2025 Community Health Implementation Plan

Lehigh Valley Health Network
part of Jefferson Health

Introduction

The Community Health Implementation Plan outlines how Lehigh Valley Health Network (LVHN), part of Jefferson Health, will be responsive, over the next three years and beyond, to the significant health needs identified in the 2025 Community Health Needs Assessment (CHNA). Based on the prioritization process outlined below, each licensed facility within the Lehigh Valley Health Network region has prioritized two or more health needs that will be addressed in the Implementation Plan and that are specific to that county's community.

To determine which priorities to commit to for the next three-year cycle, LVHN followed a rigorous process that involved both publicly available data and qualitative data collected from community members throughout 2024 and early 2025. Public data from sources including the American Community Survey and the Centers for Disease Control and Prevention were analyzed for each county, and an interactive dashboard was built allowing users to filter topics of interest (such as demographics and incidence of specific health conditions) by county and city. To collect qualitative content, external partners from within each community were contracted by LVHN to host community conversations in community-based settings and interview key community and public health stakeholders. Please see LVHN.org/CHNA for the full 2025 Community Health Needs Assessment reports for each campus and corresponding county.

The priority areas outlined in this report address the significant health needs raised by the community and were selected by LVHN regional leaders based on three criteria:

1. MAGNITUDE/IMPACT
To what extent does the health system see this health need as a large-scale pressing need in the community?

2. CAPACITY
Does Jefferson/LVHN already have initiatives underway that can be built up or expanded? Is there collective bandwidth to address this health need either independently or through partnership?

3. ALIGNMENT
Are there other priorities or strategic initiatives in the community or health system, including clinical and population health goals or strategic plans from city, school districts or other community entities, already in existance or planned in the next three years that the health system could align to?

In addition, the selected priority areas build on the work highlighted in the 2022 Community Health Implementation Plan. Those efforts that were signaling early successes will be continued and further deepened in this Community Health Implementation Plan.

The table below shows the key areas of concern that were prioritized by regional leaders. Several needs emerged as top concerns across the Jefferson/LVHN region. These included social and economic disadvantage; housing; older adult health; mental health, suicide and alcohol use; obesity; and access to health care.

Need Identified	Carbon	Dickson City	Hazleton	Lehigh	Northampton	Monroe	Schuylkill
Social/Economic Disadvantage*	✔	✔	✔	✔	✔		✔
Housing*		✔		✔	✔		✔
Older Adult Health*	✔	✔		✔	✔		
Mental Health, Suicide, Alcohol*	✔			✔	✔	✔	✔
Obesity*		✔		✔	✔		
Access to Health Care*				✔	✔	✔	
Language/Cultural Barriers			✔	✔			
Lack of Health Insurance			✔				
Cancer	✔						
County Among the Least Healthy		✔					✔
Chronic Disease Burden						✔	
Health Outcomes of Moms and Babies						✔	✔
Rural Health Needs/Transportation						✔	✔

**Top priorities network-wide*

Caring for an entire community

Whether a county, town, neighborhood or group of underserved individuals, a community calls for a team of dedicated people to really take care of it. Research shows us that health care only contributes a small portion to overall health outcomes. Other drivers of health, including health behaviors, social and economic factors, and the physical environment, have a greater impact on health over time. In addition, we recognize that all people need access to particular assets within communities to thrive. These assets are the vital conditions of a place including basic needs for health and safety (e.g., food access, primary care and mental health care), humane housing, lifelong learning opportunities, a thriving natural environment, accessible transportation and opportunity for meaningful work and wealth. Access to these vital conditions is preventive and can help improve long-term health outcomes. Strategies that target these upstream drivers are prioritized where possible in this Implementation Plan. Other strategies are more responsive to the needs of an individual who may be atrisk or facing an urgent crisis.

Given that health care is only one contributor to health outcomes, LVHN leaders believe in partnering with other sectors and stakeholders to address health needs in the communities where our patient population is most accessible. Our intention around partnering with community entities is reflected in the wide range of community partners listed throughout the implementation plan, including nonprofit agencies and school districts.

We also recognize that there are many more health-related concerns that are not explicitly addressed in this plan and that many of the health-related concerns and social determinants are often inter-dependent. While there is continuous work underway to address all the health needs identified, the 2025 Community Health Implementation Plan focuses these efforts on two areas where we hope to see demonstrable improvements in over the next few years.

Therefore, LVHN will measure the impact of the initiatives outlined below over the next three years. This evaluation will include indicators that will demonstrate the reach of the efforts. These are the number of participants or number of events and the impact of the initiatives, including obtaining health insurance, improvement in behavioral health outcomes and improvement in healthy eating. Some of the measures of success that will be tracked over the next three years are outlined with each initiative below.

We hope the information in the 2025 CHNA and Community Health implementation Plan encourages you to join our quest to make the seven counties LVHN serves better and healthier places to live.

Note: in the process of developing the 2025 CHNA and corresponding Implementation Plan, LVHN merged with Jefferson Health. This will be the final LVHN Community Health Needs Assessment. Going forward, plans will feature the Lehigh Valley region of Jefferson Health.

LVHN leaders believe in partnering with other sectors and stakeholders to address health needs in the communities.

Carbon County (LVH–Carbon)

Prioritized Health Need # 1: Stigma Around Behavioral Health Needs

NEED PRIORITIZED

Excessive drinking, opioid use, suicide and unmet mental health needs are all impacting the region. The suicide rate in Carbon is nearly twice the rate in the state (28/100,000 versus 15/100,000). Stigma around behavioral health issues prevents people from seeking the care they need.

APPROACHES FOR 2025–2028

Decrease stigma and increase the skills of professionals and community members to recognize mental health concerns and promote mental wellness. Offer events and educational webinars about the signs of mental health distress and how to promote mental wellness, and distribute critical treatments such as naloxone, used to reverse an opioid overdose, throughout the county.

COMMUNITY PARTNERS

Jim Thorpe and Lehighton School Districts, CMP Drug and Alcohol Commission, Police Departments

METRICS OF SUCCESS

- # of events and educational sessions
- # of attendees broken down by staff, community members and students
- # of naloxone kits distributed and locations
- # and type of educational materials provided

Prioritized Need # 2: Food Insecurity

NEED PRIORITIZED

11% of people in Carbon live in poverty, including 19% of children; 13% of people in Carbon County receive SNAP Benefits. Less healthy foods are commonly used because they are often cheaper and more convenient.

APPROACHES FOR 2025–2028

Partner with local community-based organizations to help address food insecurity in three ways:

- Sponsor employee food drives for Helping Harvest.
- Host and support Summer Meals Program to ensure youth in Carbon County still have free and healthy meals during the summer months when school is closed.
- Support United Way's Double SNAP Initiative through local farmers markets to create greater access to affordable fruits and vegetables for SNAP beneficiaries.

COMMUNITY PARTNERS

Sodexo, Helping Harvest, United Way of the Greater Lehigh Valley, farmer's markets and food bank/pantries

METRICS OF SUCCESS

- # boxes of food donated to Helping Harvest
- # of meals served in Summer Meals Program
- $ contributed to Double SNAP

Significant health needs not prioritized: In Carbon County for LVH–Carbon, the health needs that were identified but will not be addressed in the implementation plan include older adult health and cancer. LVHN provides significant cancer treatment and care in the community already. There are currently limited resources for initiatives specifically targeting the health of older adults or partners to work with.

Lackawanna County (LVH–Dickson City)

Prioritized Need # 1: Growing Health Needs of Older Adults

NEED PRIORITIZED

About 20% of the population of Lackawanna County is aged 65+. Increasing costs, limited transportation and difficulties navigating the system present barriers to accessing health care. The need for mental health services is especially great among seniors who are socially isolated. Additionally, 26% of adults age 65+ have diabetes.

APPROACHES FOR 2025–2028

To address the growing health needs of older adults in Lackawanna County, LVHN will focus on three aspects of health in seniors:

Behavioral Health: Increase awareness of mental health needs and resources available through LVH–Dickson City through health fairs and expos, establish partnership with senior centers, support Vital Choice or similar program, include stigma reduction videos in internal TV programming (WFMZ), embed behavioral health specialists in primary care practices

Transportation: Deepen partnership with COLTS to improve the experience of care and access for seniors.

Diabetes: Provide diabetes screenings throughout the county, including leveraging existing WFMZ programming, and throughout the hospital, include diabetes prevention information.

COMMUNITY PARTNERS

- Area Agency on Aging, Senior Centers, COLTS (County of Lackawanna Transit System)

METRICS OF SUCCESS

- Behavioral Health
  - # people contacted through health fairs and events
  - # hours WFMZ presented behavioral health content
- Diabetes
  - # screenings
- Transportation
  - # transports provided

Prioritized Need #2: Food Insecurity

NEED PRIORITIZED

About 18% of people in the county receive SNAP benefits. Community members struggle to afford food – particularly healthy food options – and have expressed a need for increased food distribution and volume of food. Existing food banks and distribution sites in the Dickson City area have been serving increased numbers of people and new people.

APPROACHES FOR 2025–2028

- Continue and expand the Summer Lunch Program to ensure youth in Carbon County still have free and healthy meals during the summer months when school is closed.
- Support the Double SNAP Initiative through local farmers markets to create greater access to affordable fruits and vegetables for SNAP beneficiaries; expand food collection drive, which benefits Weinberg Northeast Regional Food Bank to include more clinical sites.

COMMUNITY PARTNERS

- Weinberg Northeast Regional Food Bank, United Way, Hawk Foundation, Friends of the Poor

METRICS OF SUCCESS

- # boxes donated to Weinberg Northeast Regional Food Bank
- # of meals served in Summer Meals Program
- # sites participating in food collection
- $ contributed to Double SNAP

Significant Health Needs Not Addressed: In Lackawanna at LVH–Dickson City, the identified health need that is not being fully addressed is housing. There is a lack of identified effective intervention in this community that is known to the health system and a lack of partners with expertise to address this need. By focusing on diabetes care in older adults and food insecurity, LVHN is in part addressing other identified needs, including social and economic disadvantage, obesity and health in a poor county.

Lehigh County (LVH–Cedar Crest and LVH–17th Street) and Northampton County (LVH–Muhlenberg and LVH–Hecktown Oaks)

Prioritized Need #1: Insufficient Mental Health and Suicide Prevention Services

NEED PRIORITIZED

Community members and leaders explained that excessive drinking, opioid use, suicide and unmet mental health needs are all impacting the region. Stigma contributes to mental health concerns. There is particular concern for children and youth, elders, LGBTQ+ individuals and Spanish-speakers. Additional crisis services and neighborhood resources are needed.

APPROACHES FOR 2025–2028

This priority area would be a continuation from previous CHNA cycles with a focus on prevention, skill-development and increased awareness. Current and future initiatives and strategies in this area include:

- Provide greater access for youth to mental health services through LVHN's School-based Behavioral Health Program, which provides in-school behavioral health systems for districts throughout the two counties.
- Decrease stigma and increase the skills of professionals and community members and promote wellness.
- Implement a group-based model of community conversations and solidarity care called Integrated Community Therapy (ICT) in locations throughout Lehigh and Northampton counties.
- Leverage existing behavioral health care navigators throughout the health network.
- Support Blue Zones "moais," small groups of friends that support and encourage each other, to increase social connection and well-being among community members.
- Reduce stigma and increase awareness through community outreach, community partnerships and event sponsorships.

COMMUNITY PARTNERS

School districts and colleges, Department of Human Services in Lehigh and Northampton counties, Suicide Prevention Task Forces in Lehigh and Northampton counties, NAMI, Blue Zones Project – Lehigh Valley, United Way of the Greater Lehigh Valley, City of Allentown Health Bureau, City of Bethlehem Health Bureau

METRICS OF SUCCESS

- # children served in school-based behavioral health
- clinical outcomes of school-based behavioral health including sense of hope, increase in skills and coping
- # new community partnerships formed
- # webinars/trainings and attendees
- # people trained in ICT, number of rounds implemented and number of locations
- # people participating in Blue Zones moais

Prioritized Health Need #2: Inequitable Access to Quality Health Care

NEED PRIORITIZED

Barriers to obtaining care include transportation, lack of insurance, cost of copays and a lack of awareness about available services. Some people struggle to navigate the system (with particular concern toward elders and non-English speakers). Few clinicians take Medicaid; 6% of people in Easton and 11% of people in Allentown are uninsured. The percentage is higher for individuals who are Latino (8% and 14% respectively in the two cities).

APPROACHES FOR 2025–2028

Educate people about available services and connect them to the services. Bring more services, education and screenings to the community, with a particular focus on Medicaid enrollment and renewal. Effectively deploy a mobile van in Northampton to provide preventative health services and education.

COMMUNITY PARTNERS

Valley Health Partners (including Street Medicine), PATHS, United Way of the Greater Lehigh Valley, places of worship, community centers

METRICS OF SUCCESS

- # events/people educated about services
- # people referred for services
- # targeted deployments of van and # served
- # enrolled in health insurance

Prioritized Health Need #3: Lack of Affordable and Quality Housing

NEED PRIORITIZED

Homelessness, overcrowding, multiple moves and poor housing quality are all associated with increased health risks for both children and adults. Overall access to safe, quality, affordable housing is lacking. Many community members are living in inadequate housing. Elders, children, those with disabilities, those with criminal records and LGBTQ+ people are of particular concern.

APPROACHES FOR 2025–2028

Through partnerships, support community housing efforts, particularly for workforce and affordable housing initiatives. Current and future strategies may include:

- Continue partnership with Bethlehem HUD Choice Neighborhoods initiative.
- Support neighborhood-based housing improvements through the Leonard Parker Pool Institute for Health.
- Provide community education about safe/adequate housing and connect people to resources.
- Partner with Street Medicine and the health bureaus on remediation issues and providing medical care for those who are homeless.
- Partner with the Pennsylvania Housing Alliance in eviction prevention efforts and implementing bestpractices around how health care systems partner to address housing.

COMMUNITY PARTNERS

Allentown Health Bureau, Ripple Community, Inc., North Penn Legal Services, City of Bethlehem, Community Action Development Corp. of Bethlehem, United Way of the Greater Lehigh Valley, New Bethany, Real Estate Lab, City of Allentown, Pennsylvania Housing Alliance

METRICS OF SUCCESS

- # community partnerships formed
- # projects planned
- Metrics related to HUD Choice grant
- Metrics related to evictions

Prioritized Health Need #4: Prevalence of Obesity and Diabetes

NEED PRIORITIZED

About 32% of people in Lehigh County and 27% of people in Northampton County are obese; 11% of adults in both counties have diabetes. Increasing rates of diabetes are due in part to poor lifestyle choices and food habits. There is a need for prevention programs to decrease the risk for developing diabetes.

APPROACHES FOR 2025–2028

- Partner with the Kellyn Foundation to provide education in elementary schools in Lehigh and Northampton counties to teach health nutrition and support food voucher program through Kellyn's Mobile Market.
- Partner with community based organizations like the YMCA, Boys and Girls Club and Community Bike Works to provide physical activity opportunities for youth and healthy lifestyle support.
- Provide diabetes prevention efforts and coaching to increase awareness and address the influences of physical activity, healthy eating and mental health.
- Outreach to diabetic patients who are overdue for a health care visit to support management of their diabetes.

COMMUNITY PARTNERS

Kellyn Mobile Market, Kellyn educational programming, Blue Zones, Community Bike Works, YMCA, Boys and Girls Club

METRICS OF SUCCESS

- # prevention and education efforts
- # participants
- # new community partnerships formed
- Pathway outcomes

Significant Health Needs Not Addressed: In Lehigh and Northampton counties (LVH–Cedar Crest, LVH–Muhlenberg, LVH–Hecktown Oaks, and LVH–17th Street), one identified health need not being addressed in this implementation plan is language barriers (Lehigh County only). This is already being addressed by other organizations in the community and therefore was a lower priority need compared to the four identified above. The needs of older adults will also be addressed through the prioritized needs and strategies outlined above.

Luzerne County (LVH–Hazleton)

Prioritized Health Need #1: Language Barriers to Accessing and Utilizing Health Care

NEED PRIORITIZED

About 45% of people in Hazleton, and 34% of people in Luzerne have limited English proficiency, creating barriers to accessing health-related services.

APPROACHES FOR 2025–2028

Continue to diversify colleagues in the Hazleton market to be more reflective of the community being served, including through human resource recruitment and workforce development efforts to improve health outcomes for vulnerable populations.

COMMUNITY PARTNERS

Dominican House, Hazleton Integration Project, Hazleton School District, Penn State Hazleton, YMCA, Catholic Social Services, Hazleton Police Department, Collaborative Autism Movement

METRICS OF SUCCESS

- # current colleagues who become trained medical interpreters
- bilingual clinicians and colleagues hired for open positions in the Hazleton market (HR-Talent Acquisition data)
- Interpreter services metrics—# encounters for hospital and community practice sites

Prioritized Health Need #2: Improve the Health and Wellness of Children in the Community

NEED PRIORITIZED

About 25% of children in Luzerne County and 37% of children in Hazleton are living in poverty. Many children have difficulty accessing the immunizations and physical exams needed for school enrollment. In addition, 19% of the population (in both the county and the city) receive SNAP benefits, and 4% of children in the county and 7% of children in Hazleton are uninsured. What specifically would you like to say about wellness as a need? Is there something around behavioral health? Or, would you like to just stay with what we have below?

APPROACHES FOR 2025–2028

Partner with the Hazleton Area School District to address the health and well-being of the students including:

- Provide school physicals and immunizations, allowing children to enroll in school.
- Through the Nurse's Pantry and HAPD Camp Aspire, provide hygiene products (also clothing/shoes) for students of various ages.
- Partner with parents to educate them and their children about Paths/MA and Jefferson Health plan in the future.
- Participate in health and wellness fairs.
- Provide free drive-through flu vaccine clinic.
- Provide increased access to mental health services through school-based behavioral health.

COMMUNITY PARTNERS

Hazleton Integration Project (or HIP Center), United Way of Greater Hazleton, Hazleton Area School District, Weller Center, Hazleton Area Police Department, YMCA

METRICS OF SUCCESS

- Number of screenings held, number referred for treatment, number of school physicals completed, number of immunizations given, number of families assisted with getting insurance
- # insurance cards distributed
- # people educated
- # people enrolled
- # school physicals
- # immunizations and flu shots
- Amount of pantry supplies distributed
- # events and attendees

Significant Health Needs Not Addressed: All of the prioritized needs in Luzerne County (LVH–Hazleton) are addressed in the implementation plan. By focusing on the health of students in the district, both social and economic disadvantages and health insurance will be a part of the comprehensive strategy

Monroe County (LVH–Pocono)

Prioritized Health Need #1: Insufficient Behavioral Health Services and Stigma Around Mental Health

NEED PRIORITIZED

Mental health needs have increased. Stigma prevents people from seeking treatment. School students need mental health services. Additionally, Monroe County has the highest use of alcohol in the state, and alcohol use disorder is prevalent.

APPROACHES FOR 2025–2028

Decrease stigma and increase the skills of professionals and community members to recognize mental health concerns and promote mental wellness.

COMMUNITY PARTNERS

Nurse Family Partnership, Saw Creek Community Center, Pocono Pride Fest, Community Day, Safety Day, Elder Justice Day, Mental Health Walk, CMP Drug and Alcohol Commission

METRICS OF SUCCESS

- The number of behavioral health awareness events LVH–Pocono hosts or in which it partners
- The number of mental health awareness or skill-building trainings held and the number of participants

Prioritized Health Need #2: Prevalence of Obesity and Diabetes

NEED PRIORITIZED

About 26% of people in both Monroe County and East Stroudsburg are obese. Additonally, 11% of people age 20 and over have diabetes, as does 27% of the Medicaid population. Many individuals have complex health issues of which diabetes is a part.

APPROACHES FOR 2025–2028

Expand Healthy Living, a diabetes prevention pilot program, increase nutrition education outreach and partner with the Community Paramedic Program.

COMMUNITY PARTNERS

Pocono YMCA

METRICS OF SUCCESS

- # of patients screened
- # of patients receiving education
- Clinical outcomes for Healthy Living program

Significant Health Needs Not Addressed: In Monroe County for LVH–Pocono, the identified health needs not included in this implementation plan include access to health care, health outcomes for moms and babies, and transportation. While there are some efforts underway in the county to address these needs, there are limited resources to be able to expand those efforts throughout the county.

Schuylkill County (LVH–Schuylkill)

Prioritized Health Need #1: Stigma Around Behavioral Health Needs

NEED PRIORITIZED

Drug addiction and overdose, suicide and unmet mental health needs are all concerns in Schuylkill County.

APPROACHES FOR 2025–2028

Decrease stigma and increase the skills of professionals and community members to recognize mental health and substance use concerns and promote wellness.

COMMUNITY PARTNERS

Carbon, Monroe, Pike Department of Human Services

METRICS OF SUCCESS

- The number of behavioral health awareness events LVH–Schuylkill hosts or in which it partners
- The number of mental health awareness or skill-building trainings held and the number of participants

Prioritized Health Need #2: Insufficient Access to Primary Care Throughout the County

NEED PRIORITIZED

People in Schuylkill County (especially lower income, uninsured and older people) have limited access to primary care. Numerous physicians in the county are approaching retirement. Other barriers to care include cost and transportation. Those without a physician use the ER as primary care. There is a strong desire for more primary care services in the county.

APPROACHES FOR 2025–2028

Increase clinicians through the Walter & Irene Baran Rural Family Medicine Residency, partner with transportation resources, leverage the planned survey of transportation needs. Remind community members of the extended hours for care at JeffExpress urgent care at Schuylkill Medical Plaza. Develop a plan to apply for new rural hospital federal funds. Leverage existing connections with community organizations (HIVE, STS, Chamber) to address transportation needs.

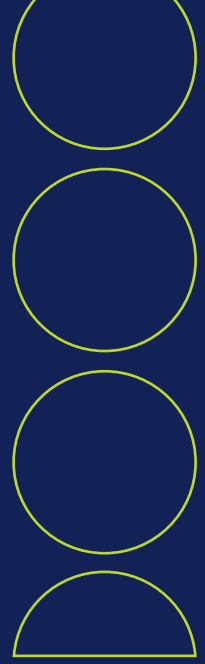
COMMUNITY PARTNERS

Primary Health Network, Schuylkill Connects, Schuylkill Transportation System Technical Assistance Committee, HIVE Transportation Committee, Chamber Infrastructure Committee, senior housing and senior centers

METRICS OF SUCCESS

- Number of family medicine residents hired
- Number of staff hired
- Clinician utilization data
- Number of events attended/contacts made by residents
- Number of transports provided for patients
- Cost of transportation provided for patients

Significant Health Needs Not Addressed: In Schuylkill County for LVH–Schuylkill, the identified health needs not prioritized in this implementation plan include housing, health outcomes for moms and babies, and social and economic disadvantages. There are limited resources to address these needs sufficiently.



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