Bethlehem Health Bureau

COMMUNITY HEALTH IMPROVEMENT PLAN 2023-2025

BETHLEHEM
pennsylvania
Health Bureau

INTRODUCTION

The Bethlehem Health Bureau conducted a community health needs assessment in the fall of 2023 to identify the health-related needs and issues impacting Bethlehem residents. A diverse group of 25 stakeholders were engaged in the community health needs assessment process and subsequent development of the community health improvement plan (CHIP). The community health needs assessment included qualitative and quantitative data to inform discussions with key stakeholders and determine priority areas. A copy of the community health needs assessment can be found at: City of Bethlehem (bethlehem-pa.gov).

The community health improvement plan is a long-term, systematic effort to address public health problems based on the results of the community health needs assessment. Each health issue/condition was prioritized according to the magnitude, impact, feasibility, and resources currently dedicated to the issue. Workgroups were established to develop the key strategies and action plans for each of the identified priorities:

Priority 1: Mental Health

Priority 2: Substance Use

Priority 3: Chronic Disease Prevention

Priority 4: Food Security

The community health improvement plan is designed to align and build upon already existing plans and initiatives currently in place. The relationship between the Health Bureau's already existing plans is documented below.

PLAN IMPLEMENTATION AND MONITORING

A three-year community health improvement plan was developed for each of the four priority areas. The three-year plans outline the overall goal, objectives, proposed strategies, partners, assets, timeframes, and long-term outcomes for each priority. Action plans were then subsequently developed to provide further granular detail regarding annual activities for each strategy. The annual action plans define the activities, timeframes, process measures, and individual(s) responsible for each strategy. The process measures are tracked in GIS and displayed on dashboards to monitor progress.

The four established workgroups meet quarterly throughout the year. A Health Bureau representative chairs each of the four work groups and facilitates the meeting discussion. The purpose of the quarterly meetings is to ensure that the action plans are being implemented accordingly and address any existing barriers that exist.

The entire CHNA/CHIP stakeholder group meets at the end of each year to discuss implementation plan progress as well as establish strategies and action plans for the upcoming year. The annual meeting also provides an opportunity to reassess the overall CHIP goals along with emerging issues or data needs.

An annual progress report is developed for each of the four action plans and a final report will recap the outcomes for the entire three-year CHIP after the plan concludes.

PRIORITY 1: MENTAL HEALTH		Goal: Improve access to mental health care.			
Objectives	**Proposed Strategies**	**Partners**	**Assets**	**Timeline (Year 1, 2, or 3)**	**Long-Term Outcomes (CHNA Data)**
Increase mental health literacy and awareness by implementing one educational campaign by December 31, 2025.	• Create a short video targeting parents on the signs and symptoms of mental health issues among adolescents. • Conduct a mental health anti-stigma campaign • Improve mental health screening in schools. • Promote mental health first aid training.	Center for Humanistic Change, NAMI, Bethlehem Area School District, Pinebrook		Year 2 Year 2 Years 1-3 Years 2-3	Percentage of individuals reported having at least 1 poor mental health day in the past month Baseline: 41.8% SLUHN 2021 Percentage of students feeling sad or depressed most days in the past 12 months Baseline: 42% PAYS 2021
Improve connectivity to mental health treatment through Community Connections by 10% by December 31, 2025.	• Expand the Community Connections program. • Improve discharge planning policies from hospitals and mental health settings. • Convene community partners together to discuss systemic challenges with the current mental health system and advocate for changes. • Improve care in senior living facilities by	St. Luke's University Health Network, Lehigh Valley Health Network, NAMI, Bethlehem Police Department, NC, and LC Crisis, Pinebrook Family Answers	Community Support Program County's newly hired Aging Coordinator	Year 1 Year 3 Year 1 Years 1-3	Percentage of individuals with a mental health diagnosis Baseline 15% SLUHN CHNA 2021 Community Connections connectivity rate for those referred with mental health needs. Baseline: Community Connections 2022

	providing in-house services.				Mental health provider ratio Baseline: 390.1 (NC), 480:1 (LC) County Health Rankings 2022
Reduce disparities in access for cultural groups less likely to seek or obtain mental health care by implementing a minimum of 2 initiatives with vulnerable populations by December 31, 2025.	• Partner with LGBTQ+ organizations. • Partner with the faith community in communities of color	Bradbury Sullivan, churches, Haven House		Year 1 Year 2-3	Bradbury Sullivan Data
Decrease deaths by suicide by 5% from baseline by December 31, 2025.	• Partner with the Northampton County Suicide Prevention Task Force. • Promote QPR training. • Promote the suicide prevention hotline (988) and Trevor Project Lifeline. • Encourage all Northampton County schools to participate in the PAYS survey.	Northampton County Suicide Prevention Task Force, Pennsylvania Department of Health	EpiCenter, QPR Facilitators, PAYS data	Years 1-3	Percentage of BASD students who considered suicide Baseline: 18.5% PAYS 2021 Percentage of BASD students who attempted suicide Baseline: 11.1% PAYS 2021 Number of Northampton County

	• Analyze emergency room suicidal ideation and attempt data. • Enhance warm hand-offs in hospital settings.				residents who died by suicide Baseline: 39 Coroner's Office 2021

PRIORITY 2: SUBSTANCE USE		Goal: Decrease deaths from overdoses.			
Objectives	**Proposed Strategies**	**Partners**	**Assets**	**Timeline**	**Long-Term Outcomes (CHNA Data)**
Improve connectivity to care by 10% for substance use disorder among Community Connections clients by December 31, 2025.	• Community Connections social workers will follow up with individuals with substance use disorder or who recently overdosed to connect those individuals to treatment.	Bethlehem Police Department, Bethlehem EMS, HOPE Center, Community Connections Program Staff	Mobile recovery unit	Years 1-3	Percent of clients connected to treatment Baseline: Community Connections 2022
Implement a minimum of 5 interventions aimed at decreasing fatal overdoses by December 31, 2025	• Create an Overdose Fatality Review Team for Northampton County to identify risk factors and system gaps. • Develop interventions based on recommendations from the OFR team.	Northampton County Heroin and Opioid Overdose Task Force Members	Legalization of fentanyl testing strips, DOH Opioid grant, OFR legislation	Year 1 Years 2-3	Opioid death rate for Bethlehem Baseline: 26.1 per 100,000 City Health Dashboard 2017-19 Number of overdoses Baseline: 137 Bethlehem EMS 2021
Increase access to naloxone by 10% by December 31, 2025.	• Evaluate the agencies currently receiving naloxone to determine if there are gaps in distribution. • Promote free naloxone. • Educate the community on the Good Samaritan Law • Support CHC's efforts to educate transportation providers about naloxone.	Northampton County Heroin and Opioid Overdose Task Force Members, Northampton County EMS Agencies	Free naloxone provided by the state, local media outlets	Year 1 Years 1-3 Year 1 Years 1-3 Year 2	Opioid death rate for Bethlehem Baseline: 26.1 per 100,000 City Health Dashboard 2017-19

	• Work with local EMS agencies and police departments to implement naloxone leave policies. • Promote NaloxBoxes in public places.			Year 2	
Reduce stigma associated with substance use disorder by 10% by December 31, 2025.	• Disseminate a video from Wisconsin that highlights success stories from individuals who have recovered from substance use disorder.	Northampton County Heroin and Opioid Task Force members	Wisconsin Department of Health Pennsylvania Department of Health	Year 1	Stigma associated with SUD Baseline: BHB Stigma Survey

PRIORITY 3: CHRONIC DISEASE PREVENTION		Goal: To reduce the mortality and morbidity rates of chronic diseases related to obesity, diabetes, stress levels and heart disease.		
Objectives	**Proposed Strategies**	**Partners**	**Timeline (Year 1, 2, or 3)**	**Long-Term Outcomes**
Decrease the prevalence of obesity, diabetes, stress levels and heart disease by 10% by 2025. Improve fruit, vegetable, whole grain, fiber intake, sleep, and physical activity levels by 10 % by 2025.	1. Implement all the components of Lifestyle Medicine in a minimum of 1 worksite per year, focusing on worksites with a disproportionately high number of Hispanic employees. 2. Implement 3 Intensive Therapeutic Lifestyle Change programs in the Bethlehem Area School District and south side community.	Kellyn Foundation, Lehigh University, BASD	1,2,3 1,2,3	Number of residents diagnosed with obesity, diabetes and heart disease.
Increase availability of fresh food access by providing refrigeration to 100% of all pantries by 2025.	1. Conduct an assessment of food pantry locations and ability to refrigerate produce.	Second Harvest Food Bank, Feeding America, farms with CSA	1,2,3 1,2,3	Number of residents diagnosed with obesity, diabetes and heart disease.

	2. Facilitate refrigeration for pantries that do not have refrigeration. 3. Forge necessary partnership, if needed, to improve pantry locations to better serve the communities need to decrease food insecurity.		2,3	
Improve overall health by 10 % through promoting healthy eating and nutritious foods by 2025.	1. Conduct cooking demonstrations at Spanish supermarkets and bodegas. 2. Offer healthy meal prep kits with Spanish foods.	Lehigh University College of Health, Northampton Community College, C-town, Chandi, Spanish bodegas	1,2,3 2,3	Number of residents diagnosed with obesity, diabetes and heart disease.

PRIORITY 4: FOOD SECURITY		Goal: To reduce food insecure households.		
Objectives	**Proposed Strategies**	**Partners**	**Timeline (Year 1, 2, or 3)**	**Long-Term Outcomes**
Reduce household hunger by 10% by 2025.	1. Make available 24 Community Garden plots for residents to grow fresh fruits and vegetables. 2. Ask community gardeners to adopt the Plant a Row concept and grow an extra row to donate. 3. Kellyn to provide fresh fruits and vegetables via their mobile market. 4. Facilitate a CommonHub that farmers can source produce to for business to purchase from. 5. Facilitate a food recovery system that recovers unused food and donates it to food pantries or residents who are food insecure.	Kellyn, food banks, Second Harvest, Plant a Row, farmers	1,2,3 1,2,3	Reduce food insecure households.