

State Health Improvement Plan Annual Report 2024



Table of Contents

Message from the Secretary of Health

Executive Summary

2024 State Health Improvement Plan - The Year in Review

State Health Improvement Plan Structure Overview

2023-2028 State Health Improvement Plan Overarching Goals

Appendix A: Health Equity Goals and Objectives

Appendix A1: SHIP Goal 1.1: Increase financial well-being, food security, and safe affordable housing

- 1.1 Trends in the SHIP Objectives
- 1.1 SHIP Partner Strategies, Activities, Successes and Highlights

Appendix A2: SHIP Goal 1.2: Increase community safety by reducing the number of violent incidences that occur due to racism, discrimination, or domestic disputes

- 1.2 Trends in the SHIP Objectives
- 1.2 SHIP Partner Strategies, Activities, Successes and Highlights

Appendix A3: SHIP Goal 1.3: Improve environmental health, focusing on environmental justice communities

- 1.3 Trends in the SHIP Objectives
- 1.3 SHIP Partner Strategies, Activities, Successes and Highlights

Appendix B: Chronic Disease Prevention Goals and Objectives

Appendix B1: SHIP Goal 2.1: Increase the population at a healthy weight through increasing availability and accessibility of physical activity and affordable nutritious food

- 2.1 Trends in the SHIP Objectives

- 2.1 SHIP Partner Strategies, Activities, Successes and Highlights

Appendix B2: SHIP Goal 2.2: Reduce the impact of tobacco and nicotine use

- 2.2 Trends in the SHIP Objectives
- 2.2 SHIP Partner Strategies, Activities, Successes and Highlights

Appendix C: Whole Person Care Goals and Objectives

Appendix C1: SHIP Goal 3.1: Increase access to medical and oral health care

- 3.1 Trends in the SHIP Objectives
- 3.1 SHIP Partner Strategies, Activities, Successes and Highlights

Appendix C2: SHIP Goal 3.2: Improve mental health and substance use outcomes through improved mental health services, trauma informed trainings, and substance use interventions

- 3.2 Trends in the SHIP Objectives
- 3.2 SHIP Partner Strategies, Activities, Successes and Highlights

Appendix C3: SHIP Goal 3.3: Improve health outcomes through improved chronic diseases management

- 3.3 Trends in the SHIP Objectives
- 3.3 SHIP Partner Strategies, Activities, Successes and Highlights

Appendix C4: SHIP Goal 3.4: Improve maternal and infant health outcomes by improving prenatal, perinatal, and postnatal care

- 3.4 Trends in the SHIP Objectives
- 3.4 SHIP Partner Strategies, Activities, Successes and Highlights

Appendix D: 2024 SHIP Leadership and Steering Committee

Appendix E: SHIP Goal 1.1 Team Members/Organizations

Appendix F: SHIP Goal 1.2 Team Members/Organizations

Appendix G: SHIP Goal 1.3 Team Members/Organizations

Appendix H: SHIP Goal 2.1 Team Members/Organizations

Appendix I: SHIP Goal 2.2 Team Members/Organizations

Appendix J: SHIP Goal 3.1 Team Members/Organizations

Appendix K: SHIP Goal 3.2 Team Members/Organizations

Appendix L: SHIP Goal 3.3 Team Members/Organizations

Appendix M: SHIP Goal 3.4 Team Members/Organizations

Appendix N: List of Acronyms

Message from the Secretary of Health

Greetings,

We are excited to share Pennsylvania's 2024 State Health Improvement Plan (SHIP) Annual Report. Throughout 2024, SHIP partners representing diverse sectors documented their work addressing the health priorities identified in the SHIP. Their work towards our shared vision of a healthier Pennsylvania for all is reflected in this report.

The Pennsylvania Department of Health acknowledges and thanks SHIP partners across the Commonwealth for their commitment to implementing the SHIP.

We look forward to continued collaboration as we work toward the ambitious goals and objectives outlined in the SHIP to improve the health of all Pennsylvanians.

Sincerely,



Debra L. Bogen, MD, FAAP
Secretary of Health

Executive Summary

The Pennsylvania State Health Improvement Plan (SHIP) is a comprehensive five-year strategy to improve the health and well-being of all Pennsylvanians. It serves as a roadmap to address key health challenges. The SHIP was developed by the Pennsylvania Department of Health (PA DOH) in partnership with the Healthy Pennsylvania Partnership (HPP), a collaboration of stakeholders from across the state and is part of a larger, ongoing cycle of public health improvement. The SHIP is built upon the findings of the State Health Assessment (SHA), which identifies health challenges, resources, and opportunities for improvement.

This annual report highlights the progress made in 2024 by many diverse partners. It shows how organizations worked together to implement the SHIP's goals and strategies, breaking down information silos and building powerful collaborations. The work is a testament to the power of shared purpose and vision.

The SHIP and SHA are also essential components of the Public Health Accreditation Board (PHAB) accreditation, a seal of quality that ensures our public health initiatives meet recognized standards.

The documented activities in this report demonstrate the significant work being done on the ground, serves as a resource for identifying best practices, fosters new collaborations, and ensures transparency in our collective efforts to improve the health of our communities. Our goal is to continue expanding on this documentation in future reports to provide a more comprehensive view of our progress and challenges.

SHIP 2024 - The Year in Review

After the SHIP's release in April 2023, we had to implement the plan. Building goal teams and gathering information on partner activities proved difficult, with some members struggling with participation and reporting. In response, DOH's SHIP team worked directly with goal team leads to identify hurdles and develop actionable solutions.

The DOH's SHIP team also conducted outreach to 25 state SHIP teams and held individual meetings with 12 of them to discuss their SHIP implementation barriers, successes, and best practices. Many of these states reported experiencing similar difficulties and barriers when moving from SHIP development to SHIP Implementation.

The issues, solutions, and best practices collected from other states were presented to the SHIP Steering Committee for feedback. Using this information, planning meetings were held to develop the "Get SHIP Done!" charter – a detailed workplan with specific activities, assigned roles, and clear timelines.

The charter was initiated in the summer of 2024 and included the following goals:

- Evaluate and Address Barriers to SHIP Implementation
- Increase Support to SHIP Goal Teams
- Increase SHIP Outreach and Promotion
- Increase SHIP Participation
- Display SHIP Implementation Progress

The DOH's SHIP team implemented and continues to host regular meetings with internal partners to monitor progress and with the SHIP goal team leads to discuss improvements and share updates.

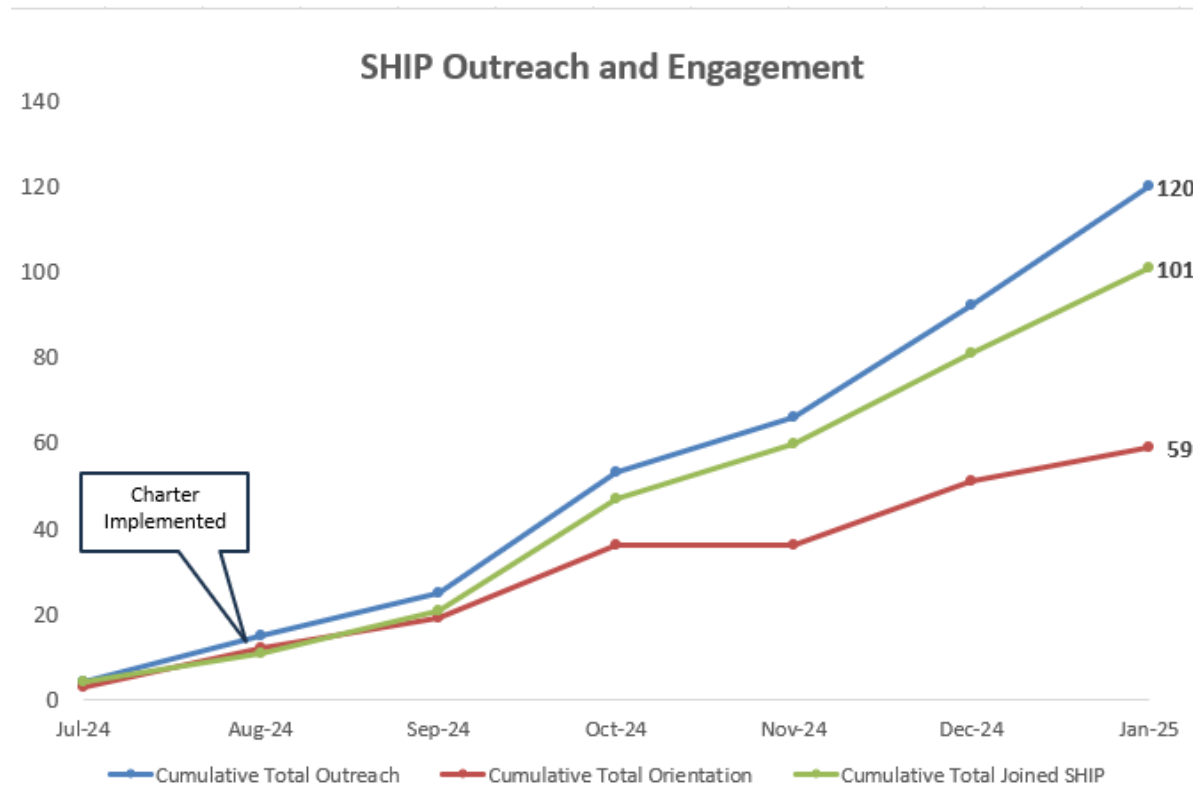
The lessons learned and best practices from other states were implemented to better support our SHIP goal teams. These include providing administrative support for tasks like scheduling meetings and sharing resources. A new SharePoint site was created to simplify collaboration and information sharing among members.

The most significant change involved a strategic reorientation of our focus. Instead of requesting teams to create new work, the priority shifted to documenting the substantial work currently underway across the state and to link those doing similar work. This new approach significantly lessened the administrative burden for goal team leads while simultaneously providing a more comprehensive understanding of ongoing efforts, facilitating the identification of collaborative opportunities, and revealing service gaps.

As a result, goal teams revised their strategies to better capture the valuable activities of SHIP partners and incorporate existing data.

Since August 2024, bi-monthly virtual presentations were held to introduce new organizations to the SHIP and encourage membership. New promotional materials were created, and the SHIP website was updated with more details and a FAQ section.

Progress on outreach and new member participation during the first six months of this initiative was tracked. The following chart visualizes the growth from August 2024 to January 2025.



Implementation of the Get SHIP Done! Charter helped to simplify and increase reporting from the SHIP goal teams. The information reported by SHIP goal team members in 2024 was used to create the SHIP Dashboard and this annual report.

The SHIP Dashboard was released in the Spring of 2025. It is designed to visually monitor and track Pennsylvania's progress toward achieving the goals and objectives outlined in the 2023-2028 SHIP. The dashboard improves transparency, accountability, and collaboration, and enables data-informed decisions to enhance public health outcomes across the state. It is an interactive tool which provides key performance indicators, data visualizations, and progress reports. It features information on specific objectives, goals, targeted strategies, engaged partners, and annual activities, offering a comprehensive overview of the state's efforts to improve public health outcomes.

The SHIP Dashboard can be found at this link:

<https://app.powerbigov.us/view?r=eyJrIjoizGU5YTkwZDYtYzc0ZC00MTEwLTk4ZjMtNzU3YzMwM2VIZGQ2IiwidCI6IjQxOGUyODQxLTAxMjgtNGRkNS05YjZjLTQ3ZmM1YTIhMWJkZSJ9>

Next Steps

While significant progress was made in 2024, the work is not done. The Plan-Do-Check-Act approach will continue to be used to review progress, identify new challenges, and make ongoing improvements. This continuous evaluation is crucial for engaging diverse community partners and ensuring every voice is heard.

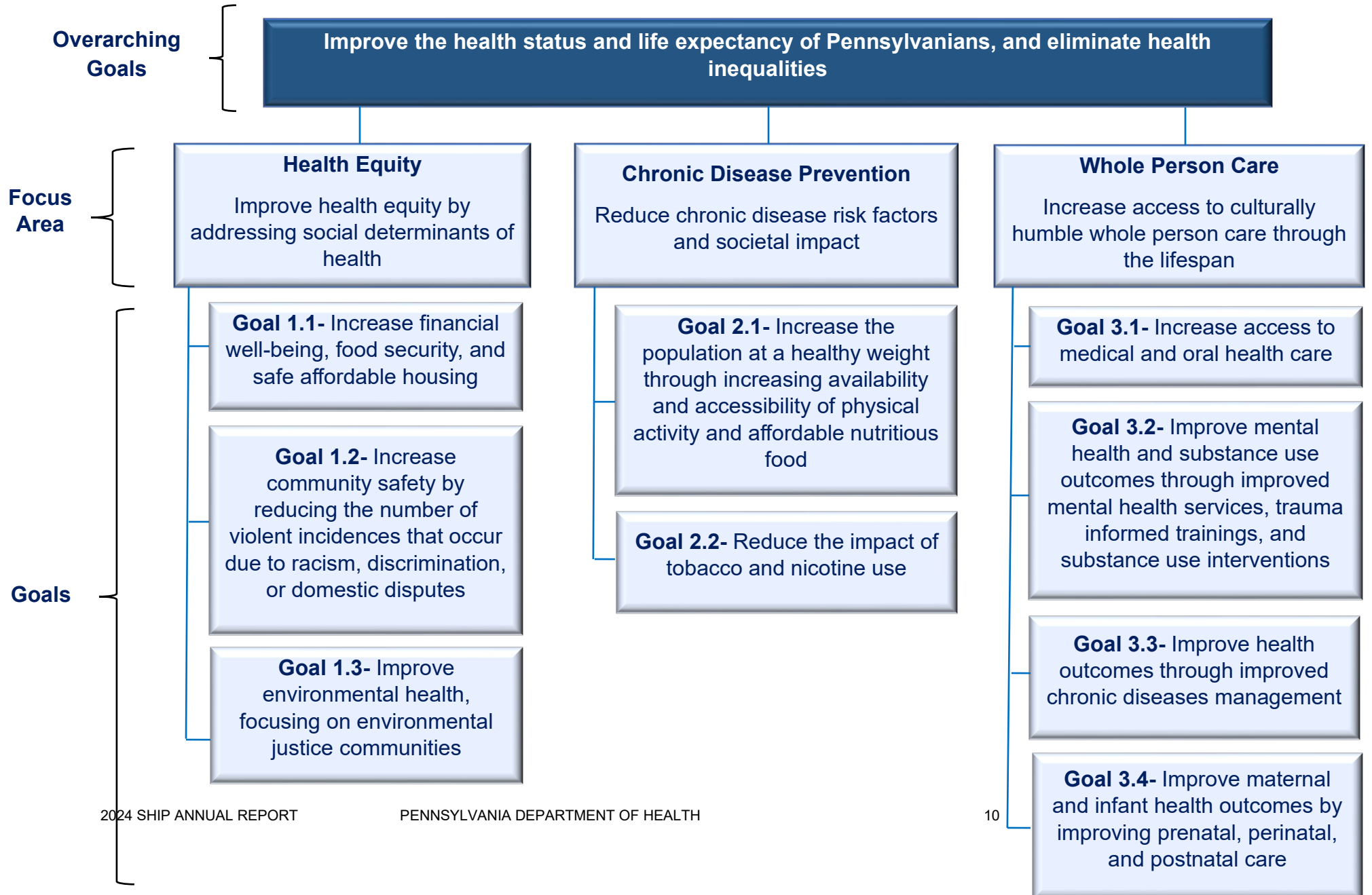
Ultimately, the goal is to build a collaborative network that successfully improves the health of all Pennsylvanians. If your organization's work aligns with the SHIP's goals, we invite you to join the SHIP teams. For more information, please email RA-ship@pa.gov.

Acknowledgments

This annual report is the result of the work and collaboration of many different community partners, health care associations, health systems, health and human services organizations, community collaborations, local public health agencies, government agencies, and more. The appendices at the end of this report provide the names and organizations of individuals that participated in SHIP goal team meetings and worked to make progress on the goals and objectives identified in the SHIP.

The SHIP is only as good as its implementation. We thank our SHIP members and organizations for their contributions to this annual report and for their efforts in 2024 to move towards the vision of a healthy Pennsylvania for all.

2023-2028 State Health Improvement Plan Structure Overview

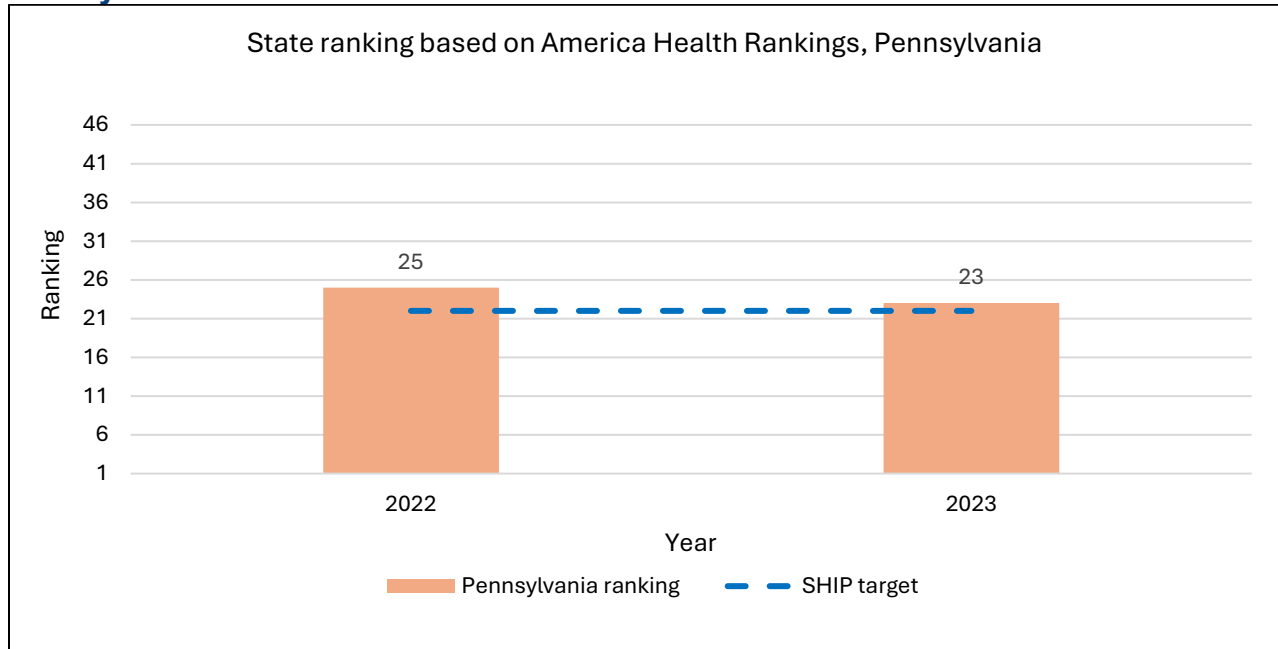


2023-2028 State Health Improvement Plan Overarching Goals

The 2023-2028 SHIP has overarching goals to improve the health status and life expectancy of Pennsylvanians and eliminate health inequities. The graphs below provide the most recent data used to track and measure the progress for these overarching goals.

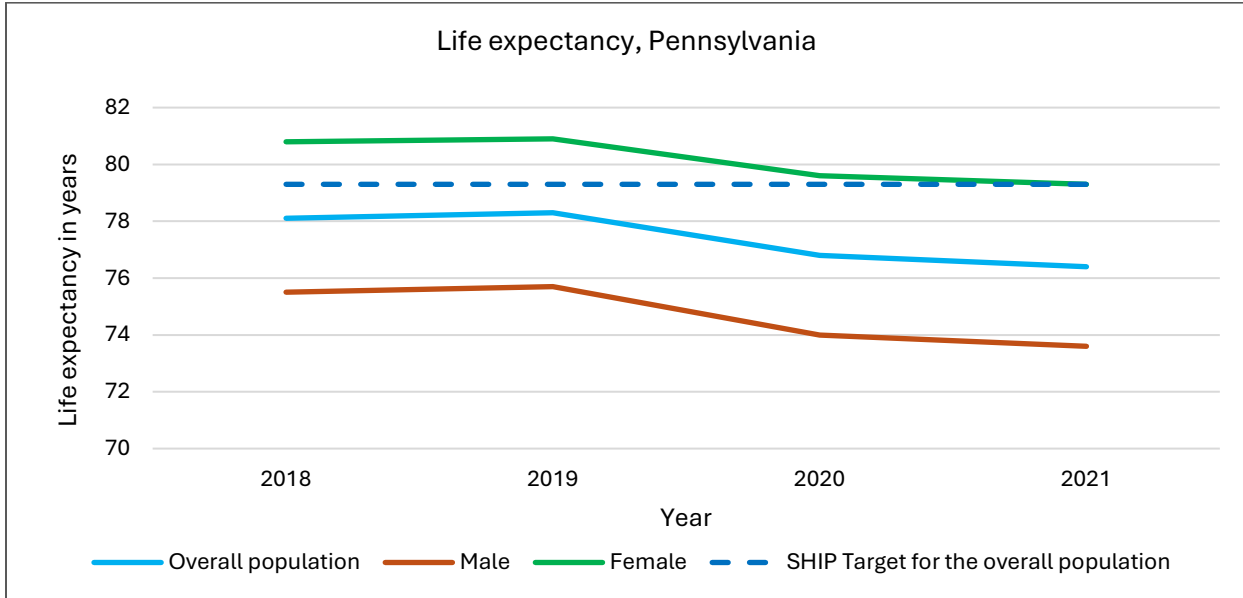
The target year of 2028 reflects the endpoint of the SHIP. Due to varying data availability and reporting lags across indicators, the most recent data available in 2028 will be used to assess progress toward each objective.

Increase Pennsylvania’s ranking in America Health Rankings from 25th in 2022 to 22nd by 2028



Source: America's Health Rankings composite measure

Increase the life expectancy of Pennsylvanians from 76.8 years in 2020 to 79.3 by 2028



Source: National Center for Health Statistics, CDC

Appendix A

Health Equity Goals and Objectives

The three health equity SHIP goals concentrate on improving health equity by addressing social determinants of health. The goals center on improving the quality of life for vulnerable populations by tackling issues such as poverty, homelessness, food insecurity, community safety, and environmental health.

Appendix A1

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

Objectives:

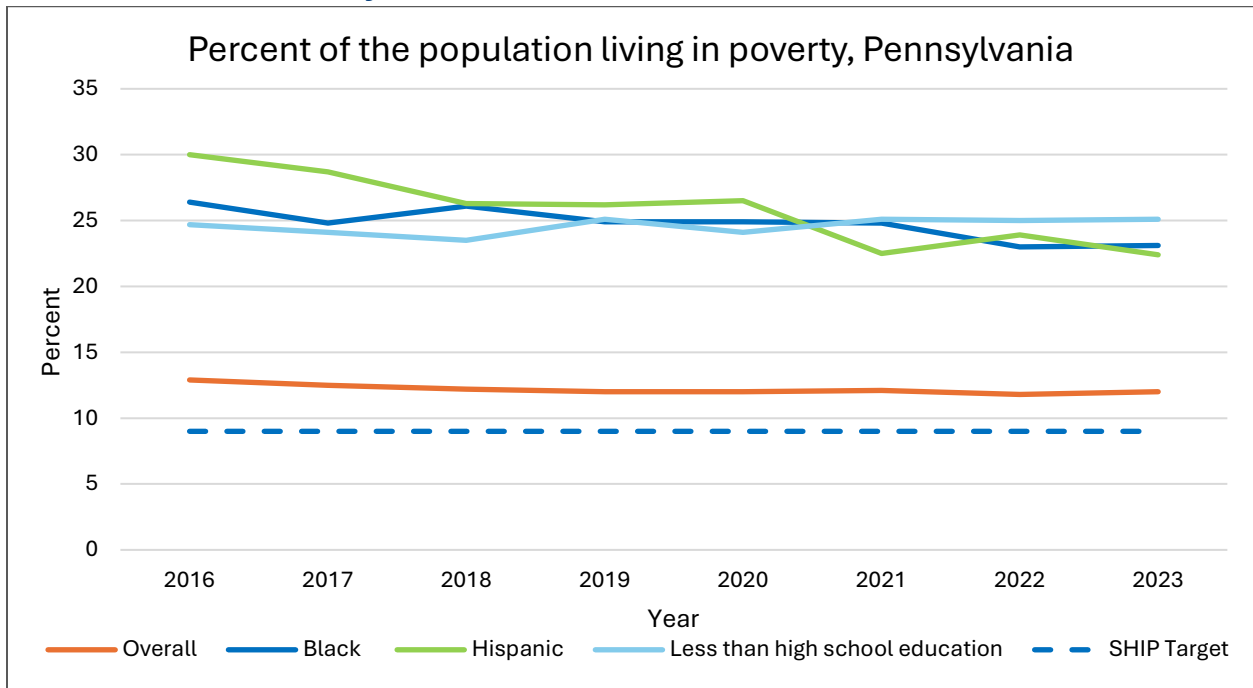
- Decrease population living in poverty
- Reduce homelessness
- Reduce housing cost burden
- Reduce food insecurity

1.1 Trends in the SHIP Objectives

The four objectives, along with the progress toward the SHIP targets, are detailed below. The most recent available statewide data for the 1.1 objectives are 2022 and 2023. This data can be used to look at previous trends for these objectives and provide an overall view of progress towards the 1.1 SHIP Goal.

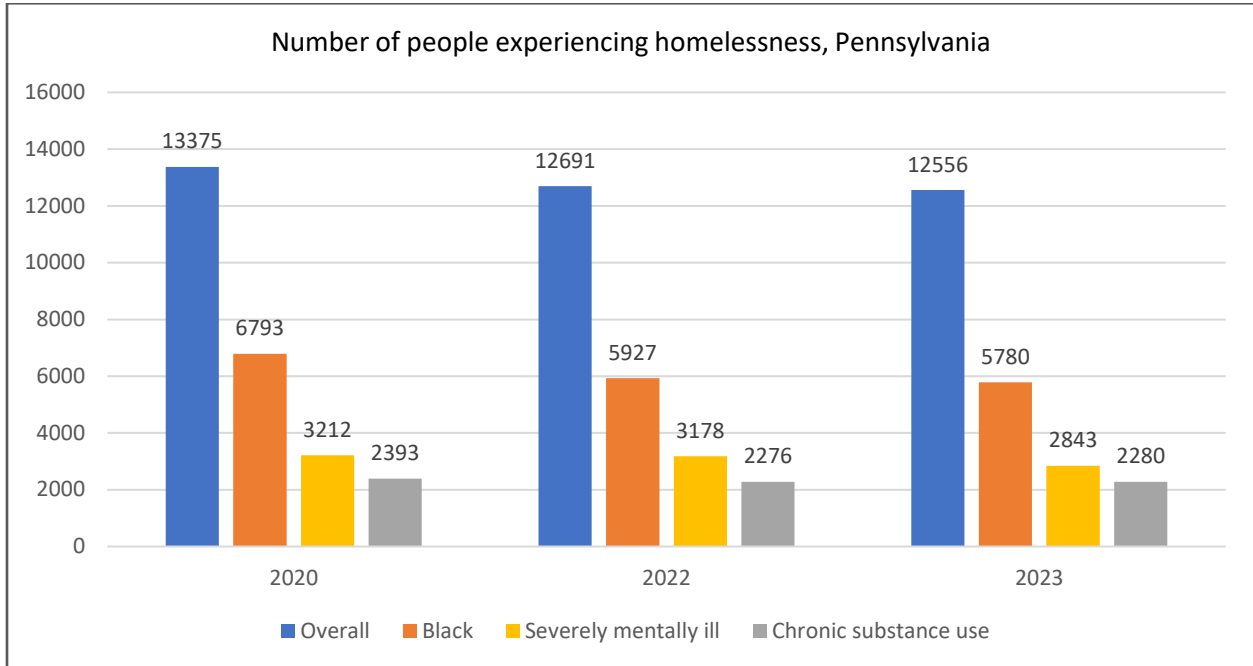
The target year of 2028 reflects the endpoint of the SHIP. Due to varying data availability and reporting lags across indicators, the most recent data available in 2028 will be used to assess progress toward each objective.

Objective 1.1.1: Decrease the percentage of the population living in poverty from 12.1% in 2021 to 9.0% by 2028



Source: U.S. Census Bureau, American Community Survey

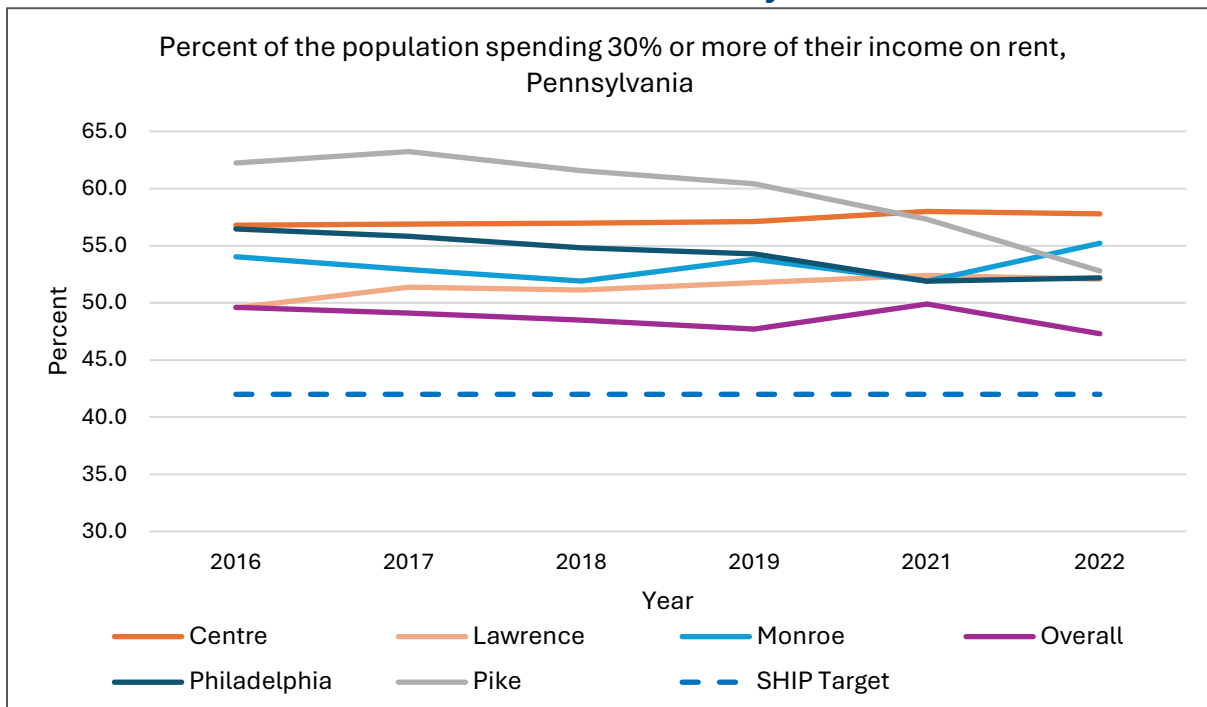
Objective 1.1.2: Reduce the number of people experiencing homelessness from 13,375 in 2020 to 12,037 by 2028



Source: US Department of Housing and Urban Development, CoC Homeless Populations and Subpopulations Reports.

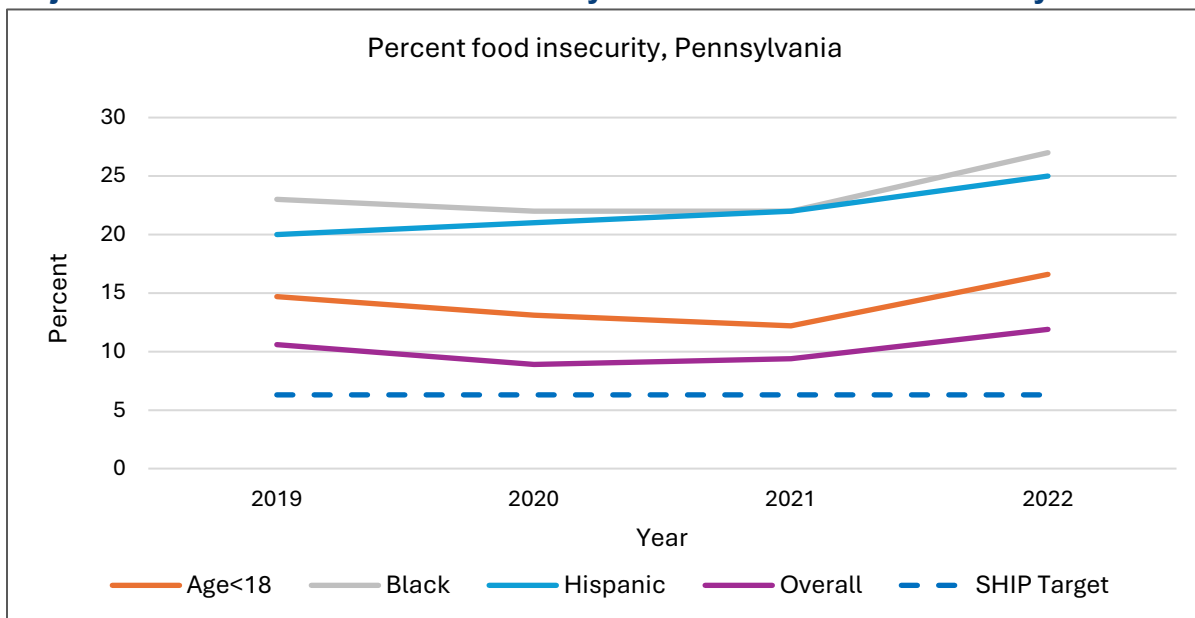
Note: The SHIP target for the overall population is 12,037, with different targets for the specific populations: Black (6,114), severely mentally ill (2,891), and individuals with chronic substance use (2,158).

Objective 1.1.3: Reduce the percentage of the population spending 30% or more of their income on rent from 47% in 2021 to 42% by 2028



Source: U.S. Census Bureau American Community Survey. Note: This measures the percentage of households that pay 30% or more of their household income on rent, among occupied units paying rent. It is computed based on 5-year ACS estimate. For example, the 2021 estimate is based on a 5-year ACS estimate (2017-2021).

Objective 1.1.4: Reduce food insecurity from 8.9% in 2020 to 6.3% by 2028



Source: Feeding America, Map the Meal Gap

1.1 SHIP Partner Strategies, Activities, Successes and Highlights

SHIP Goal 1.1 Team members contributed the following information on strategies and activities conducted throughout the Commonwealth in 2024 to increase financial well-being, food security, and safe affordable housing. This information includes overviews of activities as well as successes and highlights of the work of SHIP partners and their organizations.

Strategy: Reduce barriers to affordable housing

SHIP Partner Activities/Successes/Highlights	Organization(s)
The Inglis Self-Determination Housing of Pennsylvania Section 811 Project Rental Assistance Program (PRA) provides affordable housing for people with disabilities and facilitated 72 lease signings in 2024.	Inglis Self-Determination Housing of Pennsylvania
<p>Inglis Self-Determination Housing of Pennsylvania provided several trainings in 2024:</p> <ul style="list-style-type: none"> • The Prepared Renter Education Program was presented 26 times, educating 700 attendees. • The Prepared Renter Education Program Train the Trainer was presented four times, training 14 attendees. • The Health and Housing training was presented four times training 122 attendees. • The Eviction Processes and Prevention Explained training was presented four times, training 174 attendees. • The Assistance Animals Explained training was presented four times, educating 186 attendees. • The Navigating Housing for Formally Incarcerated Individuals training was presented three times, training 161 attendees. • The 811 PRA Overview training was presented six times training 339 attendees. • A new Introduction to Housing Concepts training was held and trained 21 attendees. 	Inglis Self-Determination Housing of Pennsylvania
The Center for Community Action and Blair County Re-Entry Coalition began development of the Criminal Justice Advisory Board (CJAB) in Bedford County. One of the items identified to address through the coalition and CJAB process was development of cross systems coordination and services for inmates with no housing plan. The goal is	Center for Community Action Blair County Re-Entry Coalition

<p>to create a coordinated cross-system with support services for successful reentry and reduce recidivism through a network of providers and partners representing housing, education, employment, behavioral health, probation, health care, and drug and alcohol.</p>	<p>Criminal Justice Advisory Board, Bedford County</p>
<p>Housing and Emergency Services Program</p> <p>In the wake of the end of the crucial Federal Emergency Rental Assistance program’s end in 2024, many households—particularly in high rent-burden communities like Bucks County—were left facing housing instability and the risk of homelessness. In response, Bucks County Opportunity Council (BCOC) leveraged a combination of resources, including the existing Homeless Assistance Program grant, a new grant from Bucks County, and a newly established partnership with a private funder, to bridge the gap left by the end of ERA assistance, bringing together multiple areas of the community from the private and public sector to solve local challenges</p> <p>BCOC actively sought private funding to help fill the gap when grant funds were insufficient. As a result, BCOC was able to braid state, county, and private resources, allowing for increased assistance to more households and at higher levels than in previous years.</p> <p>In 2024, BCOC assisted a total of 442 households, comprising 1,081 individuals, through the Housing and Emergency Services program.</p> <p>These households received support either to prevent eviction or to cover move-in costs for a new unit. The individuals and families served were from all areas of Bucks County.</p>	<p>Bucks County Opportunity Council</p>

Strategy: Increase access to food in areas of low income and low access

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>Pay-What-You-Can (PWYC) Market Stands 2024</p> <p>PWYC markets provided fresh, locally grown produce in areas of low income and low access. Markets allowed individuals the dignity of contributing if they can and freely sharing with those who cannot. Their model is: “take what you need, pay what you can.”</p> <p>Beyond access to food, markets served as a catalyst for building and rebuilding connections to fresh food, deepening connections among neighbors, and strengthening the community.</p> <p>A coalition of network farmers, growers, community members, and nonprofits came together each season to make this happen across five locations in Erie County: Edinboro, three Eastside locations, and downtown in Perry Square.</p> <p>In 2024 PWYC markets had:</p> <ul style="list-style-type: none"> • 75 Market events • 3,518 Market visitors • 246 Farmers Market Nutrition Program vouchers used • 24,772 pounds of produce distributed with 7 average pounds per person • \$3.83 as the average amount collected per person • 250 Community Dinner Guests <p>Donors and volunteers included the Grow and Glow Urban Collaborative, Wild Field Urban Farm, Erie Farm to School, Conscious Food Project at Raintree Farms, Erie Downtown Partnership, Blooming Valley Farms, Erie Food Policy Advisory Council, and Groundwork Erie.</p> <p>Volunteers lent their expertise, and grew, harvested, gleaned, collected, moved, and distributed food throughout the season to build a healthier, more connected community.</p>	<p>BUILD, Hamot Health Foundation</p>

<p>Community members provided feedback on how eating fresh food is helping with chronic health concerns, elevating their mood, helping in recovery from surgeries and chemo treatments, providing pre- and post-partum nutrition, and increasing access to fresh produce. The markets also provided an opportunity to refer individuals to other needed services.</p>	
<p>Westmoreland Community Action’s Shared Housing program received a grant-funded garden in 2024 that was not available in 2023. This garden increased access to fresh produce and provided skill development to the served population.</p>	<p>Westmoreland Community Action</p>

Strategy: Increase awareness of housing support initiatives

<p>SHIP Partner Activities/Successes/Highlights</p>	<p>Organization(s)</p>
<p>The Pennsylvania Human Relations Commission and Housing Alliance of Pennsylvania worked on the following:</p> <ul style="list-style-type: none"> • Compiled, shared and encouraged attendance at conferences on fair housing. • Hosted the 2024 Housing Equality Conference in Pittsburgh, Pennsylvania, reaching 165 people. • Shared fair housing information and resources through quarterly newsletters. • Hosted 10 guests on the fair housing interview show, Pennsylvania Human Relations Commission Speaks: Fair Housing in the 21st Century, broadcast on PCNtv. • Hosted roundtable discussion with stakeholders to inform the Pennsylvania Housing Action Plan. 	<p>Pennsylvania Human Relations Commission</p> <p>Housing Alliance of Pennsylvania</p>
<p>In 2024, Central Susquehanna Opportunities (CSO) served as a coordinated entry access site for 2-1-1 and fielded many calls for homelessness assistance. CSO is a leader in the county coalition meetings where homelessness concerns are identified.</p>	<p>Central Susquehanna Opportunities</p>

<p>CSO quickly exhausted all emergency housing funding for hotel stays. Local shelters were consistently full with no openings. To address this need, CSO Management completed regular outreach throughout the service area to establish new partnerships with businesses invested in serving the community. Together they reviewed current needs, available services, available funding, and created a plan to combine efforts to help fill gaps.</p> <p>Committees with a combination of public and private sector representatives have been formed and are actively working to secure new funding to meet and to facilitate an environment for data sharing.</p>	
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Strategy: Increase access to safe affordable housing

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>The PA DHS worked with the PA Department of Community and Economic Development and partners to include the research and stakeholder input from the Housing and Supports strategy work into the Housing Action Plan.</p>	<p>PA Department of Human Services (DHS)</p> <p>PA Department of Community and Economic Development</p>
<p>Volunteers of America utilized the Housing First model to increase housing for people in Northeastern Pennsylvania.</p>	<p>Volunteers of America</p>
<p>BUILD, Hamot Health Foundation provided opportunities for safe affordable housing to reduce homelessness.</p>	<p>BUILD, Hamot Health Foundation</p>
<p>STEP used their Supportive Housing Program (SHP) and the Master Leasing Program (MLP), leveraging its existing One-Stop Process, to ensure customers applying to these programs were afforded the wholistic and bundled approach to all services.</p> <p>While most customers come to STEP simply seeking help with rent and other living expenses, dedicated case workers give them the tools to continue to be securely housed</p>	<p>Lycoming-Clinton Counties Commission for Community Action (STEP, Inc.)</p>

<p>and stay current on bills. Coordinated intake also allows customers to work with Family Navigators to achieve outcomes to help them move towards self-sufficiency by focusing on goals in other areas.</p> <p>149 of 218 enrolled individuals maintained safe and affordable housing for 90 days; 29 of 68 enrolled individuals obtained safe and affordable housing; and 107 of 136 enrolled individuals avoided eviction or foreclosure.</p>	
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Strategy: Increase collaboration on safe affordable housing initiatives

SHIP Partner Activities/Successes/Highlights	Organization(s)
The 1.1 SHIP Goal Team compiled and reviewed a list of housing organizations and coalitions and invited them to join this SHIP team.	1.1 SHIP Goal Team
South Central Community Action Program (SCCAP), through its administration of @Home in Adams County, has taken an innovative approach to address poverty in the community by coordinating resources to tackle housing, economic, and transportation challenges. The initiative has mobilized a diverse coalition of local governments, nonprofits, and businesses to advocate for affordable housing, economic development, and sustainable transportation.	South Central Community Action Program

Strategy: Prevent discrimination in housing and foster housing opportunities

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>The Pennsylvania Human Relations Commission enforced civil rights to prevent discrimination in housing.</p> <p>156 housing cases were docketed in 2024. The top three complaints for housing cases were disability, retaliation, and race.</p>	Pennsylvania Human Relations Commission

<p>The Pennsylvania Human Relations Commission provided free virtual and in-person trainings on a wide variety of fair housing issues and provided monthly fair housing webinars.</p> <p>In 2024, 56 fair housing trainings were provided to over 2,200 participants.</p>	<p>Pennsylvania Human Relations Commission</p>
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Strategy: Identify and increase awareness of areas with large homeless populations

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>The 1.1 SHIP Goal Team shared results of yearly point-in-time (PIT) count of sheltered and unsheltered people experiencing homelessness collected by the U.S. Department of Housing and Urban Development.</p>	<p>1.1 SHIP Goal Team</p>
<p>Westmoreland Community Action’s Young Adult Services program provided a multifaceted approach to holistic support to youth and young adults in need in Westmoreland County and the region.</p> <p>The organization provided a variety of housing options including transitional housing, rapid re-housing, host homes, and homelessness prevention services.</p> <p>In the 2024 calendar year, the youth program served 207 individuals aged 18 to 24 within Westmoreland County and 23 youth regionally. These services included homelessness prevention supports, rapid rehousing, transitional housing, host homes, youth re-entry services, and participation in the Youth Justice Advisory Board.</p>	<p>Westmoreland Community Action</p>
<p>Indiana County's rural footprint easily conceals homeless individuals and families hiding in the middle of the woods in tents, abandoned sheds, or vehicles parked in remote areas. At the end of 2024, Indiana County Community Action Program (ICCAP) had nearly 400 homeless individuals on their waiting list and their shelter was full housing 19 individuals. Knowing that they needed to gain community support, ICCAP developed a “What does Homelessness look like in Indiana County?” campaign on social media, the</p>	<p>Indiana County Community Action Program</p>

<p>radio, and in the newspaper. They spoke with local civic groups, the county department of human services, state and local representatives, and the Indiana County School Board.</p> <p>This campaign was incredibly successful at bringing awareness to every level of the community, creating buy-in for ICCAP to pursue HOME-ARP Non-Congregate shelter funding to develop their Pathway Homeless Shelter. This shelter remains the only emergency shelter in Indiana County that houses adults and children, which increases housing capacity by 20 units that could house 1-3 individuals in the same household.</p>	
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Strategy: Connect veterans to housing

SHIP Partner Activities/Successes/Highlights	Organization(s)
The Lebanon VA Medical Center shared a spreadsheet of VA homeless outreach teams and healthcare for homeless veteran leads to increase knowledge of available services.	Lebanon VA Medical Center
The Veterans Outreach of Pennsylvania increased awareness of Tiny Homes Programs through presentations on this program.	Veterans Outreach of Pennsylvania
Veterans Grove Village has a veteran community with 15 tiny homes and provides housing to veterans. This program used a therapeutic community model to promote mental wellness through an interpersonal and socially interactive approach and served veterans from all over Southcentral Pennsylvania.	Veterans Outreach of Pennsylvania
The Veterans Administration Health Care for Homeless Veterans Program provided outreach and assistance services to homeless veterans.	Veterans Administration Health Care for Homeless Veterans Program

Strategy: Increase access to charitable food providers

SHIP Partner Activities/Successes/Highlights	Organization(s)
The Central Pennsylvania Food Bank used Hunger Mapping to identify gaps in charitable food access, discussed utilization of government programs, and identified the main drivers of food insecurity.	Central Pennsylvania Food Bank
The Central Pennsylvania Food Bank partnered with mobile pantries and satellite locations of existing pantries to expand access to charitable food providers in underserved areas.	Central Pennsylvania Food Bank
The Central Pennsylvania Food Bank worked to increase the number of destinations that offer Supplemental Nutrition Assistance Program or SNAP registration assistance.	Central Pennsylvania Food Bank
The Greater Pittsburgh Community Food Bank worked to address gaps in food bank services.	Greater Pittsburgh Community Food Bank
South Central Community Action Programs worked to distribute 957,965 pounds of fresh, local produce, using 306 volunteers and 146 farms, markets, gardens, and other sources to 13,180 individuals over 2024.	South Central Community Action Programs
The food pantries of Bedford and Huntington County served as resources for individuals and families facing food insecurity by providing distributions of essential and healthy food items. These food pantries are supported by the Center for Community Action and vary in daily operating hours to ensure folks in both communities are served at any given time.	Center for Community Action

Strategy: Increase equitable food access for individuals who have barriers to obtaining food

SHIP Partner Activities/Successes/Highlights	Organization(s)
Mom’s Meals delivered medically tailored meals to individuals who are home bound or need assistance with activities of daily living.	Mom’s Meals
Schuylkill Community Action relaunched their Summer BLAST (Better Lives Always Start Today) Program after a multi-year hiatus. The Summer BLAST Program provided a safe and structured environment at no cost to 213 elementary-age children across four locations—Pottsville, Frackville, Mahanoy City, and Tamaqua. Through a combination of educational activities and recreational engagement, the program promoted positive social interactions, personal growth, and healthy lifestyle choices. The children participating received nutritious meals, addressing food insecurity concerns during the summer months.	Schuylkill Community Action
In 2024, Central Susquehanna Opportunities, Inc. partnered with GIANT and Geisinger to launch a Fresh Food Mobile Food Pantry unit to serve households in rural areas with limited food access in Columbia, Montour, and Northumberland Counties.	Central Susquehanna Opportunities, Inc.
The Central Pennsylvania Food Bank strategically partnered with pantries to increase weekend and evening hours access in areas with limited hours for working families.	Central Pennsylvania Food Bank

Strategy: Increase collaboration on and awareness of food insecurity initiatives throughout the Commonwealth

SHIP Partner Activities/Successes/Highlights	Organization(s)
The SHIP team identified and provided outreach to organizations throughout the Commonwealth that worked on addressing food insecurity and invited them to join this SHIP team.	1.1 SHIP Goal Team PA Department of Health (DOH) SHIP Team
The Community Action Association of Pennsylvania identified and connected community-based organizations (CBOs) throughout the Commonwealth that work on food insecurity	Community Action Association of Pennsylvania

<p>initiatives to join PA Navigate, a platform designed to connect Pennsylvanians with health and social care services in their local community.</p> <p>The Community Action Association of Pennsylvania Community Engagement team connected with each CBO to ensure the services provided on the network are up to date, with continual improvement in engagement and outreach resources individualized to each CBO, thus making CBOs not just ready to receive clients through the system, but ready to engage communities at large.</p>	<p>PA Navigate</p>
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Strategy: Increase collaboration on and awareness of poverty initiatives throughout the Commonwealth

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>The SHIP team identified and provided outreach to organizations throughout the Commonwealth that are working on poverty initiatives and invited them to join this SHIP team.</p>	<p>1.1 SHIP Goal Team PA DOH SHIP Team</p>
<p>The Community Action Association of Pennsylvania identified and connected community-based organizations throughout the Commonwealth that are working on poverty initiatives to join and list services on PA Navigate.</p>	<p>Community Action Association of Pennsylvania PA Navigate</p>

Strategy: Increase collaboration on and awareness of housing initiatives throughout the Commonwealth

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>The SHIP team identified and provided outreach to organizations throughout the Commonwealth that are working on housing initiatives and invited them to join this SHIP team.</p>	<p>1.1 SHIP Goal Team PA DOH SHIP Team</p>

The Community Action Association of Pennsylvania identified and connected community-based organizations throughout the Commonwealth that are working on housing initiatives to join and list services on PA Navigate.	Community Action Association of Pennsylvania PA Navigate
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Strategy: Increase collaboration and information sharing among key partners whose work aligns with the 1.1 SHIP Goal and Objectives

SHIP Partner Activities/Successes/Highlights	Organization(s)
The Northeast Regional Heat Equity Action Team, Southwest Regional Heat Equity Action Team, and Southcentral Regional Heat Equity Action Team focused their efforts on SHIP Goal 1.1 and hosted community-based presentations in 2024.	PA DOH, Office of Health Equity
Outreach and promotion of the SHIP goal team was conducted through SHIP presentations and distribution of SHIP informational materials.	1.2 SHIP Goal Team PA DOH SHIP Team

Appendix A2:

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

Objectives:

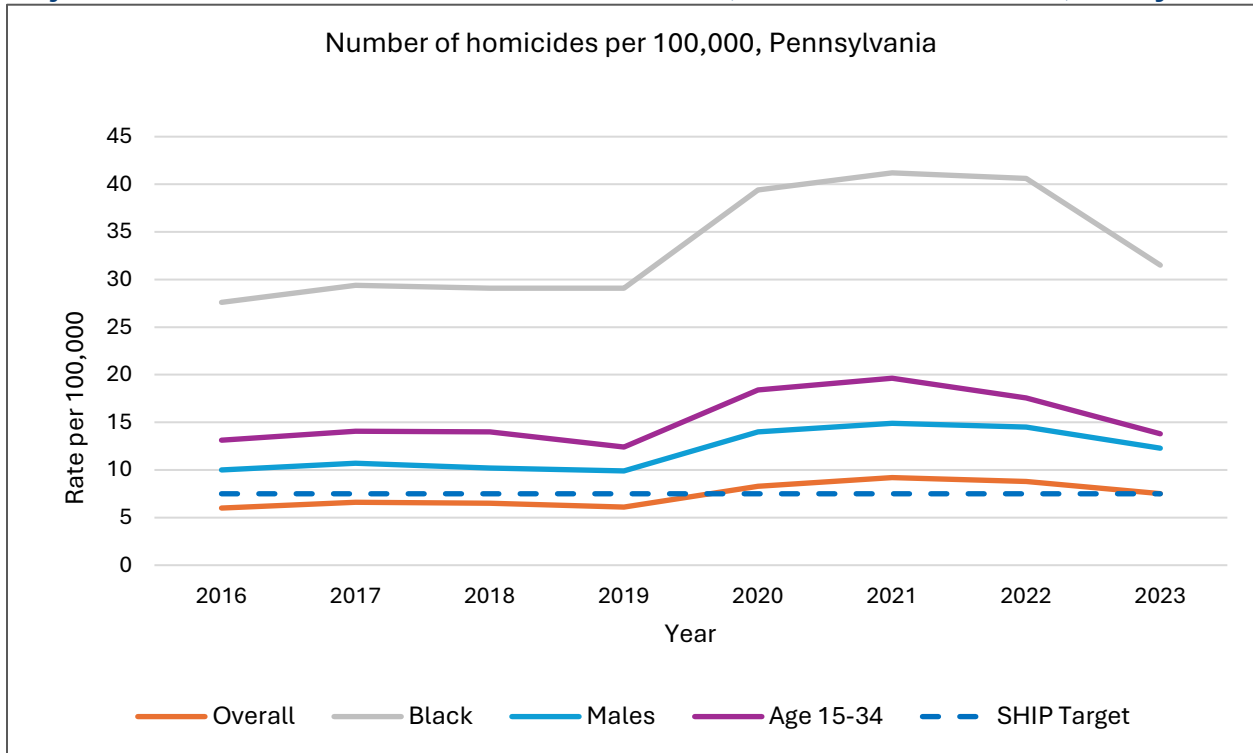
- Reduce homicide rates
- Reduce elder abuse

1.2 Trends in the SHIP objectives

The two objectives, along with the progress toward the SHIP targets, are detailed below. The most recent available statewide data for the 1.2 objectives are 2023 and 2024. These data can be used to look at previous trends for these objectives and provide an overall view of progress towards the 1.2 SHIP Goal.

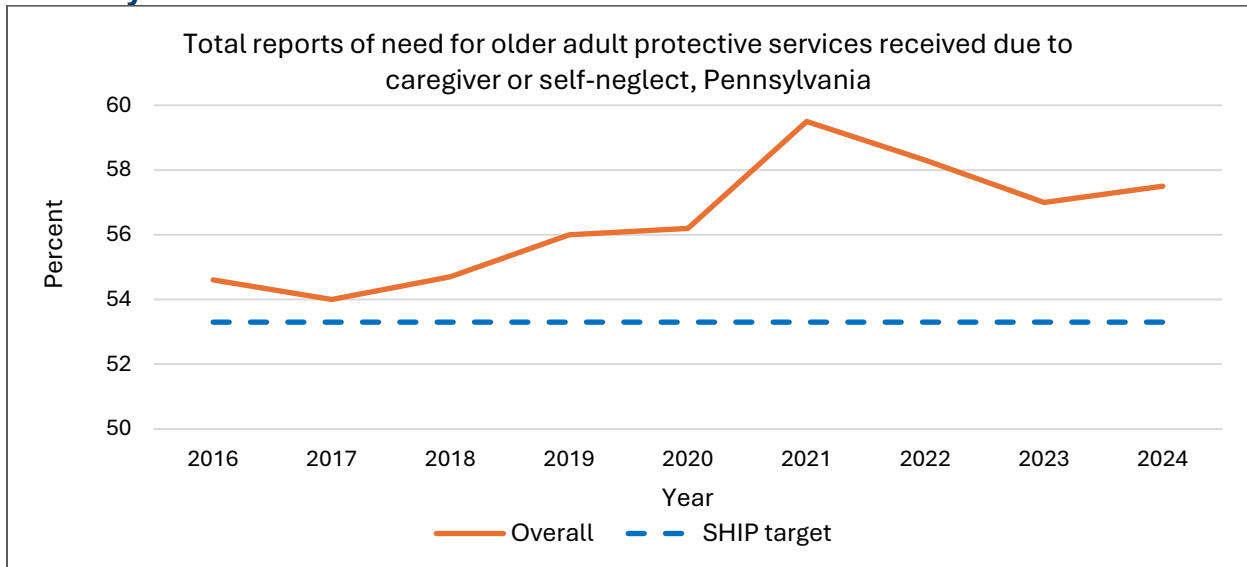
The target year of 2028 reflects the endpoint of the SHIP. Due to varying data availability and reporting lags across indicators, the most recent data available in 2028 will be used to assess progress toward each objective.

Objective 1.2.1: Reduce homicides from 8.3/100,000 in 2020 to 7.5/100,000 by 2028



Source: Pennsylvania Death Certificate Dataset

Objective 1.2.2: Decrease the total reports of need for older adult protective services received due to caregiver or self-neglect from 58.3% in 2021-2022 to 53.3% by 2028



Source: Pennsylvania Department of Aging, Older Adults Protective Services.

Note: Data presented for this indicator refers to state fiscal year; for example, 2021 indicates 2020-2021.

1.2 SHIP Partner Strategies, Activities, Successes and Highlights

SHIP Goal 1.2 Team members contributed the following information on strategies and activities conducted throughout the Commonwealth in 2024 to increase community safety by reducing the number of violent incidences that occur due to racism, discrimination, or domestic disputes. This information includes overviews of activities as well as successes and highlights of the work of SHIP partners and their organizations.

Strategy: Reduce gun violence

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>In the fall of 2024, the PCCD Office of Gun Violence Prevention, hosted four community listening sessions and received more than 800 responses to a stakeholder feedback survey asking for input on policies, programs, and strategies to address gun violence. A strategic plan and initial report were published in March 2025. Additional information and a copy of the <i>2025 OGVP Initial Report and Strategic Plan</i> is available on PCCD’s Office of Gun Violence Prevention webpage: https://www.pa.gov/agencies/pccd/programs-and-services/reducing-gun-violence/ogvp.html</p> <p>PCCD’s Commission adopted its FFY 2024 Byrne State Crisis Intervention Program (SCIP) Funding Plan to address the intersections of gun violence and behavioral health crises. In April 2025, the U.S. Department of Justice, Bureau of Justice Assistance notified PCCD that it had approved Pennsylvania’s FFY 2024 SCIP Funding Plan. Additional information and a copy of the FY 2024 Pennsylvania SCIP Funding Plan is available on PCCD’s Byrne State Crisis Intervention Program webpage: https://www.pa.gov/agencies/pccd/programs-and-services/reducing-gun-violence/byrne-state-crisis-intervention-program-scip.html</p> <p>PCCD was awarded a \$4 million federal FFY 2024 Community Violence Intervention and Prevention Initiative (CVIPI) Grant to advance hospital-based violence intervention programs (HVIPs) across the state in collaboration with the Health Alliance for Violence</p>	<p>PA Commission on Crime and Delinquency (PCCD)</p>

Intervention (HAVI). HVIPs help reduce retaliatory violence and improve outcomes for patients with violent injuries.	
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Strategy: Increase awareness and prevention of suicide

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>The following events were held in 2024 that focused on the awareness and prevention of suicide including teens, veterans, law enforcement, and rural communities:</p> <ul style="list-style-type: none"> • Out of the Darkness Suicide Awareness Prevention Walk, held on September 28, 2024, in Washington County. • Together with Veterans Focus Group, held on October 30, 2024, in Greene County • Suicide Prevention and Awareness Summit, held on September 2024, in Greene County. 	<p>Washington County</p> <p>Greene County</p>

Strategy: Improve services for victims of crimes

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>The PCCD established the Victims' Services Advisory Committee (VSAC), pursuant to Chapter 3, Subchapter C of the Pennsylvania Crime Victims Act. Representatives included a diverse group such as victim advocates, survivors, law enforcement, prosecutors, and service providers to ensure comprehensive and inclusive support for victims across Pennsylvania.</p> <p>In 2024, the VSAC underwent strategic planning and conducted a statewide needs assessment that will be published in 2025 and will help to identify gaps in services.</p> <p>PCCD's VSAC was directed by Lt. Governor Austin Davis to gather and disseminate information about the resources, programs, and benefits that help victims of gun violence. To support this effort, PCCD awarded a competitive grant to ICF, Inc. to conduct a</p>	<p>PCCD</p>

comprehensive statewide needs assessment. ICF, Inc. is expected to deliver their final report and recommendations to VSAC and PCCD in April 2025.	
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Strategy: Increase gun safety

SHIP Partner Activities/Successes/Highlights	Organization(s)
Community workers provided safe firearm storage training, educational materials about safe firearm handling and storage, and information on biometric lock boxes for safe quick access. Safe firearm storage messaging was also disseminated through various modalities, including digital marketing.	PA Department of Health (DOH) Penn Presbyterian Medical Center, Philadelphia
The PA DOH distributed gun locks to increase gun safety.	PA DOH
State Health Centers conducted outreach and education on gun locks and distributed zip tie gun locks.	PA DOH, Bureau of Community Health Systems
The PCCD's Office of Gun Violence Prevention is tasked by Executive Order 2024-02 to support the development and implementation of public awareness campaigns and other strategies to increase knowledge and adoption of resources related to gun violence prevention, including firearm safety practices like safer storage and child access prevention strategies, in collaboration with the PA DOH's Division of Violence Prevention, the PA DHS and other key stakeholders.	PCCD PA DOH PA Department of Human Services (DHS)
The PCCD's FY2024 Byrne State Crisis Intervention Program Funding Plan reserved approximately \$1 million in federal funds to support firearm suicide prevention, intervention, and postvention strategies, including safer storage mechanisms and firearm safety education campaigns.	PCCD

Strategy: Reduce violent incidences

SHIP Partner Activities/Successes/Highlights	Organization(s)
The PA DOH provided sexual violence prevention and education programming. Prevention focused on black women and girls, individuals with intellectual disabilities, the LGBTQ community, and older adults.	PA DOH, Violence and Injury Prevention Program
The PA State Police held workshops for police to provide education on responding to individuals in mental health crisis.	PA State Police
The PCCD invested in statewide and local initiatives designed to prevent and reduce violence.	PCCD

Strategy: Increase education on domestic abuse and abuse within families

SHIP Partner Activities/Successes/Highlights	Organization(s)
Purple One provided lunch and learn education to discuss later in life abuse.	Purple One
Purple One provided trainings on how to recognize domestic violence victims, respond appropriately, and refer victims to the best resources.	Purple One
Purple One provided trainings on domestic violence to the Office of Children Youth and Families workers.	Purple One
The PCCD continued to support statewide and local strategies to bolster victims' services and supports for survivors of domestic violence, including evidence-based approaches for reducing domestic violence homicide like the Lethality Assessment Program (LAP).	PCCD PA DHS

Strategy: Increase awareness of domestic violence pertaining to repeat abuse instances including marginalized communities

SHIP Partner Activities/Successes/Highlights	Organization(s)
The YMCA Harrisburg educated victims about the repeat pattern of domestic violence.	YMCA Harrisburg
Orange Circles educated schools about violence prevention and the cycle of violence and the repeat of violence to victims.	Orange Circles
The PCCD implemented Pennsylvania’s STOP Implementation Plan, which guides use of federal Violence Against Women Act funds and supports local STOP Implementation Teams to address sexual assault, dating violence, domestic violence, and stalking.	PCCD

Strategy: Increase collaboration and information sharing among key partners whose work aligns with the 1.2 SHIP Goal and Objectives

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>The SHIP team identified missing key partners and conducted outreach to include these partners on the SHIP goal team.</p> <p>Promotion of the SHIP goal team was conducted through SHIP presentations and distribution of SHIP informational materials.</p>	<p>1.2 SHIP Goal Team</p> <p>PA DOH SHIP Team</p>

Appendix A3:

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

Objectives:

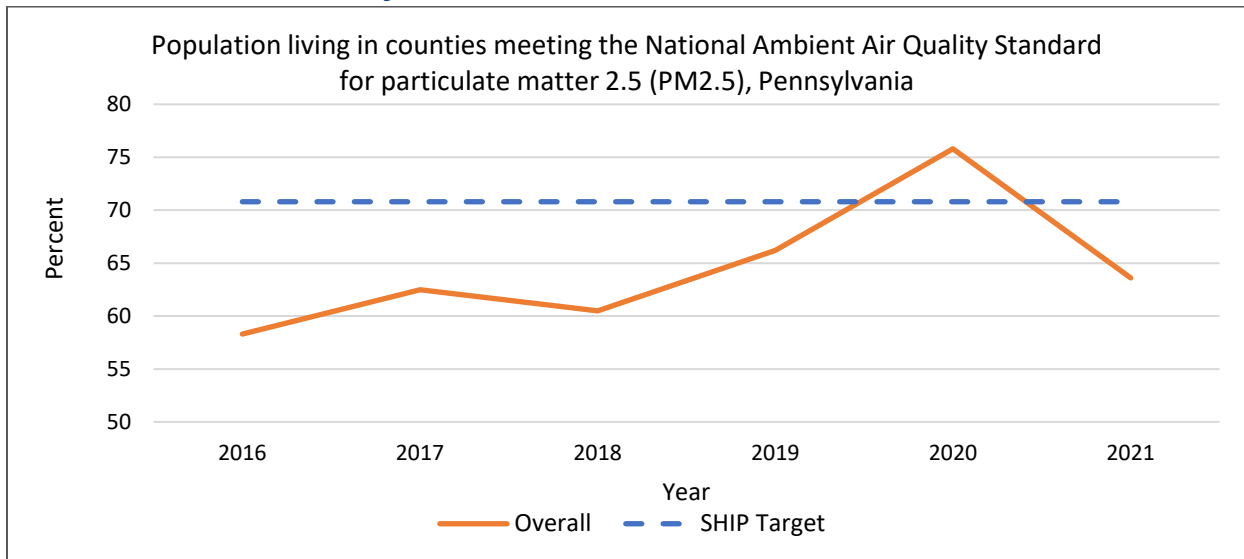
- Increase population living in counties with good air quality
- Reduce number of heat-related hospitalizations
- Increase the number of children tested for lead

1.3 Trends in the SHIP objectives

The three objectives, along with the progress toward the SHIP targets, are detailed below. The most recent available statewide data for the 1.3 objectives are 2021 and 2022. This data can be used to look at previous trends for these objectives and provide an overall view of progress towards the 1.3 SHIP Goal.

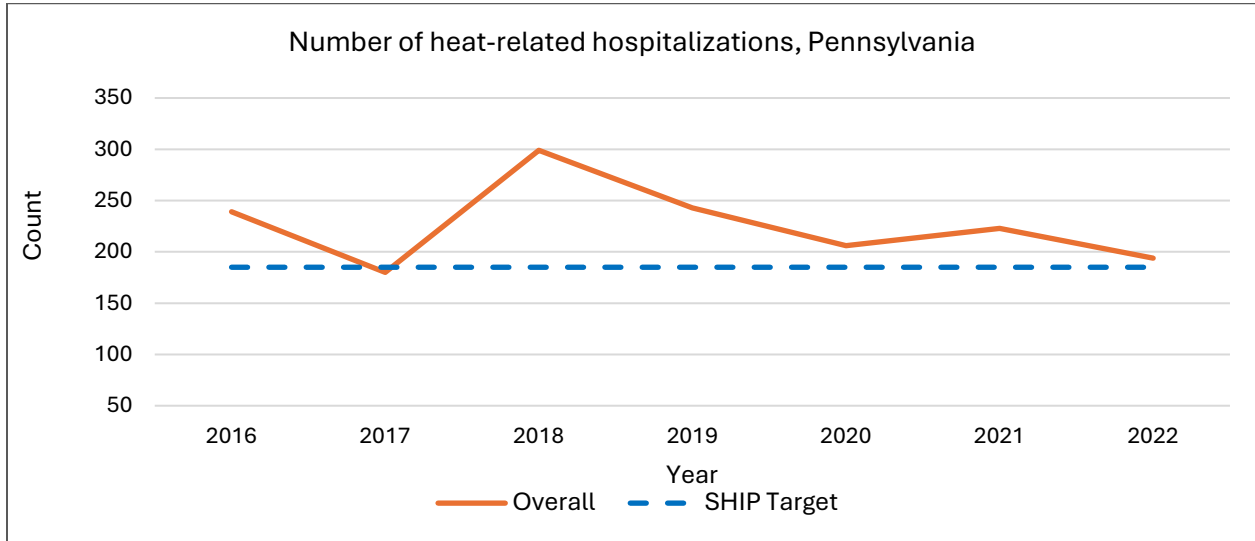
The target year of 2028 reflects the endpoint of the SHIP. Due to varying data availability and reporting lags across indicators, the most recent data available in 2028 will be used to assess progress toward each objective.

Objective 1.3.1: Increase population living in counties meeting the National Ambient Air Quality Standard (NAAQS) for particulate matter 2.5 (PM2.5) from 66.2% in 2019 to 70.8% by 2028



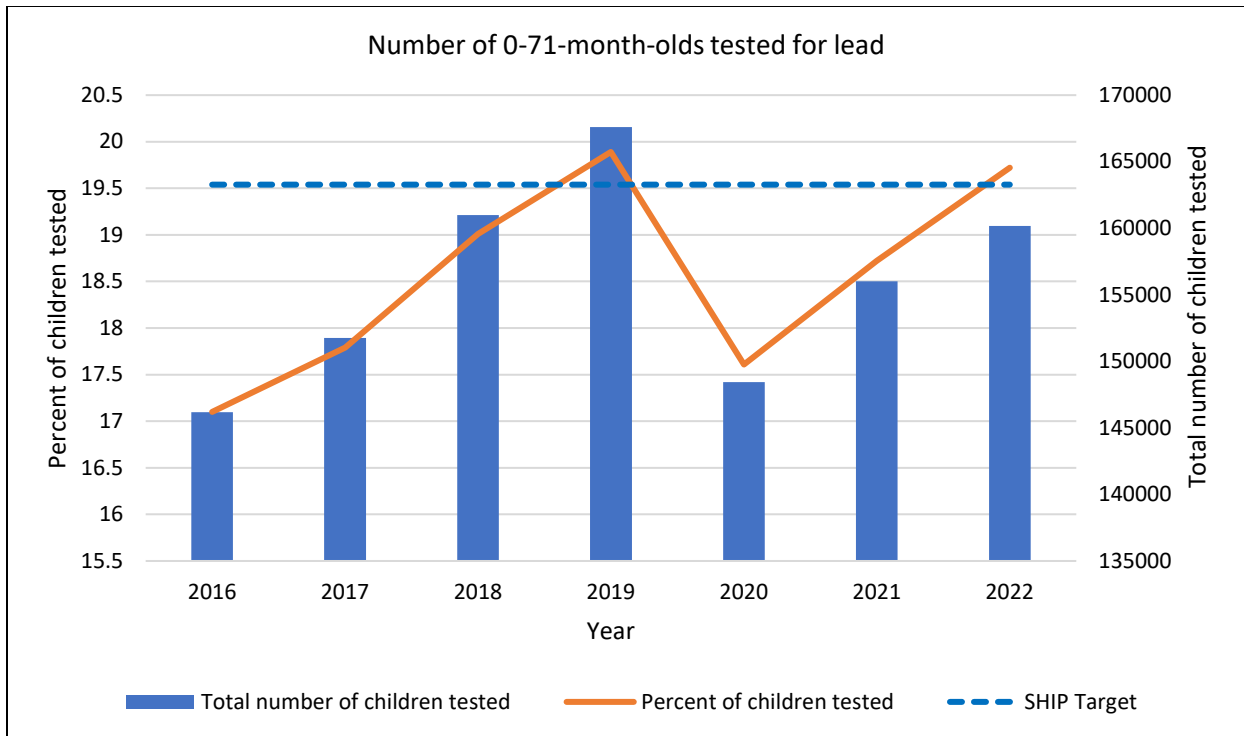
Source: U.S. Environmental Protection Agency data through Enterprise Data Dissemination Informatics Exchange (EDDIE)

Objective 1.3.2: Reduce number of heat-related hospitalizations from 206 in 2020 to 185 by 2028



Source: Environmental Public Health Tracking

Objective 1.3.3: Increase the number of 0–71-month-olds tested for lead from 148,432 in 2020 to 163,275 by 2028



Source: Pennsylvania Childhood Lead Surveillance Annual Report

1.3 SHIP Partner Strategies, Activities, Successes and Highlights

SHIP Goal 1.3 Team members contributed the following information on strategies and activities conducted throughout the Commonwealth in 2024 to improve environmental health. This information includes overviews of activities as well as successes and highlights of the work of SHIP partners and their organizations.

Strategy: Improve air quality in Environmental Justice Areas

SHIP Partner Activities/Successes/Highlights	Organization(s)
The PA Department of Conservation and Natural Resources facilitated the planting of 651 trees in the PA Department of Environmental Protection’s Environmental Justice Areas throughout the state in 2024.	PA Department of Conservation and Natural Resources

Strategy: Educate on air quality for schools in high-industrial areas

SHIP Partner Activities/Successes/Highlights	Organization(s)
The PA DOH developed air quality-related materials to distribute to the PA Department of Education, school administrators, etc.	PA Department of Health (DOH), Bureau of Epidemiology

Strategy: Educate healthcare professionals on climate-related health risks

SHIP Partner Activities/Successes/Highlights	Organization(s)
The PA DOH published climate and health training on Train PA and shared a heat health advisory through the Pennsylvania Health Alert Network, as needed.	PA DOH, Bureau of Epidemiology

Strategy: Develop educational materials to address/prevent heat stress in children

SHIP Partner Activities/Successes/Highlights	Organization(s)
The PA DOH developed kid-friendly and teacher-focused education materials (posters, training module, etc.).	PA DOH, Bureau of Epidemiology

Strategy: Mitigate harmful environmental toxins and create healthier living spaces

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>In 2024, Women for a Healthy Environment:</p> <ul style="list-style-type: none"> • Renovated 15 homes, addressing health hazards. • Held 90 community workshops, educating over 1300 people. • Conducted 52 healthy home assessments. • Delivered 78 workshops for schools and childcare centers. • Certified 30 early learning centers as Eco-Healthy®. • Tested 20 school buildings for lead and/or radon. • Distributed 1,090 lead-removing water pitchers. 	Women for a Healthy Environment
The Pennsylvania Office of Rural Health agricultural safety and health specialist taught about 1,000 growers on the safe use and storage of pesticides.	Pennsylvania Office of Rural Health

Strategy: Increase heat safety awareness, education, and surveillance

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>Participated in an extreme heat tabletop exercise with local partners in Philadelphia and were able to build and maintain connections with Philadelphia partners.</p> <p>Enhanced syndromic surveillance for heat-related illness (HRI) by working with Health Monitoring Systems to refine the HRI definition and develop an internal dashboard.</p>	PA DOH, Bureau of Epidemiology

<p>Heat safety materials for schools were translated into several languages.</p> <p>A presentation was given on extreme heat to the County and Municipal Health Departments.</p>	
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Strategy: Increase collaboration and information sharing among key partners whose work aligns with the 1.3 SHIP goal and objectives

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>The SHIP team identified missing key partners and conducted outreach to include these partners on the SHIP goal team.</p> <p>Promotion of the SHIP goal team was conducted through SHIP presentations and distribution of SHIP informational materials.</p>	<p>1.3 SHIP Goal Team</p> <p>PA DOH SHIP Team</p>

Appendix B

Chronic Disease Prevention Goals and Objectives

The two SHIP chronic disease prevention goals concentrate on reducing chronic disease risk factors and societal impact. These goals center around promoting healthy lifestyles and addressing risk factors such as poor nutrition, inactivity, and tobacco and nicotine use.

Appendix B1

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

Objectives:

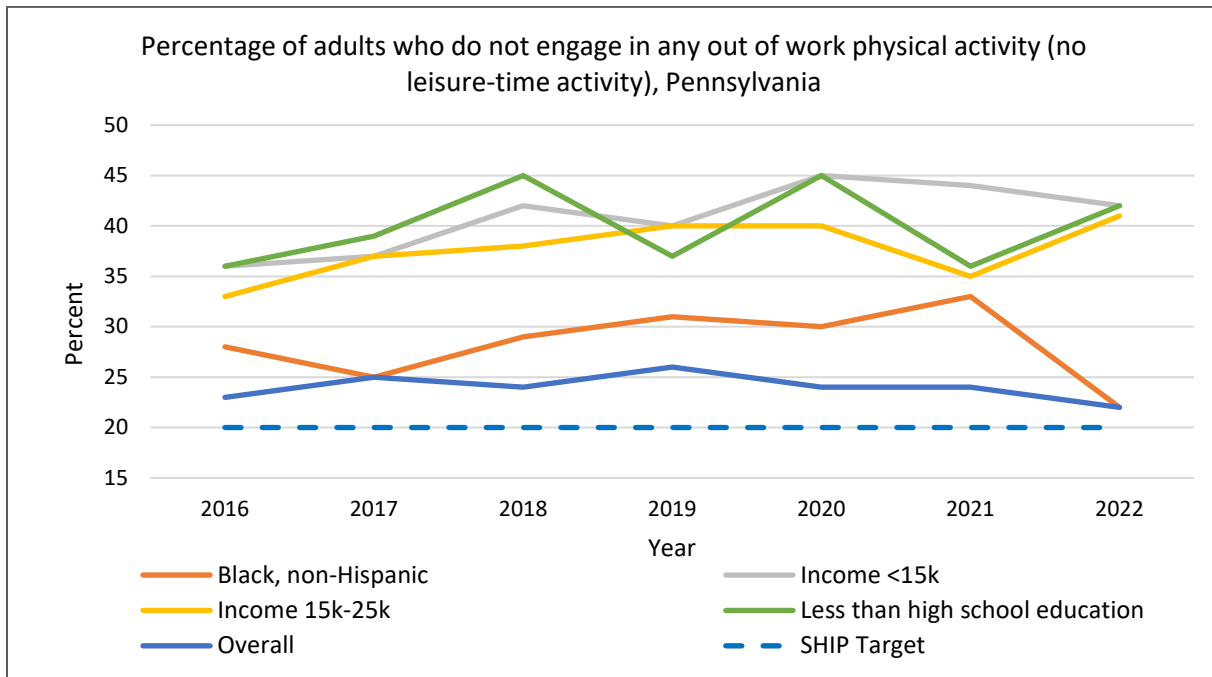
- Increase adult physical activity
- Increase high school student physical activity
- Increase adult fruit and vegetable consumption
- Increase high school student fruit and vegetable consumption
- Reduce adult obesity
- Reduce childhood obesity

2.1 Trends in the SHIP Objectives

The six objectives, along with the progress toward the SHIP targets, are detailed below. The most recent available statewide data for the 2.1 objectives are 2021, 2022, and 2023. This data can be used to look at previous trends for these objectives and provide an overall view of progress towards the 2.1 SHIP Goal.

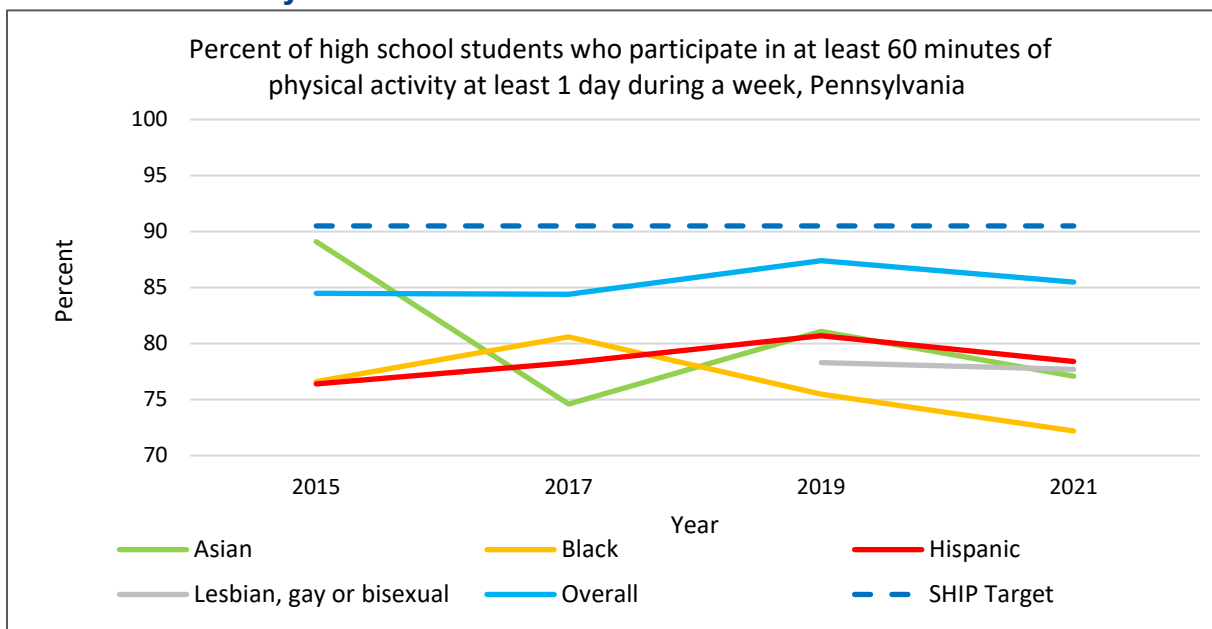
The target year of 2028 reflects the endpoint of the SHIP. Due to varying data availability and reporting lags across indicators, the most recent data available in 2028 will be used to assess progress toward each objective.

Objective 2.1.1: Reduce the percentage of adults who do not engage in any out-of-work physical activity (no leisure-time activity) from 24% in 2021 to 20% by 2028



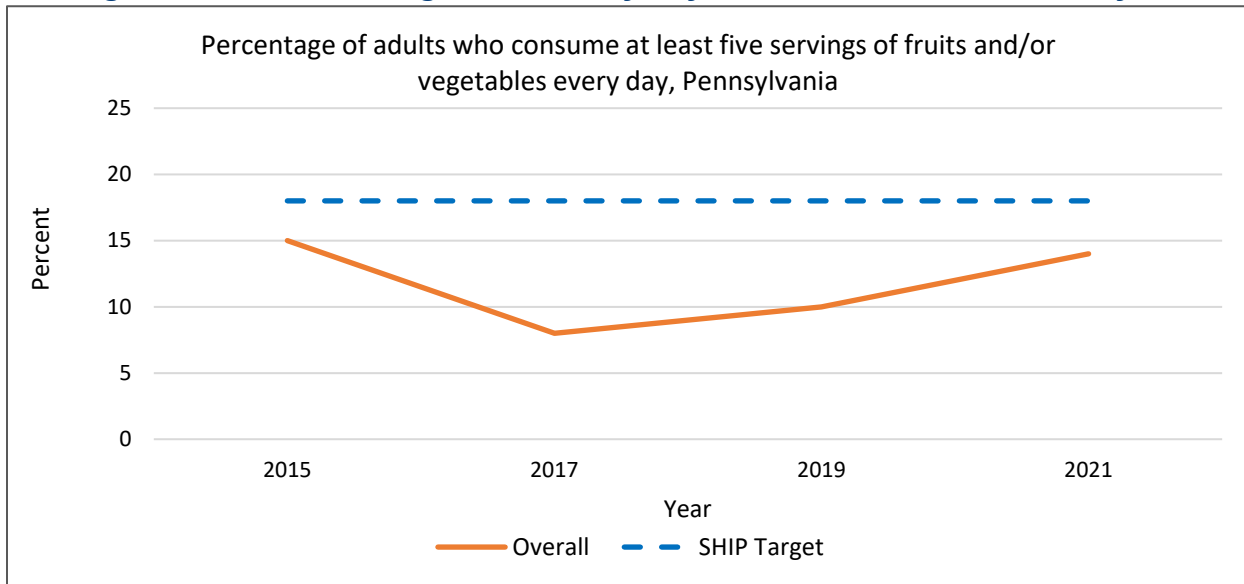
Source: Pennsylvania Behavioral Risk Factor Surveillance System (BRFSS)

Objective 2.1.2: Increase the percentage of high school students who participate in at least 60 minutes of physical activity at least 1 day during a week from 87.4% in 2019 to 90.5% by 2028



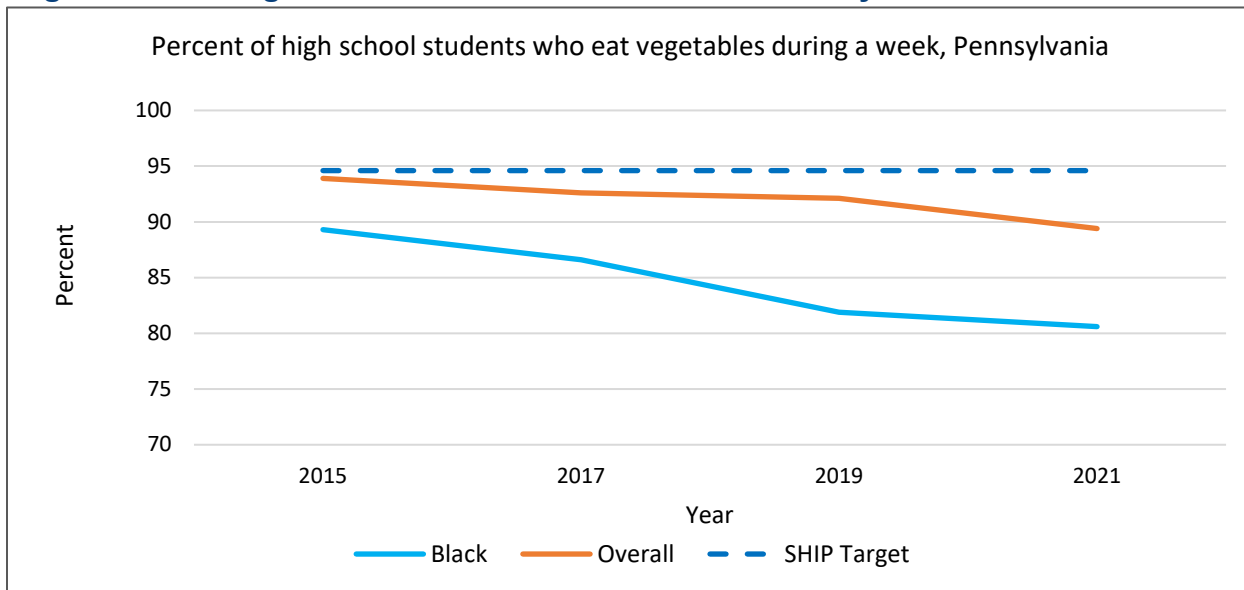
Source: Youth Risk Behavior Survey (YRBS)

Objective 2.1.3: Increase the percentage of adults who consume at least five servings of fruits and/or vegetables every day from 14% in 2021 to 18% by 2028



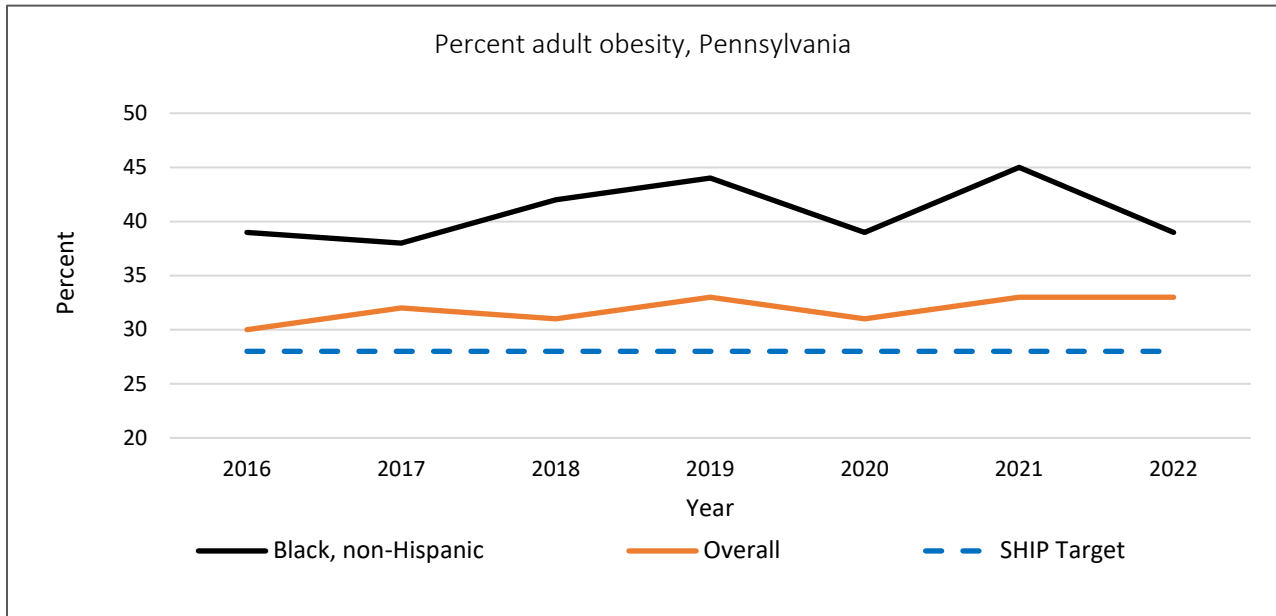
Source: BRFSS

Objective 2.1.4: Increase the percentage of high school students who eat vegetables during a week from 92.1% in 2019 to 94.6% by 2028



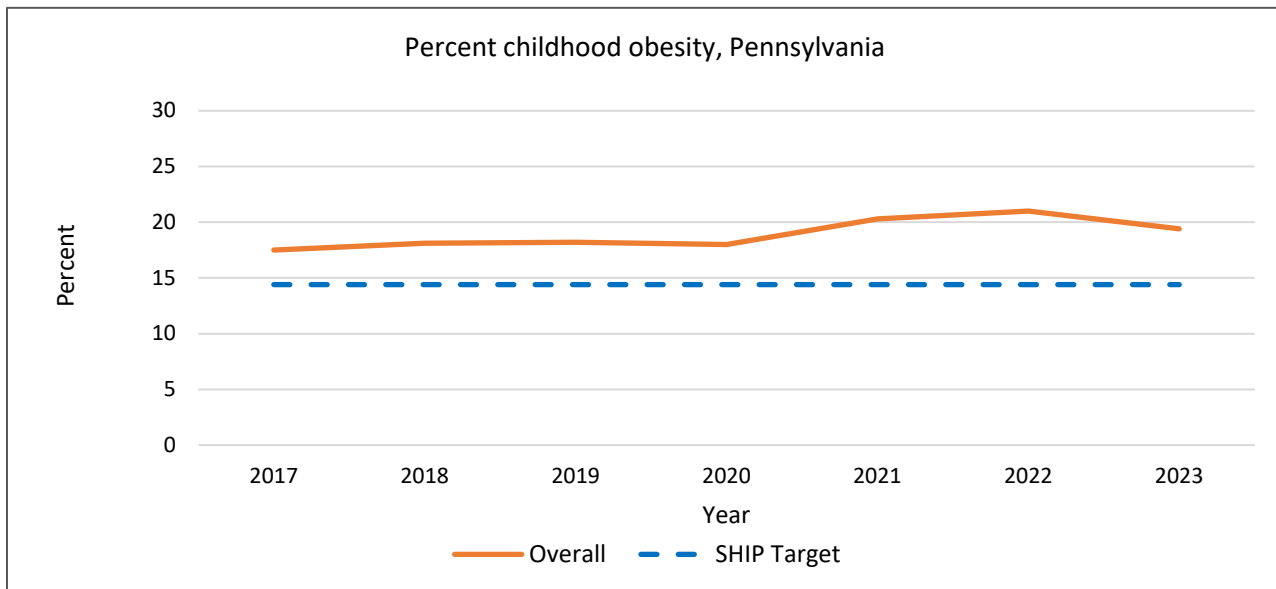
Source: YRBS

Objective 2.1.5: Reduce adult obesity from 33% in 2021 to 28% by 2028



Source: BRFSS

Objective 2.1.6: Reduce childhood obesity from 18.1% in 2017-2018 to 14.4% by 2028



Source: Pennsylvania Department of Health, School Health Statistics

2.1 SHIP Partner Strategies, Activities, Successes and Highlights

SHIP Goal 2.1 Team members contributed the following information on strategies and activities conducted throughout the Commonwealth in 2024 to increase the availability and accessibility of physical activity and affordable nutritious food. This information includes overviews of activities as well as successes and highlights of the work of SHIP partners and their organizations.

Strategy: Combine physical activity opportunities and social support to build, strengthen, and maintain social networks that encourage positive behavior change

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>The PDC planned and promoted a Statewide Active Transportation Summit held in York in late June, with educational sessions, networking, tours, and workshops emphasizing the relationship between active transportation and health.</p> <p>PDC/WalkWorks attended and provided information and a tour about the Social Determinants of Health (SDOH) elements of Active Transportation at the Statewide Health Equity Summit, attended and promoted SDOH/transportation at the Latino Health Summit, and tabled at Boroughs Conference.</p>	<p>Pennsylvania Downtown Center (PDC)</p> <p>PA Department of Health (DOH)</p>

Strategy: Increase access to safe and free/low-cost physical activity opportunities

SHIP Partner Activities/Successes/Highlights	Organization(s)
<ul style="list-style-type: none"> • Get Your Tail on the Trail partnered with 211 and social service organizations. • Created messaging about the importance of incidental Pennsylvania opportunities. • Promoted Get Your Tail on the Trail programs. 	<p>211</p> <p>Get Your Tail on the Trail</p>

Strategy: Increase Primary Care Physicians' prescriptions for exercise

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>The PA DCNR invited primary care physicians to host their own Walk with a Doc.</p> <p>DCNR connected with the DCNR Park Rx committee to compare notes.</p>	<p>PA Department of Conservation and Natural Resources (DCNR)</p>

Strategy: Increase active transportation options

SHIP Partner Activities/Successes/Highlights	Organization(s)
<ul style="list-style-type: none"> • Reached out to Metropolitan and Rural Planning Organizations (MPO/RPOs), PennDOT Districts, counties and municipalities. • The PA DOH coordinated with PennDOT to participate in Connects Program Outreach sessions being held in all 12 PennDOT Districts across the state. WalkWorks presentation slides were developed and approved, and the first three District presentations were completed. Two were in person and one was virtual. • The PA DOH continued to have WalkWorks representation included in Connects Program Outreach sessions. WalkWorks presented at eight additional sessions, four in person, and four virtual. 	<p>PA DOH</p> <p>PA Department of Transportation (PennDOT)</p> <p>WalkWorks</p>
<ul style="list-style-type: none"> • Educated about need to fund active transportation networks proportionately with motor vehicle investments. • Statewide Active Transportation (AT) Advocates participated in ongoing discussions with PennDOT Multimodal, Policy, and Planning Deputates to emphasize the need for commensurate funding and inclusion of sidewalks and accessibility more comprehensively. • Statewide AT Advocates conversations continued with Multimodal, Policy, and Planning. 	<p>PennDOT</p>

Strategy: Encourage walkability, walking, and bicycling for transportation and recreation through programs and improvements in the built environment, including bike and pedestrian infrastructure, equipment such as Bike Repair Stations and Bike Share, and programs like Safe Routes to School and trails within 10 minutes of every Pennsylvanian

SHIP Partner Activities/Successes/Highlights	Organization(s)
<ul style="list-style-type: none"> Promoted Walking School Bus and Bike Bus/Train through education about concept and supports like apps. Recorded presentation about traffic gardens developed by the Montgomery County Office of Public Health using PennDOT Highway Safety Improvement Program (HSIP) funding. 	<p>Montgomery County Office of Public Health</p> <p>PennDOT</p>
<ul style="list-style-type: none"> Considered overlap in future PA DCNR Recreation for All Plan. Opened conversations related to kick-off of the updated DCNR Recreation for All Plan. Participated in DCNR Statewide Comprehensive Outdoor Recreation Plan updates. 	<p>PA DCNR</p>

Strategy: Increase the number of communities with bicycle and pedestrian friendly designations and/or policies, like Complete Streets or Vision Zero

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>Vision Zero Philadelphia coordinated with national certification organizations.</p> <ul style="list-style-type: none"> Communicated with Walk-Friendly Community Program lead and confirmed it is currently unfunded. <p>Vision Zero Philadelphia coordinated with National League of American Bicyclists on a regional advocacy workshop highlighting Bicycle-Friendly America Program that was held in July in Philadelphia.</p> <ul style="list-style-type: none"> Promoted adoption of Complete Streets Policies or Vision Zero Action Plans. 	<p>Vision Zero Philadelphia</p>

<p>Vision Zero Philadelphia developed/built on information available from city and national Vision Zero groups.</p> <ul style="list-style-type: none"> • Bicycle Coalition of Greater Philadelphia held the annual Vision Zero Philadelphia Conference on March 31. <p>https://visionzerophl.com/</p>	
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Strategy: Assist communities in creating Active Transportation Plans, Complete Street Policies, and Vision Zero Plans

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>Provided funding opportunities for Active Transportation Plans (ATPs) from multiple sources (WalkWorks and U.S. Department of Transportation Safe Streets and Roads for All (SS4A))</p> <ul style="list-style-type: none"> • Released 2024 WalkWorks Funding Opportunity Announcement (FOA) for Active Transportation Plans and received and reviewed applications for Active Transportation Planning funds. • Updated and released 2024 WalkWorks FOA for Community Capacity-Building Pre-Planning Program and accepted applications for Capacity-Building Program. <p>Educated about need for ATPs and funding availability.</p> <ul style="list-style-type: none"> • Offered an informational webinar about the WalkWorks ATP FOA and the WalkWorks Capacity-Building FOA. • Tabled at the Latino Health Summit, attended the Statewide Health Equity Summit, and tabled at Boroughs Conference. • A Statewide Active Transportation Summit was held in June and included a keynote on Week Without Driving, Accessibility and Car-Dependency, Pedestrian Dignity Walkshops and other mobile tours, and classroom sessions on AT-related topics. <p>Supported scoping and budget estimates for planning processes.</p> <ul style="list-style-type: none"> • Assistance was provided through the Community Capacity-Building Pre-Planning Program allowing three communities to work with WalkWorks and consultants to develop scope and budget for new ATP applications. 	<p>PA DOH</p> <p>Pennsylvania Downtown Center</p>

<p>Awarded communities with planning funds.</p> <ul style="list-style-type: none"> • Awarded funding to nine communities, announced \$255,000 in awards, and held onboarding meetings. <p>Supported communities through the process of developing plans.</p> <ul style="list-style-type: none"> • Continued to support current cohort of nine WalkWorks planning grant awardees; held onboarding meetings for new cohort. <p>Supported communities in updating and renewing plans.</p> <ul style="list-style-type: none"> • Developed a table of existing ATPs. 	
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Strategy: Increase access to healthy, nutritious foods and beverages, including food banks, community gardens, and farm markets

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>Philadelphia Department of Public Health applied to support implementation of the Philadelphia Food Justice Initiative.</p> <p>Pennsylvania Farm to Child Nutrition Summit was held on June 18, 2024, at Chatham University - Eden Hall Campus, Gibsonia, Pennsylvania (PA Department of Education, Pennsylvania State University, and Pennsylvania Farm to School Network under USDA Farm to School Grant).</p>	<p>Philadelphia Department of Public Health</p> <p>PA Department of Education</p> <p>Pennsylvania State University</p> <p>Pennsylvania Farm to School Network</p>
<p>Philadelphia based promotional campaigns were held to promote farm markets.</p> <p>A Full Futures Action Team Meeting was held in February to define goals for assessing community needs and discuss a timeline and assign individuals to complete project tasks.</p> <p>A Full Futures Action Team Meeting was held in March to review data already in use by school district and community partners.</p>	<p>PA Department of Agriculture</p> <p>PA Department of Education, Division of Food and Nutrition</p>

<p>A Full Futures Action Team Meeting was held in April to review USDA recommended tool kit for community needs assessment.</p> <ul style="list-style-type: none"> Worked to increase the number of schools that participate in the farm to school grant program. 	<p>PA Department of Human Services (DHS), Office of Child Development and Early Learning</p> <p>PA DOH, Division of Nutrition and Physical Activity</p>
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Strategy: Educate on healthy food habits

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>Education Secretary Mumin visited the Bethlehem Library and Greater Valley YMCA in June to highlight the availability of free summer meals which has been promoted on social media.</p>	<p>PA Department of Education</p>
<p>Mom's Meals provided continuing education units for online training sessions about social determinants of health and nutrition, for professionals, social workers, and dieticians. Sessions were provided twice a month and were open to all and free of cost.</p>	<p>Mom's Meals</p>

Strategy: Implement food service guidelines in worksites and community settings

SHIP Partner Activities/Successes/Highlights	Organization(s)
<ul style="list-style-type: none"> Scaled Good Food Healthy Hospitals (GFHH) and supported current participating hospitals to implement food service guidelines. Awarded eight health equity and nutrition security grants to GFHH participating hospitals: https://foodfitphilly.org/wp-content/uploads/2024/08/GFHH-Nutrition-Security-Announcement-screen.pdf. Held GFHH Annual Recognition Ceremony and Taskforce Meeting on September 25, 2024. 	<p>PA DOH</p> <p>The Hospital and Healthsystem Association of Pennsylvania</p> <p>Philadelphia Department of Public Health</p>

<ul style="list-style-type: none"> • Between 7/2024 and 1/2025, a total of 967 technical assistance hours were provided to participating hospitals. • As of December 31, 2024, there were 64 GFHH participating hospitals and 11 health systems, located in 28 counties. 	
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Strategy: Increase number of participants in the school free and reduced meal plans

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>In his February 2024 budget address, Governor Shapiro announced Universal Breakfast will continue. The School Nutrition Association of Pennsylvania and partners met with his staff and were asked to provide a tiered approach to phasing in Universal School Meals.</p> <p>The Pennsylvania Food Policy Council drafted a 2023 Annual Report that included a recommendation for Universal School Meals to address gaps between Income Eligibility Guidelines for free school meals and median household incomes that exceed Guidelines but are not sufficient to prevent food insecurity for children.</p>	<p>Pennsylvania Food Policy Council</p> <p>School Nutrition Association of Pennsylvania</p>
<p>Under a USDA School Breakfast Expansion Grant, the PA Department of Education, Division of Food and Nutrition, awarded \$1,197,445 to 164 Pennsylvania schools to expand the School Breakfast Program and increased the nutritional value of breakfast meals.</p>	<p>PA Department of Education, Division of Food and Nutrition</p>

Strategy: Implement high-impact obesity prevention standards in early care and education state systems and systems supports

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>The Child and Adult Care Food Program (CACFP) Story Map was completed by the PA DOH with support of partners (PA Department of Education and the Office of Child</p>	<p>PA Department of Education</p>

<p>Development and Early Learning) and the Nemours Healthy Kids, Healthy Futures Grant. https://storymaps.arcgis.com/stories/31c4cae2008947af9e195567289807d5</p> <p>Draft licensing regulations are expected to be released in 2025 for public comment.</p>	<p>PA DHS, Office of Child Development and Early Learning</p> <p>PA DOH</p>
<p>The PA DOH, in partnership with Tuscarora Intermediate Unit 11 offered several system support programs: Go NAPSACC (Nutrition and Physical Activity Self-Assessment for Child Care); Early Care and Education Peer Leadership Development; and Create Healthy Futures.</p>	<p>PA DOH</p> <p>Tuscarora Intermediate Unit 11</p>
<p>Keystone Kids Go (KKG) convened bi-monthly to work toward implementing the KKG Action Plan. In September 2024, the KKG met in person for a full day of strategic planning for 2025. https://www.keystonekidsgo.org/.</p>	<p>Keystone Kids Go</p> <p>PA DOH</p>

Strategy: Provide school support via assessment, training and technical assistance on school health policies, and wellness practices and programs

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>Provided technical assistance and training to Erie's Public Schools (EPS) to complete School Health Index (SHI) for all 15 schools in the district and to convene the district wellness council to identify priority areas for improvement.</p> <p>All 15 schools in EPS have completed all modules of SHI and evaluator prepared analysis of data. The District Wellness Manager presented a summary of results to the school board on April 9, 2024. The district convened the district wellness council and ensured representation across Whole School, Whole Community, Whole Child components. EPS also completed an assessment of the district's Out-of-School Time program using the Healthy Eating and Physical Activity Standards 2.0.</p>	<p>Erie's Public Schools</p> <p>Slippery Rock University</p> <p>PA DOH</p>

<p>EPS held the first district wellness council meeting in June 2024 before the school year ended. The district wellness manager presented the results of the SHI and the council brainstormed priority areas of opportunities based on the assessment results.</p> <p>EPS district wellness manager surveyed district wellness council members over the summer to identify top priority goals to include in the 24-25 school year action plan. Six goals were identified via the survey. EPS held the first district wellness council meeting in September 2024. The council had enough participants to lead and form six subcommittees, and each subcommittee will focus on developing and implementing activities to address one of the priority goals.</p> <p>EPS district wellness council formed six subcommittees which met in October and November to develop activities to address the six goals prioritized by the members at the September meeting. In December, each subcommittee submitted final action steps to the District Wellness Manager, who created a combined comprehensive school health and wellness action plan. This action plan will be presented to district leadership in January 2025.</p>	
<p>Convened statewide school wellness coalition representative of all Whole School, Whole Community, Whole Child (WSCC) components and align resources, training, and technical assistance to support schools with WSCC implementation.</p> <p>Subcommittee meetings were held in January 2024 to provide further details of the Center for Disease Control (CDC) nongovernmental organizations technical assistance opportunities. Stakeholders indicated that lack of capacity was a barrier to participation in many of the opportunities. Staff from the PA DOH and the PA Department of Education explored SHAPE America's "Leading Healthy Schools" program and also the WSCC Emotional Well-Being Learning Collaborative offered by the University of Maryland. Engage Health and Physical Education (HPE) in Pennsylvania began collecting program information from stakeholders to create a resource guide for schools. Strategic action planning took place in June 2024 to guide future collaborative activities.</p>	<p>PA Department of Education</p> <p>PA DHS</p> <p>SHAPE PA</p> <p>Other State Agencies</p>

<p>Engage HPE in Pennsylvania held a quarterly all-partner meeting in June 2024. The strategic planning meeting was postponed until August 2024. Connections were made with the out-of-school time (OST) statewide network to begin discussing how Healthy Eating and Physical Activity standards and assessment tools could be used in OST programs.</p> <p>Engage HPE in Pennsylvania held a quarterly all-partner meeting in September 2024. An in-person strategic planning meeting was held in October 2024 and 14 Engage HPE in Pennsylvania members attended. Attendees used CDC data briefs to identify goals related to four priority areas: school nutrition environments, school physical activity/physical education, school health services, and out-of-school time. Engage HPE in Pennsylvania also held an all-partner meeting in December and OPEN Physical Education (PE) presented on the Active Schools model and types of free curriculum available for HPE teachers.</p>	
<p>Offered statewide training on Whole School, Whole Community, Whole Child /Comprehensive School Physical Activity Programs (CSPAP) to develop school capacity to implement strategies and initiatives to increase physical activity opportunities for students.</p> <p>The CSPAP training went live in the Desire to Learn learning management system (D2L) January 18, 2024, and by the end of February, 86 people were enrolled in the course. The training is a way to offer health and physical education teachers’ professional development specific to their subject area. But it is also appropriate for anyone interested in learning how to increase and improve physical activity offerings in the school building by using an evidence-based framework. The training is also relevant for school nurses, classroom teachers, and even administrators. Upon completion, participants received six hours of free Act 48 credits. As of March 31, 2024, 172 teachers and administrators have been trained, and 16 teachers have successfully completed the D2L training.</p> <p>The online, self-paced CSPAP training in D2L experienced a huge jump in enrollment in May thanks to promotion by the Director of the PA DOH’s Division of School Health. At the end of April, about 98 people were registered (mostly Health and Physical Education teachers) for the training. On Friday, May 3, 2024, the Director of the Division of School</p>	<p>SHAPE PA</p> <p>Slippery Rock University</p> <p>PA DOH</p>

Health sent out an email promotion to the listserv of all school nurses in Pennsylvania. Over the weekend, over 100 school nurses registered to take the training and the numbers continued to increase to current enrollment of 372 (majority of the 274 people who signed up since May 3 are school nurses). By the end of June 2024, a total of 382 school staff completed CSPAP training either through in-person, virtual or online events (D2L). Almost half of participants (45.6%) indicated they were likely to make a school health related change in the next 6-12 months because of the training. 94% of participants increased their knowledge because of the training.

Expanding on the CSPAP trainings offered in the 23-24 school year, a Community of Practice (CoP) with a deeper dive into each of the five CSPAP components was offered in partnership with Slippery Rock University's School Wellness Education Department in the 24-25 school year. A total of nine monthly webinars were hosted from September 2024 through May 2025 and open office hours were held in the week following the monthly webinars to provide follow-up technical assistance. The first webinar, "Creating a Sustainable District Wellness Program" was held on September 13 and 43 school staff attended.

Monthly CoP webinars were held in October, November and December, with presentations from subject matter experts on a variety of CSPAP components. Follow-up technical assistance was offered via open office hours. 106 participants completed the online D2L CSPAP training from July-December 2024.

There is a connection with future HPE teachers through partnerships with SHAPE PA (Slippery Rock and Lock Haven Universities). Twenty-six of the attendees at the November CoP event students were from Slippery Rock University and a third of the online CSPAP D2L training completions were from Lock Haven University. Over 180 college students from Slippery Rock University, Lock Haven University and West Chester University attended the SHAPE PA annual conference in November. This was an opportunity to provide pre-service professional development to future HPE teachers.

Strategy: Provide physical activities to increase exercise among targeted population segments with the goal of decreasing obesity related diseases

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>The Wilkes-Barre City Health Department, the Wilkes-Barre Housing Authority, and Misericordia University utilized Public Health Improvement Grant funding to advance opportunities for a weekly wellness program, Walk With A Doc, targeted toward seniors (55 and older) in public housing with limited access to fitness facilities in the Wilkes-Barre area.</p> <p>With a diabetes rate of 35% and 33% of people characterized as obese, a need was identified to increase physical activity among this group. The aged 65 and older group was the fastest growing between 2010 and 2022 with its population increasing by 14.4%.</p> <p>In Wilkes-Barre public housing, there are single people (ages 55 to 65) with no family, limited income and medical conditions that warrant their occupancy. In 2023, one in three adults aged 50–80 (34%) reported feeling isolated from others (29% some of the time, 5% often) in the past year.</p> <p>This program ran from January 2024 through March 2024 with the goal of decreasing obesity related diseases and provided an opportunity for weekly social interaction. Sessions included wellness checks, blood pressure monitoring and balance education offered by a Doctorate program Physical Therapy student. Presentations were held on nutrition, mental health challenges of aging and loss of partners, senior home safety and low impact strength building.</p> <p>Results of this program showed that residents in East End Towers increased their stamina by 10%, gained new acquaintances, and sustained enough interest in the program to continue participating through summer of 2024. This program provided seniors with easy access to a certified professional program run by academic and medical staff, a consistent regularly scheduled class, quality of life tips, improved measurable outcomes regarding health and nutrition, weekly social interactions, and strengthened community partnerships.</p>	<p>Wilkes-Barre City Health Department</p> <p>Wilkes-Barre Housing Authority</p> <p>Misericordia University</p>

<p>The students also received “real world” experience by interacting and caring for a single age demographic with varied backgrounds and personalities.</p>	
<p>The Wilkes-Barre Housing Authority Walk with a Doc and the Wilkes-Barre City Health Department collaborated with the Wilkes-Barre Housing Authority to conduct this program aimed at Seniors. Two separate classes were held in the Winter and Fall of 2024 with an average of six to eight senior residents taking part in an 8-week class.</p> <p>Classes were held in the community room of two low-income housing units and focused on a wellness component that charted the health progress of each user. Seventeen people walked 61 miles from January to November. Blood pressure was measured before each walk and every walk included health education.</p>	<p>Wilkes-Barre City Health Department</p> <p>Wilkes-Barre Housing Authority</p>

Strategy: Increase safe outdoor physical activity

<p>SHIP Partner Activities/Successes/Highlights</p>	<p>Organization(s)</p>
<p>The Wilkes-Barre City Health Department and the Get Your Tail on the Trail (GYTOTT) project utilized Public Health Improvement Grant funding to provide trail counters, also known as step counters, to track Luzerne County residents’ utilization rate of outdoor trails.</p> <p>In Luzerne County, 66% of adults are overweight and 32% of the men and 30% of women report no physical activity per month.</p> <p>Luzerne County has thousands of miles of trails that provide an inexpensive option for physical exercise. GYTOTT helped to increase physical activity and trail usage through friendly, data driven competition. The trail counters allowed individuals to track their exercise, chart progress, achieve their goals, and earn motivating prizes.</p> <p>In three trail counter exercises, there was a count of 1660 clicks, which translated into 830 individuals utilizing three trails in the community. Tracking these trails gave GYTOTT and</p>	<p>Wilkes-Barre City Health Department</p> <p>Pennsylvania Environmental Council</p>

<p>the Wilkes-Barre City Health Department the ability to measure numbers of trail users in the county, get people outdoors, and encourage physical activity. To date, there are 1805 users who are Delaware and Lehigh National Heritage Corridor trail members.</p> <p>https://tailonthetrail.org/</p>	
<p>The PEC promoted over twenty-five outdoor events including the Winter Solstice hike at Nescopeck and the North Pocono Trails, as well as several pop-up events along the Delaware and Lehigh National Heritage Corridor trail.</p> <p>In summer 2024, PEC collaborated with Lackawanna Heritage Valley Authority to conduct trail counter calibration and relocated four counters to new sites along the Heritage Trail. Lock maintenance and data downloads were also performed. All fourteen trail counters were downloaded before removal for hard reset on January 2nd. This made the data more accurate and more easily accessible to partners.</p> <p>The PEC staff participated in the Riverfest event from June 21-23, 2024, and interacted with 210 attendees.</p> <p>There were five dedicated bike rides in 2024. At an event at PEC Headquarters, 100 bicycle helmets for children were distributed.</p>	<p>Pennsylvania Environmental Council (PEC)</p> <p>Lackawanna Heritage Valley Authority</p>

Strategy: Address health disparities related to obesity and nutrition among minority populations

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>The Wilkes-Barre City Health Department utilized Public Health Infrastructure Grant funding to conduct a Health Fair in conjunction with the National Association for the Advancement of Colored People, or the NAACP, Wilkes-Barre branch.</p> <p>The objective of this fair was to increase access to wellness and nutrition programs clinics to engage minority populations to address identified health disparities. This fair was centrally located in Wilkes-Barre City allowing access to information for individuals who</p>	<p>National Association for the Advancement of Colored People Wilkes-Barre Branch</p> <p>Wilkes-Barre City Health Department</p>

<p>are dealing with health disparities. In Luzerne County, the major health disparities concerns include obesity, lack of health insurance, diabetes, and heart disease.</p> <p>More than 300 attendees visited 24 Health Care providers for information on various medical issues including the areas above. This effort gave people with chronic conditions the opportunity to utilize wellness options to improve their health. Insurance vendors were also available to explain health care options for lower income individuals or for those who lost health care.</p> <p>The Health Fair came at the end of the nationally recognized National Minority Health Month to help increase attendance. This annual observance builds awareness about the health disparities that persist among racial and ethnic minorities. This month encourages health departments to attack the issue of health inequities by community education and involvement.</p>	
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Strategy: Increase access to healthy meals for school aged children

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>The Wilkes-Barre City Health Department through the Greater Wyoming Valley Area YMCA (GWVA YMCA) utilized Public Health Improvement Grant funding to distribute 7,024 pounds of produce and other foods to 310 families from July 1 - September 30, 2024. This initiative provided access to healthy food to meet the nutritional needs of children that did not have access to meals in the summer.</p> <p>The GWVA YMCA provided access to free meals from July 1-August 11, 2024, at six locations throughout the county at various locations. Six sites were at the Food and Fun open feeding program provided by Mt. Zion Food Services. During this time, over 90 children were provided food daily, accounting for 2,550 lunches and 2,550 snacks.</p> <p>The GWVA YMCA served 19 days of free breakfasts and lunches to 145-160 youth daily, or about 4,900 meals, from July 1- August 15, 2024, at a summer learning program at Heights Elementary.</p>	<p>Wilkes-Barre City Health Department</p> <p>Greater Wyoming Valley Area YMCA</p>

<p>GWVA YMCA also partnered with the Office of Vocational Rehabilitation to provide four summer workers with disabilities a job coach to help with food prep and packing. This partnership worked so well that all parties agreed to continue it next year.</p> <p>Marywood University dietician interns provided nutrition information, presentations, and nutritious recipes to 251 people during six different events from July 17-August 24, 2024.</p> <p>These initiatives filled a need during the summer months as Wilkes-Barre Area School District children receive 95% of subsidized meals during the school year. The county childhood poverty rate and poverty level for people between the ages of 18 and 59 is higher than the state average rate. The meals were balanced, nutritious and provided access to fresh fruits and vegetables which may not have been available if not for the Public Health Infrastructure Grant funding.</p>	
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Strategy: Increase healthy food distribution

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>In 2024, the Greater Wyoming Valley Area YMCA (GWVA YMCA) distributed 27,821 pounds of food to 919 families. The GWVA YMCA acted as the Wilkes-Barre City Health Department’s Summer Food Service Program Sponsor.</p> <p>The GWVA YMCA provided a “taste and plant” program working in July and August 2024 at one site in the City of Wilkes-Barre, the Wilkes-Barre Family YMCA, and at the White Haven Community Library Food and Fun program.</p>	<p>Wilkes-Barre City Health Department</p> <p>Greater Wyoming Valley Area YMCA</p>
<p>In 2024, the Wilkes-Barre City Health Department sold Supplemental Nutrition Assistance Program, or SNAP, vouchers to Farmer’s Market visitors with access cards. This year, the amount sold was \$3,129 and \$2,772 was redeemed. Unclaimed vouchers stand at \$357 and will be rolled over into 2025.</p>	<p>Wilkes-Barre City Health Department</p>

<p>The Catholic Youth Center provided monthly classes for teens regarding good hygiene and included distribution of personal items and an educational brochure. Over 3,523 personal products were distributed to young people from 182 economically challenged families.</p> <p>The PEC reached 310 individuals and Walk with a Doc reached 17 individuals. 1375 Walkitecture booklets were distributed by the Wilkes-Barre City Health Department and third parties, and the Walkitecture APP had 2115 users. PEC provided consistent and evidence-based programs to increase physical wellness.</p> <p>The Greater Wyoming Valley Area YMCA's Food and Fun in the Park had 296 attendees.</p> <p>The YMCA food distribution program provided 27,821 pounds of food for 919 families.</p> <p>The Wilkes-Barre City Health Department Supplemental Nutrition Assistance Program (SNAP) sold 1564 vouchers to meet the food and nutritional needs of the city.</p> <p>A Preventative Health Educator served on the Luzerne/Wyoming County Area Agency on Aging, Zero Tolerance Suicide Prevention, Live Well Luzerne Committee, the Safe Kids Coalition, the Luzerne County Transportation Authority, the Luzerne County Penn State Extension Council and the Luzerne County Alzheimer's Association.</p> <p>In total, through outreach events, attendance at community partnership meetings, evidence-based subcontractor work, SNAP, and food distributions the Wilkes-Barre City Health Department Preventative Health Bureau had over 52,850 interactions with the public in 2024.</p>	<p>Wilkes-Barre City Health Department</p>
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Strategy: Provide public health educational events on nutrition and exercise

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>The Wilkes-Barre City Health Department utilized Public Health Improvement Grant funding to hold public health and educational events for their 2024 Preventative Health Plan.</p> <p>LUZERNE COUNTY HEALTH and WELLNESS FAIR The Health and Wellness Fair was held in September 2024 and drew 175 residents and 41 vendors. The fair featured a health check, lab tests, doctors, nurses, and a hot meal. The event was held at the Can-Do Park and provided bilingual information to the lower part of Luzerne County.</p> <p>HEALTH AND WELLNESS FAIR 2024 On April 25, the Wilkes-Barre City Health Department participated in the fair by distributing information on diabetes, nutrition, childcare, health insurance options and in cooperation with the Wilkes-Barre Housing Authority housing information. More than 250 people were served in this effort.</p> <p>JUNETEENTH At this event held at Martin Luther King, Junior Park on June 15, a volunteer of the Wilkes-Barre City Health Department welcomed more than 500 visitors. Brochures on nutrition and wellness were distributed.</p> <p>FARMER’S MARKET In 2024, more than 3200 residents were reached at Farmer’s Market between June 21 and November 14. Nutrition education, information on immunizations, and the programs of the Wilkes-Barre City Health Department was provided.</p> <p>HEAD START REGISTRATION DAY The Wilkes-Barre City Health Department participated in the annual Head Start registration day. Bilingual materials were distributed along with educational coloring books,</p>	<p>Wilkes-Barre City Health Department</p>

information on child nutrition, vaccines, and healthy eating and exercise habits. This event served 197 Head Start families.

DOWNTOWN CHILDREN’S DAY

On August 16, the Wilkes-Barre City Health Department participated in the Downtown Business Kid’s Day. Information on healthy eating, early learning and home and school safety was distributed to 118 children who were accompanied by an adult.

WILKES-BARRE SCHOOL DISTRICT NEIGHBORHOOD EVENT

On September 27, the Wilkes-Barre City Health Department staff reached more than 430 middle and high school aged students at two events on the grounds of the Wolfpack Stadium parking lot. Information on nutrition, reading, teen dating, and bullying was presented along with physical activity booklets.

MATTER OF BALANCE (MOB)

The Greater Wyoming Valley Area YMCA (GWVA YMCA) held a MOB class with 13 individuals, five times in September and twice in October at Wesley Village. The GWVA YMCA planned an additional class for October at the Wilkes-Barre Family YMCA.

The Wilkes-Barre City Health Department, through Geisinger’s Trauma Unit, held an 8-week MOB course from September-October 25 at St. John’s Apartments. Seven seniors completed the class.

POWER SCHOLARS

Greater Wyoming Valley Area YMCA held a FREE, six-week summer learning program called Power Scholars Academy (PSA). This program advances academic achievement with a morning of math and literacy taught by certified teachers, and an afternoon of enrichment activities. Scholars rotate through a variety of enrichment activities during the afternoon that focus on the arts, science, technology, career exploration, physical activity and games, health and fitness, and community and career exploration. The program also includes free breakfast, lunch, and snacks.

<p>As possible, field trips and reverse field trips visiting PSA sites expose scholars to a rich array of resources in and around our community. This program served over 120 students.</p>	
<p>FOOD AND FUN IN THE PARK Seven community parks - Hollenback Park, Jefferson Park, Mineral Springs Village, Boulevard Townhomes, Duryea Community Park, the Wilkes-Barre Family YMCA, and White Haven Community Library - conducted physical fitness outreach activities to children under eighteen. 296 students were served, and lunch was provided.</p>	

Strategy: Increase collaboration and information sharing among key partners whose work aligns with the 2.1 SHIP Goal and Objectives

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>The SHIP team identified missing key partners and conducted outreach to include these partners on the SHIP goal team.</p> <p>Promotion of the SHIP goal team was conducted through SHIP presentations and distribution of SHIP informational materials.</p>	<p>2.1 SHIP Goal Team</p> <p>PA DOH SHIP Team</p>

Appendix B2

SHIP Goal 2.2: Reduce the impact of tobacco and nicotine use

Objectives:

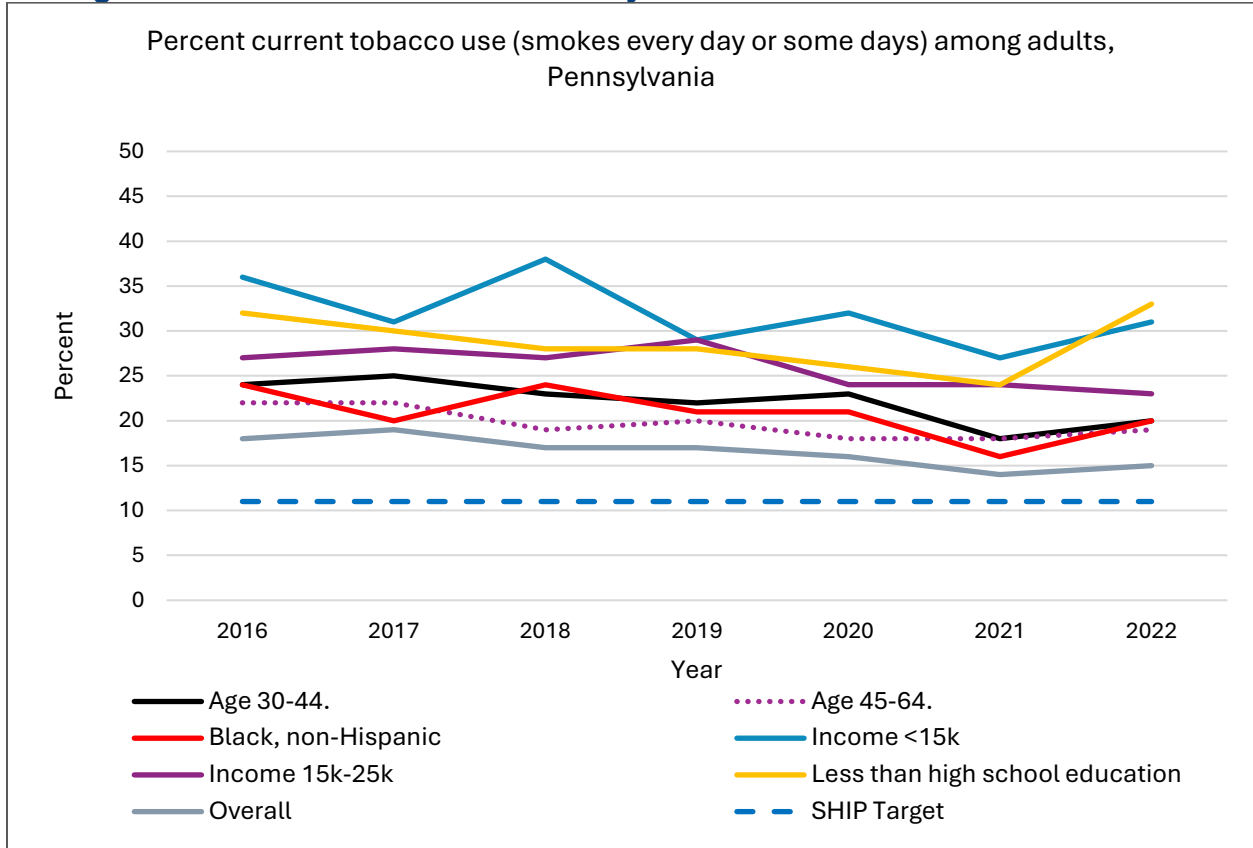
- Reduce tobacco use among adults
- Reduce vaping among high school students

2.2 Trends in the SHIP objectives

The two objectives, along with the progress toward the SHIP targets, are detailed below. The most recent available statewide data for the 2.2 objectives are 2021 and 2022. This data can be used to look at previous trends for these objectives and provide an overall view of progress towards the 2.2 SHIP Goal.

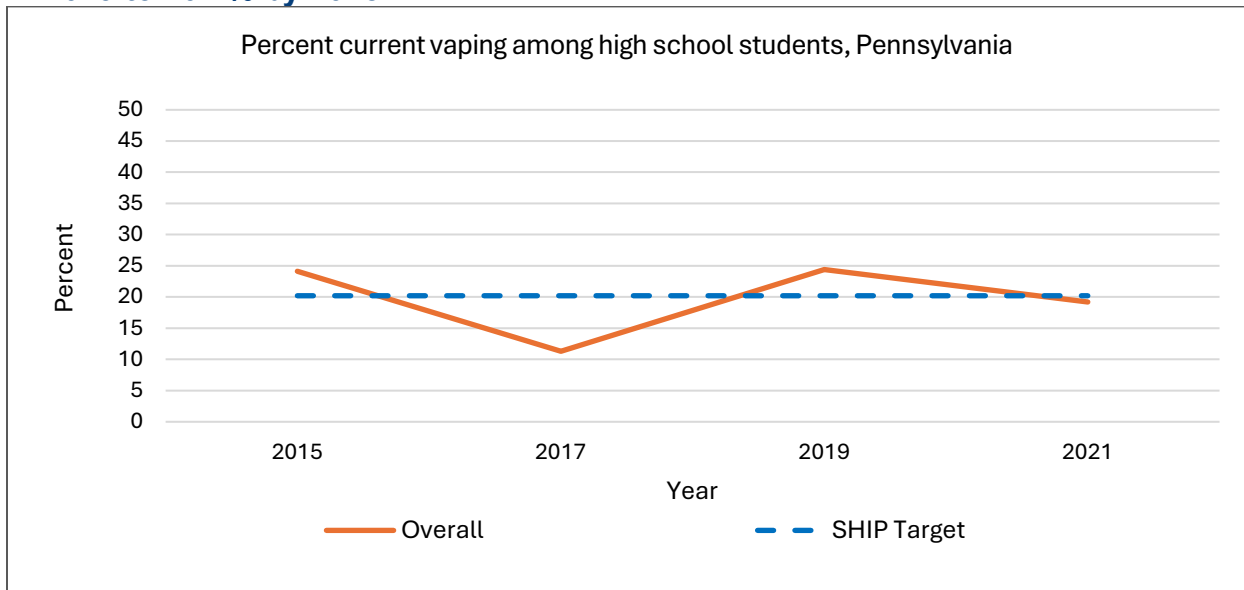
The target year of 2028 reflects the endpoint of the SHIP. Due to varying data availability and reporting lags across indicators, the most recent data available in 2028 will be used to assess progress toward each objective.

Objective 2.2.1: Reduce current tobacco use (smokes every day or some days) among adults from 14% in 2021 to 11% by 2028



Source: BRFSS

Objective 2.2.2: Reduce current vaping among high school students from 24.4% in 2019 to 20.2% by 2028



Source: YRBS

2.2 SHIP Partner Strategies, Activities, Successes and Highlights

SHIP Goal 2.2 Team members contributed the following information on strategies and activities conducted throughout the Commonwealth in 2024 to reduce the impact of tobacco and nicotine use. This information includes overviews of activities as well as successes and highlights of the work of SHIP partners and their organizations.

Strategy: Increase school personnel training on tobacco and vaping cessation programs

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>The PACT received funding from the JUUL Labs Inc Settlement (JLI) to begin implementation of programing in partnership with Pennsylvania school districts.</p> <p>In partnership with the Public Health Management Corporation, the evaluation protocols for CATCH My Breath, INDEPTH and Not On Tobacco were developed for facilitators to complete when they implement a program. All facilitator surveys were required for facilitators to receive their facilitator and facility stipends. Facilitators were to encourage students to complete the surveys, although students can refuse. Additionally, the PACT team internally tracked recruitment efforts and completion of school policy assessments and ACT to Address Youth Cessation. PACT focused primarily on recruitment and training of the CATCH My Breath, INDEPTH and Not On Tobacco programs in FY24 and had great success in recruitment and training. Forty school personnel recruited to become trained in CATCH My Breath, INDEPTH and Not On Tobacco. Fifteen facilitators and 15 facilities received incentives for implementation of programs in FY24. Twenty-one facilitators received “extensions” and completed the program in the Fall 2024 school year.</p> <p>PACT also led the statewide Vaping Epidemic Work Group which met five times throughout FY24. Topics for meetings included guest speaker Dr. Jeremiah Mock, presentation on environmental impacts of e-cigarettes, regional updates and discussions, Day at the Capitol recap and discussions, and vaping epidemic efforts reporting.</p>	<p>Pennsylvania Alliance to Control Tobacco (PACT)</p>

Strategy: Increase coordination of care to address tobacco use and other physical and behavioral health needs

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>Behavioral Health Home Plus (BHHP):</p> <ul style="list-style-type: none"> • The BHHP model focuses on breaking down barriers to the coordinated delivery of primary physical and behavioral health care for individuals with serious mental illness. • BHHP emphasizes getting participants engaged with primary care, addressing modifiable risk factors that lead to poor health outcomes, and closing gaps in care. • BHHP uses a wellness coaching model to address modifiable risk factors that can impact chronic diseases like diabetes and hypertension, and tobacco use disorders. • Outcomes are monitored using a value-based payment model that includes two tobacco metrics: <ul style="list-style-type: none"> ○ Tobacco cessation counseling ○ Varenicline prescriptions 	<p>Community Care Behavioral Health</p>
<ul style="list-style-type: none"> • Community Care Behavioral Health offered training opportunities for Behavioral Health providers on tobacco recovery. • Community Care Behavioral Health partnered with UPMC Dental to provide tobacco focused training for Public Health Dental Hygiene Practitioners within the UPMC dental network. • Community Care Behavioral Health partnered with UPMC Community HealthChoices (CHC) to deliver tobacco recovery training and resources for CHC providers and members. 	<p>Community Care Behavioral Health</p>

Strategy: Remove remaining Clean Indoor Air Act (CIAA) exemptions

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>The PACT worked with members of the Pennsylvania legislature in 2024 to educate on the importance of changing the CIAA exemptions. House Bill 1657 was tabled in the House of Representatives on June 11, 2024.</p> <p>PACT educated lawmakers and their staff on the importance of the CIAA and will reintroduce the bill when the legislature returns to session in January 2025.</p>	PACT
<p>The goal team worked to identify new partnerships to create consensus and support, such as the Pennsylvania Restaurant and Lodgers Association and casino employees.</p>	2.2 SHIP Goal Team

Strategy: Support emergent PA DOH and PACT initiatives

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>The goal team engaged SHIP members to support PACT activities, such as Day at the Capitol event, legislative visits, and other communication and education.</p>	2.2 SHIP Goal Team

Strategy: Increase awareness and utilization of the PA Free Quitline

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>The PA DOH provided virtual educational materials and resources for healthcare providers on the Pennsylvania Free Quitline.</p>	PA DOH
<p>The PA DOH provided virtual information on the Pennsylvania Free Quitline, including what to expect when calling the Quitline and what is offered by the Quitline for individuals who want to quit tobacco and nicotine use.</p>	PA DOH

The goal team promoted Pennsylvania Quitline media campaigns and e-referral integration.	2.2 SHIP Goal Team
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Strategy: Launch and promote evidence-based mass media campaigns to reduce tobacco and vaping use

SHIP Partner Activities/Successes/Highlights	Organization(s)
The Philadelphia Department of Public Health promoted the Tobacco Recovery is Recovery Media campaign toolkit - Pennsylvania's Statewide Tobacco-Free Recovery Initiative https://tobaccofreerecoverypa.com/wp-content/uploads/2023/10/2023_Tobacco-Recovery-is-Recovery-Media-Campaign-Social-Media-Toolkit.pdf	Philadelphia Department of Public Health
The goal team coordinated with SHIP partners to promote current and future state-wide/regional media campaigns and obtain resource contributions from partner agencies.	2.2 SHIP Goal Team

Strategy: Increase youth oriented vape-free spaces, vaping treatment and vaping education

SHIP Partner Activities/Successes/Highlights	Organization(s)
The Philadelphia Department of Public Health promoted tobacco and vape-free policies in public spaces.	Philadelphia Department of Public Health

Strategy: Enhance provider competence to provide tobacco use disorder treatment by increasing training to physical health, behavioral health and dental providers

SHIP Partner Activities/Successes/Highlights	Organization(s)
The Pennsylvania Alliance to Control Tobacco increased awareness of The American Lung Association's recently published toolkits for Dentists. https://www.lung.org/getmedia/0a65a28c-1e71-470b-ac40-ea33326e7e03/OralHealthToolkit-2024DEC.pdf	Pennsylvania Alliance to Control Tobacco

Penn Medicine and the PA DOH provided virtual advanced tobacco training scholarships for certification of behavioral health providers.	Penn Medicine PA DOH
University of Pennsylvania, Penn Medicine, provided Tobacco Treatment Specialist Training to help behavioral health providers develop advanced skills in tobacco dependence treatment.	University of Pennsylvania, Penn Medicine

Strategy: Maintain or increase Master Settlement Agreement (MSA) funding to support tobacco prevention and control activities

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>Day at the Capitol 2024 took place on May 7, 2024, and focused on comprehensive clean indoor air policies, Master Settlement Agreement funding sustainability, and stock albuterol legislation. The PACT utilized an app to store important documents for advocates, legislative visit schedules, events during the day - including keynote speaker Sterlen Barr and a press conference - in addition to providing information via email ahead of the event. Advocates visited 78 legislators during Day at the Capitol 2024. Groups found that 31% of Pennsylvania legislators indicated support of sustaining funding of Tobacco Control Programming, and 49% of Pennsylvania legislators were supportive of the Compressive Clean Indoor Air Ask.</p> <p>PACT advocates had a total of 355 visits with legislators in 2024.</p>	PACT

Strategy: Increase collaboration and information sharing among key partners whose work aligns with the 2.2 SHIP Goal and Objectives

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>The SHIP team identified missing key partners and conducted outreach to include these partners on the SHIP goal team.</p> <p>Promotion of the SHIP goal team was conducted through SHIP presentations and distribution of SHIP informational materials.</p>	<p>2.2 SHIP Goal Team</p> <p>PA DOH SHIP Team</p>

Appendix C

Whole Person Care Goals and Objectives

The four SHIP whole person care goals concentrate on increasing access to culturally humble whole person care through the lifespan. The goals center around increasing access to adequate and quality health care, improving mental health and substance use outcomes, chronic disease management, and maternal and infant health outcomes.

Appendix C1

SHIP Goal 3.1: Increase access to medical and oral health care

Objectives:

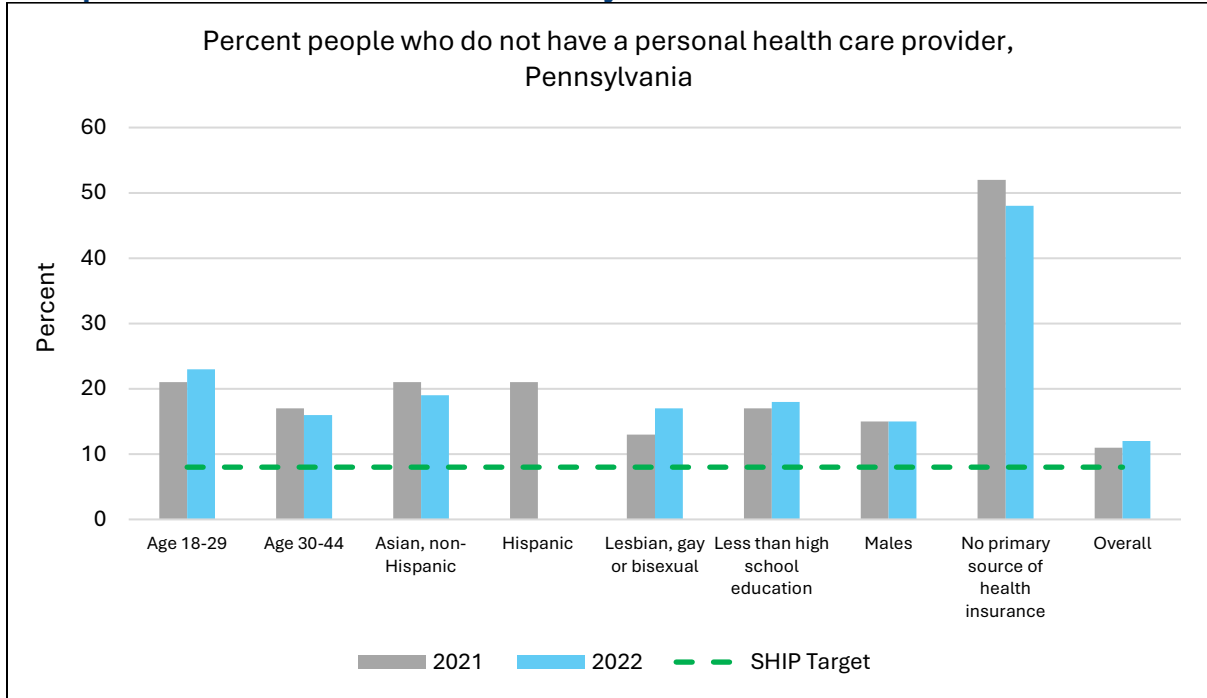
- Reduce the number of people who do not have a personal health care provider
- Increase dentist visits

3.1 Trends in the SHIP objectives

The two objectives, along with the progress toward the SHIP targets, are detailed below. The most recent available statewide data for the 3.1 objectives is 2022. This data can be used to look at previous trends for these objectives and help to provide an overall view of progress towards the 3.1 SHIP Goal.

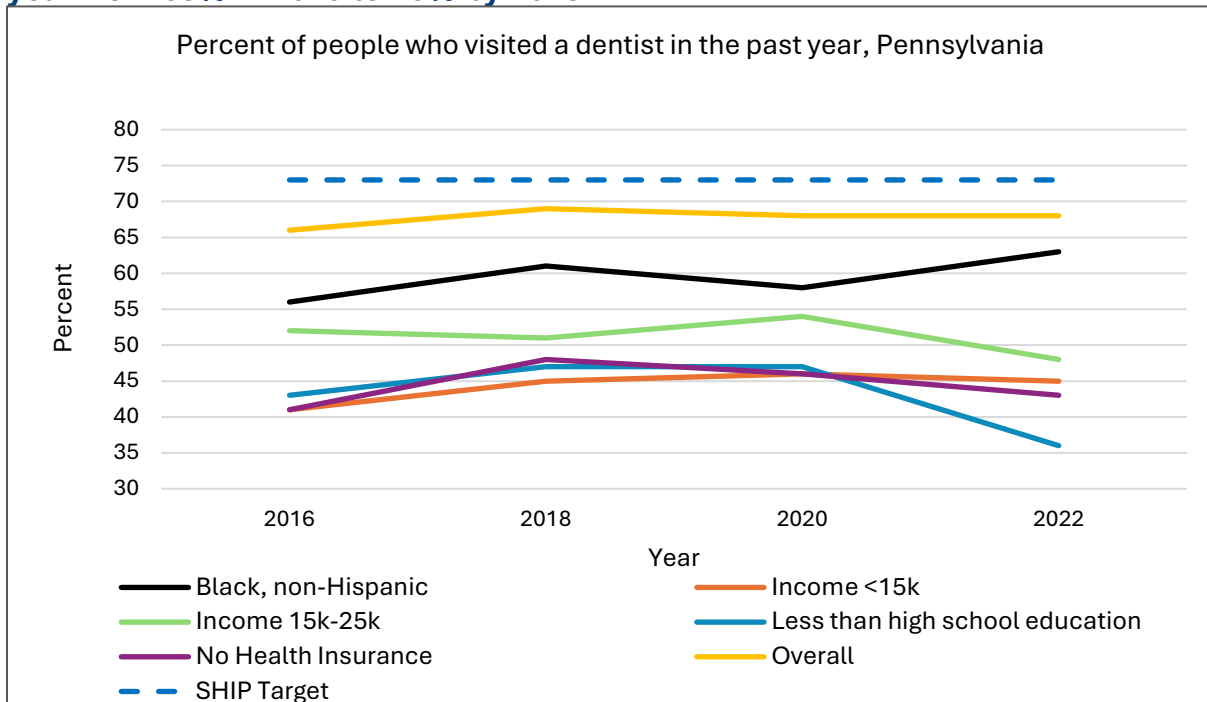
The target year of 2028 reflects the endpoint of the SHIP. Due to varying data availability and reporting lags across indicators, the most recent data available in 2028 will be used to assess progress toward each objective.

Objective 3.1.1: Reduce percentage of people who do not have a personal health care provider from 11% in 2021 to 8% by 2028



Source: BRFSS

Objective 3.1.2: Increase percentage of people who visited a dentist in the last year from 68% in 2020 to 73% by 2028



Source: BRFSS

3.1 SHIP Partner Strategies, Activities, Successes and Highlights

SHIP Goal 3.1 Team members contributed the following information on strategies and activities conducted throughout the Commonwealth in 2024 to increase access to medical and oral health care. This information includes overviews of activities as well as successes and highlights of the work of SHIP partners and their organizations.

Strategy: Increase training and education for health care providers

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>Woods System of Care is committed to sharing its expertise to train current providers as well as the next generation of providers in primary, oral and behavioral health to better serve individuals with intellectual and/or developmental disabilities, autism, and complex medical and behavioral health needs.</p> <p>In 2024, Woods System of Care:</p> <ul style="list-style-type: none"> • Held primary care trainings for: Emergency room residents from Nazareth and St. Mary’s Medical Center; Pennndel special education teachers; and family practice residents from St. Mary’s Medical Center. • Trained over 50 interns at the Medical Center at Woods in Langhorne, including Nurse Practitioner students, from LaSalle University, Temple University, University of Pennsylvania, St. Joesph’s University, and Gwynedd Mercy. • Trained 10 fellows at Penn Dental Medicine at Woods in Langhorne, Pennsylvania in Advanced Education in General Dentistry to serve as primary care providers for oral health for people with medically complex and specialized health care needs with a combination of clinical and didactic coursework. 	<p>Woods System of Care</p>
<p>In 2024, the Pennsylvania Office of Rural Health held the following continuing education events:</p> <ul style="list-style-type: none"> • 2024 Community and Public Health Conference with 250 in attendance • 2024 Grant Writing Webinar series with 40 in attendance • 2024 Rural Health Care Transformation Summit with 100 in attendance 	<p>Pennsylvania Office of Rural Health</p>

Strategy: Integrate dental, medical, and behavioral health services to create better health outcomes for individuals with complex needs

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>On November 20, 2024, the Pennsylvania Charitable Healthcare Coalition held their first in-person conference since 2019, specifically for staff working in free and charitable clinics which serve uninsured and underinsured Pennsylvanians. This included a breakout session specifically encouraging strategies to incorporate dental care into primary care visits.</p>	<p>Pennsylvania Charitable Healthcare Coalition</p>

Strategy: Integrate behavioral health and oral health into primary care practice, including integrating patient navigators and community health workers

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>Collaborated with the Community Health Worker (CHW) Collaborative to gather information on the following:</p> <ul style="list-style-type: none"> • CHW employer perspective of availability of care for physical, dental and behavioral health • CHW employer rating of resources available to support CHWs connecting patients to physical, dental and behavioral health • Percentage of clients being referred to each type of care by CHWs • Common barriers faced when assisting clients with accessing each type of care: <ul style="list-style-type: none"> ○ Top three identified issues to access physical care are lack of transportation, lack of insurance, and lack of available appointments. ○ Top three identified issues to access dental care are lack of transportation, lack of insurance, and lack of providers. <p>Data was shared by the CHW Collaborative. This is not their interpretation of the data or official report:</p> <ul style="list-style-type: none"> • CHWs provide services in all 67 counties. • See data here: CHW Employer Survey Data 03.19.24.pptx 	<p>3.1 SHIP Goal Team</p> <p>Community Health Worker (CHW) Collaborative</p>

This information was shared with Pennsylvania Association of Area Agencies on Aging.	
Pennsylvania Medicaid Managed Care Organizations shared the full CY2023 provider missed opportunity report in April 2024 with medical providers. This report included a list of all members that had primary care physician visits in 2023 and ended the year without a dental visit. Providers were encouraged to educate their patients on the importance of dental care and refer to dental providers.	Pennsylvania Medicaid Managed Care Organizations
Meetings were conducted and scorecards were reviewed for several measures including the collaboration between physical and dental health.	Pennsylvania Medicaid Managed Care Organizations

Strategy: Promote oral health to children and adults

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>In 2024, PCOH:</p> <ul style="list-style-type: none"> • Exhibited at 24 events • Reached 3,361 people • Presented at 43 events • Provided nearly 50 hours of presentations to 2,156 people • Shipped 4,299 pieces of oral health materials and had 2,465 resources downloaded through the PCOH clearinghouse and website. Materials included general oral health information, tobacco and nicotine cessation, prevention, increasing access, fluoride, and workforce. • PCOH was named a 2024 Highmark Bright Blue Futures Rising Star. This award recognizes extraordinary nonprofits that are advancing health equity. Nearly 250 organizations applied. • In April, PCOH partnered with Penn Dental Medicine to host “Celebrating 70 Years of Smiles in Philadelphia,” which included a water tour, awards luncheon, continuing education course, and water presentation. Stakeholders continue to 	Pennsylvania Coalition for Oral Health (PCOH)

<p>connect PCOH with local advocates to fight fluoridation rollback threats and share oral health information.</p> <ul style="list-style-type: none"> • PCOH maintains a water fluoridation map on their website. Due to the national conversation on community water fluoridation (CFW), traffic tripled from October to November. • PCOH released a statement affirming CWF as a safe and effective oral health prevention measure, released new documents to help community members understand CFW, and maintained a statewide taskforce to promote and retain CWF access at the community level. 	
<p>Cavity Free Kids events were held to provide education on the importance of sealants and fluoride.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>Public health dental hygiene practitioners attended various community events to provide dental education.</p> <p>A pediatric interactive dental activity was created to educate children on proper brushing/ flossing techniques and diet. This module engaged children through games, hands-on activities and fun quizzes to encourage maintaining oral health.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>

Strategy: Increase the availability of oral health educational materials

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>Tracked the number of individuals and organizations that request and use oral health education materials through the PCOH Clearinghouse.</p>	<p>PCOH</p>
<p>The PCOH offered free resources that can be shared directly with community members to help them connect with dental care:</p> <p>Finding Dental Care resource available in English and Spanish: https://paoralhealth.org/wp-content/uploads/2023/04/Finding-Dental-Care-9.pdf</p>	<p>PCOH</p>

<p>Medicaid dental benefit pamphlet available in English and Spanish: https://paoralhealth.org/wp-content/uploads/2024/07/Medicaid-Patient-Tri-Fold-1.pdf</p>	
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Strategy: Increase access to dental screening and sealants in children

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>Pennsylvania school sealant programs continued to grow this year; in the 2023-2024 school year more students were screened and received sealants than ever before. The nine participating programs screened 2,029 students and placed 7,831 sealants on 1,493 children in 90 schools.</p>	<p>PCOH PA DOH Oral Health Program</p>
<p>The PCOH and the Pennsylvania Dental Hygienists' Association created an education document to share with public health dental hygiene practitioners (PHDHPs) and school districts to assist their understanding of the changes made to mandated oral health screenings with Act 55. On December 14, 2023, Act 55 was signed into law in Pennsylvania. Act 55 amended the language of school-based "dental examinations" to "dental screenings," and enables PHDHPs to complete the mandated dental screenings.</p>	<p>PCOH Pennsylvania Dental Hygienists' Association</p>
<p>Public health dental hygiene practitioners partnered with pediatric dentistry offices to provide infant oral exams to non-compliant members ages 0-2.</p> <p>Visits were provided to Head Start Centers which included presentations of age-appropriate information as an introduction to a dentist and a dental office, oral hygiene instruction, nutritional concerns and good health habits. All children at the Head Start center participated in the presentations and those children whose parents provided consent had a dental assessment completed by a dentist, practiced tooth brushing techniques, and had a fluoride application given by the public dental health hygienist.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>Public health dental hygiene practitioners provided outreach to pediatric members to help them overcome barriers, provide oral health education, and assist member households</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>

<p>with establishing dental homes at practices so members can receive long-term care from the same provider.</p> <p>Members aged 3 - 17 years old who were due for a well-child visit were targeted for outreach. During outreach, these members received education about the importance of scheduling a dental visit and received additional education and appointment assistance if interested.</p>	
<p>Partnerships with Federally Qualified Health Centers were used to conduct joint wellness days. Public health dental hygiene practitioners and Community Quality Engagement Teams outreached to members to provide education, address barriers, and schedule members for the event where they receive their well-care visit and preventive dental visit within one office.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>

Strategy: Increase affordable access to health care

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>The PCOH leads a Community Water Fluoridation Task Force, Family Oral Health Collective Task Force, Medicaid Adult Dental Benefit Workgroup, Oral Health Workforce Community of Practice, and School Sealant Program Task Force. These groups come together regularly to share ideas and help direct programming. In particular, the Medicaid workgroup was key in advocating for legislation to restore dental coverage for Pennsylvanians enrolled in medical assistance. House Bill (HB) 1417 from the 23-24R Legislative session would have restored the adult dental benefit in Medicaid, a critical need to support both patients and providers. While HB 1417 did not pass during this session, it did successfully pass the House with bipartisan support. This is the farthest that the legislation to restore the benefit to its pre-2011 condition has made it.</p>	<p>PCOH</p> <p>Community Water Fluoridation Task Force</p> <p>Family Oral Health Collective Task Force</p> <p>Medicaid Adult Dental Benefit Workgroup</p> <p>Oral Health Workforce</p> <p>Community of Practice</p>

	School Sealant Program Task Force
Pennie ended open enrollment in 2024 with 434,571 Pennsylvanian's enrolled in coverage for plan year 2024. This represents a 17% increase in total enrollments over the previous year. This includes a 23% increase in dental enrollments over the previous year.	Pennie
The Pennsylvania Charitable Healthcare Coalition relaunched their website, complete with an up-to-date listing of all free and charitable clinics in Pennsylvania with live links to each clinic's website. The clinics are listed by the counties they serve. https://www.pacharitablehealth.org/cliniclocations	Pennsylvania Charitable Healthcare Coalition
The Pennsylvania Charitable Healthcare Coalition launched a one-year Google ad campaign in July 2024 to recruit both clinical and non-clinical volunteers to assist in the provision of patient care and administrative support in free and charitable clinics in Pennsylvania. Ads run through August 2025. Prospective volunteers complete a short form that is sent to Pennsylvania Charitable Healthcare Coalition and staff refer appropriate volunteers to clinics in their area. Whether the clinic or volunteer proceeds through onboarding, training and volunteering is not managed by Pennsylvania Charitable Healthcare Coalition.	Pennsylvania Charitable Healthcare Coalition
The Pennsylvania Charitable Healthcare Coalition partnered with the Pennsylvania Health Access Network to provide a webinar in September 2024 to free and charitable clinics to review who is eligible for Medicaid programs, Children's Health Insurance Program, or Pennie coverage, and provide a reminder about dates for the open enrollment period. Additionally, staff at Pennsylvania Health Access Network are trained to help people understand what options they qualify for, how to understand financial assistance and compare plans, and how to apply; and are available to assist patients at free and charitable clinics.	Pennsylvania Charitable Healthcare Coalition Pennsylvania Health Access Network
The PCOH developed two free resources dedicated to increasing dental services for Medical Assistance. One is dedicated to ensuring adults understand current MA coverage and the other is for providers to encourage Medical Assistance participation.	PCOH

Since 2018, PCOH tracked dental services delivered through free and charitable clinics. A 2023 survey highlighted 10,000+ individuals served, 47,000+ dental procedures, and \$5.6 million provided in dental service.	PCOH
The PA DHS offered a training session for dental offices to help providers and staff learn more about the Medicaid enrollment process.	PA DHS

Strategy: Increase the oral health workforce

SHIP Partner Activities/Successes/Highlights	Organization(s)
Dental and dental hygiene programs invited PCOH to present to students about public health career opportunities, caring for the older adult population, advocacy, and other topics. We reached nearly 650 students through our programming this year.	PCOH
The PCOH and partners reached over 1,200 high school students at events this year to talk about oral health careers and educational opportunities. Beyond that, PCOH connected with school counselors and other adults who work with students on career planning.	PCOH
The PCOH awarded grants through the Appalachian Regional Commission and McElhattan Foundation to continue addressing dental workforce priorities in 2025, with a focus on the dental assisting workforce.	PCOH

Strategy: Increase training and educational opportunities for oral health providers

SHIP Partner Activities/Successes/Highlights	Organization(s)
The PCOH launched an inaugural training opportunity. The Dental Assisting Radiology Training (DART) Program facilitates online instruction from a certified dental assisting instructor to assist current dental assistants with preparing and passing the Dental Assisting National Board Radiation Health and Safety exam. The goal is to support the	PCOH

dental assistant workforce and ensure the dental providers are practicing at the top of their scope.	
The PCOH attended three water operator association conferences this year to talk about community water fluoridation. Pennsylvania water operators are now able to earn continuing education for taking Fluoridation Learning Online, an online course housed on the PCOH course portal about fluoridation training through the Centers for Disease Control and Prevention.	PCOH
The public health dental hygiene practitioners dental care management team developed a dental office simulation activity to share with dental and dental hygiene students at the University of Pittsburgh School of Dental Medicine. The training helped students to conceptualize and understand the dynamics of office environments and helped to promote teamwork and relationships between all people in a practice.	Pennsylvania Medicaid Managed Care Organizations

Strategy: Increase the percentage of certified community health workers (CHW) who offer oral health information and dental referrals to their clients

SHIP Partner Activities/Successes/Highlights	Organization(s)
The PCOH researched if all training providers included training on oral health information. There is also a free community health worker course offered on their website to earn continuing education credits.	PCOH

Strategy: Increase access to dental care to improve oral health outcomes for vulnerable populations

SHIP Partner Activities/Successes/Highlights	Organization(s)
Primary Health Network initiated a dental integration program at the Sharon Medical Group Primary Care location in Mercer County. A public health dental hygiene practitioner provided screenings and cleanings in a primary care setting.	Primary Health Network

<p>A dental van was utilized to hold community dental events. Sites were selected based on targeted zip codes with high volumes of members overdue for a dental exam. The quality outreach team reached out to members with dental and well visit care gaps to schedule appointments for each event and reminder calls were made the day prior to confirm all appointments. Community dental events are seasonal and are typically held in the summer months. There are plans to continue hosting these events next summer in 2025.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>In 2024, a vendor conducted telephonic outreach to assist pediatric members with developmental disabilities with locating a dentist who can accommodate special needs patients and schedule an appointment.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>A mobile dental van provided dental services in high non-compliant areas where members have transportation issues. Public health dental hygiene practitioners (PHDHP) all received training on utilizing the Neighborly platform to identify social needs in Medicaid members and connecting them with resources in the community. The Neighborly platform is accessible for members and can also be used by hygienists to place referrals for members.</p> <p>The mobile “pop-up” strategy initiative is connected to the mobile dental unit visits at participating Federally Qualified Health Center and primary care physician locations. These locations provide clinical space which allowed the PHDHP team to utilize the two mobile dental chairs and two portable compressor units to provide preventive services. This program allowed the dental team to perform the exams required to meet the new oral evaluation dental services measure. With this new equipment, the team can also apply sealants in the mobile pop-up setting.</p> <p>Mobile unit and pop-up fluoride varnish/dental sealants provide face to face encounters in high non-compliant areas. The goal was to serve members with preventive services (exam, prophylaxis, radiographs, topical application of fluoride, silver diamine fluoride, sealant application, nutritional counselling, and oral hygiene instructions.) Once a member was seen in the mobile dental unit, PHDHPs assisted with dental navigation, finding a dental home by providing warm hands offs, referral to specialists, and follow up calls to close care gaps.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>

<p>A mobile dental unit designed to meet the member within their community was staffed by in-network dentists who were local to the location where the unit was parked for the day. These events provide an opportunity for members to receive a dental cleaning and examination, as well as a referral to a dental home for any additional services they may need.</p> <p>Partnerships were made with in-network dentists with mobile capabilities to hold dental events in medical provider offices or community locations that are central to members. A public health dental hygiene practitioner was on-site to provide coordination of care by assisting members with finding a dental home in the area for long-term care. These community events included a language interpreter, when necessary, and the dentists provided services to members with developmental or physical disabilities.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>Dental health kits were distributed at community events and included a toothbrush, toothpaste and a “Caring for your Child’s Teeth” brochure. Parents were educated and encouraged to take their children to the dentist.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>A mobile dental partnership scheduled overdue members for preventive visits at mobile dental events held in community locations.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>

Strategy: Provide incentives to increase oral health care

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>Federally qualified health centers with dental departments received incentive payments for a 5% improvement of oral evaluation dental services rate and qualified for a bonus when the 50th or 75th percentiles were achieved.</p> <p>Providers received an incentive payment for all dental sealants provided in October if they had a year-over-year increase in dental sealants from the previous October.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>

Value-based payments for oral evaluation dental services provided incentive payments for providers in the value-based dental program.	Pennsylvania Medicaid Managed Care Organizations
An incentive was provided for primary care physicians of members ages 0-3 to have oral health-focused conversations with staff and caregivers and refer the members (with no dental history) to dentists within the network as part of well child and fluoride varnish visits.	Pennsylvania Medicaid Managed Care Organizations
Federally qualified health centers held preventive dental events on a quarterly basis. Children and parents/guardians who participated received educational materials, oral hygiene aids, and small gifts. The members and their parents/guardians received exams, cleanings, topical fluoride application, and dental sealants as appropriate.	Pennsylvania Medicaid Managed Care Organizations
Pregnant members ages 21 years and older and members ages 0-14 years old who completed a dental exam were eligible for a \$20 prepaid debit card through the rewards program. Members ages 15-20 years old who completed a dental exam were eligible for a \$20 Uber gift card through the rewards program.	Pennsylvania Medicaid Managed Care Organizations
Members were rewarded for completing a visit with a dental provider during the measurement year. Members ages 6 months to 20 years old were eligible to receive the incentive once per year for completing any visit with a dentist. Members received information regarding the incentive through mailed materials, at dental events, and during public health dental hygiene practitioner outreach. Members must enroll in the incentive program to be eligible.	Pennsylvania Medicaid Managed Care Organizations
The dental provider incentive rewarded providers who completed three different services for a member during the same episode of care. Services included a dental examination, prophylaxis, and topical fluoride varnish application. The incentive was broken up by age group (6 months to 5 years old; 6 years to 20 years old) and new or returning patients.	Pennsylvania Medicaid Managed Care Organizations

Strategy: Increase dental care access for smokers

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>A public health dental hygiene practitioner (PHDHP) made outreach calls and offered initial tobacco cessation counseling to members. If a member accepted, a counseling session occurred. The member was then referred to the PA Quitline for further counseling and treatment. The PHDHP completed the Tobacco Cessation Counselor training program and was certified and credentialed. Emphasis was on high-risk smokers including members with chronic obstructive pulmonary disease and pregnant members. The PHDHP emphasized the importance of a dental exam and preventive visit and offered to help the member find a dentist.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>

Strategy: Improve oral health during pregnancy

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>Education on the importance of oral health and dental visits, and assistance in scheduling a dental appointment was provided through several initiatives including the Maternity Home Visitation Program and Community Based Care Management/Maternal Home Visiting Program.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>As part of the prenatal packet that goes to members when they become pregnant, a section was included on the importance of dental care for moms and babies. There was also information about how to get assistance with scheduling appointments. Case management also conducted outreach to members identified as pregnant and assisted with locating a dentist if the member needed it.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>Outreach to pregnant members at risk was provided by a case manager or community health worker to assist in securing evaluation, care, and other oral health needs.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>

Strategy: Improve oral health for individuals with diabetes

SHIP Partner Activities/Successes/Highlights	Organization(s)
Diabetic member maintenance visits ensured members with diabetes received regular annual dental visits.	Pennsylvania Medicaid Managed Care Organizations
The A1C by zip code program used a greater than 9.0 HbA1C to identify members for outreach if they had comorbidities and lived in rural and urban areas with lower life expectancy than state average. Stratification pulled these members for participation. Care managers then referred members in the program to public health dental hygiene practitioners for oral hygiene instruction and education by case management staff.	Pennsylvania Medicaid Managed Care Organizations

Strategy: Increase outreach and education to individuals on the importance of regular dental appointments

SHIP Partner Activities/Successes/Highlights	Organization(s)
Phone calls, outreach, and assistance was provided to schedule appointments for members in need of a dental visit.	Pennsylvania Medicaid Managed Care Organizations
The dental-related emergency department outreach aimed to reduce barriers to oral health and reduce emergency department utilization due to dental-related issues. Public health dental hygiene practitioners provided telephone outreach to adults who visited the emergency department for dental concerns. Common causes for dental-related emergency department visits were limited supply of dentists willing to accept Medicaid beneficiaries, insufficient dissemination of information about community dental resources, and lack of alternatives to emergency departments for management of acute dental problems. The most common diagnoses identified were dental pain, dental infection, and dental abscess. The aim of this initiative was to establish a dental home for members to receive routine dental care.	Pennsylvania Medicaid Managed Care Organizations

Strategy: Increase access to health care and proactive health choices for under-resourced communities of Pennsylvania

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>The LION Mobile Clinic used a student-led free clinic model to increase access to health care and proactive health choices for under-resourced communities of Pennsylvania.</p> <p>The clinic provided comprehensive health care services for the rural communities in Centre County including, blood pressure screening, preventive health screening, health literacy education, vaccines, culinary medicine, tobacco use cessation counseling, and social determinants of health screenings.</p> <p>The LION Mobile Clinic trained the next generation of health providers, scholars and educators through this student-run, no-cost medical clinic through teaching, research, and real experience within Pennsylvania communities.</p> <p>https://students.med.psu.edu/student-groups/lion-mobile-clinic/</p> <p>https://www.psu.edu/news/administration/story/note-neeli-advancing-rural-health-through-lion-mobile-clinic</p>	<p>Penn State College of Medicine, LION Mobile Clinic</p>
<p>Primary Health Network set up a mobile health clinic at the Cornerstone of Beaver County, a 24-hour emergency men’s shelter that provides food, beds and support for people experiencing homelessness.</p> <p>The Primary Health Network mobile clinic provided primary care services, minor sick visits, medication management and education, and vaccines.</p> <p>This mobile health clinic increased access to care for people experiencing homelessness and addresses barriers to care such as transportation.</p>	<p>Primary Health Network Cornerstone of Beaver County</p>
<p>The Primary Care Mobile Health Program provided 94 primary care clinics across Beaver, Erie, Lawrence, Mercer, and Venango counties. The clinics were held in collaboration with</p>	<p>Primary Health Network</p>

other organizations such as homeless shelters. The clinics served to connect services with "out of care" individuals and try to connect them to a medical home.	
A remote area medical clinic was held in September 2024 to assist members of the community to access free primary care including vision and dental services. 307 individuals were served and over \$179,000 in services provided. This event will be held in 2025 as well.	Hamot Health Foundation
Identified areas in Pennsylvania lacking health care providers and ran programs to address these shortages. Provided money to organizations to expand or improve access to primary care. Provided assistance to pay off student loans for health care providers to work in underserved areas.	PA DOH, Primary Care Office

Strategy: Increase affordable access to mobile phones, internet, and appropriate technologies to all Pennsylvania citizens with medical and behavioral health service needs

SHIP Partner Activities/Successes/Highlights	Organization(s)
Digital Connectivity Technology Program - The Pennsylvania Broadband Development Authority worked to distribute \$20 million in laptops through a competitive grant process to public-facing community anchor institutions and units of local government.	Pennsylvania Broadband Development Authority
Pennsylvania was awarded/selected for two national pilot groups - ADA Medicaid Pilot Project and The Consortium for Oral Health Building State Capacity for Integration Learning Collaborative.	PCOH

Strategy: Increase the number of individuals with access to continuous and usual sources of primary and preventive care

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>Worked to determine number of recognized patient-centered medical homes (PCMHs) present in Pennsylvania and how many individuals are served by certified PCMHs.</p> <p>The 3.1 Goal Team created a searchable spreadsheet of National Committee for Quality Assurance (NCQA) certified PCMHs in the state. This spreadsheet is searchable by county.</p> <p>The 3.1 Goal team determined that 45/67 counties have access to a NCQA certified PCMH.</p>	<p>3.1 SHIP Goal Team</p>

Strategy: Increase collaboration and information sharing among key partners whose work aligns with the 3.1 SHIP goal and objectives

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>The SHIP team identified missing key partners and conducted outreach to include these partners on the SHIP goal team.</p> <p>Promotion of the SHIP goal team was conducted through SHIP presentations and distribution of SHIP informational materials.</p>	<p>3.1 SHIP Goal Team</p> <p>PA DOH SHIP Team</p>

Appendix C2

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

Objectives:

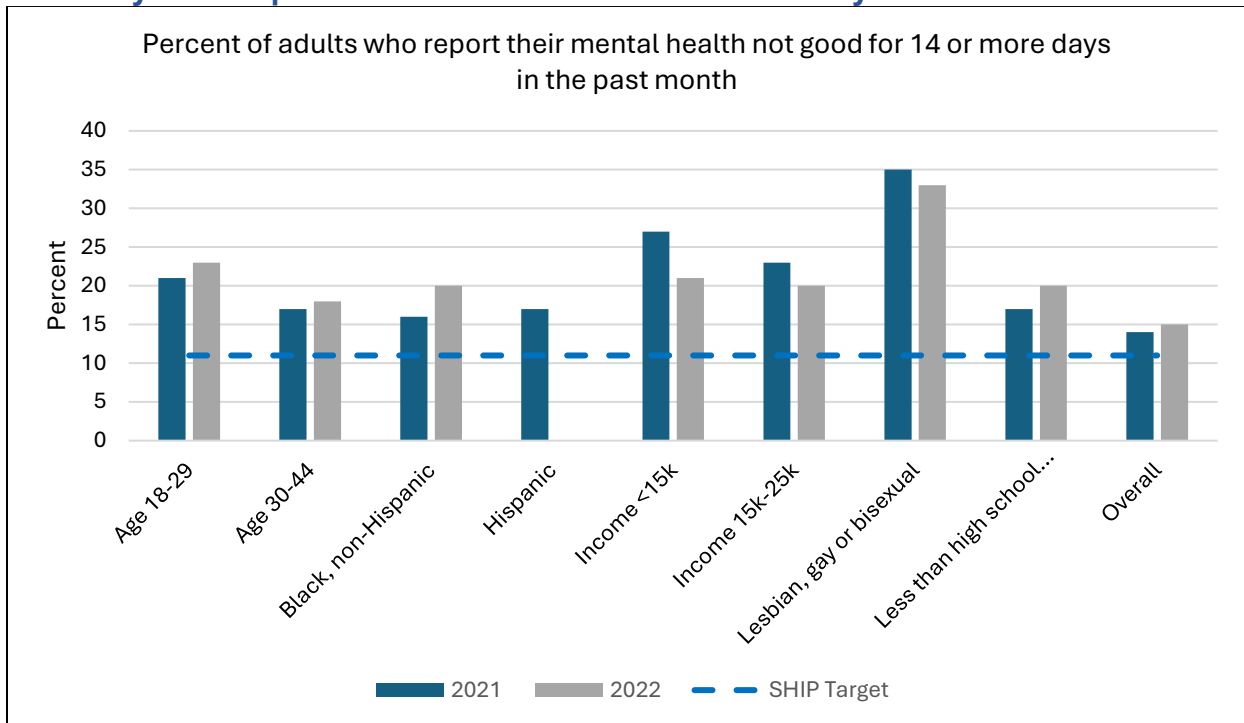
- Decrease poor mental health days
- Reduce suicide rates
- Decrease the percent of high school students who feel sad or hopeless
- Reduce drug overdose deaths
- Increase mental health provider to population ratio

3.2 Trends in the SHIP objectives

The five objectives, along with the progress toward the SHIP targets, are detailed below. The most recent available statewide data for the 3.2 objectives are 2021, 2022, and 2023. This data can be used to look at previous trends for these objectives and help to provide an overall view of progress towards the 3.2 SHIP Goal.

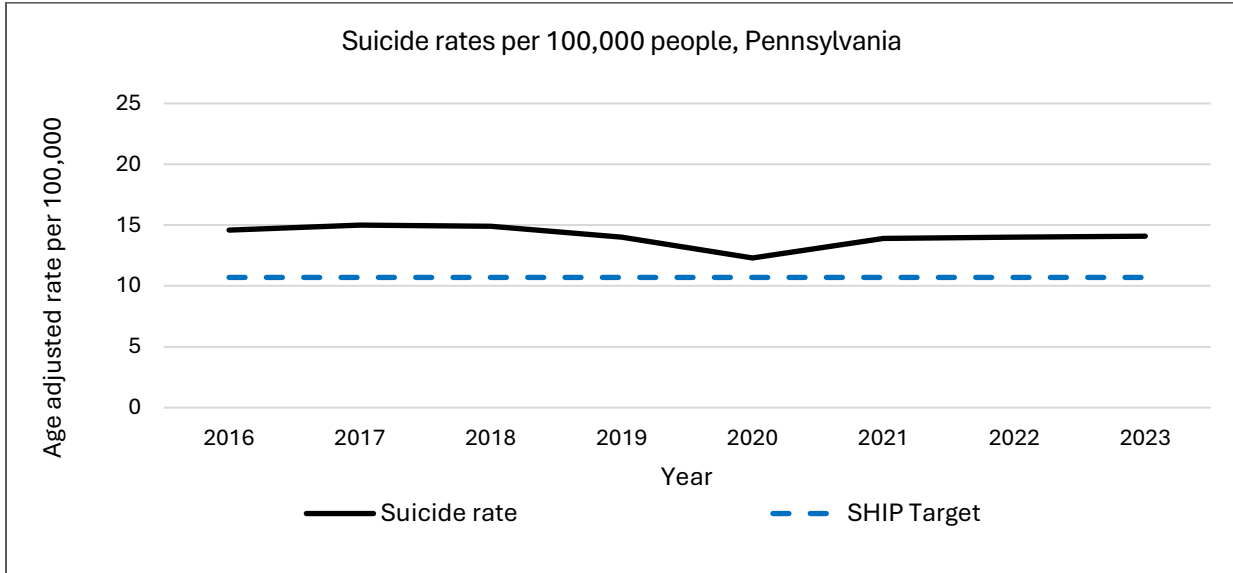
The target year of 2028 reflects the endpoint of the SHIP. Due to varying data availability and reporting lags across indicators, the most recent data available in 2028 will be used to assess progress toward each objective.

Objective 3.2.1: Decrease adults who report their mental health not good for 14 or more days in the past month from 14% in 2021 to 11% by 2028



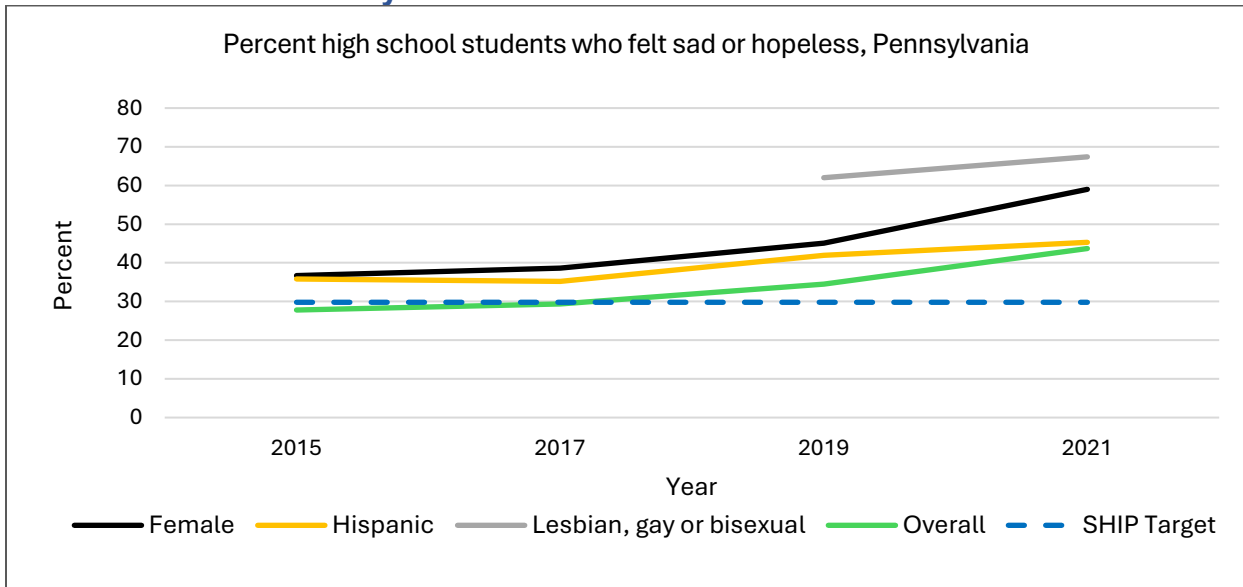
Source: BRFSS

Objective 3.2.2: Reduce suicide rates from 14.0/100,000 in 2019 to 10.7/100,000 by 2028



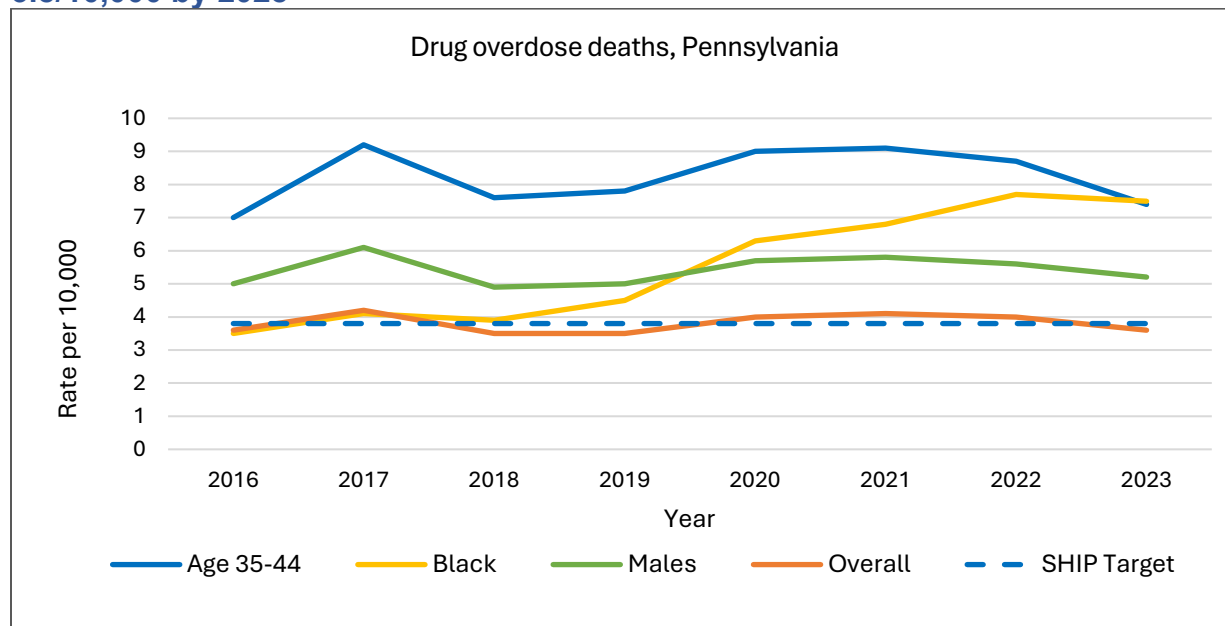
Source: Pennsylvania Death Certificate Dataset

Objective 3.2.3: Decrease high school students who felt sad or hopeless from 34.5% in 2019 to 29.8% by 2028



Source: YRBS

Objective 3.2.4: Reduce drug overdose deaths from 4.1/10,000 in 2021 to 3.8/10,000 by 2028



Source: Pennsylvania Drug Overdose Surveillance Interactive Data Report

Table: Drug overdose deaths, priority counties, Pennsylvania

Counties	2016	2017	2018	2019	2020	2021	2022	2023
Montour	6.6	9.9	6.6	11.6	8.3	11.1	6.6	11.2
Philadelphia	5.3	7.7	7	7.3	7.6	8	9	8.5
Cambria	7	6.5	4.7	4.2	5.1	7.2	6.9	5.1
Fayette	4.5	5.7	3.2	3	5.1	6.5	5.7	6.2
Lawrence	4.6	5.8	4.2	3.5	4.4	6.3	9.8	7.2
Luzerne	4.4	4.6	5	4.2	5.2	6	5.1	4.3
Allegheny	5.9	6.8	4	4.7	5.5	5.8	5.6	5.5
Mercer	2.8	3.5	4.8	3.7	4	5.8	4.8	3.6
Carbon	2.8	4.4	5.3	4.2	4.5	5.6	5.3	4.3
Armstrong	5.9	4.4	3.4	3.1	4.1	5.2	2.5	3
Lackawanna	3.4	3.8	4.5	3.1	4.3	4.9	4.2	3.2
Lehigh	3.4	4.2	3.6	4	3.7	4.9	4.3	3.9
Washington	4.9	4.4	3.5	3.7	4.8	4.8	4.1	2.4
Westmoreland	4.7	5.4	3.4	3.3	3.4	4.7	3.4	2.7
Tioga		1.7		1.7	2	4.6	1.7	1.5
Pennsylvania	3.6	4.2	3.5	3.5	4	4.1	4	3.6
SHIP Target	3.8	3.8	3.8	3.8	3.8	3.8	3.8	3.8

Source: Pennsylvania Drug Overdose Surveillance Interactive Data Report

Objective 3.2.5: Decrease population to mental health provider ratio from 420:1 in 2021 to 378:1 by 2028

Table: Population to mental health provider ratio, priority counties, Pennsylvania

Counties	2016	2017	2018	2019	2020	2021	2022	2023
Juniata	8246	8288	8171	6176	6191	6155	5824	4668
Sullivan			6089	6071	6066	5913	5868	5855
Cameron		4677	4592	4492	4447	4330	4459	2209
Potter	3419	4221	4201	3324	4132	4113	4065	3244
Perry	3807	3818	3548	3076	2892	2718	2705	2562
Forest	2470	3661	2432	2426	2416	2322	2344	2209
Northumberland	3108	3191	3068	2846	2753	2149	1984	1839
Fulton	2090	2091	2084	2421	2076	2072	2075	1615
Wyoming	2138	2293	2277	2080	1675	1562	1302	1369
Snyder	2022	1839	1700	1689	1682	1493	1321	1166
Pennsylvania	600	560	530	480	450	420	400	370
SHIP Target	378	378	378	378	378	378	378	378

Source: Reference: County Health Rankings and Roadmaps

Note: Mental health provider estimates are based on CMS National Provider Identifier data through County Health Rankings and Roadmaps. Provider categories and data processing methods have changed over time, including the addition of new provider types and geospatial methods, which may affect comparability across years.

3.2 SHIP Partner Strategies, Activities, Successes and Highlights

SHIP Goal 3.2 Team members contributed the following information on strategies and activities conducted throughout the Commonwealth in 2024 to improve mental health and substance use outcomes. This information includes overviews of activities as well as successes and highlights of the work of SHIP partners and their organizations.

Strategy: Enhance support and resources for first responders to respond to mental health and substance use disorder cases.

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>In 2024, the EHSF made significant strides in enhancing the support and resources available to first responders through the Compassionate Opioid Response Education (C.O.R.E.) Initiative. This program was launched to address critical issues in emergency response, including substance use disorder, compassion fatigue, motivational interviewing, and harm reduction strategies. By equipping emergency medical services (EMS) personnel with the necessary tools, EHSF strengthened their ability to provide compassionate and effective care while also tackling the growing challenge of burnout and moral fatigue within the field.</p> <p>Throughout the year, EHSF provided 418 hours of training to EMS agencies and first responders, ensuring they are well-equipped to handle substance use disorder cases with empathy and evidence-based strategies. A total of 76 individuals participated in agency-specific and public events, benefiting from expert-led training sessions. Additionally, Continuing Education Credits (CEUs) were awarded, further supporting professional development.</p> <p>One of the core components of the C.O.R.E. Initiative is the Naloxone Leave Behind Program, which enables EMS agencies to distribute naloxone kits in the field or on the scene of an overdose call. This effort facilitates life-saving interventions and meaningful pathways to recovery by linking individuals in crisis to long-term support.</p> <p>A powerful example of the program’s success came just two weeks after a training session in York County, when a first responder applied the skills learned to connect an overdose</p>	<p>Emergency Health Services Federation (EHSF)</p>

<p>patient with a Certified Recovery Specialist (CRS). This successful warm-hand-off was a direct result of the training and underscores the power of collaborating in creating real, positive changes in the community through first responders.</p> <p>The training provides first responders with evidence-based intervention strategies and tangible resources, such as the Naloxone Leave Behind Program, to help bridge the gap between emergency response and recovery. By reinforcing their ability to create meaningful change, the initiative has restored a sense of purpose and morale within EMS agencies, helping to combat burnout and improve retention within the field.</p> <p>With proven success in York County, the next step for EHSF is to expand the C.O.R.E. Initiative into additional counties. The groundwork has already been laid, and with the necessary funding, EHSF can broaden their reach and provide these essential resources to more first responders and the communities they serve.</p> <p>As the program evolves in 2025, EHSF will continue to work toward strengthening the EMS system, enhancing the well-being of first responders and improving community health outcomes.</p>	
<p>Penn Medicine provided first responder trainings, handouts, and flyers.</p>	<p>Penn Medicine</p>
<p>The First Responder Addiction and Connection to Treatment was promoted to ensure first responders, public safety professionals and their agencies have the tools necessary to respond and fight the opioid epidemic.</p>	<p>PA DOH, Office of Drug Surveillance and Misuse Prevention (ODSMP)</p>

Strategy: Improve health outcomes for people with substance use disorders

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>In collaboration with the BOL, the Office of Drug Surveillance and Misuse Prevention launched a new overdose bio surveillance program to enhance surveillance of suspected unintentional overdose-related emergency department visits in Pennsylvania. The program</p>	<p>PA DOH, ODSMP</p>

<p>aimed to identify new and novel substances introduced into the drug supply, analyze comprehensive toxicology data on drugs contributing to overdose, and inform data-driven response strategies.</p> <p>Participating health systems identified, stored, and shipped leftover biological specimens from suspected unintentional overdoses to BOL for toxicological testing.</p> <p>In addition to toxicology testing results, data collected as part of this program included race, ethnicity, age, sex, and residence zip code of the patient. This information enabled key stakeholders, including local public health practitioners, harm reduction partners, and health care providers to better understand the social determinants and/or physical health conditions that place individuals at a disproportionate risk for non-fatal overdose.</p>	<p>PA DOH, Bureau of Laboratories (BOL)</p>
<p>Harm Reduction Supply Distribution</p> <p>The overdose epidemic continues to claim thousands of Pennsylvanians each year. Preliminary data shows that in 2023, 4,722 drug overdose deaths occurred equating to nearly one Pennsylvanian dying from a drug overdose every two hours. The emergence of xylazine, often called “tranq,” in the illicit drug supply has further complicated this public health crisis. Xylazine is an animal tranquilizer increasingly found mixed with opioids. It can cause serious health problems, including complex and difficult to treat skin lesions and wounds. These wounds can become so severe they can lead to the need for skin grafts and even amputation of limbs.</p> <p>In response to the growing need for organizations to have access to high-quality harm reduction supplies, ODSMP launched a special project to provide access to xylazine associated wound care kits and sharps disposal containers. In January 2024, an electronic survey was sent to harm reduction organizations across Pennsylvania accessing interest in receiving kits and containers.</p>	<p>PA DOH, ODSMP</p> <p>PDPH</p> <p>Center for Forensic Science Research and Education</p>

Xylazine Associated Wound Care Kits

Because xylazine associated wounds are more complex and challenging to care for than other wounds, new protocols were needed to care for the wounds. ODSMP consulted with PDPH on the best practices for caring for xylazine associated wounds.

In May 2024, ODSMP secured the necessary supplies and began assembling the kits. Throughout the summer of 2024, ODSMP assembled and shipped 50,000 kits to more than 200 organizations in 50 counties.

Trainings for Care of Xylazine Associated Wounds.

ODSMP provided basic instructions on how to use the supplies to care for xylazine associated wounds in each kit along with a link to PDPH's Recommendations for Caring for Individuals with Xylazine Associated Wounds. Because these wounds are more complex and recalcitrant than the types of wounds previously seen by clinicians and front-line outreach workers, it was evident that more detailed trainings could be beneficial.

Following the success of the wound care kit project, ODSMP, PDPH and the Center for Forensic Science Research and Education (CFSRE) collaborated to host two virtual training opportunities for clinical and non-clinical professionals who work with people who use drugs. The training content was a slightly revised version of trainings that PDPH had been conducting for a few years owing to the high prevalence of xylazine in the Philadelphia drug supply. CFSRE handled all technical issues related to the trainings.

The virtual, live trainings were conducted on October 23, 2024 (non-clinical session), and November 6, 2024 (clinical session). Rachel Neuschatz, MSN, RN, CWCN of the Division of Substance Use Prevention and Harm Reduction at the Philadelphia Department of Public Health was the featured presenter for both sessions. The trainings were offered at no cost to attendees and individuals who are certified or are pursuing certification as a Certified Recovery Specialist could utilize either session to fulfill Pennsylvania Certification Board education requirements. Additionally, continuing medical education credits were provided for attendees of the clinical session.

<p>Attendance at the live training demonstrated demand for this information, with 243 individuals attending the non-clinical training and 221 attending the clinical training. The trainings were recorded and will remain available for at least the next year. Attendees of the recorded content also received applicable continuing education credits. Responses to the post-training surveys were overwhelmingly positive.</p>	
<p>Naloxone Leave-Behind Kits</p> <p>In 2023 and 2024, the Office of Drug Surveillance and Misuse Prevention (ODSMP) deployed three different opportunities for public safety professional agencies (e.g., Fire, Emergency Medical Services/ Emergency Medical Technician, law enforcement, and Child Welfare agencies) who were eligible to participate in ODSMP’s First Responder Addiction and Connection to Treatment program to receive free naloxone leave-behind kits. The leave-behind kits were intended for distribution by public safety professionals to community members and consisted of the following items: 1 bag, 4mg Narcan nasal spray (2 doses of naloxone per pack), CPR rescue breathing mask, gloves, how to use naloxone resource, substance use disorder treatment resource, and hand sanitizing wipes.</p> <ol style="list-style-type: none"> 1. By August 2023: ODSMP partnered with the University of Pittsburgh Program Evaluation and Research Unit to distribute 8,908 leave-behind kits. 2. By October 2023: As a result of strong interest among public safety agencies to receive free kits in August, the ODSMP compiled an additional 3,000 kits in-house for distribution to local public safety agencies. 3. By August 2024: ODSMP partnered with the Department of General Services to utilize warehouse space for the storage and in-house packing of an additional 15,000 naloxone leave-behind kits. <p>Altogether in calendar years 2023 and 2024, ODSMP distributed nearly 27,000 naloxone leave-behind kits throughout the Commonwealth.</p>	<p>PA DOH, ODSMP</p> <p>University of Pittsburgh Program Evaluation and Research Unit</p> <p>Department of General Services</p>
<p>In March 2024, the ODSMP began shipping four sizes of sharps containers to organizations providing services to people who inject drugs. The sizes offered were one quart, two-gallon, eight gallon and small pocket size sharps that can hold ten syringes.</p>	<p>PA DOH, ODSMP</p>

<p>These sizes were selected after consultation with harm reduction organizations which dispense and collect back syringes and educate clients on proper syringe disposal. ODSMP distributed 75,700 sharps containers to 213 organizations across the state.</p> <p>Distributing this number of sharps containers translates to more than 50,000 gallons of used syringes being collected and properly disposed of by these organizations. This protected the health and safety of our communities and first responders.</p>	
<p>The ODSMP awarded over \$3.3 million dollars in grant funds to emergency departments, harm reduction organizations, community-based organizations across Pennsylvania who will conduct linkage to care, harm reduction, and overdose prevention and response activities.</p>	PA DOH, ODSMP
<p>The Delco Revive program provided trainings on Narcan, CPR and Stop the Bleed and distributed Narcan, xylazine test strips, and fentanyl test strips as well as Stop the Bleed kits.</p>	Delaware County Health Department
<p>Education was provided to community stakeholders and legislators on the benefits of syringe services</p>	PA DOH PDPH
<p>Free vaccination clinics for Hepatitis A and B were provided for people in drug and alcohol treatment.</p>	Berks County
<p>Offered drug testing strips, naloxone training, and medication lock boxes.</p> <p>Local EMS provided leave behind bags which were utilized to leave naloxone on-scene with patients and their support system.</p> <p>The Fulton County Medical Center provided warm handoffs at the emergency room and Fulton Practice.</p>	Fulton County Family Partnership, Inc.
<p>Pennsylvania Association of Community Health Centers worked to align with the Patient Advocacy Program and assisted with addressing current needs and gaps.</p>	Pennsylvania Association of Community Health Centers

<p>The Resident Impact Grant program (funded by the PA DOH) supported a project led by the Allegheny Health Network Forbes Family Medicine (FFM) Residency program in Monroeville. The goal is to reduce opioid use disorder (OUD) for individuals in the Monroeville/Pittsburgh area.</p> <p>The FFM Residency program collaborated with partner EMS teams and their hospital's emergency department to reduce OUD in their community by identifying overdose patients via EMS and emergency departments (ED), providing naloxone at ED discharge and coordinating follow up with the Family Medicine Clinic for OUD treatment (including MAT) and additional primary care and social services supports. Patients were provided with a naloxone package that includes a card about services available and information about the family medicine clinic. Patients could also receive a preliminary bridge prescription to support their recovery while their eligibility for other services was processed and facilitated with FFM team. A post-ED follow-up phone call was used to offer the opportunity to schedule with the Family Medicine Clinic for the health services they need.</p> <p>The project began in June 2024 and will wrap up in June 2025 budget-wise, though their work will continue. The outcome measures include assessing:</p> <ol style="list-style-type: none"> 1. The number of uninsured patients that subsequently fill a prescription for buprenorphine/naltrexone. 2. The number of uninsured patients who receive a box of Naloxone. 3. The number of uninsured patients that establish care for OUD at FFM. 4. The number of uninsured patients with a documented second fill for buprenorphine/naltrexone demonstrating prolonged treatment. <p>The strategy is to fill the gap between identifying the patient (post overdose) and establishing a source of primary care that includes treatment for OUD in the context of their overall health and primary care over time. Public health studies confirm that folks with a usual source of primary care have better health outcomes – live longer, experience less chronic disease burden, are hospitalized less frequently and less likely to need ambulance, ED and other emergent care.</p>	<p>Allegheny Health Network Forbes Family Medicine Residency Program</p>
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<p>Funding is provided by the PAFP Resident Health Impact Grant (RIG) program, a program funded through the Residency Expansion Program by PA DOH. This program administers grants to evidence-based strategic projects designed to increase access to primary care to expand the reach of primary care to improve the health of communities. Many family medicine residency programs are safety net clinics, providing care to all regardless of insurance status in rural, urban, and suburban communities across Pennsylvania.</p>	
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Strategy: Increase education on substance use disorder treatment

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>The ODSMP, the PDPH, and Center for Forensic Science Research and Education collaborated to host two virtual training opportunities for clinical and non-clinical professionals who work with people who use drugs in the fall of 2024. The trainings were offered at no cost to attendees and individuals who are certified or are pursuing certification as a Certified Recovery Specialist could utilize either session to fulfill Pennsylvania Certification Board education requirements.</p> <p>Additionally, continuing medical education credits were provided for attendees of the clinical session. Attendance at the live training demonstrated demand for this information, with 243 individuals attending the non-clinical training and 221 attending the clinical training. The trainings were recorded and will remain available for at least the next year. Attendees of the recorded content will also receive applicable continuing education credits. Responses to the post-training surveys were overwhelmingly positive.</p>	<p>PA DOH, ODSMP</p> <p>PDPH</p> <p>Center for Forensic Science Research and Education</p>

Strategy: Increase education on disparities in drug overdose rates

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>Inequities in naloxone administration among fatal overdose decedents by race and ethnicity in Pennsylvania, 2019-21 was published in the journal "Addiction" and was</p>	<p>PA DOH, ODSMP</p>

<p>authored by ODSMP staff and PA DOH epidemiologists. https://onlinelibrary.wiley.com/doi/10.1111/add.16478</p> <p>The study showed that Black individuals were far less likely than white individuals to have any evidence they received a potentially lifesaving intervention when experiencing a drug overdose in Pennsylvania. The current drug overdose landscape is characterized by staggering racial inequalities; in Pennsylvania, the drug overdose rate in 2021 was twice as high for Black individuals as it was for white individuals.</p>	<p>PA DOH, Bureau of Epidemiology</p>
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Strategy: Increase Access Mental Health Services for Under Served Populations

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>Woods opened its Center for Behavioral Health at Woods in Langhorne to serve residents in the Lower Bucks area with the purpose of increased access to mental health services for people with intellectual/developmental disabilities (I/DD) and autism.</p> <p>Woods shared expertise to train current providers as well as the next generation of providers in primary, oral and behavioral health to better serve individuals with intellectual and/or developmental disabilities, autism, and complex medical and behavioral health needs.</p> <p>In 2024, Woods:</p> <ul style="list-style-type: none"> • Trained 11 interns at the Center for Behavioral Health at Woods in Langhorne. • Hosted twice-per-month group case discussions and presented on relevant topics for nurse practitioners, students, and residents. • Presented at numerous events, including the National Medical Advisory Committee/Nursing Leadership/Infection Preventionists' Summit at Devereux Advanced Behavioral Health on Medical comorbidities in adults with I/DD; MAX Association for World Mental Health Day on clinical overview and components of dual diagnosis; didactic to Temple Medicine psychiatry residents on management of agitation for I/DD patients. 	<p>Woods System of Care</p>

<ul style="list-style-type: none"> • Was a guest for Student Network Organization Focus on student mental health dos and don'ts. • Continued partnership with Chester County to create a continuum of services for mental health. • Added a new and much needed behavioral health mobile crisis team program for the county. 	
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Strategy: Increase mental health education, training, and resources

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>PA Department of Education published the Common Ground Framework to support training, and preparation of pre-service educators, as well as educators.</p> <p>The Common Ground Framework includes three sets of competencies—Cultural Awareness, Trauma-Aware, Mental Health and Wellness, and Technological and Virtual Engagement—for teacher training, both preparation and professional development, to provide educators with the skills and approaches that will enable them to better serve learners from all walks of life.</p> <p>This framework ties in supports for behavioral health, trauma-informed practices, equitable practices, and mental health.</p> <p>https://www.pa.gov/agencies/education/programs-and-services/educators/certification/new-educators/program-framework/common-ground-framework.html</p>	PA Department of Education
Penn Medicine Lancaster provided adult mental health first aid training.	Penn Medicine Lancaster
Magellan hosted a behavioral health symposium with key stakeholders.	Magellan
Tower Health Reading Hospital collaborated with Behavioral Health at Fall Prevention Event for older adults and Mental Health Resource Fair.	Tower Health Reading Hospital

Strategy: Increase education and resources to improve youth behavioral health outcomes

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>Northeast Pennsylvania Area Health Education Center (AHEC) and the Wright Center for Community Health offered education to improve youth behavioral health outcomes.</p> <p>Northeast Pennsylvania AHEC and the Wright Center for Community Health started a webinar series in 2024 to educate primary care teams about youth behavioral health issues and to ultimately improve health outcomes. Each session offered continuing education credits for participants.</p> <p>Sessions in 2024 included:</p> <ul style="list-style-type: none"> • April 17, 2024: The Acute Assessment of Suicidal Ideation in Adolescents • June 19, 2024: Autism Spectrum Disorder: Symptomology and Interventions • September 18, 2024: Practice Update for the Management of ADHD in Primary Care • November 20, 2024: Assessment and Management of Depression in Children and Adolescents in Primary Care <p>Additional sessions planned for 2025 include:</p> <ul style="list-style-type: none"> • January 15, 2025: Management of Anxiety Disorders in Children and Adolescents • March 19, 2025: Trends and Evidence-Based Treatment in Adolescents and Substance Use Disorder • May 21, 2025: Trauma-Informed Care; An Overview • August 20, 2025: Mental Health Implications of Gender Identity and Expression in Youth • October 15, 2025: Empowering Conversations: Reducing Shame and Blame in Pediatric Behavioral Health 	<p>Northeast Pennsylvania Area Health Education Center</p> <p>The Wright Center for Community Health</p>
<p>OCYF and the OMHSAS teamed up with Pennsylvania Care Partnership to provide free trauma training for child welfare professionals in Pennsylvania in 2024. This training was</p>	<p>PA DHS, Office of Children, Youth, and Families (OCYF)</p>

<p>conducted by Lakeside Global and is sponsored by the Pennsylvania Care Partnership's System of Care Grant funding and OCYF.</p> <p>The courses offered include: RCE 100: Relational Health, Communication Skills, and Emotional Health; 100: The Power of Belonging; 101: Effective Communication (Part 1); 102: Effective Communication (Part 2); Trauma 101: An Overview of Trauma-Informed Care; Trauma 102: Basic Skills of Trauma-Informed Care; Trauma 103: Recognizing Vicarious and Secondary Trauma for Professionals; Trauma 104: Grief and Trauma; Trauma 108: Trauma and Racism; Trauma 109: Trauma in a Pandemic; and, Trauma 201: Exploring the Legacy of Trauma.</p> <p>In 2024, the Pennsylvania Care Partnership provided 62 trauma trainings and 2242 people attended. These trainings included, Other Trauma - Applying Trauma Principles, Other Trauma - Deepening Trauma Awareness, Other Trauma - Trauma 104, Other Trauma - Trauma 110, Trauma 101: An Overview of Trauma-Informed Care, Trauma 102: Basic Skills of Trauma-Informed Care, Trauma 103: Recognizing Vicarious and Secondary Trauma for Caregivers, Trauma 105: An Introduction to Trauma for Parents and Caregivers, Trauma 107: Trauma-Informed Cultural Sensitivity, Trauma 108: The Trauma of Racism, and Trauma 109: Trauma in a Pandemic.</p>	<p>PA DHS, Office of Mental Health and Substance Abuse Services (OMHSAS)</p> <p>Pennsylvania Care Partnership</p> <p>Lakeside Global</p>
<p>OMHSAS, Children's Bureau staff provided several conference presentations on trauma-informed care (TIC) and on their TIC implementation Tools. Information was presented on TIC at the Interagency Children's Conference, at VOCE Forum on Pennsylvania 's Children, and at the Pediatric Capacity Building Institutes.</p> <p>OMHSAS Children's Bureau staff also spent 2024 providing technical assistance to child and adolescent psychiatric residential treatment facilities (PRTF). These PRTFs are completing a self-audit process that OMHSAS developed for them to document their TIC implementation progress for the purpose of assessing whether they can be designated by OMHSAS as Trauma Aware or Trauma-Sensitive PRTFs.</p> <p>Additionally, OMHSAS Children's Bureau published an article on Myths related to TIC.</p>	<p>PA DHS, OMHSAS, Children's Bureau</p>

OMHSAS Children’s Bureau staff also served as the co-lead of the Trauma-training and Organizational Support Action team with HEAL PA in 2024, and while that group did not provide actual trainings, they established criteria for trainings that wish to be considered to be training for "trauma-awareness," and began developing a database of trainings that lists which criteria are met by each training listed.	
PA DOH - Berks County State Health Center promoted mental health awareness in schools through peer-to-peer support groups for youth to address teen suicide attempts. Mental health assessments and trainings on teen mental health were also provided to schools.	PA DOH - Berks County State Health Center
Dauphin County, National Alliance on Mental Illness (NAMI) provided suicide prevention training to teens in schools.	Dauphin County, NAMI
Penn Medicine Lancaster provided youth Mental Health First Aid Trainings.	Penn Medicine Lancaster

Strategy: Provide trauma informed mental health training

SHIP Partner Activities/Successes/Highlights	Organization(s)
HEAL PA, the PA Department of Education, and Resilient PA provided Trauma informed trainings and resources.	HEAL PA PA Department of Education Resilient PA
Resilient PA provided online resources on trauma informed care across the commonwealth.	Resilient PA
Reading Hospital Tower Health provided trainings on Mental Health First Aid, Trauma 101, Trauma 102, Implicit Bias, and Stress-less.	Reading Hospital Tower Health
TrueNorth Wellness Services provided Mental Health First Aid Trainings.	TrueNorth Wellness Services

Strategy: Increase supports for individuals who experienced trauma

SHIP Partner Activities/Successes/Highlights	Organization(s)
Reading Hospital Tower Health provided peer support through the Trauma Survivor Network to trauma patients.	Reading Hospital Tower Health
The Pennsylvania Office of Rural Health held the 2024 Rural Human Trafficking Summit continuing education event with 100 in attendance.	Pennsylvania Office of Rural Health

Strategy: Increase mental health supports

SHIP Partner Activities/Successes/Highlights	Organization(s)
Radico Psychological and Consultation Services, LLC provided teletherapy, tele-coaching, speaking engagements, and consulting for mental health.	Radico Psychological and Consultation Services, LLC

Strategy: Increase education on mental health and substance use challenges

SHIP Partner Activities/Successes/Highlights	Organization(s)
Mental Health First Aid Trainings were held for adults and youth.	Reading Hospital Fulton County Lancaster County
Lancaster County held mental health forums.	Lancaster County
Magellan hosted a behavioral health symposium.	Magellan
The Emergency Health Services Federation hosted trainings on overcoming stigma and empowering EMS in response to substance use.	The Emergency Health Services Federation

Community Care Behavioral Health provided anti stigma resources and education for mental health and substance use.	Community Care Behavioral Health
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Strategy: Connect veterans to mental health and substance use resources

SHIP Partner Activities/Successes/Highlights	Organization(s)
The SHIP team provided outreach to veteran coalitions to join the 3.2 SHIP Goal Team and discussed information on the Veteran Crisis Line to increase knowledge and utilization.	3.2 SHIP Goal Team

Strategy: Increase outreach and information gathering on needed mental health resources

SHIP Partner Activities/Successes/Highlights	Organization(s)
A Community Health Needs Assessment was conducted to gather input from the community on health needs including mental health and substance use support services to identify and address the needs of the community.	Fulton County Family Partnership Fulton County Medical Center

Strategy: Increase suicide prevention education and resources

SHIP Partner Activities/Successes/Highlights	Organization(s)
Gun lock education and distribution was provided to prevent suicide.	Lancaster County Safe Firearm Storage Initiative Lebanon County Veterans Association YWCA

	Penn Medicine PA DOH
Reading Hospital Tower Health provided gun safes and hosted a suicide prevention day to educate the community about suicide.	Reading Hospital Tower Health
The PA DHS promoted the 988 suicide and crisis lifeline to increase awareness and utilization.	PA DHS

Strategy: Increase collaboration and information sharing among key partners whose work aligns with the 3.2 SHIP goal and objectives

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>The SHIP team identified missing key partners and conducted outreach to include these partners on the SHIP goal team.</p> <p>Promotion of the SHIP goal team was conducted through SHIP presentations and distribution of SHIP informational materials.</p>	<p>3.2 SHIP Goal Team</p> <p>PA DOH SHIP Team</p>
The Northcentral Regional Heat Equity Action Team and Southeast Regional Heat Equity Action Team focused their efforts on SHIP Goal 3.2 and hosted community-based presentations in 2024.	PA DOH, Office of Health Equity

Appendix C3

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

Objectives:

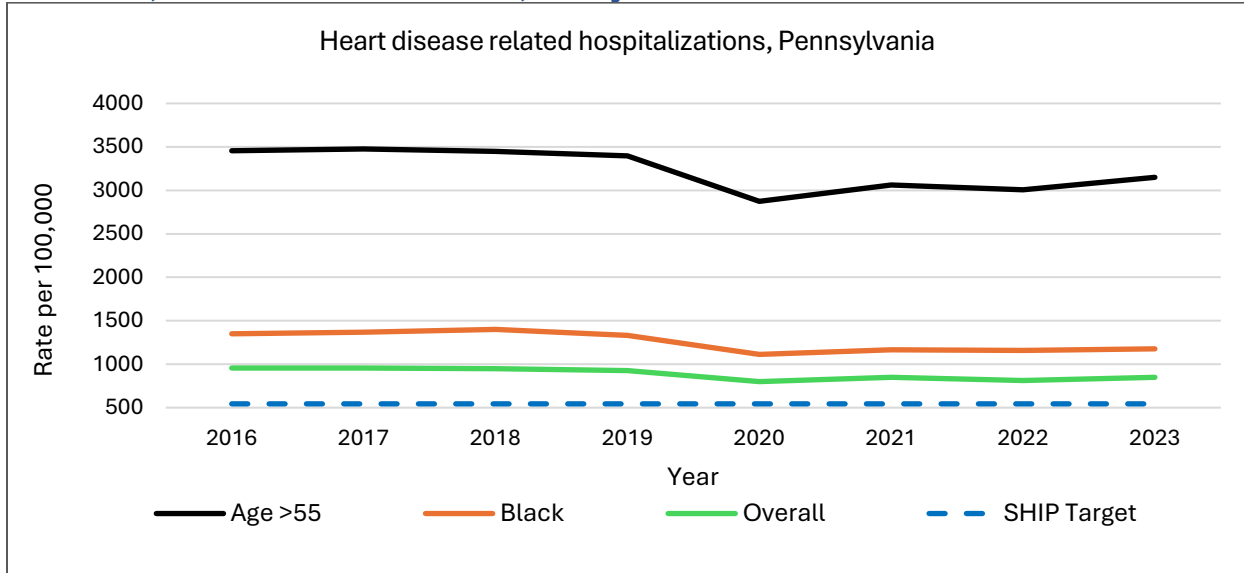
- Decrease heart disease related hospitalizations
- Decrease cancer deaths
- Decrease diabetes related hospitalizations
- Decrease COPD related hospitalization
- Decrease Alzheimer's related hospitalization

3.3 Trends in the SHIP objectives

The five objectives, along with the progress toward the SHIP targets, are detailed below. The most recent available statewide data for the 3.3 objectives is 2023. This data can be used to look at previous trends for these objectives and help to provide an overall view of progress towards the 3.3 SHIP Goal.

The target year of 2028 reflects the endpoint of the SHIP. Due to varying data availability and reporting lags across indicators, the most recent data available in 2028 will be used to assess progress toward each objective.

Objective 3.3.1: Decrease heart disease related hospitalizations from 926.8/100,000 in 2019 to 543.5/100,000 by 2028



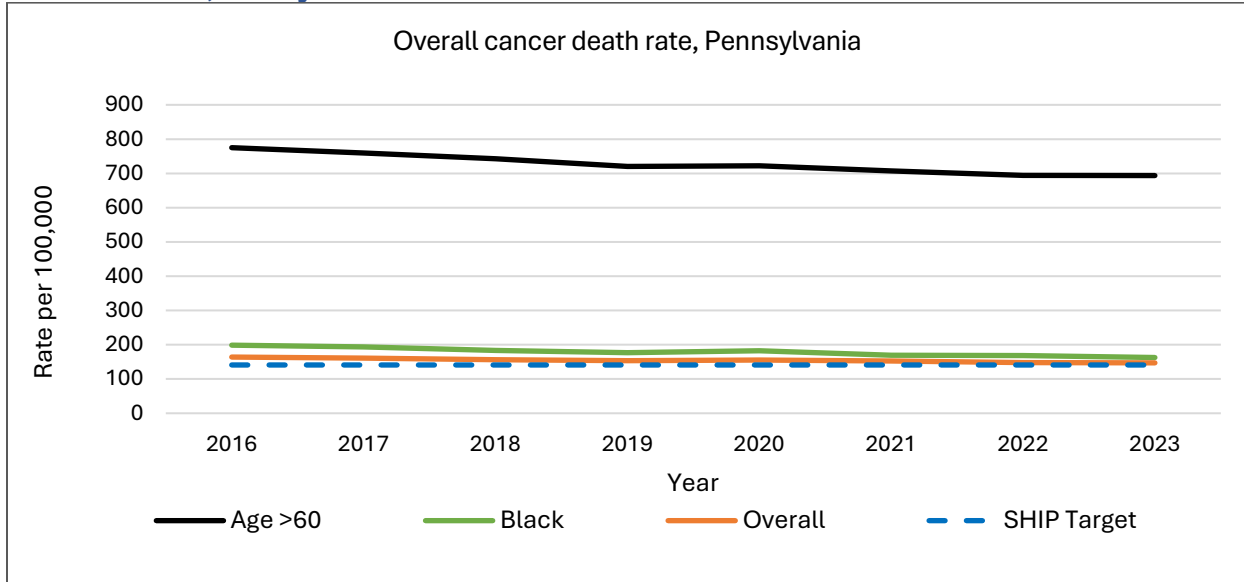
Source: Pennsylvania Health Care Cost Containment Council (PHC4)

Table: Heart diseases hospitalization rate per 100,000 population, priority counties, Pennsylvania

Counties	2016	2017	2018	2019	2020	2021	2022	2023
Philadelphia	1241.2	1207.5	1219.5	1157.8	1002.2	1068.4	1015.4	1024.8
Blair	1017.6	1133.5	1115.2	1138.3	1026.4	957.8	915.2	957
Schuylkill	1083.9	1126.7	1126.7	1111.7	976.7	1063.4	1079	1151.2
Cambria	1061	997.1	993.2	1109.2	896	943.4	935.9	918.2
Fayette	1242.5	1276	1246.7	1104.6	901.4	1027.8	971.5	1029.7
Bradford	1034	988.1	1107.6	1103.6	1012.6	963	848.3	939.1
Carbon	1129.8	1142.2	1102.7	1067.6	944.2	975.8	879.6	1029
Mercer	1046.8	1162.8	1058.7	1063.1	916.1	918.1	935.9	964.6
Clearfield	1095	1072.7	991.4	1057.4	932.1	867	730.8	841
Cameron	1051.1	1084.5	1244.8	1052.8	1037.9	693.5	739.8	807.6
Westmoreland	1051.5	1067.6	1051.8	1051.9	891.9	948.3	910.5	953.4
Northampton	1046.7	1028.7	1071.6	1036	896.2	975.5	891.1	916.3
Jefferson	960.6	972	935.9	1029.1	877.3	817.5	804.8	864.1
Huntingdon	933.8	1040.9	930.7	1026.5	948.8	771.4	785.8	835
Overall	955.7	954.5	947	926.8	799.4	850.6	813.1	848.2
SHIP Target	543.5	543.5	543.5	543.5	543.5	543.5	543.5	543.5

Source: PHC4

Objective 3.3.2: Reduce the overall cancer death rate from 152.7/100,000 in 2019 to 140.95/100,000 by 2028



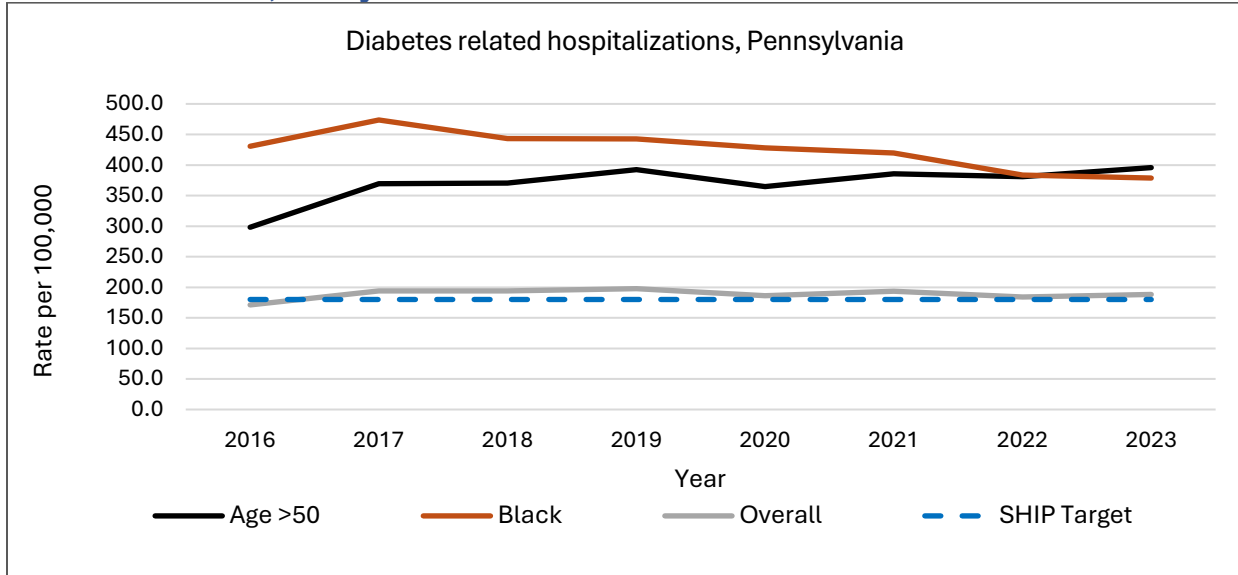
Source: Pennsylvania Death Certificate Dataset

Table: Cancer death rate per 100,000 population, priority counties, Pennsylvania

Counties	2016	2017	2018	2019	2020	2021	2022	2023
Sullivan	149.2	213.1	181.7	221	150.8	239.6	106.6	103.1
Potter	174.9	179.3	162.7	202.2	137	160.9	179.6	177.7
Mifflin	147.8	166.9	170.6	201.8	177	149.9	156.6	163
Schuylkill	197.9	192	192.2	193.7	185.3	172.7	160.6	181
Greene	155.6	189.8	176.7	191.2	186.6	186.9	200	171.7
Perry	173.2	163.7	169.3	191.2	194.2	168.9	166.1	185.3
Elk	186.8	170.2	146.7	183.6	156.9	173.1	156	169.2
Lycoming	164.6	178.8	166.2	178.2	172.8	170.9	156.4	149.8
Washington	156.7	180.4	172.1	175	167.6	173	148.1	159.1
Forest	145.9	172.8	147.2	174	153.5	184.8	181.2	185.5
Northumberland	191.9	168.8	167.9	173.2	172.1	157.1	152.9	169.1
Fayette	190.7	190.6	185.8	172.5	162.5	175.1	177.2	164.2
Tioga	141.3	172.2	178.8	171.5	144.8	145.9	175.1	173.4
Jefferson	162.8	171.6	178.3	168.9	157.6	145.6	154.3	167.3
Overall	164	160.6	156.4	153.2	155.2	152.8	147.6	147.1
SHIP Target	140.9	140.9	140.9	140.9	140.9	140.9	140.9	140.9

Source: Pennsylvania Death Certificate Dataset

Objective 3.3.3: Decrease diabetes related hospitalizations from 197.7/100,000 in 2019 to 180.0/100,000 by 2028



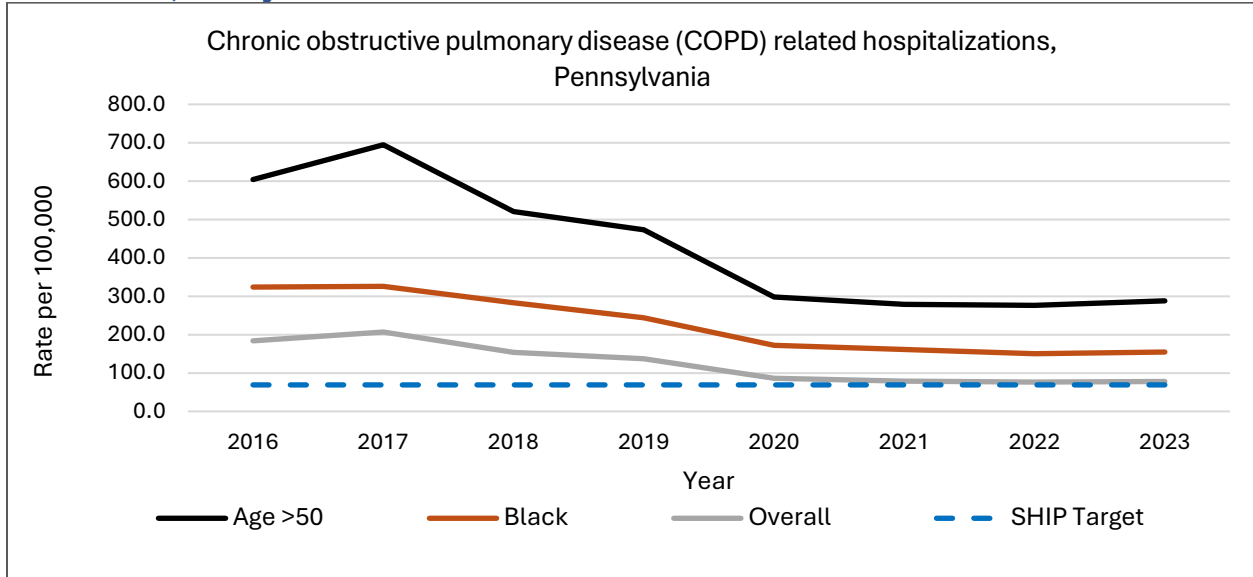
Source: PHC4

Table: Diabetes related hospitalization rate per 100,000 population, priority counties, Pennsylvania

Counties	2016	2017	2018	2019	2020	2021	2022	2023
Philadelphia	325.6	358.8	339.6	331.4	315.8	323.7	292.6	282.8
Fayette	197.7	267.4	303.5	281.2	261.9	274.5	294.4	267
Schuylkill	172.7	219.2	246.3	271.5	251.5	279.4	263.2	275.6
Mercer	192.2	203.8	222.6	256	224.6	222	196	236.2
Luzerne	174.6	198.6	208.2	243.4	223.8	222.4	217.8	235.7
Dauphin	205.2	246.9	245.7	240.3	217.6	231.1	199.5	221.8
Northampton	183.4	189.3	213.6	235.9	213.8	229.3	233	253.7
Monroe	171	168.2	200.7	234.1	206.8	194.3	201.7	190.5
Lawrence	163.2	184.6	224.1	231.4	207.4	215.5	167.2	196.9
Beaver	167.9	218.8	226.1	228.8	208.5	222.7	252.3	209
Fulton	149.7	158.1	154.1	228.4	130	159.3		
Carbon	166.6	205.8	178	219.3	255.7	235	208.3	278.8
Northumberland	199.2	211.4	212.3	218.7	238.7	244.4	250.7	274.8
Overall	171.1	193.8	194	197.7	186.3	193.4	183.9	188.1
SHIP Target	180	180	180	180	180	180	180	180

Source: PHC4

Objective 3.3.4: Decrease COPD related hospitalization from 136.9/100,000 in 2019 to 69.0/100,000 by 2028



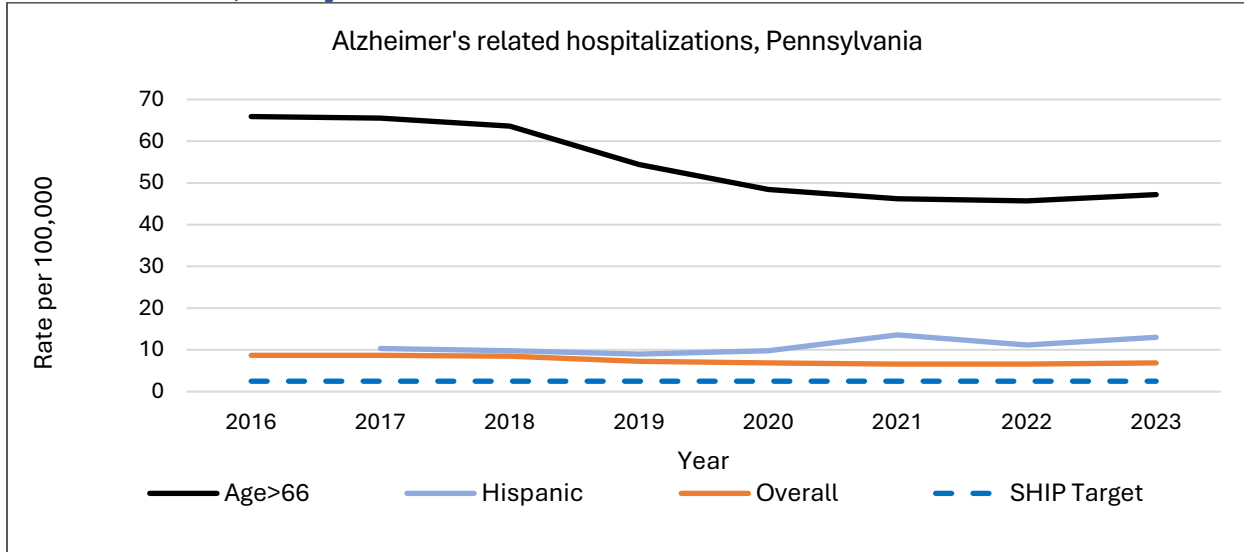
Source: PHC4

Table: COPD related hospitalization rate per 100,000 population, priority counties, Pennsylvania

Counties	2016	2017	2018	2019	2020	2021	2022	2023
McKean	331.4	458.3	374.4	386.5	197.5	98.7	83.1	44.2
Cameron	254.3	332.4	329.4	352				
Potter	259.2	326.5	273.6	279.4	91.2			
Elk	179.5	270.3	187.6	246.1	101.1	104.1	73.8	71.6
Philadelphia	291.2	289.1	260	231.5	164.4	162.2	151.5	147.5
Bradford				231.1				
Fayette	283.5	366.4	307.1	218.1	120.7	113.9	156.8	142.5
Clearfield	192.3	238.7	189.3	191.6	94.7	82.2	99.9	95.1
Greene	274.3	242.9	179.9	191.6	76.6	75.5	110.3	101.3
Mercer	257.1	343.6	201.3	176.5	95.7	81.7	95.6	78.9
Monroe	184.6	163.1	206.8	170.7	119.2	72.9	59.7	70.9
Blair	224.9	322.4	198.8	167	106.6	108.8	73	78.6
Huntingdon	196.8	236.2	175.8	165.2	129.7	88.4	124.2	149.6
Overall	183.7	206.8	153.8	136.9	86.4	79.1	76.4	78.2
SHIP Target	69	69	69	69	69	69	69	69
Bedford	125.5	155	105.7		55.8	30.3	58.7	55.2

Source: PHC4

Objective 3.3.5: Decrease Alzheimer's related hospitalization from 7.3/100,000 in 2019 to 2.5/100,000 by 2028



Source: PHC4

Table: Alzheimer's related hospitalization rate per 100,000 population, priority counties, Pennsylvania

Counties	2016	2017	2018	2019	2020	2021	2022	2023
Jefferson		50	54.6	48.7	45.2	29.6	36.5	29.9
Clearfield	29.7	33.6	24.7	31.7	29.4	20.9	23.6	20.5
Somerset	32.3	34.1	26.2	31	19.4			
Cambria	38.4	27.8	29	17.5	20.9	11.3	10.1	
Monroe				13.1	10		11.4	19.3
York	16	12.1	11.7	12.5	11.2	9	6.5	8.6
Northampton	19.3	19.4	17.2	12.2	12.9	15.1	13.4	14
Lehigh	6.3	6.5	8.2	11.6	13	12	14.6	15.5
Bucks	5.5	10.8	12.5	11.2	8	8.7	8.4	8.9
Schuylkill		10.1	17	9	10.8	10	8.7	9.4
Overall	8.7	8.7	8.5	7.3	6.9	6.6	6.6	6.9
SHIP Target	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5

Source: PHC4

3.3 SHIP Partner Strategies, Activities, Successes and Highlights

SHIP Goal 3.3 Team members contributed the following information on strategies and activities conducted throughout the Commonwealth in 2024 to improve health outcomes through improved chronic diseases management. This information includes overviews of activities as well as successes and highlights of the work of SHIP partners and their organizations.

Strategy: Increase dementia and Alzheimer’s education and support

SHIP Partner Activities/Successes/Highlights	Organization(s)
<ul style="list-style-type: none"> • Supported health systems and payers in their efforts to accurately assess, detect, and diagnose cognitive impairment, and deliver quality care and support to patients and their caregivers upon diagnosis. • Assisted partners in identifying quality improvement opportunities and implementing system/practice-wide change. • Dementia Project Extension for Community Healthcare Outcomes for Primary Care: Connected multidisciplinary dementia care experts with health care teams in a free continuing education series of interactive, case-based video conferencing sessions. • EssentiALZ training series: Educated professional care providers on current evidence-based, person-centered practices to care for individuals living with dementia. • Provided guidance to assist health systems in gaining their Age-Friendly Health Systems, Geriatric Emergency Department recognition. • Consulted with partners as they implemented the recently approved Guiding an Improved Dementia Experience dementia care model that focuses on caregiver support and dementia care navigation. • Impact was measured by the number of lives ages 65 and over (patient panel size) influenced by these projects and educational initiatives. 	Alzheimer’s Association
<p>Dementia Friends Pennsylvania provided free resources and information sessions on dementia both virtually and in-person to community members.</p> <ul style="list-style-type: none"> • Topics covered during Sessions included: 10 early signs/symptoms, dementia, five key messages, brain healthy habits, communication tips. Everyone received a 10-page workbook, resource packet, and certificate. 	Dementia Friends Pennsylvania

<ul style="list-style-type: none"> • Information was available in 10 languages and curriculum for children in elementary, middle, and high school. • Community members can become Champions once they are a Dementia Friend by attending a 90-minute virtual training. Champions provide Information Sessions in their communities. 	
<p>Dementia Friendly Pennsylvania supported the 13 Dementia Friendly Communities across Pennsylvania in their local efforts, while working to increase the number of communities in Pennsylvania.</p> <p>Resources were shared as well as an interactive calendar of events, recordings from webinar series, and connection to Speakers Bureau on the Dementia Friendly Pennsylvania website.</p>	Dementia Friendly Pennsylvania
<p>2024 Data Dementia Friends Pennsylvania:</p> <ul style="list-style-type: none"> • 318 Dementia Friends information sessions were held in 2024 in 67 counties • 7,364 Dementia Friends were made in 2024 • The total number of Dementia Friends in Pennsylvania is 22,386 	Dementia Friends Pennsylvania
<p>Dementia Friendly Pennsylvania:</p> <ul style="list-style-type: none"> • Seven new communities joined the Dementia Friendly Pennsylvania network in 2024 (Erie, Berks County, Lackawanna County, Chester County, Montgomery County, Crawford County, Mid Valley) • There is a total of 16 Dementia Friendly communities in Pennsylvania. Full list here: https://www.dementiafriendlypa.org/dementia-friendly-communities/current-communities 	Dementia Friendly Pennsylvania

Strategy: Strengthen public health infrastructure to address Alzheimer's disease and related dementias

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>Building Our Largest Dementia Infrastructure Public Health Program in Allegheny County worked with community partners to build infrastructure for those with Alzheimer's and related dementias.</p>	<p>Dementia Friends Pennsylvania</p> <p>Dementia Friendly Pennsylvania</p>

Strategy: Spread the reliable delivery of age-friendly care - based on the 4Ms framework (what Matters, Medication, Mentation, Mobility) - to all health care settings

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>UPMC Mercy became a geriatric center of excellence and an Age Friendly healthcare system recognized by the Institute for Healthcare Improvement.</p> <p>UPMC Mercy implemented the 4Ms framework of Age-Friendly Care. This framework encompasses Matters Most (older adult's preferences/goals), Medications (safe medication use), Mobility (fall preventions and safe mobility), and Mentation (dementia, delirium and depression). https://www.ihl.org/networks/initiatives/age-friendly-health-systems</p>	<p>UPMC Mercy</p>

Strategy: Increase education, support, and resources for Alzheimer's and age-friendly care

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>UPMC Mercy hosted supporting programs and initiatives including an Alzheimer's Disease support group, a volunteer evening readers program, a volunteer patient activities room, and an annual Age-Friendly conference.</p>	<p>UPMC Mercy</p>

Strategy: Improve management and monitoring of high blood pressure

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>The PA DOH funded 10 nonprofit organizations across the state to provide the Healthy Heart Ambassador Blood Pressure Self-Monitoring Program. Participants were required to have a diagnosis of high blood pressure with the goal of controlling and reducing their high blood pressure.</p> <p>The Blood Pressure Self-Monitoring Program is free four-month program where participants meet with a coach a minimum of twice a month for about 10 minutes and are required to take their own blood pressure readings at home a minimum of twice per month. Participants also attended monthly nutrition seminars that provide information on heart-healthy diets.</p> <p>Program participants received a free blood pressure monitor if they did not already have one.</p> <p>Organizations collected participant demographic information, blood pressure readings, and information on whether they've shared their readings with their health care provider.</p> <p>The Blood Pressure Self-Monitoring Program measured:</p> <ul style="list-style-type: none"> • Reduction in systolic and diastolic blood pressure readings from the beginning to the end of the program • Number of participants • Retention rate • Number of participants who shared their readings with their PCP • Demographic information to make sure we're reaching the target population (age, race, ethnicity, gender, zip code, language preference) • Satisfaction survey results 	<p>PA DOH, Bureau of Health Promotion and Risk Reduction</p>

<p>Healthy Heart Ambassadors Blood Pressure Self-Monitoring provided one on one and Group Sessions on:</p> <ul style="list-style-type: none"> • Physical Activity and Nutrition Education • Medication Adherence • BP Self-Monitoring 	Latino Connection
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Strategy: Improve health outcomes for stroke patients

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>Stroke Program A learning collaborative was created in rural western Pennsylvania with three designated stroke centers and two of their EMS providers. This work was facilitated by Quality Insights, who lead the quality improvement/process improvement projects with an overall goal to increase better health outcomes for stroke patients.</p>	<p>PA DOH, Bureau of Health Promotion and Risk Reduction Quality Insights</p>
<p>Coverdell Stroke Program The PA DOH created an additional stroke learning collaborative like the current one that is established.</p>	<p>PA DOH, Bureau of Health Promotion and Risk Reduction</p>

Strategy: Improve chronic disease management

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>The Allentown Health Bureau conducted cholesterol, glucose, and blood pressure screening for 75 program participants and offered individual dietary/lifestyle counseling session(s) for participants with abnormal glucose and/or lipid levels. https://www.allentownpa.gov/en-us/Government/Departments/Community-Economic-Development/Health-Bureau/Nutrition-and-Physical-Activity-Program/Cholesterol-Blood-Sugar-and-Blood-Pressure-Screening-Program</p>	Allentown Health Bureau

<p>The Allentown Health Bureau used grant funding from the PA DOH to provide a free 4-month Blood Pressure Self-Monitoring Program. A minimum of 25 participants who were previously diagnosed with high blood pressure either with or without medication were recruited to measure and track blood pressure at home to manage and lower blood pressure. The goal is for program participants to decrease their systolic blood pressure by 2mmHg and their diastolic blood pressure by 2mmHg.</p> <p>Participants received a blood pressure monitor, met with a trained coach two times a month for 10 minutes, and attended monthly nutrition seminars.</p>	<p>Allentown Health Bureau PA DOH</p>
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Strategy: Improve health outcomes and management of chronic disease for people with serious mental illness

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>Behavioral Health Home Plus (BHHP):</p> <ul style="list-style-type: none"> • The BHHP model focused on breaking down barriers to the coordinated delivery of primary physical and behavioral health care for individuals with SMI. • BHHP emphasized getting participants engaged with primary care, addressing modifiable risk factors that lead to poor health outcomes, and closing gaps in care. • BHHP used a wellness coaching model to address modifiable risk factors that can impact address chronic diseases like diabetes and hypertension, and tobacco use disorders. • BHHP used a Value Based Payment model which included 2 HEDIS metrics to track outcomes. <ul style="list-style-type: none"> ○ Hemoglobin A1c Control for Patients with Diabetes (HBD) ○ Controlling High Blood Pressure (CBP). 	<p>Community Care Behavioral Health</p>

Strategy: Increase chronic disease screenings, referrals for positive screenings, and follow-up (activities will focus on increasing screenings and referrals and follow up for diabetes, heart disease, COPD, Alzheimer's and cancer

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>Provided a calendar of events that listed available health screenings.</p> <p>Trained providers on updated screening recommendations.</p>	<p>Pennsylvania Area Health Education Centers</p> <p>Penn State Project ECHO</p>

Strategy: Increase access to and education on preventive care for underserved communities

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>Provided mobile mammography screenings.</p>	<p>Delaware County Health Department</p> <p>Jefferson Hospital</p> <p>Fox Chase Center</p>
<p>LION Mobile Clinic provided comprehensive mobile healthcare services, addressed food insecurity, promoted economic development, and enhanced sustainability practices.</p>	<p>LION Mobile Clinic</p>
<p>Designed and implemented a Cardiovascular Risk Prevention program targeting, primarily, underserved Hispanic/Latino and Black women.</p> <p>Promoted proper nutrition and physical activity, and emphasized the importance of having a strong, positive self-esteem to address both the physical and emotional aspects of wellness and help mitigate the risks that contribute to cardiovascular diseases.</p>	<p>Latino Connection</p> <p>PA DOH</p> <p>Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN)</p>

Strategy: Increase cancer prevention education

SHIP Partner Activities/Successes/Highlights	Organization(s)
Presented information about prostate cancer and screening recommendations.	UPMC PA DOH Pennsylvania Cancer Coalition Latino Connection

Strategy: Support the objectives and strategies in the 2023-2033 Pennsylvania State Cancer plan to reduce the overall cancer death rate

SHIP Partner Activities/Successes/Highlights	Organization(s)
SHIP representatives joined and participated in the PA Cancer Coalition (PCC). Pennsylvania Comprehensive Cancer Control (PA CCCP) Staff served on the SHIP Team. Worked to identify three SHIP chronic disease partner groups or organizations for dissemination of the 2023-2033 cancer plan.	Pennsylvania Cancer Coalition 3.3 SHIP Team

Strategy: Increase capacity of Diabetes Prevention Program (DPP) providers

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>Provided project management services to CDC-recognized organizations including:</p> <ul style="list-style-type: none"> • 45 PA DOH-supported CDC-recognized sites (77 total organizations in PA). • 69 Lifestyle Coaches (at PA DOH sites). <p>Increased awareness of prediabetes and the National DPP.</p> <ul style="list-style-type: none"> • Conducted 590 visits with the Pharmaceutical Assistance Contract for the Elderly or PACE providers. • Engaged 278 Weinberg Regional Food Bank Facebook members online. 	<p>PA DOH, Bureau of Health Promotion and Risk Reduction</p>

Strategy: Increase enrollment and retention of priority populations in Pennsylvania’s Diabetes Prevention Program (DPP)

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>Established and promoted screenings for prediabetes and social determinants of health (SDOH), and referrals from clinical and community sources.</p> <ul style="list-style-type: none"> • 2,847 individuals enrolled in Pennsylvania’s DPP. • Four organizations made SDOH referrals using the Find Help and Pennsylvania Navigate platforms. <p>Supported virtual asynchronous delivery.</p> <ul style="list-style-type: none"> • 13 DPP providers were enrolled in Health and Lifestyle Training. 	<p>PA DOH, Bureau of Health Promotion and Risk Reduction</p>

Strategy: Increase Pennsylvania’s Diabetes Prevention Program (DPP) sustainability

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>Increased coverage and reimbursement.</p> <ul style="list-style-type: none"> 19 of the total 77 CDC-recognized organizations are also Medicare DPP providers. <p>Established/expanded National DPP Umbrella Hub Arrangements (UHA). UHAs are a business approach to connect Community-Based Organizations with health care payment systems.</p> <ul style="list-style-type: none"> There is one existing UHA and one in the works. 	<p>PA DOH, Bureau of Health Promotion and Risk Reduction</p>

Strategy: Increase collaboration and information sharing among key partners whose work aligns with the 3.3 SHIP goal and objectives

SHIP Partner Activities/Successes/Highlights	Organization(s)
<p>The SHIP team identified missing key partners and conducted outreach to include these partners on the SHIP goal team.</p> <p>Promotion of the SHIP goal team was conducted through SHIP presentations and distribution of SHIP informational materials.</p>	<p>3.3 SHIP Goal Team</p> <p>PA DOH SHIP Team</p>
<p>The Northwest Regional Heat Equity Action Team focused their efforts on SHIP Goal 3.3 and hosted community-based presentations in 2024.</p>	<p>PA DOH, Office of Health Equity</p>

Appendix C4

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

Objectives:

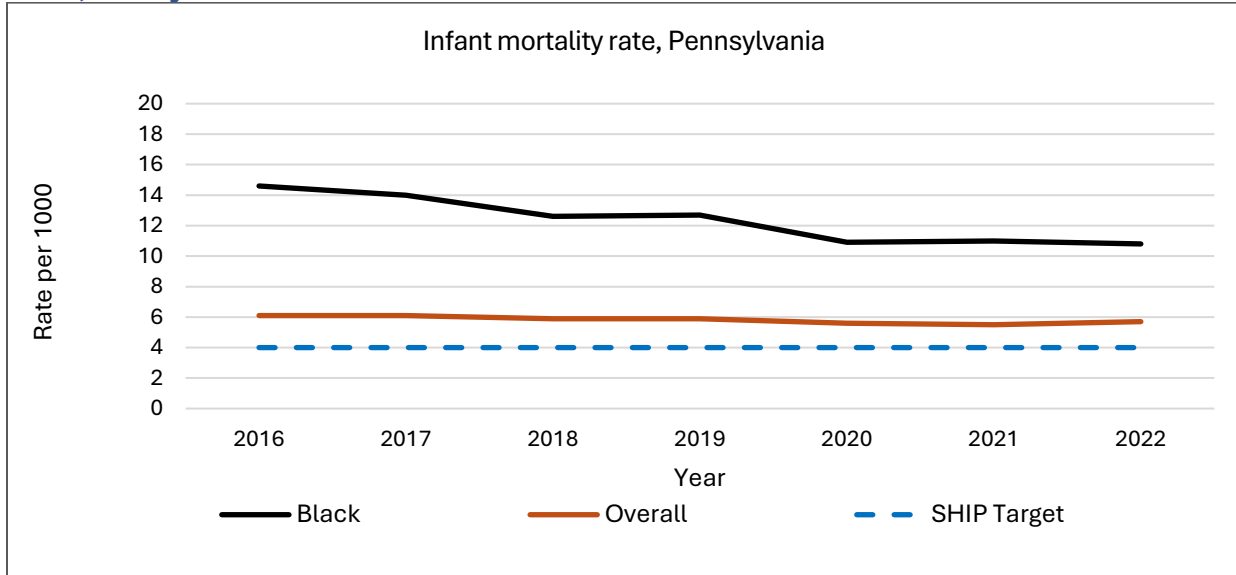
- Reduce infant mortality
- Reduce severe maternal morbidity

3.4 Trends in the SHIP objectives

The two objectives, along with the progress toward the SHIP targets, are detailed below. The most recent available statewide data for the 3.4 objectives is 2022. This data can be used to look at previous trends for these objectives and help to provide an overall view of progress towards the 3.4 SHIP Goal.

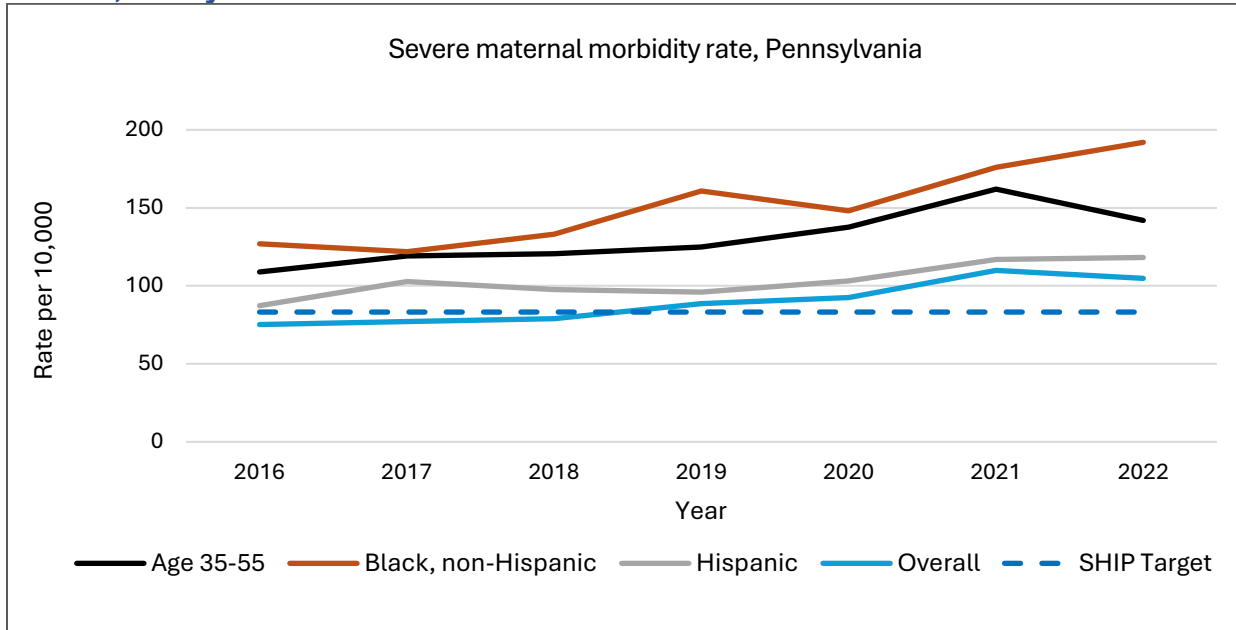
The target year of 2028 reflects the endpoint of the SHIP. Due to varying data availability and reporting lags across indicators, the most recent data available in 2028 will be used to assess progress toward each objective.

Objective 3.4.1: Reduce the rate of infant mortality from 5.6/1,000 in 2020 to 4.0/1,000 by 2028



Source: Pennsylvania Death Certificate Dataset

Objective 3.4.2: Reduce severe maternal morbidity from 92.4/10,000 in 2020 to 83.2/10,000 by 2028



Source: U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality

3.4 SHIP Partner Strategies, Activities, Successes and Highlights

SHIP Goal 3.4 Team members contributed the following information on strategies and activities conducted throughout the Commonwealth in 2024 to improve maternal and infant health outcomes. This information includes overviews of activities as well as successes and highlights of the work of SHIP partners and their organizations.

Strategy: Increase education and resources on safe sleep practices for infants

SHIP Partner Activities/Successes/Highlights	Organization
<ul style="list-style-type: none"> • PA Safe Sleep developed a pictorial patient education resource for patients/families who are unable to read, Additional translations of the education brochure are now available in 27 languages. • The PA Safe Sleep Program website had 5,300 unique visitors as well as visitors from 28 different countries. • In FY24, 61,000 babies were born in PA Safe Sleep hospitals. • 107 new Safe Sleep Subject Matter Experts were trained. • PA Safe Sleep work was presented as a podium at the Association of Women’s Health, Obstetrics, and Neonatal Nursing Annual Meeting in June 2024 and the American Nurses Credentialing Center (ANCC) Magnet Conference in October 2024. <ul style="list-style-type: none"> ○ Hats Off to Safe Sleep poster won the First Place ANCC Magnet Conference Commissioner Poster Award in the category of Research and Innovation. • PA Safe Sleep was featured in an article published in Pediatrics - A Hospital-Based Initiative for Infant Safe Sleep Practice. Link to article: https://publications.aap.org/pediatrics/article/doi/10.1542/peds.2024-067659/200623/A-Hospital-Based-Initiative-for-Infant-Safe-Sleep?searchresult=1?autologincheck=redirected • PA Safe Sleep won the Innovation Hub’s Best Practice Award from the Association of Maternal and Child Health Programs. • Staff, providers, families, and caregivers were educated on safe sleep through information provided on safe sleep surfaces. 	<p>PA Safe Sleep</p>

Strategy: Increase perinatal health education and resources for providers

SHIP Partner Activities/Successes/Highlights	Organization
<ul style="list-style-type: none"> • Provider education was conducted through routine education, monthly and quarterly provider webinar series, and meetings focused on the importance of reviewing and closing member care gaps. The methods to close gaps and reports/resources were available to providers through the provider webpage and NaviNet. • Provider newsletters included information on the benefits of preconception counseling for healthier pregnancies and available contraception options based on the Preferred Drug List. • A provider webinar was held to discuss changes to the 2024 incentive program designed to recognize and reward the quality performance of maternity care practices, the Obstetrical Needs Assessment Form Program, and the Healthcare Effectiveness Data and Information Set measures. • A resource guide was distributed to providers with comprehensive information on support and resources that are available to members. • Providers had access to a provider web-based site with a wide range of resources including additional training resources with self-paced, and instructor-led trainings. • Monthly maternity workgroups discussed trends and possible barriers members may have in receiving prenatal and postpartum care and discussed suggestions for improvement. 	<p>Pennsylvania Medicaid Managed Care Organizations</p>

Strategy: Increase education, resources and outreach on perinatal health and available maternal and infant health programs

SHIP Partner Activities/Successes/Highlights	Organization
<ul style="list-style-type: none"> • Prenatal packets were sent to all newly pregnant members with information regarding pregnancy education, available programs and resources, and the Medical Assistance home visitation program. 	<p>Pennsylvania Medicaid Managed Care Organizations</p>

<ul style="list-style-type: none"> • A congratulations packet was sent once member delivered, which included important information about the postpartum period, post birth warning signs, and how to care for a new baby. • Postpartum mailers provided resources and educational information for members, including the importance of a postpartum visit, education regarding Long-Acting Reversible Contraception availability and requirements, postpartum depression, appropriate interventions, and additional resources. • Follow up calls were made to members who were sent an educational packet in the postpartum well child outreach campaign. The outreach representative confirmed receipt of the educational packet and began to prepare the parent/guardian on pivotal well child visits that should include lead testing and developmental screenings. Barriers to care were assessed, and resources were offered. (This initiative continues). • A postcard was sent to all members (parent/guardian) who were unable to be reached. • A resource library provided information for new and expecting parents including a resource list, a self-care checklist, a substance-use information guide, and videos that walk moms through what to expect at their prenatal and postpartum visits. • Members received a packet that included a lead flier with appointment card, and a DoctorChat and Nurseline magnet, One pass information, and an Early and Periodic Screening, Diagnosis and Treatment mailer. 	
<p>Community baby showers were held to distribute information on maternal health programs and to refer members who are not already in case management for evaluation.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>Mobile wellness unit vendors set up information from the trunks of their cars and distributed literature pertinent to pregnancy, while the members who are pregnant or new moms drove to each station to receive the information.</p> <p>There were typically 5-6 vendors at these events who have services that are beneficial to the pregnant members and new moms, including Special Supplemental Nutrition Program for Women, Infants and Children, Education Leading to Employment and Career Training programs, Nurse Family Practitioners, etc.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>

<p>Community health workers, community health navigators/maternal health navigators (CHNs/MHNs) conducted outreach to members in the following ways:</p> <ul style="list-style-type: none"> • Care Connectors (CC) referred members to CHNs/MHNs when unable to contact members for a low-risk survey. • Case Managers (CM) referred high risk members to CHNs who they were unable to reach or have lost contact with. • CM/CCs referred members to CHNs/MHNs who they were unable to contact and/or did not have a postpartum visit scheduled with their OBGYN. • CHNs/MHNs completed surveys when they were able to establish contact with the member. 	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>Care management intervention was provided for high-risk mothers, and outreach was provided to members newly enrolled while pregnant.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>Members were informed of a Family Visiting Program and, if interested, were sent a referral to maternity case management.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>Primary care physician information was obtained for newborns, and education was provided on the importance of at least six well child visits by 15 months.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>During the postpartum period, the maternity case management program educated new mothers on risks, self-care, and safety for the baby. The team ensured that medical and behavioral health needs were addressed along with providing connections to health care and community resources.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>Early pregnancy notification letters were provided to members about the full suite of services that program staff can provide including preconception/interconception care, antepartum, and postpartum education and support.</p> <p>A maternity web page provided pregnancy and postpartum information/resources and the maternity program overview. A select chat function provided an opportunity to connect with</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>

maternity case manager and become engaged with the maternity program through the website.	
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Strategy: Increase access to services to improve health outcomes for birthing people and families with young children

SHIP Partner Activities/Successes/Highlights	Organization
<p>Maternity Care Coalition (MCC) works in historically marginalized communities challenged by poor social determinants of health. To address the complex needs of birthing people and families with young children, MCC offered a range of direct services in 2024, including:</p> <ul style="list-style-type: none"> • Home Visiting – MCC’s signature MOMobile® program included a range of home visiting models that support families to meet their goals related to maternal and infant health, child development, early learning, and basic needs. • Childcare and Early Childhood Education – This evidence-based Early Head Start program offered comprehensive child development and parenting support and promoted school readiness for children ages 0-3 through home-based and center-based early learning. • Community and Parenting Education – A continuum of community-based programs, parenting and childbirth education groups, and access to basic needs resources including diapers, wipes, infant formula, and cribs through the Cribs for Kids program. • Reproductive Health - A care coordination and systems navigation program that ensured access to reproductive health care services, education, and support. • Community Doula and Lactation – Services included lactation workshops, matching families with doulas through MCC’s Community Doula Network, and a racial justice-centered Doula and Lactation Community Health Worker training program. • Behavioral Health – MCC offered in-home individual and family therapy, targeted interventions for pregnant and postpartum parents with substance dependence, and support for families during and following incarceration. 	Maternity Care Coalition

<p>During fiscal year 2024, Maternity Care Coalition (MCC) provided services to 4,252 unduplicated families including:</p> <ul style="list-style-type: none"> • Case management for 1235 pregnant and parenting families enrolled in the MOMobile home visiting programs. • Home-based and center-based Early Head Start services for 324 families with children ages 0-3. <ul style="list-style-type: none"> ○ Home-based services for 59 pregnant people and 150 families with children ages 0-3 ○ Center-based EHS services for 115 children ages 0-3 • Community doula and lactation support services for 497 birthing people. • Family therapy and individual counseling for 116 families enrolled in MCC home visiting services. • Workforce development services for 62 participants in the Perinatal Community Health Worker Training series. • Education and peer support for 405 parents enrolled in parenting and childbirth education groups. • Safe sleep education and a crib, crib sheet, and blanket sleeper for 983 families. • Sexual health and decision-making workshops for 1,174 high-school students. • Limited services such as food, formula, diapers, and referrals for clients and community members. 	<p>Maternity Care Coalition</p>
<p>Volunteers of America of Pennsylvania’s Maternal Services, an in-home support program, takes a whole-family approach to care coordination for mothers and their children in the perinatal period, extending support to siblings and strengthening household stability. Peer support groups have evolved into strong, self-sustaining networks of encouragement and connection among participating mothers and their children.</p>	<p>Volunteers of America of Pennsylvania</p>

Strategy: Increase access to perinatal health care

SHIP Partner Activities/Successes/Highlights	Organization
<p>Interconception Care (ICC) and Fourth Trimester project: The IMPLICIT (Interventions to Minimize Preterm and Low Birthweight Infants using Continuous Improvement Techniques) Network expanded to include 16 active and participating ICC sites statewide, to provide screening, referral, and brief interventions for four risk factors to birthing people at their children's well-child visits.</p> <p>Through IMPLICIT's ICC Project, 3,274 birthing people received care who may not have received care otherwise. In addition, 372 birthing people received an early postpartum visit (within 21 days of birth) through the IMPLICIT's Fourth Trimester Project. An updated IMPLICIT Toolkit was also published in 2024: https://www.marchofdimes.org/implicittoolkit https://www.fmec.net/implicit</p>	<p>University of Pennsylvania (the Pennsylvania hub of the multi-state IMPLICIT Network)</p> <p>PA DOH, Bureau of Family Health</p>
<p>Transportation was provided to members for medical appointments through the Medical Assistance Transportation Program.</p> <p>A contract with a vendor provided postpartum visits for members that could not get or go to their appointments with their OB/GYNs.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>The importance of prenatal and postpartum care was discussed during care management outreach and assistance was provided with resource coordination for barriers such as transportation.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>Prenatal provider alerts were delivered to the team for members that indicated they did not have a prenatal provider and would like assistance in locating one. The team reached out to the member and provided assistance with locating a provider in the area and scheduling the appointment.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>

<p>The care management maternity program incorporated telehealth into its entire program which was staffed by registered nurses and licensed social workers who reached out to providers as needed.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
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Strategy: Increase access to prenatal health care in rural areas

SHIP Partner Activities/Successes/Highlights	Organization
<p>Amish Mobile Clinic provided prenatal and gynecological community outreach in the Amish community in Jefferson and Indiana Counties.</p> <p>The Amish community has limited access to transportation and are self-pay patients as their religious beliefs hinder them from obtaining insurance coverage. This program provided assistance for some of the financial and transportation burdens the Amish community has when accessing prenatal care and helped to cover visits, screenings, and testing.</p> <p>The Punxsutawney Area Hospital (PAH) Prenatal and Community Outreach team visited the Amish Community Clinic utilizing the PAH Wellness Bus, which is a mobile unit used for community visits. This program offered preventive screenings and identified high risk patients for follow up appointments and care coordination. Services offered included antenatal testing if applicable, ultrasound, maternal fetal medicine to behavioral health (history of depression or high screening score), and nutritional counseling (to address gestational diabetes or poor weight gain). Patients were educated on healthy pregnancy, infant safety, depression and pregnancy warning signs and were given instructions on how to contact a health care provider. Patient education was tailored to the specific individual. Outreach helped to assist in overall improved health and established a relationship for continuation of care.</p>	<p>Punxsutawney Area Hospital</p>

Strategy: Identify rural areas with lack of maternal health care access including postnatal care

SHIP Partner Activities/Successes/Highlights	Organization
The 3.4 SHIP Teams monitored and discussed hospital closures and maternity health deserts.	3.4 SHIP Goal Team

Strategy: Increase access to perinatal health preventive screenings and testing

SHIP Partner Activities/Successes/Highlights	Organization
The Pennsylvania Academy of Family Physicians improved access to anatomy scans (ultrasounds) by providing transportation and blood pressure cuffs for use at home to monitor blood pressure.	Pennsylvania Academy of Family Physicians
Distributed blood pressure cuffs to pregnant and postpartum women, specifically targeting women of color.	Erie County Department of Health and BirthRoot Doulas
March of Dimes increased health care access to women and children by providing screening, testing, and patient recruitment through mobile health fleet.	March of Dimes
LION Mobile Clinic utilized mobile clinics to increase preventive health screenings.	LION Mobile Clinic
A remote blood pressure (BP) monitoring program post-discharge was provided for members who had preeclampsia to monitor blood pressure in the postpartum period for high risk or post treatment. Members received reminders via text message to check BP twice a day then reported results to the obstetrician’s office. This allowed the physician to monitor but not require the member to go to a medical facility or office unless there were concerns. The length of program was determined based on BP readings, usually between 7-14 days.	Pennsylvania Medicaid Managed Care Organizations

Strategy: Improve nutrition for pregnant individuals with diabetes

SHIP Partner Activities/Successes/Highlights	Organization
The MANNA program provided medically tailored meals and nutrition education to pregnant case managed members with type 1, type 2, or gestational diabetes.	Pennsylvania Medicaid Managed Care Organizations

Strategy: Increase outreach to ensure adequate perinatal care is received

SHIP Partner Activities/Successes/Highlights	Organization
Community Health Navigators (CHN) provided three face-to-face attempts at the member’s home with telephonic attempts in between. If needed, attempts included research and attempts to last known address and contact numbers, especially if member has a history of homelessness or living in shelters. Once engagement was established with the member, the CHN provided education as well as assistance in addressing any barriers or social determinants of health concerns and scheduling any maternity related appointments and connection to a case manager if necessary.	Pennsylvania Medicaid Managed Care Organizations
<p>The team contacted newly identified pregnant members to provide support with scheduling prenatal visits and postpartum visits after delivery.</p> <p>Methods of outreach to members included phone calls, face-to-face clinic/community/hospital visits, MyChart messages, and conference calls between case managers and members.</p> <p>A home visit by a Community Health Assistant was performed when member was unable to be reached.</p>	Pennsylvania Medicaid Managed Care Organizations
The Community Health Worker (CHW) initiative is part of the overall CHW initiative included under the Comprehensive Diabetes Care and Controlling Blood Pressure section. As part of their work, the CHWs located in Pittsburgh, Harrisburg, and Allentown focused on supporting maternity Case Management in locating hard to reach pregnant members. Once members	Pennsylvania Medicaid Managed Care Organizations

<p>were reached and any immediate social determinant of health needs were met, CHWs held culturally relevant conversation about the importance of receiving perinatal care and linked the member back to maternity Case Managers for additional support.</p>	
<p>During the prenatal period, maternity case management focused on earlier identification and engagement of pregnant members along with enhanced support for healthcare providers. The registered nurse Case Manager provided telephonic case management for all members who were identified as rising and high-risk pregnancies. Assistance was provided with scheduling the visits and/or locating a provider.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>

Strategy: Increase timely perinatal health care

SHIP Partner Activities/Successes/Highlights	Organization
<p>A voluntary texting and incentive program for pregnant members provided members with texts twice a week during their pregnancy. Gift card incentives were provided for completing the first prenatal visit by the end of 14 weeks and for attending the postpartum visit 7 - 84 days after giving birth.</p> <p>During pregnancy, the phone program provided free cell phones to high-risk case managed pregnant members to keep members connected with their case managers and providers to support compliance with prenatal and postpartum care.</p> <p>During the postpartum period, the program targeted premature and low-weight births, by using mobile phones to promote prenatal and post-partum care (ending at three months postpartum) and to keep moms connected with case managers.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>Gift cards and rewards were provided for:</p> <ul style="list-style-type: none"> • Members who completed one prenatal visit in the first trimester. • Members who completed one postpartum visit between 7-84 days after delivery. • Members who completed an in-home postpartum visit. 	<p>Pennsylvania Medicaid Managed Care Organizations</p>

<ul style="list-style-type: none"> Members who engaged in the maternity program and completed required prenatal visits. 	
<p>Providers collaborated to identify barriers and develop initiatives to ensure women receive postpartum care.</p> <p>A Maternity project team met monthly to work to make improvements to timely prenatal care, identify barriers to care and interventions to mitigate these barriers, and increase understanding of member-provider interaction.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>A maternity postcard mailer was sent to pregnant expansion zone members who are not yet engaged in care with an obstetrician.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>Member outreach was optimized through a coordinated appointment assistance outreach campaign to ensure that the right members received outreach from the right group at the right time. This outreach included utilizing contact information gathered from previous outreach campaigns, retail pharmacy partnerships, community engagement, and other initiatives.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>Providers were electronically notified after a pregnant member was discharged from the emergency department or inpatient admission to help support coordination of care in the prenatal period.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>The provider maternity dashboard was used to better identify clinicians involved with a member's perinatal care to support coordination of care for the member. It also gave providers an opportunity to see if a prenatal visit occurred and the evidence was not submitted on a claim.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<ul style="list-style-type: none"> Member wellness plans provided well-woman visit education to establish a relationship with an OB/GYN or family practitioner. Well-woman digital communications were provided to members including texts to remind members to schedule their visit. Postpartum digital communications were sent to members, including texts to remind members to complete their postpartum visit. 	<p>Pennsylvania Medicaid Managed Care Organizations</p>

<ul style="list-style-type: none"> Case managers conducted outreach to every mom to schedule an appointment and follow-up to be sure that the visit occurred. 	
<p>Care gap flags notified member-facing staff if the member has not seen an OB/GYN or family practitioner or if the member has not had their postpartum visit.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>A maternity education and incentive program was launched in December 2023. This program included real time verification of pregnancy, increased clinical expertise from content partners March of Dimes, the American College of Obstetrics and Gynecologists, National Institute of Health and the Centers for Disease Control, and increased technical abilities.</p> <p>A simple sign-on was used for a downloadable application to increase ease of use and improve member experience. Members received an e-gift card as an incentive for registration, a prenatal visit, and a postpartum visit. The application encouraged completion of the prenatal assessment, which was fed into the case management system for follow-up on any assessment questions that indicated rising or high-risk pregnancy, to increase the promptness of maternal case management contact.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>An outreach program for prenatal and postpartum members ran continuously throughout the year. Calls were made at 26 and 32 weeks prenatally, and up to two calls during the postpartum period. (This program was placed on hold 5/13/2024.)</p> <p>The maternity team began a telephonic outreach pilot calling all members who had a pregnancy claim. Outreach was not limited to rising or high-risk members. This pilot tested if having this touchpoint with members early on would result in healthier moms and positively impact timeliness of prenatal care rate. Outreach began in June and evaluated the success of reaching members and potential impact in three months. Many participants had healthy pregnancies.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>Members' cases were reviewed several weeks prior to the 6-week delivery timeframe and member outreach was provided to schedule an appointment. Postpartum appointment reminder mailers were triggered upon receipt of a delivery claim.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>

Automated calls were made to members and if they indicated they were pregnant, attempts were made to schedule a prenatal visit. If a member indicated they are not currently pregnant, attempts were made to schedule an annual OB/GYN visit. Automated calls were also made to pregnant women starting at 36-40 weeks to assist with scheduling a postpartum visit.	Pennsylvania Medicaid Managed Care Organizations
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Strategy: Increase provider incentives to improve the quality and timeliness of perinatal health care

SHIP Partner Activities/Successes/Highlights	Organization
Pennsylvania Medicaid Managed Care Organizations incentivized providers to improve perinatal health care through targeted quality benchmarks.	Pennsylvania Medicaid Managed Care Organizations

Strategy: Improve maternal substance use outcomes

SHIP Partner Activities/Successes/Highlights	Organization
Moms who tested positive for substance use were connected to supports and services.	PA DOH, Bureau of Community Health Systems Beaver County State Health Center
Comprehensive intensive case management and nurse navigation services assisted expectant mothers who were struggling with substance abuse.	Pennsylvania Medicaid Managed Care Organizations
Members accessed treatment and case management services for Opioid Use Disorder through Pennsylvania’s Opioid Use Disorder Centers of Excellence. Pregnant and postpartum members received additional education and support to receive timely and appropriate prenatal and postpartum care with the support of the Care Management services.	Pennsylvania Medicaid Managed Care Organizations

Strategy: Provide tobacco use and cessation support

SHIP Partner Activities/Successes/Highlights	Organization
Members who currently use tobacco or have a history of tobacco use were identified and provided education on the benefits of cessation and were connected to resources, including the PA Quit Line.	Pennsylvania Medicaid Managed Care Organizations
Pennsylvania Medicaid Managed Care Organizations educated providers on tobacco counseling reimbursement.	Pennsylvania Medicaid Managed Care Organizations

Strategy: Increase behavioral services during prenatal, perinatal, and postnatal care

SHIP Partner Activities/Successes/Highlights	Organization
<p>Perinatal TiPS Program: The Jewish Healthcare Foundation led a statewide perinatal behavioral health consultation and access program to address maternal mental health conditions and substance use disorder, which are the leading causes of pregnancy-related deaths in Pennsylvania, according to the 2024 Pennsylvania Maternal Mortality Review Annual Report. In partnership with UPMC Western Psychiatric, Penn State Hershey Medical Center, and the PDPH, once fully implemented the program will provide perinatal care providers with consultation, resource referrals, and education. By fostering provider-to-provider relationships, it aims to enhance service utilization and improve outcomes for parents and newborns. 2024 Pennsylvania Maternal Mortality Review Annual Report: https://www.pa.gov/content/dam/copapwp-pagov/en/health/documents/topics/documents/programs/2024%20MMR%20Annual%20Report.pdf</p>	<p>The Jewish Healthcare Foundation</p> <p>PA DOH, Bureau of Family Health</p> <p>UPMC Western Psychiatric</p> <p>Penn State Hershey Medical Center</p> <p>PDPH</p>
<p>With the leadership of Healthy Start, Inc. in Pittsburgh, the Statewide Healthy Start Maternal Behavioral Health Initiative promoted the use of perinatal behavioral health supports and services at Pennsylvania's Healthy Start sites (Hamilton Health Center, The Foundation of Delaware County, Maternity Care Coalition, PDPH, Albert Einstein Medical Center, and Healthy Start, Inc. in Pittsburgh). The goal of this initiative is to increase the Healthy Start</p>	<p>Healthy Start, Inc. Pittsburgh</p> <p>PA DOH, Bureau of Family Health</p>

network's capacity to support the behavioral health needs of pregnant, postpartum, and parenting individuals and families in the counties served by their organizations (Allegheny, Dauphin, Delaware, Cumberland, Montgomery, Perry, Philadelphia, and Westmoreland counties).	
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Strategy: Increase behavioral health and physical health collaboration to improve perinatal health outcomes

SHIP Partner Activities/Successes/Highlights	Organization
The Integrated Care Program (ICP) collaborated to discuss members with a serious persistent mental illness. The care plan was shared with member's primary care physician via fax with cover letter explaining ICP process and was also shared verbally with the member.	Pennsylvania Medicaid Managed Care Organizations

Strategy: Increase screening, education, resources and referrals for perinatal depression

SHIP Partner Activities/Successes/Highlights	Organization
PA Medicaid Managed Care Organizations provided outreach, educational materials, screenings, and resources for prenatal and postpartum depression, and facilitated follow up or referrals when appropriate to ensure timely care.	Pennsylvania Medicaid Managed Care Organizations

Strategy: Provide group prenatal health education to improve social connections and perinatal health outcomes

SHIP Partner Activities/Successes/Highlights	Organization
A program was provided to help pregnant women get together with other pregnant women to talk and ask questions. Members could download and app or visit the website to enroll and engage in the program through the 35th week of pregnancy. Members received a confirmation email with a group assignment and introduction of their facilitator and program elements. An individualized welcome call was completed with the member and group facilitator. Participants	Pennsylvania Medicaid Managed Care Organizations

engaged in bi-weekly group video sessions and designated group discussion boards that included education around contraception and family planning.	
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Strategy: Increase support and counseling for pregnancy and child loss

SHIP Partner Activities/Successes/Highlights	Organization
A Perinatal loss/Grief support team who were trained and certified as Perinatal Bereavement Counselors provided support to members who experienced a pregnancy or child loss.	Pennsylvania Medicaid Managed Care Organizations

Strategy: Improve perinatal health outcomes through home visiting services

SHIP Partner Activities/Successes/Highlights	Organization
In 2024, Volunteers of America of Pennsylvania (VOAPA) Maternal Health Program delivered vital in-home visitation support to more than 320 mothers and 350 babies across seven Pennsylvania counties (Luzerne, Wyoming, Schuylkill, Lehigh, Allegheny, Westmoreland, and Beaver). Through personalized home visits, case management, and assistance with accessing healthcare, housing, employment, and meeting other basic needs, the program tackled critical barriers facing families during the perinatal period. VOAPA is working toward expanding Maternal Services to include Lawrence, Mercer, Clarion, Carbon, Dauphin, Lancaster, York, and Lackawanna counties.	Volunteers of America of Pennsylvania
The PA DHS worked to increase access to home visiting services that encourage the use of preventive services, identify and resolve barriers to care, and mitigate social determinants of health barriers.	PA DHS
As part of the Maternal Home Visiting program under Community Based Care Management, Community Based Organizations (CBOs) provided home visiting services to pregnant members and children up to 18 months old. The CBOs utilized evidence-based and/or evidence-informed curriculum that provided information and services which included, but were not limited to, the importance of prenatal/postpartum care, keeping current on well-child	Pennsylvania Medicaid Managed Care Organizations

<p>appointments, keeping current on immunizations, the importance of dental care, assessments for social determinants of health needs, and family planning.</p> <p>Members and their children were provided with holistic support, considering mental and social factors, rather than just the symptoms of a disease.</p> <p>Early Intervention referrals and other needs were identified through the home visits with the members.</p>	
<p>A Maternity Home Visiting Program provided services for pregnant members with HIV and infants up to 18 months old in Philadelphia and Delaware Counties. The services included creating a Service Care Plan with the members and sharing resources to support their physical and emotional well-being.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>Referrals were made to maternal home visiting partners across the Commonwealth during initial calls to members and home nursing was routinely offered for mom-baby well visits postpartum.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>Pennsylvania Medicaid Managed Care Organizations partnered with community-based organizations to complete outreach and schedule home visits for members within the postpartum timeframe.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>The Maternal, Infant and Early Childhood Home Visitation Program assessed unmet needs, made referrals to evidence based home visiting programs when needed, and ensured member received preventive care, including postpartum visits for mom.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>The Family Visiting Program (FVP) partnered with Evidence Informed Organizations (EIOs) throughout service areas to provide home visiting services, assessments, and referrals for ongoing services for first time and high-risk mothers, parents and infants, and any other pregnant woman or family expressing interest in enrolling in FVP. In addition to the contracted EIOs and evidence-based organizations (EBOs), Community Health Workers provided home visiting services as work occurred to increase the number of contracted EIOs/EBOs in</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>

additional counties. Providers were made aware of this program online and through the maternal health team.	
A licensed practitioner performed an in-home or a virtual visit with the postpartum member, coordinated with the member's primary care physician (PCP), reengaged membership, educated on family planning, and improved the member/PCP relationship.	Pennsylvania Medicaid Managed Care Organizations
Referrals were sent to Nurse Family Partnerships and several other maternal child home visiting community-based organizations. Monthly disposition reporting was received from partners on enrollment and the number of visits. The care management team continued to collaborate with established and new maternal home visiting partners to build capacity.	Pennsylvania Medicaid Managed Care Organizations

Strategy: Increase education on doula services

SHIP Partner Activities/Successes/Highlights	Organization
<p>The doula talking points for staff use was updated. This document helped to guide conversations that care management staff had with members regarding doula services and included the definition of doulas, information on the services the doula provides, the benefits of doula services, and the contact information and referral process for agencies the plan is contracted with to provide doula services.</p> <p>The program flyer and program welcome letter were updated to include the information on doulas to encourage member and care coordinator discussions on doula services.</p> <p>Resources were updated to include information on available doula services and how to connect members.</p>	Pennsylvania Medicaid Managed Care Organizations

<p>Discussions were held with members about maternal home visiting services including doula services and benefits to see which was the best fit for pregnant members.</p> <p>Doula information was available at baby showers and community events. Community partners, including doulas, were invited to the community baby showers to provide education on available services.</p> <p>Recruitment materials were developed to go out in outreach packets, and a strategy plan was developed for structured member education around doulas in 2025.</p>	
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Strategy: Increase the number of Doulas and Lactation Community Health Workers

SHIP Partner Activities/Successes/Highlights	Organization
<p>Doula and Lactation Community Health Worker (DLCHW) 2024 Training Updates:</p> <p>Maternity Care Coalition’s (MCC) state-accredited DLCHW training program employed a trauma-informed, racial justice-centered learning framework to prepare trainees to provide prenatal, birth, and postpartum doula services. Upon completing the 27-session training, graduates joined MCC’s Community Doula Network, where they were matched with expectant families and received stipends for delivering comprehensive doula and lactation support. Additionally, graduates benefited from individualized guidance to obtain Pennsylvania Perinatal Doula certification within one year of completing the program.</p> <ul style="list-style-type: none"> • In 2024, MCC hosted four DLCHW trainings in Southeastern Pennsylvania, successfully training a total of 67 community doulas. • That same year, MCC matched 676 families with doulas and provided lactation consultations to 47 families. <p>Trainings provided: Delaware County, March 2024 – May 2024, 17 participants Montgomery County, June 2024 – August 2024, 14 participants</p>	<p>Maternity Care Coalition</p>

<p>Philadelphia, September 2024 – November 2024, 20 participants Chester County, October 2024 – January 2025, 16 participants</p>	
<p>Montgomery County Office of Public Health trained people of color as doulas to increase capacity in the county. The doulas received a stipend for their training. After completing doula training, doulas could apply for Pennsylvania doula certification. Additionally, all doulas could complete the Perinatal Community Health Worker certification process. Doula services were added to the centralized intake form which links individuals and families to Maternal, Child, and Family Supports Programs to streamline family services in Montgomery County.</p>	<p>Montgomery County Office of Public Health PA DOH, Bureau of Family Health</p>
<p>The Erie BirthRoot (BR) Community Doula Program trained and employed birth and bereavement doulas, some of whom are also trained/certified as Perinatal Community Health Workers or lactation consultants. BR prioritizes providing services to Black and brown pregnant individuals. The BR curriculum prepared doulas to help birthing people whose pregnancy ends in loss through the bereavement process. The fourth trimester is an important part of this curriculum.</p>	<p>Erie County Department of Health BirthRoot Doulas PA DOH, Bureau of Family Health</p>
<p>Pettaway Pursuit Foundation and the Foundation for Delaware County trained new doulas and provided prenatal, birth, and postpartum doula services to Delaware County residents free-of-charge.</p>	<p>Delaware County Health Department Pettaway Pursuit Foundation The Foundation of Delaware County PA DOH, Bureau of Family Health</p>
<p>Trained 16 new doulas to serve Delaware County residents.</p>	<p>Delaware County Health Department Maternity Care Coalition</p>

Strategy: Expand access to doula services

SHIP Partner Activities/Successes/Highlights	Organization
<p>The Delaware County Health Department started development of a centralized intake for maternal child health information and a database of doula information including languages spoken, service areas, certifications, and specialties. Neither are available to the public yet but are still being developed.</p>	<p>Delaware County Health Department The Foundation for Delaware County</p>
<p>The Pennsylvania Doula Commission increased the number of Perinatal Certified Doulas (CPD) by providing financial scholarships for the cost of the CPD application fee.</p>	<p>Pennsylvania Doula Commission</p>
<p>Birth Doulas were offered to members that do not have an advocate/partner during the delivery.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>Mass recruitment was sent to 19 Doulas enrolled as Medical Assistance providers in PROMISE on 10/17/24. One new contract was added with seven total to date.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>The Community Doula Support Program (CDSP) provided support to families affected by substance use disorder, opioid use disorder, and very high social stressors through their birthing journey. All active doulas worked to become Certified Perinatal Doulas. Supplemental training was offered for doulas on principles such as harm reduction and how to administer Naloxone (Narcan). The program held a walking program, weekly parent groups, and connected families to community resources. Participants received supplies including diapers, wipes, baby clothes, and other necessities. CDSP worked closely with a lactation program to offer wraparound support, and a lactation toolkit was created to help doulas support families through their lactation journeys.</p>	<p>PDPH PA DOH, Bureau of Family Health</p>
<p>Healthy Start Pittsburgh's Community-Based Doula Program provided no-charge prenatal, labor, and postpartum doula services to 370 clients in Allegheny County, prioritizing Black families. 100% of these clients were screened for depression and unmet social determinants</p>	<p>Healthy Start, Inc. Pittsburgh</p>

<p>of health needs, and 100% of people with positive screens were referred to supports. In addition, 100% of clients with a diagnosed hypertensive disorder of pregnancy (38 clients) received heart-health specific blood pressure management support through this program. Eight community members were provided with no-charge doula training, and support in completing Pennsylvania's Certified Perinatal Doula credentialing process.</p>	<p>PA DOH, Bureau of Family Health</p>
<p>A doula program, which began in areas with a large African American population, expanded to all members living in Allegheny County and members who live in Westmoreland County but delivered in Allegheny County.</p> <p>The Doulas supported members throughout the perinatal period through face to face and home visits, assisting with attendance at provider visits, promoting health education, coaching through labor and delivery, and providing after-birth support and social determinant of health (SDOH) resources. Doulas also made referrals for SDOH needs.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>A doula program for perinatal women provided five doula face-to-face in-home visits prior to birth. The Doula was present for labor and delivery to provide continuous support to mom and/or partner. The Doula performed two postpartum visits, along with care coordination with the assigned maternal case manager. The Doula informed the plans for obstetrician case managers of the identified members, social determinants of health needs, and collaborated to mitigate any concerns.</p> <p>The goal of this support is to lower the mortality rate of premature infants and the costs associated with their healthcare.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>Maternity staff discussed the role of a doula during pregnancy, labor and postpartum periods to ensure members had a good understanding of the scope of services provided by doulas and how to access these services. Staff facilitated referrals when members were interested in participating.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>

Strategy: Improve perinatal and infant health outcomes and promote health equity for birthing people

SHIP Partner Activities/Successes/Highlights	Organization
<p>Through the Maternity Quality Enhancement Program, providers were eligible for additional reimbursement when they improved and reached targeted benchmarks with a health equity component.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>Policy and Advocacy and Coalition-Building Highlights from 2024:</p> <p>Maternity Care Coalition (MCC) advocated for policy and legislative changes that address the systemic causes of racial and social inequities in maternal and child health. MCC’s Policy and Advocacy team worked to ensure that policies are equitable and responsive to families’ lived experiences and relied on frontline staff, clients, and community members to inform the agenda.</p> <p>MCC made significant progress towards their goals to increase access to comprehensive health and social services, advocate for improved perinatal and infant health outcomes, and promote equity for birthing people. With commitment to leverage resources and partnerships to drive systems change, MCC actively led and participated in statewide advocacy campaigns. The Thriving PA Perinatal Health Campaign has successfully advocated for postpartum Medicaid expansion as well as Medicaid reimbursement for doula services, which took effect in January 2025. The work of Childhood Begins at Home, a statewide campaign that informs policymakers on the importance of evidence-based home visiting (EBHV) programs, has led to increased public investment in EBHV programs across Pennsylvania.</p> <p>MCC was awarded a grant from the PA DOH to establish a community-driven Regional Maternal Health Coalition focused on improving maternal health outcomes and reducing disparities in maternal mortality and morbidity. MCC leads the coalition utilizing a collective impact approach that centers the voices of people with lived experience and leverages cross-sector collaboration and coordination to drive meaningful change. Guided by the 2024 Pennsylvania Maternal Mortality Review Report, the coalition will examine existing data, set</p>	<p>Maternity Care Coalition</p>

<p>priorities tailored to the six-county region, identify key areas for intervention, and implement strategies aimed at reducing pregnancy-related and pregnancy-associated deaths.</p> <p>MCC's recently completed strategic plan identified economic security as a key priority moving forward. To respond to the growing evidence linking economic insecurity to poor perinatal health outcomes, MCC participated in advocacy efforts and initiatives designed to promote economic mobility and self-sufficiency for families. MCC is a strategy partner in the Family Care Campaign which advocates for Paid Family Leave and has partnered with United Way of Pennsylvania to advocate for a State Earned Income Tax Credit. MCC also serves on the Steering Committee for the Philly Joy Bank, a guaranteed income pilot for pregnant Philadelphians impacted by racism to promote health equity and improved birth outcomes.</p>	
<p>Regional Maternal Health Coalitions: The Pennsylvania State University, Family Health Council of Central Pennsylvania, Maternal and Family Health Services, and Maternity Care Coalition were selected to create a maternal health coalition in their selected region that is tasked with collecting and analyzing data in 26 counties to determine factors that contribute to maternal mortality and morbidity. While creating partnerships with maternal subject matter experts, individuals with lived experience and community organizations, coalitions will implement recommendations from the Pennsylvania Maternal Mortality Review Committee referenced in the 2024 Pennsylvania Maternal Mortality Annual Report to foster improvement in maternal health outcomes for birthing people and babies in their region.</p>	<p>Maternity Care Coalition</p> <p>Family Health Council of Central Pennsylvania</p> <p>Maternal and Family Health Services</p> <p>Pennsylvania State University</p> <p>PA DOH, Bureau of Family Health</p>
<p>Pennsylvania Medicaid Managed Care Organizations worked with high volume delivery systems to enroll into the Maternity Bundle Payment program to improve measures for health equity.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>All African American pregnant members were automatically enrolled in Tier 1 Care Coordination which provided more intensive outreach and Case Management due to higher probability/risk for complications. This created a higher level of care from the start of the</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>

<p>pregnancy to ensure the same contact followed the member prenatally and postnatally, thus creating a continuum of care for the member.</p>	
<p>Community health workers conducted outreach to pregnant members to educate them on prenatal maternal health warning signs. Some examples include Fever of 100.4 or higher, severe nausea and vomiting, baby’s movements stopping or showing during pregnancy, and vaginal bleeding or fluid leaking during pregnancy.</p> <p>Since African Americans are two times more likely to experience complications and 80% of pregnancy-related deaths could be prevented, education-based engagement was implemented for expectant mothers throughout Pennsylvania with a focus on engaging those with the highest risk of complications, which included all African American family members.</p> <p>Education included information on infant mortality and how to reduce the risk and the importance of keeping primary care physician visits, ultrasound appointments, etc. Touchpoints occurred minimally prenatally and postpartum to ensure retention of education and empowerment to speak up in situations that “don’t feel right”, confirm postpartum depression screenings were administered, provide a healthcare provider conversation guide to assist members, and ensure their concerns were addressed.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>The Maternity Case Management team identified opportunities to become more involved in the community, particularly through events in areas with a higher African American population.</p> <p>By attending these events, the team built trust in the community and provided education to help support healthy pregnancies in African American women.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>Zip code targeting was used to hold community baby showers in areas with a higher African American population.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>Partnerships were developed with community-based organizations (CBOs) that allowed outreach to participants in the community to close the gaps to access care.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>

<p>A partnership in the top county for African American women of childbearing age in the Southwest zone began to support community baby showers, access to supplies for mom and baby, and local formula banks. Targeted outreach to African American members connected them to the baby showers and created a sense of community for mom and baby. Connections were made to over 100 local social service resources.</p> <p>A partnership was also established in the Southeast zone to support the two annual community baby showers and address food insecurity in the North Philadelphia Hunting Park-East Tioga community. New parents were connected to the showers through individual outreach and community promotion.</p> <p>Two additional new CBO partnerships focused on serving maternal needs and resources. The following maternal partners were identified to serve counties with high African American populations of childbearing age: Mama-Bird (highest in Northeast, Pennsylvania –Luzerne County) and Mercy Center for Women (highest in Northwest, Pennsylvania – Erie County).</p> <p>Referrals through Neighborly also served as a connector for members into the programs offered by partner CBOs.</p>	
<p>Race data was included in the maternity risk stratification model used to identify members at high risk for having adverse pregnancy outcomes and more likely to benefit from case management support. This helped case management better understand members’ needs and provide the most appropriate assistance they could, including referrals to existing programs. The risk stratification logic was reviewed, and minor updates were made.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>Perinatal care was provided in Pittsburgh and Harrisburg with a focus on the African American population. High risk pregnant members were offered remote patient monitoring equipment to measure blood pressure, glucose, and weight. Readings from the equipment were fed back to a monitoring team to ensure the members received appropriate care for abnormal readings. Members also worked with case management in the home and telephonically to provide additional support and administer depression and social determinant of health screenings.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>

<p>With a disparity in birth outcomes among African American women, the goal is to improve birth outcomes by ensuring members receive timely care. The program was launched in the second quarter of 2023. An opportunity was identified to support providers with increasing enrollment in the program. Providers were given a list of currently pregnant members which they found helpful - this increased the number of referrals to the program. Work continues to improve identification of members for the program and potentially expand the program to other practices.</p>	
<p>A program in Allegheny County worked to decrease Black infant mortality rates, reduce preterm birth rates, increase knowledge about safe sleep recommendations for infants and provide additional support in the fourth trimester. The program included stakeholders from various areas, including community members, doulas and birth workers, Community Based Organizations, Healthcare Systems, and Government representatives. The Managed Care Organization engaged this program to determine how they can support each other.</p> <p>Some items discussed were:</p> <ol style="list-style-type: none"> 1. Promoting Obstetric Racism Training, 2. Incorporating education in materials for mothers to select a pediatrician prior to delivery so that baby can receive follow up care once discharged, and 3. Working together on increasing engagement in community activities to support and educate as needed, but more importantly, gain trust in the Black communities. <p>Two sessions of the Obstetric Racism Training were held in April, and two additional ones were held in May and September.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>Beginning in January 2024, the African American Prenatal brochure was sent to all pregnant African American members. This brochure stresses the increased risks to African American mothers. It contained pregnancy resources and a link to the Black Birthing Bill of Rights. The brochure also contained an insert that alerts mom of signs/symptoms that require immediate attention.</p> <p>A new follow-up campaign for Postpartum African American members began on March 1st, 2024. A follow-up call was made to members who were sent an educational packet in the</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>

<p>postpartum well child outreach campaign above. The outreach representative confirmed receipt of the educational packet and began to educate on pivotal well child visits to include lead testing and developmental screenings. Barriers to care were assessed, and resources were offered.</p>	
<p>A disparity program worked to enhance care for high-risk moms and babies within multiple zip codes around Philadelphia and Delaware Counties. The program focused on African American disparities and pre-term births. The goal was to keep pregnant moms engaged in prenatal care and work with providers to provide quality care during and after pregnancy. Members were provided with intensive case management from OB Nurse Case Managers to provide support, education, and assist with early identification of concerning symptoms throughout the pregnancy. Community Health Workers provided telephonic visits to address any significant determinants of health and assess any needs for the newborn. Meals were provided by Metropolitan Area Neighborhood Nutrition Alliance for the duration of the pregnancy through four weeks postpartum for a total of 28 weeks. Members were offered a telephonic nutritional consultation with a licensed dietician or nutritionist with the goal of ensuring appropriate weight gain and a healthy outcome for mom and the unborn baby.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>Black, Indigenous, People of Color (BIPOC) members are more likely to experience negative birth outcomes. Engaging this population is one of the efforts to help progress health equity commitments. Community health workers (CHWs) were leveraged to outreach and engage all healthy BIPOC maternity members. The CHW conducted outreach every trimester to assess members, determine any changes in risk, and connect to available resources.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>All Maternity Care Management included a priority stratification for Black/African American birthing members.</p> <p>Maternity care managers continued supporting Black/ African American members following birth, encouraging members to pursue standard postpartum care. Care managers were also available to help support birthing members with issues following birth regarding continued access to care and Social Determinants of Health (SDOH) needs. Maternity care managers transitioned members to pediatric care managers when necessary.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>

<p>Mobile Care Managers aligned with practice locations in Allegheny County with high populations of African American members to provide mobile care management in accordance with the maternal/child home visiting program.</p> <p>Care managers in person and telephonically conducted SDOH screenings and warm hand-offs to community-based resources to mitigate barriers experienced by African American members.</p> <p>Outreach was provided for postpartum care for African American/Black women. This included continuity of care regarding Maternity and Pediatric Care Management programs.</p>	
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Strategy: Increase research and resources to improve maternal and infant health

SHIP Partner Activities/Successes/Highlights	Organization
<p>Pennsylvania Pregnancy Risk Assessment Monitoring System (PRAMS) is a joint research project between the PA DOH, Bureau of Family Health, and the Centers for Disease Control and Prevention. PRAMS is an ongoing state-level, population-based surveillance system which gathers data on selected maternal behaviors, attitudes, and experiences before, during, and shortly after pregnancy. Using information from completed PRAMS surveys, more is learned about how to improve the health of future mothers, pregnant people, and babies in Pennsylvania which is the primary goal of the PRAMS project.</p> <p>In 2024, the PA DOH, Bureau of Family Health developed a data brief entitled “Pregnancy Risk Assessment Monitoring System (PRAMS) SDOH – Mental Health Supplement.” It summarizes descriptive findings from the questions about mental health that were included in the PRAMS 2022 SDOH supplement. https://www.pa.gov/content/dam/copapwp-pagov/en/health/documents/topics/documents/research/Social%20Determinants%20of%20Health%20-%20Mental%20Health%20Data%20Brief.pdf</p>	<p>PA DOH, Bureau of Family Health</p>

<p>In 2022, the SDOH supplement, consisting of 12 questions, was added to the PRAMS survey, and included topics such as food insecurity, housing, access to health care, mental health, and racism. Among the 1,298 responses to the Pennsylvania PRAMS survey in 2022, all completed the SDOH questions. Respondents to PRAMS may choose not to respond to all survey questions. Additionally, some questions include skip patterns and therefore may not be answered by all respondents, while other questions allow for multiple response options.</p> <ul style="list-style-type: none"> • PRAMS data from the SDOH supplement in 2022 indicated in PA: <ul style="list-style-type: none"> ○ 29.5% of people who recently gave birth felt they needed mental health services such as counseling, medications, or support groups to help with feelings of anxiety, depression, grief, or other issues. The need for mental health services among respective racial groups was highest among Black respondents at 35.4%. This was followed by white respondents (31.1%) and other racial groups (25.5%). ○ Of those, 36.7% reported they did not get the mental health services that they needed. The percentage of respondents who reported not being able to get the mental health services they needed was comparably high for all racial populations with 53.3% of Black respondents, 44.5% of Asian respondents, 37.8% among other racial groups, and 32.5% of white respondents indicating they were unable to get services. The top five reasons mothers did not get the mental health support they needed are: 48% did not have time, 34.5% did not know where to go to get services, 29.6% could not afford the cost, 28.9% other (non-specific) reasons, 16.7% of mothers were concerned they may have to take medicine. 	
<p>The Pennsylvania Maternal Mortality Review Committee (MMRC) is a multidisciplinary group of professionals and partners who serve pregnant and postpartum individuals, and who collectively review deaths and examine factors that led to the death. The Pennsylvania MMRC collectively determines if the death was related to the pregnancy and if it could have been prevented. The committee then provides recommendations that could prevent future deaths and protect the health and well-being of individuals during and after pregnancy. In April 2024, the Pennsylvania MMRC released its annual Maternal Mortality Review Report: https://www.pa.gov/content/dam/copapwp-pagov/en/health/documents/topics/documents/programs/2024%20MMR%20Annual%20Report.pdf</p>	<p>Pennsylvania Maternal Mortality Review Committee</p> <p>PA DOH, Bureau of Family Health</p>

<p>The SHIP team identified current maternal and infant health legislation and ways the team can support or increase education on policies to improve maternal and infant health, including increasing education on patients' rights on Maternal Health by sharing the Attorney General Maternal Health rights brochure.</p>	<p>3.4 SHIP Goal Team</p>
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Strategy: Increase education and resources on family planning including access to contraceptives

SHIP Partner Activities/Successes/Highlights	Organization
<p>Through the annual contraceptive care resources campaign, members received an email directing them to a website with information related to contraceptive care options and resources. Members without email on file received a postcard with the link to the contraceptive care landing page.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>Nurse Case Managers discussed postpartum contraception with members starting at approximately 28 - 32 weeks gestation and continued throughout the remainder of the member's pregnancy. If the member was uncertain of the contraceptive method to use, additional education was provided via written means either given during clinic visits or mailed to the member and/or digital means via a patient education website. In the immediate postpartum period while the new mother was still admitted, Long-Acting Reversible Contraception was offered and started while inpatient as much as possible, or a prescription for oral contraceptives was provided to the member or called to the member's pharmacy prior to the member's hospital discharge.</p> <p>During the 12-week postpartum period, the Nurse Case Managers continued contraception discussion during touch points to determine the member's compliance and to answer any questions the member had.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>
<p>Member newsletters included an article on birth control options and Long-Acting Reversible Contraception.</p>	<p>Pennsylvania Medicaid Managed Care Organizations</p>

Pharmacy kiosks in provider offices offered contraception.	Pennsylvania Medicaid Managed Care Organizations
A Long-Acting Reversible Contraception (LARC) mailer was sent to nonpregnant members who are not postpartum twice a year which provided education on family planning and available options. A LARC mailer was also sent to postpartum women.	Pennsylvania Medicaid Managed Care Organizations
Maternity staff were available to support members who were interested in and/or planning to become pregnant within the next year to help improve overall health and wellness to prepare for pregnancy and optimize outcomes for mom and baby.	Pennsylvania Medicaid Managed Care Organizations
Education and resources were provided to members and providers about family planning, contraception, and Long-Acting Reversible Contraception.	Pennsylvania Medicaid Managed Care Organizations

Strategy: Increase postpartum assessments and assistance with any identified needs

SHIP Partner Activities/Successes/Highlights	Organization
During the postpartum period, the maternity case manager coordinated with the member and the obstetrician provider by assisting the members with scheduling a postpartum visit between 7-84 days. Additionally, a comprehensive postpartum assessment and social determinants of health (SDOH) were addressed. Maternity case managers assisted with coordinating a well check with a pediatrician. Communications continued for 90 days for both the mom and the baby. If ongoing needs were identified with the baby, a pediatric referral was made. If the member experienced any on-going issues (behavioral health, SDOH, etc.) the member was referred to the appropriate team (adult/pediatric case management, lifestyle, behavioral health) for ongoing support.	Pennsylvania Medicaid Managed Care Organizations

Strategy: Increase collaboration and information sharing among key partners whose work aligns with the 3.4 SHIP Goal and Objectives.

SHIP Partner Activities/Successes/Highlights	Organization
<p>The SHIP team identified missing key partners and conducted outreach to include these partners on the SHIP goal team.</p> <p>Promotion of the SHIP goal team was conducted through SHIP presentations and distribution of SHIP informational materials.</p>	<p>3.4 SHIP Goal Team</p> <p>PA DOH, SHIP Team</p>

Appendix D: 2024 SHIP Leadership and Steering Committee

Health Equity Lead

Tensae Getz, MPH, Healthcare Opportunity Initiative Coordinator, Office of Health Equity, PA DOH

Health Equity Goal Team Leads

Remy Babich, PhD, Associate Toxicologist, Division of Environmental Health Epidemiology, Bureau of Epidemiology, PA DOH

Stephanie Hasanali, PhD, Public Health Program Director, Division of Environmental Health Epidemiology, Bureau of Epidemiology, PA DOH

Nikki Maurer Gray, MPH, Executive Director, Community Health Council of Lebanon County

Janine M. Strick, BSN, RN, Child and Adolescent Immunizations Nursing Services Consultant, Bureau of Immunizations, PA DOH

Chronic Disease Prevention Lead

W. Gina Pang, MD, MPH, Public Health Physician, Bureau of Epidemiology, PA DOH

Chronic Disease Prevention Goal Team Leads

Tiffany S. Bransteitter, MSW, Obesity Prevention and Wellness Section Chief, Bureau of Health Promotion and Risk Reduction, PA DOH

Samantha Pearson, Healthy Communities Program Manager, WalkWorks Program, Pennsylvania Downtown Center

Will Sunday, Public Health Program Manager, Bureau of Health Promotion and Risk Reduction, Division of Tobacco Prevention and Control, PA DOH

Whole Person Care Leads

Patricia Bricker, Program Manager, PA AHEC; Research Project Manager, Penn State College of Medicine, Department of Family and Community Medicine

Lisa Davis, Pennsylvania Office of Rural Health and Director and Outreach Associate Professor of Health Policy and Administration, Pennsylvania State University

Whole Person Care Goal Team Leads

Iwona Boraks-Pielechaty, RN, Community Health Nurse Consultant, Bureau of Community Health Systems, PA DOH

Gabrielle El-Adas, Intern, Office of Health Equity, PA DOH

Kavita Fischer, MD, DFAPA, Regional Medical Director, Community Care Behavioral Health Organization, Insurance Services Division, Pennsylvania Psychiatric Society President Elect

Tensae Getz, MPH, Healthcare Opportunity Initiative Coordinator, Office of Health Equity, PA DOH

Shannon McKnight, MSN, RN, CIC, Community Health Nurse Consultant, Bureau of Community Health Systems, PA DOH

Aayushi Patel, Rural Health Scholar, Medical Student, Penn State College of Medicine

Tisha Patinski, Community Health Nurse, Bureau of Community Health Systems, PA DOH

Nicole Payonk, Policy and Advocacy Coordinator, Pennsylvania Coalition for Oral Health

PA DOH SHIP Team

Megan Ebert, Public Health Program Administrator, Office of Operational Excellence, PA DOH

Merhawi Gebrezgi, Epidemiologist, Office of Operational Excellence, PA DOH

Whitney McAnlis, Public Health Program Administrator, Office of Operational Excellence, PA DOH

Sunny Podolak, Public Health Program Director, Office of Operational Excellence, PA DOH

Marisa Santanna, Public Health Program Manager, Office of Operational Excellence, PA DOH

J.T. Zendt, Public Health Program Administrator, Office of Operational Excellence, PA DOH

Appendix E: SHIP Goal 1.1 Team Members/Organizations

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

SHIP Goal 1.1 Team Lead

Nikki Maurer Gray, MPH, Executive Director, Community Health Council of Lebanon County

SHIP Goal 1.1 Team Members

Dawn Bartha, Manager of Housing Services, Pennsylvania Housing Finance Agency

Chinenye Boyer, Epidemiology Research Associate, Bureau of Epidemiology, Pennsylvania Department of Health

Bridget Calhoun, DrPH, Vice Provost for Academics, Duquesne University

Cindy Celi, MSW, Manager Healthcare Partnerships, Mom's Meals

Laurie Crawford, Program Manager for Community Gardens and Food Access, Penn State Health

Elen Deng, Medical Student, Penn State College of Medicine

Nicholas Dennis, MPH, Senior Regional Housing Coordinator, Self-Determination Housing of Pennsylvania

Krissi DeSantis, Rental Officer II, Pennsylvania Housing Finance Agency

Shaniece Ebelhar, MPH, Manager of Health Initiatives, The Arc of Pennsylvania

Roxanne Ferrara, Program Coordinator Grants, Delaware County Health Department

Mandy Fitzpatrick, Executive Director, Schuylkill Connects

Morgan Flood, Policy Research Specialist, Central Pennsylvania Food Bank

Chastity Frederick, RN, BSS, MHFA-C, Maternal Child Health Supervisor, Healthy Moms Healthy Babies, City of York, Bureau of Health

Tensae Gertz, Healthcare Opportunity Initiative Coordinator, Office of Health Equity, PA DOH

Marcia Goodman-Hinnershitz, Director of Planning and Resource Development, Council on Chemical Abuse

Megan Greevy, MS, RD, LDN, Director of Nutrition Programs, Feeding Pennsylvania

Jackie James, MPA, Program Coordinator, Value Based Purchasing, Bureau of Managed Care, Office of Medical Assistance Programs, PA DHS

Kim Joyce, MBA, Chief Operating Officer, Allegheny County Health Department

Elizabeth Kerns, LSW, CCM, HCHV, Community Employment Coordinator, Lebanon VA Medical Center

Crystal Kotlowski, Senior Director, NEPA, Volunteers of America of Pennsylvania

Kristin Lazzara, MBA, MHA, Director, Strategic Operations, Allegheny Health Network Center for Inclusion Health; Vice Chair, Pennsylvania Community Health Worker Collaborative

Paige Lewandowski, Northeast RHEAT Outreach and Training Coordinator, Office of Health Equity, PA DOH

Jessica Lightner, Chief of Social Work, Lebanon VA Medical Center

Aisling McIntyre, LCSW, Senior Project Manager, UPMC Center for High-Value Health Care; UPMC Center for Social Impact

Michael McShane, MD, LION Mobile Clinic, Penn State College of Medicine

Brittany Mellinger, Fair Housing Training and Outreach Coordinator, Pennsylvania Human Relations Commission

Stephanie Meyer, LSW, Special Assistant to the Secretary, PA DHS

Hannah Moran, Project Manager, BUILD, Hamot Health Foundation

Rena Nagle, Southcentral RHEAT Outreach and Training Coordinator, Office of Health Equity, PA DOH

Dustin Peachey, Policy and Programs Assistant, Pennsylvania Association of Area Agencies on Aging, Inc.

Dawn Plummer, Director, Pennsylvania Food Policy Council, PA Department of Agriculture

Airika Pollard, LSW, Outreach/Coordinated Entry Specialist, Lebanon VA Medical Center

Stefan Pontius, Specialist of Health and Nutrition Equity, Greater Pittsburgh Community Food Bank

Sarah Prylinski, BSN, RN, Clinical Program Manager, BUILD, Hamot Health Foundation

Pauline Saunders, Manager, Quality Accountability, Bureau of Managed Care Operations, Office of Medical Assistance Programs, PA DHS

Samantha Scott, MPH, CPH, Epidemiology Research Associate, Allegheny County Health Department

Sam Serrano, Community Connections Partnership Supervisor, Greater Pittsburgh Community Food Bank

Noah Shatzer, Program Director, Harrisburg Area, YMCA

Seleda Simmons, Family Assistance and Support for Teens Coordinator, Berks Community Action Program Inc.; Founder/Executive Director, The Real Deal 610

Janine Strick, BSN, RN, Child and Adolescent Immunizations Nursing Services Consultant, Bureau of Immunizations, PA DOH

Amanda Taylor Gehman, Research Project Manager, Cancer Treatment and Prevention, Penn State Health

Eileen Thompson, RN, BSN, Director, Practice-Based Initiatives; Program Director, PA Medical Home Program; Program Director, Obesity and Food Insecurity Initiatives; Pennsylvania Chapter, American Academy of Pediatrics

Kenneth Thompson, MD, Medical Director, Pennsylvania Psychiatric Leadership Council

Crystal Turner, RHEAT Coordinator, Office of Health Equity, PA DOH

Daniel Vereb, Community Engagement Manager, Jefferson Regional Foundation

Janet Weatherly, Southwest RHEAT Outreach and Training Coordinator, Office of Health Equity, PA DOH

Tia Whitaker, CCHW, Statewide Director, Outreach and Enrollment for the Pennsylvania Association of Community Health Centers; Board Chair, Pennsylvania Community Health Worker Collaborative

Amy Williams, Program Specialist for Behavioral Health and Substance Use Disorder, Pennsylvania Association of Community Health Centers

Zach Zook, MPA, VP/Director of Impact and Policy, Central Pennsylvania Food Bank

Appendix F: SHIP Goal 1.2 Team Members/Organizations

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

SHIP Goal Team 1.2 Lead

Janine M. Strick, BSN, RN, Child and Adolescent Immunizations Nursing Services Consultant, Bureau of Immunizations, PA DOH

SHIP Goal Team 1.2 Members

Karen Bennett, Harmony Life Center

Ashley Blakeman, Allegheny County Health Department

Bridget Calhoun, DrPH, Vice Provost for Academics, Duquesne University

Allyson Fulton, Public Health Program Administrator, Violence and Injury Prevention Program, Bureau of Health Promotion and Risk Reduction, PA DOH

Tensae Gertz, Healthcare Opportunity Initiative Coordinator, Office of Health Equity, PA DOH

Marcia Goodman-Hinnershitz, Director of Planning and Resource Development, Council on Chemical Abuse

Angela Gumby, Director, Division of Quality and Special Needs Coordination, Office of Medical Assistance Programs, PA DHS

A-Mac Harris, MPH, Public Health Program Administrator, Bureau of Health Promotion and Risk Reduction, Violence and Injury Prevention Program, PA DOH

Sarah Horton, Community Psychiatry Project Manager, Penn State College of Medicine, Department of Psychiatry and Behavioral Health, Pennsylvania Psychiatric Institute

Kim Joyce, MBA, Chief Operating Officer, Allegheny County Health Department

Gifty Akomea Key, EdD, Administrator of Population, Delaware County Health Department

Samantha Koch, Director of Policy and Planning, PA Commission on Crime and Delinquency; Interim Director, Office of Gun Violence Prevention

Charlene Lane, PhD, LCSW, Bureau Director, Older Adult Protective Services, PA Department of Aging

Susan Lang, Education Support, Sim Center, Penn State College of Medicine and Pennsylvania State University - Harrisburg

Kristin Lazzara, MBA, MHA, Director, Strategic Operations, Allegheny Health Network Center for Inclusion Health; Vice Chair, Pennsylvania Community Health Worker Collaborative

Emily Lebo, HEAT Coordinator, Office of Health Equity, PA DOH

Jessica Lightner, Chief of Social Work, Lebanon VA Medical Center

Stacy Maksin, LMSW, Penn State Health, Andrews Patel Hematology/Oncology

Ruth Moore, Director, Community Relations, Penn State Health, Pennsylvania Psychiatric Institute

Lori Palisin, Executive Director of Safe Journey and the CEO of PurpleOne

Lisa Pareso, MSHSA, Manager, Rural Health Model, UPMC Washington, UPMC Greene

Tisha Patinski, Community Health Nurse, Bureau of Community Health Systems, PA DOH

Dustin Peachey, Policy and Programs Assistant, Pennsylvania Association of Area Agencies on Aging, Inc.

Mae Reale, Pennsylvania Coalition Against Domestic Violence

Rashad Salters, Public Health Program Administrator, Bureau of Health Promotion and Risk Reduction, PA DOH

Shakila Shah, Public Health Program Manager, PA DOH

Ashleigh Strange, Executive Director, Governor's Advisory Commission on LGBTQ Affairs

Amanda Taylor Gehman, Research Project Manager, Cancer Treatment and Prevention, Penn State Health

Tia Whitaker, CCHW, Statewide Director, Outreach and Enrollment for the Pennsylvania Association of Community Health Centers; Board Chair, Pennsylvania Community Health Worker Collaborative

David Wiles, CCHW, CHES, Executive Director, Pennsylvania Community Health Worker Collaborative

Donna Wolgemuth, Aging Services Specialist Supervisor, Bureau of Protective Services, PA Department of Aging

Appendix G: SHIP Goal 1.3 Team Members/Organizations

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

SHIP Goal Team 1.3 Leads

Remy Babich, PhD, Associate Toxicologist, Division of Environmental Health Epidemiology, Bureau of Epidemiology, PA DOH

Stephanie Hasanali, PhD, Public Health Program Director, Division of Environmental Health Epidemiology, Bureau of Epidemiology, PA DOH

SHIP Goal Team 1.3 Members

Chinenye Boyer, Epidemiology Research Associate, Division of Environmental Health Epidemiology, Bureau of Epidemiology, PA DOH

Celine Colbert, Tree Canopy Coordinator, Bureau of Forestry, PA Department of Conservation and Natural Resources

Lannette Fetzer, Quality Improvement Coordinator and Certified AgriSafe Nurse Scholar, Pennsylvania Office of Rural Health

Tensae Gertz, Healthcare Opportunity Initiative Coordinator, Office of Health Equity, PA DOH

Robert Gottlieb, Epidemiology Research Associate, Division of Environmental Health Epidemiology, Bureau of Epidemiology, PA DOH

Jackie James, MPA, Program Coordinator, Value Based Purchasing, Bureau of Managed Care, Office of Medical Assistance Programs, PA DHS

Theresa Kash, MPH, Executive Policy Specialist, Office of Policy, PA DOH

Emily Lebo, Public Health Program Administrator, Office of Health Equity, PA DOH

Julie Miller, PhD, DABT, Public Health Toxicologist, Division of Environmental Health Epidemiology, Bureau of Epidemiology, PA DOH

Tisha Patinski, Community Health Nurse, Bureau of Community Health Systems, PA DOH

David Saunders, Director, Office of Health Equity, PA DOH

Pauline Saunders, Manager, Quality Accountability, Bureau of Managed Care Operations, Office of Medical Assistance Programs, PA DHS

Katie Sneeringer, PhD, Epidemiologist Supervisor, Division of Environmental Health Epidemiology, Bureau of Epidemiology, PA DOH

Sara Thuma, MPH, Public Health Program Administrator, Asthma Control Program, Bureau of Health Promotion and Risk Reduction, PA DOH

Lora Werner, MPH, Interim Director, Delaware County Health Department

Appendix H: SHIP Goal 2.1 Team Members/Organizations

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

SHIP Goal Team 2.1 Leads

Tiffany S. Bransteitter, MSW, Obesity Prevention and Wellness Section Chief,
Bureau of Health Promotion and Risk Reduction, PA DOH

Samantha Pearson Healthy Communities Program Manager, WalkWorks Program,
Pennsylvania Downtown Center

SHIP Goal Team 2.1 Members

Tina Amato, MS, LDN, RD, Manager Physical Activity and Nutrition, Allentown Health
Bureau, City of Allentown

Jennifer Aquilante, Food Policy Coordinator, Philadelphia Department of Public
Health

Ali Bowling, Policy Specialist, Office of Planning and Policy, PA Department of
Conservation and Natural Resources

Erica Bozentka, WIC Director, Maternal and Family Health Services

Cindy Celi, MSW, Manager Healthcare Partnerships, Mom's Meals

Caryn Earl, Director, Bureau of Food Assistance, PA Department of Agriculture

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Gina Goode, BS, Community Health Educator, AmeriHealth Caritas Pennsylvania

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Marianne Infante, MEd, OTD, Director/Board President, Healthy Community Lifespaces Inc.

Sarah A. Jacobi, Vice President, Community Impact, Pocono Mountains United Way

Kim Joyce, MBA, Chief Operating Officer, Allegheny County Health Department

Nicole Keels-McGruder, MUPPD, Community Hero PA

Courtney Kindall, CCHW, YMCA Center for Healthy Living, Harrisburg Area YMCA

Kateri Linn, Buhl Regional Health Foundation

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Sara Murphy, Vice President-Programs and Services, Alzheimer's Association, Greater PA Chapter

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Zil Patel, Medical Science Liaison, Novo Nordisk

Tisha Patinski, Community Health Nurse, Bureau of Community Health Systems, PA DOH

Sherri Penchishen, Registered Dietitian; Director-Chronic Disease Programs, City of Bethlehem, Health Bureau

Deanna Philpott, Whole School, Whole Community, Whole Child or WSCC Coordinator, School Wellness Consultant, Erie School District

Dawn Plummer, Director, Pennsylvania Food Policy Council, Pennsylvania Department of Agriculture

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Nicholas Slotterbank, Basic Education Associate 2, Elementary and Secondary Education, PA Department of Education

Gail Snyder, MPA, Director, Community Reporting, Department of Public Health Sciences and Community Relations, Penn State Health

Dannai Wilson, Deputy Director of Community and Family Health, Allegheny County Health Department

Emilie Woods, CHES, CCHW, Community Health Manager, Penn State Health

Miriam Yattassaye, BSN, RN, Public Health Educator 2, PA DOH

David Yonki, Health Educator, City of Wilkes-Barre

Appendix I: SHIP Goal 2.2 Team Members/Organizations

SHIP Goal 2.2: Reduce the impact of tobacco and nicotine use

SHIP Goal Team 2.2 Lead

Will Sunday, Public Health Program Manager, Bureau of Health Promotion and Risk Reduction, Division of Tobacco Prevention and Control, PA DOH

SHIP Goal Team 2.2 Members

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Lian BenYishay, Program and Evaluation Coordinator, Pennsylvania Coalition for Oral Health

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Kim Joyce, MBA, Chief Operating Officer, Allegheny County Health Department

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Lisa Verbos, MA, LPC, Public Health Program Administrator, Bureau of Health Promotion and Risk Reduction, Division of Tobacco Prevention and Control, PA DOH

Appendix J: SHIP Goal 3.1 Team Members/Organizations

SHIP Goal 3.1: Increase access to medical and oral health care

SHIP 3.1 Goal Team Lead

Nicole Payonk, Policy and Advocacy Coordinator, Pennsylvania Coalition for Oral Health

SHIP 3.1 Goal Team Members

Christine Alichnie, PhD, RN, President, Nursing Foundation of Pennsylvania; Past President of Pennsylvania State Nurses Association

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Madalyn Fernbach, Medical Student, Penn State College of Medicine

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Trisha Gadson, PhD, Chief Executive Officer, Jefferson Regional Foundation

Roy Gothie, Executive Policy Specialist 2, Policy Office, PA Department of Transportation

Angela Gumby, Director, Division of Quality and Special Needs Coordination, Office of Medical Assistance Programs, PA DHS Services

Kristen Houser-Rapp, MPA, Executive Director, Pennsylvania Charitable Healthcare Coalition

Jackie James, MPA, Program Coordinator, Value Based Purchasing, Bureau of Managed Care, Office of Medical Assistance Programs, PA DHS

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Appendix K: SHIP Goal 3.2 Team Members/Organizations

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

SHIP Goal Team 3.2 Leads

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SHIP Goal Team 3.2 Members

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Mae Reale, Pennsylvania Coalition Against Domestic Violence

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Appendix L: SHIP Goal 3.3 Team Members/Organizations

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

SHIP Goal Team 3.3 Lead

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Appendix M: SHIP Goal 3.4 Team Members/Organizations

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

SHIP Goal Team 3.4 Leads

Gabrielle El-Adas, Intern, Office of Health Equity, PA DOH

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Melissa Patti, Director, Maternal and Infant Health Initiative, March of Dimes Pennsylvania Philadelphia Market

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Jessica Ritter, MA, CNP, State Office Coordinator, Safe Kids Pennsylvania

Robin L. Rothermel, Senior Director, Physician Support, Pennsylvania Medical Society

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Appendix N: List of Acronyms

ACS: American Community Survey

ADA: Americans with Disabilities Act

ADHD: Attention Deficit Hyperactivity Disorder

AHEC: Area Health Education Center

ANCC: American Nurses Credentialing Center

ARP: American Rescue Plan

ATP: Active Transportation Plans

BCOC: Buck County Opportunity Council

BHHP: Behavioral Health Home Plus

BIPOC: Black, Indigenous, People of Color

BLAST: Better Lives Always Start Today

BOL: Bureau of laboratories

BP: Blood Pressure

BR: BirthRoot

BRFSS: Pennsylvania Behavioral Risk Factor Surveillance System

CACFP: Child and Adult Care Food Program

CBP: Controlling High Blood Pressure

CBO: Community Based Organizations

CC: Care Connectors

CDC: Center for Disease Control

CDSP: Community Doula Support Program

CEU: Continuing Education Credit

CFSRE: Center for Forensic Science Research and Education

CHC: Community Health Choices

CHN: Community Health Navigator

CHW: Community Health Worker

CIAA: Clean Indoor Air Act

CJAB: Criminal Justice Advisory Board

CM: Care Manager

CoC: Continuum of Care

CoP: Community of Practice
COPD: Chronic Obstructive Pulmonary Disease
C.O.R.E.: Compassionate Opioid Response Education
CPD: Perinatal Certified Doula
CPR: Cardiopulmonary resuscitation
CRS: Certified Recovery Specialist
CSO: Central Susquehanna Opportunities
CSPAP: Comprehensive School Physical Activity Programs
CWF: Community Water Fluoridation
CVIPI: Community Violence Intervention and Prevention Initiative
D2L: Desire to Learn
DART: Dental Assisting Radiology Training
DHS: Pennsylvania Department of Human Services
DLCHW: Doula and Lactation Community Health Worker
DPP: Diabetes Prevention Program
EBHV: Evidence Based Home Visiting
EBO: Evidence Based Organization
ED: Emergency Department
EDDIE: Enterprise Data Dissemination Informatics Exchange
EHSF: Emergency Health Services Federation
EIO: Evidence Informed Organization
EMS: Emergency Medical Services
EPS: Erie's Public Schools
FAQ: Frequently Asked Questions
FOA: Funding Opportunity Announcement
FFM: Forbes Family Medicine
FFY: Federal Fiscal Year
FVP: Family Visiting Program
FY: Fiscal Year
GFHH: Good Food Healthy Hospitals
GWVA YMCA: Greater Wyoming Valley Area Young Men's Christian Association
GYTOTT: Get Your Tail on the Trail

HAVI: Health Alliance for Violence
HB: House Bill
HBD: Hemoglobin A1C Control for Patients with Diabetes
HPE: Health and Physical Education
HPP: Healthy Pennsylvania Partnership
HOME: Home Investment Partnerships Program
HRI: Heat Related Illness
HSIP: Highway Safety Improvement Program
HVIP: Hospital-Based Violence Intervention Programs
IC: Interconception Care
ICCAP: Indiana County Community Action Program
ICP: Integrated Care Program
IMPLICIT: Interventions to Minimize Preterm and Low Birthweight Infants using Continuous Improvement Techniques
KKG: Keystone Kids Go
LAP: Lethality Assessment Program
LARC: Long-Acting Reversible Contraception
LGBTQ: Lesbian, Gay, Bisexual, Transgender or Queer
MA: Medical Assistance
MCC: Maternity Care Coalition
MHN: Maternal Health Navigator
MLP: Master Leasing Program
MMRC: Maternal Mortality Review Committee
MPO: Metropolitan Planning Organization
MSA: Master Settlement Agreement
NAACP: National Association for the Advancement of Colored People
NAAQS: National Ambient Air Quality Standard
NAMI: National Alliance on Mental Illness
NAPSACC: Nutrition and Physical Activity Self-Assessment for Child Care
NCQA: National Committee for Quality Assurance
OCYF: Office of Children, Youth, and Families
ODSMP: Office of Drug Surveillance and Misuse Prevention

OGVP: Office of Gun Violence Prevention
OMHSAS: Office of Mental Health and Substance Abuse Services
OST: Out-of-School Time
OUD: Opioid Use Disorder
PA CCCP: Pennsylvania Comprehensive Cancer Control
PACT: Pennsylvania Alliance to Control Tobacco
PA DCNR: Pennsylvania Department of Conservation and Natural Resources
PA DOH: Pennsylvania Department of Health
PAH: Punxsutawney Area Hospital
PCC: PA Cancer Coalition
PCCD: Pennsylvania Commission on Crime and Delinquency
PCHC: Pennsylvania Charitable Healthcare Coalition
PCMH: Patient-Centered Medical Home
PCNtv: Pennsylvania Cable Network
PCP: Primary Care Physician
PCOH: Pennsylvania Coalition for Oral Health
PDC: Pennsylvania Downtown Center
PDPH: Philadelphia Department of Public Health
PE: Physical Education
PEC: Pennsylvania Environmental Council
PennDOT: Pennsylvania Department of Transportation
PHAB: Public Health Accreditation Board
PHAN: Pennsylvania Health Access Network
PHC4: Pennsylvania Health Care Cost Containment Council
PHDHP: Public Health Dental Hygiene Practitioner
PIT: Point-In-Time
PM: Particulate Matter
PRA: Project Rental Assistance Program
PRAMS: Pennsylvania Pregnancy Risk Assessment Monitoring System
PRTF: Psychiatric Residential Treatment Facility
PSA: Power Scholars Academy
PWYC: Pay-What-You-Can

RIG: Resident Health Impact Grant
RPO: Rural Planning Organization
SCCAP: South Central Community Action Program
SCIP: State Crisis Intervention Program
SDOH: Social Determinants of Health
SHA: State Health Assessment
SHI: School Health Index
SHIP: State Health Improvement Plan
SHP: Supportive Housing Program
SNAP: Supplemental Nutrition Assistance Program
STEP: Lycoming-Clinton Counties Commission for Community Action
TIC: Trauma Informed Care
UHA: Umbrella Hub Arrangement
UPMC: University of Pittsburgh Medical Center
US: United States
VA: Veterans Association
VOAPA: Volunteers of America of Pennsylvania
VSAC: Victims' Services Advisory Committee
WISEWOMAN: Well-Integrated Screening and Evaluation for Women Across the Nation
WSCC: Whole School, Whole Community, Whole Child
YMCA: Young Men's Christian Association
YRBS: Youth Risk Behavior Survey
YWCA: Young Women's Christian Association