Assistance

Health Problem Area Idea High cost of prescription medications; limited or no insurance coverage for prescriptions
Enhance and develop an accessible, affordable and appropriate prescription assistance strategy

Who Do We Want To Help?	How Do We Want To Help?	What To Be Mindful Of?	Who Do We Need To Help Us Implement?	What Are Our Next Steps?
Target Population	Processes and Practices	Considerations and Challenges	Stakeholders and Collaborators	Who does what by when? (Time Frame) What Resources are required?
<ul style="list-style-type: none"> ➤ Who ever needs prescription assistance but does not currently receive assistance 	<ul style="list-style-type: none"> ➤ Establish a prescription program as part of an existing network of providers ➤ Clearinghouse mechanism ➤ Focused expertise (i.e., staff participate in available technical assistance or are certified by pharmaceutical companies) ➤ Are people aware of what prescription assistance is available? ➤ Are eligible populations taking advantage of prescription assistance available to them (i.e., Veteran's through the VA)? 	<ul style="list-style-type: none"> ➤ Who is currently working on this or a similar strategy? ➤ Pharmaceutical company limitations on their indigent drug care programs ➤ Role of and impact on PACE and PACENET? ➤ Establishing reasonable eligibility requirements? ➤ State prescriptive authority and pharmaceutical rules and regulations ➤ Real costs; a good fiscal plan; cost analysis ➤ Cost sharing and formularies ➤ Generic medications 	<ul style="list-style-type: none"> ➤ Target population ➤ Physicians ➤ Mental Health Providers ➤ Dentists ➤ Carlisle Regional Medical Center ➤ County Health Department ➤ Health Share ➤ Sadler Clinic ➤ Local and regional pharmacies and pharmacists ➤ Carlisle Area Health and Wellness Foundation ➤ Faith community ➤ State Regulating Bodies/Agencies/Etc. 	<ul style="list-style-type: none"> ➤ Develop purpose statements and objectives ➤ Look at Well Span in York, PA ➤ Research programs on the Internet: http://www.rxassist.org ➤ What are local entities doing (i.e., Health Share, The Sadler Clinic, etc.)? ➤ Investigate the value, benefit and opportunity to convene a special "Prescription Medication" Issues and Ideas Forum with the purpose of clarifying the issues, gathering information (what's working/what's not) and ideas for improving the problem of prescription assistance <p>Lead: Health Share</p>

Health Resources, Education and Promotion Activities

Health Problem Area Limited understanding and appreciation for the existing health, human and social service available in the Carlisle Region, with a particular focus on individuals (and the community) making healthier decisions and adopting a healthier lifestyle

Idea Enhance and develop health education and promotion activities

Who Do We Want To Help?	How Do We Want To Help?	What To Be Mindful Of?	Who Do We Need To Help Us Implement?	What Are Our Next Steps?
Target Population	Processes and Practices	Considerations and Challenges	Stakeholders and Collaborators	Who does what by when? (Time Frame) What Resources are required?
<ul style="list-style-type: none"> ➤ People with poor risk behavior scores (per the health status assessment) ➤ Providers (to help with the strategy and to benefit from the connection) 	<ul style="list-style-type: none"> ➤ Enhance exiting service directories ➤ Establishing a shared responsibility for health (at the institutional, provider, community and individual level) ➤ Advocate for Heart Healthy Menus at local restaurants (i.e., http://www.healing-hearts.net/menu.html) ➤ Promotion and recognition for healthier living (i.e., individual, institutional, work place) ➤ More publicity of the cost of poor health and the benefit of good health ➤ Using local leaders to be the voice/champion for healthier living 	<ul style="list-style-type: none"> ➤ Who is currently working on this or a similar strategy? ➤ Existing health education and promotion strategies (duplication) ➤ Behavior changes take time ➤ Chronic diseases ➤ Healthier lifestyle and behavior choices ➤ Prevention ➤ Appropriate access ➤ Compliance ➤ Making the connection between healthier people and a healthier economy (i.e., http://www.justworkout.co.nz/articles/economic.htm) 	<ul style="list-style-type: none"> ➤ Agencies ➤ United Way ➤ Private providers ➤ Carlisle Regional Medical Center ➤ County Health Department ➤ Health Share ➤ C-PARC ➤ Sadler Clinic ➤ Parish Nurse/Ecumenical Programs ➤ Food Banks ➤ Libraries ➤ Schools ➤ Worksites ➤ YMCA ➤ Local social and civic organizations ➤ Capital Region Health Futures Council 	<p style="text-align: center;">Members of the Access/Service Delivery Task Group July 2003</p> <ul style="list-style-type: none"> ➤ Develop purpose statements and objectives ➤ Work with Capital Region Health Futures Council as part of the State Health Improvement Plan (SHIP): http://webserver.health.state.pa.us/health/cwp/view.asp?a=169&Q=201421 <p>Lead: Carlisle Area Health and Wellness Foundation (CAHWF)</p>

Capacity and Workforce

Recruitment and Retention

Health Problem Area

Capacity/Workforce Development issues, specifically the concern over the current and anticipated numbers and types of health care providers in the Carlisle regional health system; Specifically the limited number of surgeons, pediatricians, obstetricians, dentists, mental health providers and registered nurses; limited number of providers who accept Medicaid Plan, develop and implement a coordinated recruitment and retention strategy

Idea

Who Do We Want To Help? Target Population	How Do We Want To Help? Processes and Practices	What To Be Mindful Of? Considerations and Challenges	Who Do We Need To Help Us Implement? Stakeholders and Collaborators	What Are Our Next Steps? Who does what by when? (Time Frame) What Resources are required?
<ul style="list-style-type: none"> ➤ General population 	<ul style="list-style-type: none"> ➤ Establishing a community-wide or community-involved recruitment and retention strategy ➤ Work with the medical professional community and other professional communities (i.e., banking, real estate and education) to put together a marketing, recruitment and retention package ➤ Favorable loans ➤ Educational opportunities ➤ Internships and residency programs ➤ Accurately marketing what the health system and community has to offer to a clinician/provider 	<ul style="list-style-type: none"> ➤ Eligibility for state and federal recruitment and retention programs (i.e., primary care practice opportunity loan and the National Health Service Corps) ➤ Other recruitment and retention efforts ➤ What is turning providers away from our health system and community? ➤ What is attracting providers to our health system and community? ➤ What/who do we realistically need and could support? ➤ Connecting the viability of the health system to economic viability/development 	<ul style="list-style-type: none"> ➤ Private Providers ➤ Providers who were recruited here ➤ Carlisle Regional Medical Center ➤ County Health Department ➤ Health Share ➤ Sadler Clinic ➤ Carlisle Area Health and Wellness Foundation ➤ County Medical Societies 	<p style="text-align: center;">Members of the Access/Service Delivery Task Group July 2003</p> <ul style="list-style-type: none"> ➤ Develop purpose statements and objectives ➤ What are our recruitment and retention options? ➤ Find our recruitment and retention champion(s)? <p>Lead: Carlisle Area Health and Wellness Foundation (CAHWF)</p>

Health Budget and Policy

Legislative and Resource Advocacy Strategy

Health Problem Area Perception that legislation and policies are introduced, deliberated and enacted without direct and balanced community health system input; similarly, resources may not be allocated properly if resource holder are working with limited or misinformation

Idea Plan, develop and implement a coordinated legislative and resource advocacy strategy

Who Do We Want To Help? Target Population	How Do We Want To Help? Processes and Practices	What To Be Mindful Of? Considerations and Challenges	Who Do We Need To Help Us Implement? Stakeholders and Collaborators	What Are Our Next Steps? Who does what by when? (Time Frame) What Resources are required?
<ul style="list-style-type: none"> ➤ General Population ➤ Health System 	<ul style="list-style-type: none"> ➤ Providing policy makers with the most accurate health system and health status information possible in order for better dialogue and more appropriate legislative decisions to be made 	<ul style="list-style-type: none"> ➤ Who is currently working on this or a similar strategy? ➤ Little Hatch Act for public employees ➤ Perception of lobbying 	<ul style="list-style-type: none"> ➤ General Population ➤ Health System ➤ Private providers ➤ Carlisle Regional Medical Center ➤ County Health Department ➤ Health Share ➤ C-PARC ➤ Sadler Clinic 	<p>CAHWF, Health System Task Groups, and SHIP July 2003</p> <ul style="list-style-type: none"> ➤ Develop purpose statements and objectives ➤ Develop message/cause ➤ Target audiences ➤ Coordinated research (i.e., policies and practices); <p>http://movingideas.org/links/healthlinks.html;</p> <p>http://www.cthealthpolicy.org/toolbox/;</p> <p>Lead: Carlisle Area Health and Wellness Foundation (CAHWF)</p>

Continuum of Care Members

Dale Beaston	Community Volunteer	Scott Johnson	Senate Public Health & Welfare Commission
Patricia Carlucci, Chairperson	Carlisle Area School District	Stephen Krebs, MD	Carlisle Pediatrics Associates
Frank Castrina, MD	KePRO	Evelyn Lebo	Cumberland County Economic Development
Melissa Castro	NHS/Stevens Center	Richard Lytle	Cumberland County Assistance Office
Frances Del Duca	Attorney at Law	Dennis Marion	Mental Health/Mental Retardation
Linda Figueroa	Community Action Commission	Patrice Pickering	Cumberland County Office of Aging & Comm. Svc
Roderick Frazier, DDS	Sadler Health Center	David Sarcone	Dickinson College
H. Robert Gasull, Jr., MD	Retired physician	Rusty Shunk	Dickinson College
Thomas Green, MD	Appalachian Orthopedic Center	Ellie Swank	Cumberland County Office of Aging
Perry Heath	R.S. Mowery and Sons	Kristen Vlaun	Sadler Health Center
Robert Hollen, MD	Retired physician	Bob Yankovitz	Memorial Lutheran Church

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