Community Health Improvement Plan 2013-2016

Note: Healthy Communities Institute indicators as of December 2012.
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I. Executive Summary

A. Commitment to Health Improvement

Lancaster General Health (LG Health) understands that there are many factors that influence an individual’s health. As a healthcare provider, LG Health not only treats individuals who have already been diagnosed with an illness, but provides educational programs and initiatives that work to prevent or reduce incidence of illness. In addition, LG Health establishes partnerships that assist in influencing social determinants of health. The initiatives are guided by LG Health’s Mission to “advance the health and well-being of the communities we serve” and the Vision to “deliver on the promise of a healthier future.”

B. Commitment to the Community

Since the early 1990s, Lancaster General Hospital (LGH) has been conducting community needs assessments and has partnered with numerous community organizations that have a mission or goal to improve the health and well-being of Lancaster County residents.

In 1996, decisions related to community health improvement, community outreach, and meeting the health needs of Lancaster County were embedded in the organizations strategic plan and in 2006, a decision was made to create a standing Committee of the Board, the Mission & Community Benefit Committee, reinforcing the importance of community health at the highest level. The role of the Mission & Community Benefit Committee is to assist the Board of Trustees in fulfilling community-benefit obligations such as increasing availability of and access to health and wellness services irrespective of one’s ability to pay.
LGH offers a number of prevention and behavior modification programs; however, we recognize that programs are only one part of the larger picture that influences the health of a community. **Collaboration** with community organizations and groups strengthens the likelihood of having a meaningful impact on root causes of health issues. We look towards our community partners to help us understand contextual and environmental influences that impact the health status of the community we serve. Collaboration between the health system and public and private organizations is crucial in improving the health of all Lancaster County residents.

**C. Lancaster County Community Health Needs Assessment (CHNA)**

We first conducted a Community Health Needs Assessment (CHNA) in the early 1990’s in partnership with the United Way of Lancaster County. Another Needs Assessment was conducted in 1996 and served as the foundation for a Healthy Communities initiative and the establishment of a community collaborative known as Lancaster Health Improvement Partnership (LHIP). LHIP is a public/private partnership of stakeholders representing diverse organizations, groups, and businesses. This collaborative assists LG Health in the facilitation of the CHNA, as well the establishment of a **data driven process** that is the foundation for decision making in setting health priorities.

The assessment incorporates key information to identify health issues of consequence to the Lancaster community. The data used allows LG Health and community partners to observe trends, compare Lancaster County to other counties in Pennsylvania, compare ourselves to the nation, as well as use Healthy People 2020 as a benchmark or goal.

Most recently, LG Health’s LGH, Women & Babies Hospital (WBH), and Lancaster Rehabilitation Hospital, along with Ephrata Community Hospital, contracted with Healthy Communities Institute (HCI) for community health data collection. The HCI tool provides a platform which consists of a dashboard of indicators, a disparities dashboard, current Lancaster County demographics, as well as a Healthy People 2020 tracking tool. Under each indicator data are compared to previous years, and if, available genders, ages, and races/ethnicities are compared. The Floyd Institute for Opinion Research at Franklin &
Marshall College reviewed the data and produced the CHNA analysis. The CHNA final report was available to all Lancaster County residents in April 2013 on LG Health’s website.

D. Identified Community Health Needs

Currently, Lancaster County is doing a good job at addressing a number of health indicators and the statistics reflect this. These indicators appear as “green” on the HCI website. Others are indicators that must be closely watched, and appear “yellow” on the HCI website and will be addressed in section IV-C. Those indicators that are currently “red” on the HCI website will either be addressed as a key priority or as an outstanding health issue. These “red” indicators will be addressed in section IV-D.

Several precautionary indicators, such as colon cancer screenings and the number of mothers in Lancaster County who receive early prenatal care, are currently addressed through LG Health initiatives. For these indicators to remain in the cautionary status, current programs will be continued. Those that are not addressed in some capacity through LG Health initiatives must be closely watched to ensure a change in County health trends does not result in the movement of an indicator for the worse.

The following indicators have been identified as “yellow” indicators:

- Age-adjusted death rate due to breast cancer
- All cancer incidence rate
- Breast cancer incidence rate
- Cervical cancer incidence rate
- Colorectal cancer incidence rate
- Prostate cancer incidence rate
- Age-adjusted death rate due to cerebrovascular disease (stroke)
- Number of adults with asthma
- Age-adjusted death rate due to HIV
- Infant mortality rate
- Poor social and emotional support
- Recreation and fitness facilities
- Farmers market density
- Grocery store density
- Households without a car and >1 mile from a grocery store
- SNAP certified stores
- Low income persons who are SNAP participants
• Adults who are obese
• Adults who are overweight or obese
• Households with public assistance
• School dropouts
• Student to teacher ratio

The following indicators have been identified as “red” indicators:
• Children with health insurance
• Colon cancer screening
• Chlamydia incidence rate
• Gonorrhea incidence rate
• Mothers who received early prenatal care
• Annual ozone air quality
• Annual particle pollution
• Households without a vehicle

E. LGH Priorities
In order to have meaningful input on community health needs, LG Health has selected health priorities. The priorities of focus for LG Health were determined by examining the number of lives impacted, quality of life years lost, community cost savings by avoiding the health issue, and ability to influence the health need. Upon review and discussion of the data, LG Health’s Community Health Needs Assessment Task Force identified three key priorities:

A. Increase the number of people at a healthy weight
B. Reduce the use of tobacco
C. Improve mental health with a focus on depression and anxiety

1. Obesity
According to the F as in Fat 2012 report recently released by the Trust for America’s Health and the Robert Wood Johnson Foundation (RWJF), the obesity epidemic is threatening the success and security of America and most developed nations by deteriorating the health of overweight individuals, increasing national debt, decreasing productivity and plaguing our youth¹. The cause of obesity is complex and multi-faceted.
The costs of obesity to the individual and population are extreme and burdensome on many levels and affect society in relation to the direct costs to the individual as manifested by poor physical and mental health as well as decreased socialization and a decreased overall quality of life².

The most recent costs associated with obesity and its related ailments accounted for $147 billion nationally per year³. The link between obesity and the development of chronic disease multiplied by the growing rate of obesity guarantees a 10-20% increase in healthcare rates for all states by the year 2030, which would be anywhere from $48-$66 billion per year⁴. The economic consequences of obesity do not end at healthcare spending - the decreased rates of productivity linked to obesity will account for a $390-580 billion loss nationally within the next 18 years⁵.

Best practices in the prevention of obesity recommend evidence-based, comprehensive programs and policy, systems, and environmental changes that address healthy eating and increased physical activity be made available and implemented at all levels of society.

LG Health’s strategic approach to healthy weight management is planned using national, state, and local data and engages community stakeholders to utilize evidenced-based best practices around policy, systems, and environmental changes. WBH primarily focuses on weight during pregnancy particularly focusing on low-income pregnant women in Lancaster General’s Healthy Beginnings Plus (HBP) program and educational programs for peri-menopausal women.

Since 2007, LG Health has been focusing on reducing the number of individuals in Lancaster County who are obese and overweight. Understanding that no one organization could fight the obesity epidemic alone, LG Health convened over 75 groups, organizations, schools, businesses, government officials, and faith based communities to form a coalition, now known as Lighten Up Lancaster County (LULC). As a large and growing community coalition, with a membership list of over five hundred individuals, LULC continues to raise awareness of the obesity
epidemic in Lancaster County and works to serve as a resource for individuals and companies to make the healthy choice the easy choice. LG Health continues to serve as the primary convener and funder.

Chapter V-A outlines the framework and operational plan: to increase the number of adults and children maintaining a healthy weight in Lancaster County. The intermediate goals are to increase the number of individuals who are physically active and making healthy food choices. Interventions are targeted toward sectors where we live, work and play (schools, communities, and workplaces). Strategic initiatives within each sector are designed to increase awareness, educate individuals, promote behavior change, and implement policy and system changes to make the healthy choice the easy choice.

2. Tobacco
According to Healthy People 2020, tobacco use is the single most preventable cause of disease, disability, and death in the United States, yet more deaths are caused each year by tobacco use than by all deaths from human immunodeficiency virus (HIV), illegal drug use, alcohol use, motor vehicle injuries, suicides, and murders combined. An estimated 49,000 of these deaths are the result of secondhand smoke exposure. For every person who dies from tobacco use, another 20 suffer from at least one serious tobacco-related illness⁶.

Smoking makes it harder for women to get pregnant. If a woman becomes pregnant and continues to smoke during pregnancy, she puts herself and her child at risk for additional health problems related to cigarette smoke. Women who smoke during pregnancy are more likely to have a miscarriage and babies are more likely to be born prematurely or at a low birth weight⁷. Women who smoke during pregnancy are more likely to have an ectopic pregnancy, bleeding, placental issues, and even stillbirths⁸. Smoking can lead to an increased risk of Sudden Infant Death Syndrome (SIDS) and babies are more likely to have birth defects, such as a cleft lip or palate⁹.
Tobacco use poses a heavy burden on the U.S. economy and medical care system. Each year, cigarette smoking costs more than $193 billion in medical care costs, while secondhand smoke costs an additional $10 million. Tobacco use is thus one of the Nation’s deadliest and most costly public health challenges\textsuperscript{10}.

Although cigarette use among youth is decreasing, it continues to be a national problem. According to draft guidelines issued by the US Preventive Services Task Force (USPSTF), health care providers are being urged to intervene and educate youth to prevent teen smoking\textsuperscript{11}. Trends also indicate an increased lifetime use of smokeless tobacco among youth in Lancaster, in Pennsylvania, and in the United States.

The costs and consequences of tobacco dependence are numerous and complex. It is critical to the success of our organization in addressing the need for tobacco prevention and cessation to understand the factors that contribute to this addiction and the projected consequences if this need goes unmet. As a leader in healthcare, our goal is to increase awareness and knowledge of these consequences and to encourage and empower individuals toward positive behavior changes that will decrease their risk for tobacco-related chronic illnesses and premature death.

Anticipating the Pennsylvania Tobacco Master Settlement in 2000, LG Health convened community partners to begin to develop a comprehensive approach to reduce the number of youth and adults who use tobacco products. These community partners are now known as the Tobacco-Free Coalition of Lancaster County.

Chapter V-B outlines the framework and operational plan to decrease the number of youth and adults who use tobacco products.
3. Mental Health

This is the first year LG Health has selected mental health as a key health priority. Mental illness refers to mental disorders that impact the mood, thinking, or behavior of an individual and is often times associated with distress and impaired functioning, thus interrupting daily life and leading to social impairment\(^2\). There is evidence to suggest a connection between mental health and chronic disease or injury\(^3\). Chronic diseases are also thought to increase the chances that an individual will develop a mental illness, such as depression\(^4\). Depression is more common among patients suffering from chronic diseases and who have unhealthy lifestyles\(^5\). The mental health of an individual is also certain to impact the recovery of a patient from illness\(^6\).

According to the Centers for Disease Control and Prevention (CDC), mental health illness leads to more disability in the United States than any other disease\(^7\). In 2002, the mental illness economic burden was $300 billion\(^8\). A study estimates that the annual cost of anxiety disorders during the 1990’s in the United States was $42.3 billion\(^9\).

Monitoring mental illness is important not only because mental illness is associated with an increase in chronic disease, but because those who suffer from a mental illness are less likely to adhere to their treatment for illness and seek medical care for illness\(^10\).

LG Health recognizes the importance of frequent screening for perinatal depression. This is why we have implemented the use of the Edinburgh Postnatal Depression Scale (EPDS) and the PHQ-9 at HBP & Nurse Family Partnership (NFP). Every patient is screened a minimum of two times, at 28 weeks of pregnancy and again post partum. Of the 1,200 women screened this year, 27% scored high enough to require referral to the Primary Care Physician (PCP) and counseling. Over 75% of the women who scored positive during pregnancy received treatment before the baby was born and did not score positive for depression after the birth.
Currently, WBH works with women to handle feelings of depression during and after pregnancy. WBH and HBP have published a pamphlet to help mothers understand the signs and symptoms of perinatal and postpartum depression and what to do if feeling depressed. Website resources are provided as well as the phone number for a crisis intervention hotline.

Domestic violence is a public health issue. It impacts more women than heart disease, diabetes or cancer. It results in a wide variety of acute physical injuries; obstetrical, gynecological, and mental health conditions; and frequent stress-related complaints due to ongoing or past violence. Domestic violence frequently occurs during pregnancy, with homicide as the leading cause of death among pregnant women and in the year after giving birth. WBH has the opportunity to help prevent domestic violence, and assist victims. WBH’s domestic violence program includes community education projects, and training for medical staff on identifying and sensitively responding to victims in a safe and confidential setting.

Public health initiatives and mental health initiatives in general are disjointed. Without coordination, only the physical health of an individual is treated, ignoring a major component necessary for recovery and a cause of the many diseases being addressed. LG Health currently collects utilization and provider data within the health system; however, Lancaster County level medical data is limited. Through focusing on mental health, LG Health plans to improve mental health indicators.

With the treatment of health moving to prevention in the primary care setting, there is an increased opportunity for a unified approach to treating mental health and physical health. LG Health will begin by convening community organizations to create a call to action in addressing anxiety and depression throughout the community. According to research, effective mental health coalitions bring public health professionals with experience in chronic disease, both mental health and primary care providers, as well as other community advocates to the table.

Chapter V-C outlines the framework and operation plan to enhance mental health resources in our community.
F. LG Health Community Health Priority Implementation Plans

Through the implementation of the Community Health Improvement Plan, community members will gain greater knowledge about community health needs, selected LG Health health priorities, and evidence based initiatives to address the issue. Individual implementation plans have been developed for each identified priority and individuals will be able to identify how they might improve the health and well-being of our community.

Obesity- Increase the number of people at a healthy weight

<table>
<thead>
<tr>
<th>Initiative</th>
<th>LGH</th>
<th>WBH</th>
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<tbody>
<tr>
<td>Develop multimedia materials to distribute through print, video, radio</td>
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<tr>
<td>campaigns to raise awareness of obesity epidemic.</td>
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<tr>
<td>Provide healthy weight programs for adults and youth.</td>
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<tr>
<td>Provide technical assistance to health care providers to increase the</td>
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<tr>
<td>percentage of clients screened for BMI.</td>
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<tr>
<td>Participate in school wellness councils.</td>
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<tr>
<td>Coordinate school garden initiatives.</td>
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<tr>
<td>Link farmers and worksites together to increase access to fresh fruits</td>
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<tr>
<td>and vegetables through our farm to institution initiatives.</td>
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<tr>
<td>Link vendors and school cafeteria administration together for</td>
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<tr>
<td>collaborative buying to increase the number of schools that provide</td>
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<td>healthy food choices.</td>
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<tr>
<td>Educate policy makers to increase the number of municipalities</td>
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<tr>
<td>participating in the Bicycle Friendly Community Program.</td>
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<tr>
<td>Educate emergency food providers about healthy food practices for</td>
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<tr>
<td>people receiving the emergency food.</td>
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<tr>
<td>Educate new mothers on the benefits of breastfeeding at WBH.</td>
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<tr>
<td>Educate HBP patients with a BMI $\geq 30$ on the importance of gaining</td>
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<tr>
<td>$\leq 20$ pounds.</td>
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<tr>
<td>Developed Lancaster on the Move guides in partnership with Lancaster</td>
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<tr>
<td>County Park and Recreation Commission to link people to free and low-</td>
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<td>cost places to be physically active.</td>
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<tr>
<td>Develop, print, and distribute healthy cookbooks created with our</td>
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<tr>
<td>community: The Lighter Side of Lancaster:, Cooking Healthy: Latino</td>
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<tr>
<td>Style, Cocinar Saludable al Estilo Latino, African American Favorite</td>
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<tr>
<td>Traditional Recipes Made Healthy, Tasty and Easy</td>
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<tr>
<td>Coordinate a Healthy Vending initiative to increase healthy vending</td>
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<tr>
<td>choices in organizations across the county.</td>
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<tr>
<td>Continue to facilitate the growth of Lighten Up Lancaster County</td>
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<tr>
<td>Coalition.</td>
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</tbody>
</table>
**Executive Summary**

### Tobacco - Reduce the use of tobacco

<table>
<thead>
<tr>
<th>Initiative</th>
<th>LGH</th>
<th>WBH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educate school students on tobacco prevention practices through the CDC best practice program, LifeSkills.</td>
<td>☑️</td>
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<tr>
<td>Provide and or refer inpatient, outpatient, group and individual, tobacco cessation program.</td>
<td>☑️</td>
<td>☑️</td>
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<tr>
<td>Provide technical assistance to Increase the proportion of health care providers who routinely advise patients about cessation services and provide follow-up.</td>
<td>☑️</td>
<td>☑️</td>
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<tr>
<td>Educate policy makers to increase the number of municipalities that have written policies supporting tobacco free parks and playground initiative, Young Lungs at Play (YLAP).</td>
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<tr>
<td>Collaborate with local employers to increase the percent of worksites that have comprehensive tobacco policies.</td>
<td>☑️</td>
<td>☑️</td>
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<tr>
<td>Provide cessation resources and services to community partners who work with targeted/disparate populations (pregnant women, mental health, LGBT).</td>
<td>☑️</td>
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<tr>
<td>Increase the percentage of clients who quit at 30 days.</td>
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<tr>
<td>Educate youth on tobacco industry influences and practices.</td>
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<tr>
<td>Develop media messages promoting tobacco free living.</td>
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<tr>
<td>Collaborate with policy makers to Increase number smoke-free multi-unit housing policies.</td>
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<tr>
<td>Provide education to increase the percentage of HBP patients who quit smoking in pregnancy.</td>
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</tbody>
</table>

### Mental Health - Improve mental health with a focus on depression and anxiety

<table>
<thead>
<tr>
<th>Initiative</th>
<th>LGH</th>
<th>WBH</th>
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</thead>
<tbody>
<tr>
<td>Provide mindfulness based stress reduction groups to adults coping with stress and or chronic illness.</td>
<td>☑️</td>
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<tr>
<td>Educate patients on the benefits of participation in breast cancer related exercise programs.</td>
<td>☑️</td>
<td>☑️</td>
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<tr>
<td>Build a mental health logic model with community partners.</td>
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<tr>
<td>Explore the feasibility of integrated mental health services in provider practices.</td>
<td>☑️</td>
<td>☑️</td>
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<tr>
<td>Provide support groups for health related conditions including pregnancy, cancer, stroke and injury.</td>
<td>☑️</td>
<td>☑️</td>
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<tr>
<td>Initiate a distress thermometer for oncology patients.</td>
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</tbody>
</table>
Access to Care/ Health Disparities Related

<table>
<thead>
<tr>
<th>Initiative</th>
<th>LGH</th>
<th>WBH</th>
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<tbody>
<tr>
<td>Collaborate with primary care providers to Increase the percentage of women patients who are screened for breast and cervical cancer.</td>
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<tr>
<td>Provide screenings and treatment for sexually transmitted diseases.</td>
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<tr>
<td>Conduct breast and cervical cancer screenings through the Healthy Woman Program.</td>
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<tr>
<td>Provide immunizations for post partum women and low income children.</td>
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<tr>
<td>Provide the Nurse Family Partnership and Healthy Beginnings program for low income at risk women.</td>
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<tr>
<td>Facilitate Farm and Family Safety Day camps to reduce injury.</td>
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<tr>
<td>Facilitate educational lectures and linkages to health screenings in the homes of Amish women.</td>
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<tr>
<td>Facilitate educational health lectures for women and linkages to screenings in churches and community organizations.</td>
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<td>✔</td>
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<tr>
<td>Provide foundational support and facilitate a children’s advocacy center for Lancaster County which provides forensic interviews and non-invasive specialized medical examinations to children with allegations of sexual abuse.</td>
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<tr>
<td>Provide education lectures, ministerium guide and screen patients for domestic violence.</td>
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<tr>
<td>Facilitate the Dental Access of Lancaster County (DALCO) program linking low income uninsured residents with volunteer dentists.</td>
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<tr>
<td>Convene the Child Death Review Team to identify trends and opportunities for preventing childhood deaths.</td>
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<tr>
<td>Facilitate car seat technician trainings and car seat safety checks to reduce injury and death related of children from motor vehicle accidents.</td>
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<tr>
<td>Continue to provide initial health physical for new refugees within one month of arrival to Lancaster County.</td>
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<tr>
<td>Continue partnership with the Lancaster City &amp; County Medical Society to standardize treatment and control of hypertension and cholesterol.</td>
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Lancaster Rehabilitation Hospital (LRH)

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<tr>
<th>Initiative</th>
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<tbody>
<tr>
<td>Increase the percentage of patients screened for BMI and referred for services.</td>
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<tr>
<td>Screen and refer patients to group and individual, tobacco cessation program.</td>
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<tr>
<td>Provide stroke survivor support group.</td>
</tr>
<tr>
<td>Participation in Farm and Family Safety Days to reduce injury.</td>
</tr>
<tr>
<td>Financially sponsor American Heart and Stroke Foundation Lancaster County Heart Walk as well as encourage employee participation.</td>
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</tbody>
</table>

If you have difficulties accessing LG Health’s CHNA or would like to request a hard copy, please call LG Health’s Community Health and Wellness Center at (717) 544-3811. Please direct all questions and comments to Alice Yoder, RN MSN, Director of Community Health, at (717) 544-3283 or amyoder@lghealth.org.
II. Overview

A. Lancaster General Health (LG Health)

Lancaster General Health (LG Health) is a regional not-for-profit healthcare system with a reputation for excellence. LG Health is a 623-licensed bed not-for-profit health system with a comprehensive network of care encompassing Lancaster General Hospital (LGH) and Women & Babies Hospital (WBH), including a Level III-B Neonatal Intensive Care Unit. Outpatient services are provided at the Downtown and Suburban Outpatient Pavilions, along with nine Outpatient Centers, and Express and Urgent Care locations throughout the region. Lancaster General College of Nursing & Health Sciences is a private, co-educational, Middle States-accredited four-year college offering a variety of associate and baccalaureate degree and certification programs in healthcare. Other system organizations include: VNA Community Care Services; Lancaster Rehabilitation Hospital, in partnership with Centerre-Healthcare; and Lancaster General Health Physicians (LGHP), consisting of 260 primary care and specialty physicians.

Designated a Magnet hospital for nursing excellence, LG Health has been recognized regionally and nationally for its cardiology, intensive care unit and orthopedic services. Other key specialty services include open-heart surgery, obstetrics neurosurgery, trauma, pediatric care and inpatient and outpatient Behavioral Health. Outpatient programs and services include a Diabetes and Nutrition Center, Sleep Medicine Center, Wellness Center, Wound Care & Hyperbaric, Interventional Radiology, and Occupational Medicine. As a member of the Penn Cancer Network, Lancaster General Health has access to the vast research and technological resources of one of the nation’s foremost cancer institutes.
Notable expansions in services at LGH in the past 15 years include:


2000: WBH opens, becomes region’s first hospital dedicated solely to the healthcare needs of women and their newborns.

2002: LGH’s former nurses’ school becomes the Lancaster General College of Nursing & Health Sciences.

2004: The Lancaster General Orthopedic Center opens at LGH.

2006: The Lancaster General Health Foundation begins, serving as the centralized collection point for all contributions and funding requests for the health system.

2007: Lancaster Rehabilitation Hospital opens in partnership with Centerre Healthcare.

2008: A Downtown Outpatient Pavilion and an adjacent 11-level parking garage opens at LGH.

2010: LG Health begins implementing a $100 million electronic medical record, including Community Connect that allows independent physician practices to share the same electronic medical record.


LG College of Nursing & Health Sciences receives a landmark 10-year re-accreditation of its programs by the Middle States Commission on Higher Education. The college today educates 1,365 students in 19 post-secondary certificate, associate, and bachelor degree programs.

i. Communities We Serve

LG Health’s primary and secondary service areas comprise all of Lancaster County, Pennsylvania. LG Health also serves patients in Berks, Chester, Dauphin, Lebanon, and York counties. Located in south central Pennsylvania, Lancaster County is 950 square miles in size and is home to 526,000 people. About 16% of the population is over the age of 64; 51% of the population is female. The median income is $51,022, and 9.4% of the population lives below the federal poverty level. LGH’s market share in Lancaster County is approximately 56%.
There are many factors that influence an individual’s health (see figure 1). As a healthcare provider, LG Health not only treats individuals who have already been diagnosed with an illness, but provides educational programs and initiatives that work to prevent or reduce incidence of illness. We acknowledge that conditions in which people are born, grow, live, work, age, and the health system, play a key role in determining someone’s health.

![Figure 1. Factors that influence health.](image)

Partnerships are established that assist in influencing such social determinants of health. LG Health offers a number of prevention and behavior modification programs, however we look to our community partners to understand macro trends impacting the community in areas like education and the economy. Collaboration between the health system and public and private organizations is crucial in
improving the health of all Lancaster County residents. For more information on LG Health’s collaborative efforts, please see section II-D-iii.

ii. Mission and Vision

LG Health’s Mission is to “advance the health and well-being of the communities we serve.”

LG Health’s Vision is to “deliver on the promise of a healthier future.” Through this vision we will engage, educate, and guide people to take charge of their health and we will transform the way care is delivered by providing coordinated and affordable, high-quality services.

B. Lancaster General Hospital (LGH)

LGH is a 533-bed non-profit hospital located in Lancaster County, PA, home to more than 526,000 people. LGH is currently licensed by the Pennsylvania Department of Health, accredited by The Joint Commission and a three-time recipient of Magnet status by the American Nurses Credentialing Center.

LGH provides healthcare services including orthopedics, obstetrics, cardiology, open-heart surgery, neurosurgery (including a JCAHO-certified Stroke Center), oncology, trauma, and many other key specialties.

C. Women & Babies Hospital (WBH)

WBH opened in June 2000 after receiving feedback from a Community Advisory Board. This advisory board helped to develop WBH’s facility design and programs. In 2009, the facility underwent expansion to increase post-partum rooms, the neonatal intensive care unit, and its triage and nursery beds. WBH is focused on women’s healthcare and includes the county’s only Level III NICU. In 2010, WBH delivered 82.4% of the county’s babies.

The top diagnosis related groups, by volume, for FY12 inpatient visitors are:
1. Normal newborn  
2. Vaginal delivery without complicating diagnoses  
3. Neonate with other significant problems  
4. Cesarean section without cc/mcc  
5. Cesarean section with cc/mcc  
6. Vaginal delivery with complicating diagnoses  
7. Prematurely without major problems  
8. Uterine adexa for non-malignancy without cc/mcc  
9. Vaginal delivery with sterilization/ or D C  
10. Full term neonate with major problems  

D. Lancaster Rehabilitation Hospital (LRH)

Lancaster Rehabilitation Hospital’s (LRH) mission is to deliver comprehensive, efficient medical rehabilitation to persons with disabling conditions in order to provide the opportunity to achieve the highest attainable level of functional improvement. In addition to LRH’s dedication to providing expert medical rehabilitation, there exists a commitment to the Lancaster and surrounding areas for proactively enhancing the health and wellness of not only our patients, but additionally families, friends, and the community as a whole.

LRH opened its’ doors in June 2007. Since that time, we have cared for the lives of more than 5,973 individuals, to date. We have provided medical care and comprehensive functional therapies. The quality outcomes of these aforementioned individuals whose lives we have touched can actually be measured. The holistic impact remains immeasurable due to the education, wellness, and other intangible care initiatives provided both during and after their rehabilitation stay.

LRH has partnered with LG Health and Ephrata Community Hospital for the last five years with collaborative efforts of the Stroke Survivor’s Club. This community health initiative offers anyone with interest, as well as those who
have experienced a stroke and their families, an opportunity for stroke education, wellness teachings, and community support, his groups meets four times annually. Over the last five years, from 2007-2012, we have seen a growing trend in acute inpatient stroke rehabilitation while treating 52, 158, 204, 240, 215 patients respectively each year, and 243 total seen in 2012. This represents 16%-21.2% of our overall patient population.

While stroke care is just one of many rehabilitation categories (RICs) for which LRH treats, we additionally care for individuals who have experienced traumatic events resulting in brain and/or spinal cord injuries. Medical and functional rehabilitation is key to their recovery, as well as the innumerable hours of teaching provided to them and their families, all geared to community re-entry, health, and wellness.

Nearly 500 patients have received such care and education at LRH since 2007. Not only does this promote health, wellness, and recovery for trauma patients, it also enhances a patient’s ability to remain in the Lancaster Community and LG Health continuum to enhance their medical journey.

In addition to providing rehabilitative care and our commitment to health and wellness, LRH has partnered with LG Health to promote decreasing acute care length of stays (LOS) by collaboratively focusing on the reduction of acute hospitalization days. While the onset days (days from presentation of acute symptoms and admission to the acute care hospital, to admission to LRH) were 16.4 days in 2007, they were 11.9 days in 2012. This translates into patients being discharged from the acute care sooner, beginning their rehabilitation and recovery earlier, thus ultimately returning to the community faster.
In addition to LOS initiatives, LRH remains a dedicated focus on returning patients to their community environment and preserving their independence, premorbid lifestyle, and level of function. Ultimately, this decreases the need for nursing home and residential care in the community and improves the health and wellness of the population that we serve. Since opening in 2007, LRH has afforded all 5,973 individuals the hope an opportunity to successfully return directly to the community. Over the last five years, 75% of our patients have successfully achieved this goal (compared to the national average of 68%). We are proud of their accomplishments.

LRH was created to care for the medical rehabilitation needs of our community and surrounding areas. We have touched the lives of many during their recovery journeys. In this process, we have also improved the health and wellness of patients, families, and the community as a whole. We remain dedicated to this mission.

E. Structure and Process:

i. Board of Trustees

1. History

LG Health is led by a Board of Trustees made up of dedicated community and business leaders who volunteer their time and expertise. They are committed to the community and ensure that LG Health’s health services reflect the values, traditions, and priorities of the diverse communities we serve. To emphasize the importance of community health being a priority, the LG Health Board of Trustees has a Mission & Community Benefit Committee that is often led by the Chair-Elect of the
board. The Mission & Community Benefit Committee is one of 11 standing Committees of the Board.

ii. Mission & Community Benefit Committee

1. Charter

Since 1996, decisions related to community health improvement, community outreach, and meeting the health needs of Lancaster County had been addressed through the strategic planning committee. In 2006, the formation of the Mission & Community Benefit Committee, of the Board of Trustees was established (see Addendum A for Mission & Community Benefit Charter). Key accountabilities of this committee are to:

1. Establish health priorities and the tenure of each. Review strategies, implementation plans, and budgets for each primary health priority.

2. Assist with developing and fostering community collaborations that support identified community health needs.

3. Monitor community health data and needs, and recommend organizational response.

4. Establish community sponsorship guidelines and monitor related expenditures.

5. Review community benefit activities and expenditures on a quarterly basis, and report on such to the Board of Trustees at least annually.

6. Monitor access to care trends and issues, and recommend strategies to address concerns that are identified.

7. Provide guidance on corporate citizenship responsibilities and activities in areas of health education, volunteerism, advocacy,
community development, and sponsorship that relate to Lancaster General’s mission.

8. Seek information from management, physicians, employees, and members of the community at large for the purpose of fulfilling its duties.

9. Make regular reports to the Board of Trustees, and make recommendations on actions that support the mission and community benefit responsibilities of the corporation.

10. Oversee any strategic issues contained in the Strategic Plan of the Corporation related to the mission of the Corporation which have been delegated to the Committee by the Board of Trustees.

iii. Core Principles of Community Health Improvement

The core principles for selecting health priorities are:

1. Collaboration-focused through seeking input from community partners
2. Data-driven process
3. Accountable to the community through measurement and evaluation

All programs and initiatives are evidence based whenever possible and designed with supporting data to drive successful outcomes.

1. Focus on Collaboration

LG Health has established long-standing partnerships with physicians, government agencies, businesses, schools, and local and regional non-profits. Figure 2 provides the conceptual framework for the process LG Health uses to assess community needs, establish priorities, and set broad community indicators as well as hospital specific goals and measures. Lancaster Health Improvement Partnership (LHIP) is the primary partnership.

LHIP is a multidisciplinary coalition of individuals working together to help Lancaster County residents achieve optimal health and overall well-being.
LHIP regularly partners with LG Health to analyze federal, state, and local data to identify our community’s most pressing health concerns. In 2012, LHIP and the Lancaster County Business Group on Health (LCBGH) coordinated to report the Community Health Needs Assessment (CHNA) data for Lancaster County to the community.

LHIP members (see addendum B for a list of current LHIP members) represent diverse organizations in the community and provide continuing input on community health needs with a particular focus on low income and minority populations.

LCBGH is a non-profit affiliate of The Lancaster Chamber of Commerce & Industry. LCBGH is an employer-led business coalition focusing on cost and quality issues of employer-sponsored health plans. LCBGH promotes collaborative dialogues among key stakeholders—business, healthcare providers, insurers and brokers—to keep healthcare affordable.

**Figure 2.** Community health improvement overview.
2. Data Driven Process

As noted in figure 3, the following data is collected and analyzed as the basis for identifying needs and placing priorities:

- Morbidity
- Mortality
- Behavioral Risks (youth and adult)
- United Way Community Needs Report
- Demographics & Trends
- Focus Groups
- Hospital/Health System Data
- Healthy People 2010/2020 Goals
- Comparison County/State Data
- Gap Analysis

![LANCASTER GENERAL HEALTH COMMUNITY HEALTH IMPROVEMENT PROCESS](image)

**Figure 3.** Community health improvement overview.

LHIP reviews published data on the health of Lancaster County residents and recommends health priorities.

As LHIP partners analyze data, community experts are convened to assist and analyze specific data. For example, the Harm Reduction
Coalition reviews HIV/AIDS and STD data to identify significant trends that assist LG Health in the CHNA process.

Figure 4 highlights the establishment of collaborative that focus on specific health issues. In addition to the Harm Reduction Coalition, some examples of “issue specific” coalitions are Lighten Up Lancaster County Coalition, Tobacco-Free Coalition of Lancaster County, and Refugee Health Network.

![Diagram of Lancaster General Health Community Health Improvement Process]

**Figure 4.** Community health improvement overview.

3. Focus on Accountability and Measurement

Figure 5 shows the relationship between the community based indicators, the LG Health scorecard, and tracking/evaluation of progress.
Figure 5. Community health improvement overview.

Priorities are determined through collaboration with LHIP and other expert community partners.

Figure 6 provides a visual for how the broad based community indicators and LG Health specific indicators complement each other to achieve national goals. In a county with no health department, community collaboration is essential.
Figure 6. LG Health process detail graphic.

Scorecards allow for comparison to the previous quarter or fiscal year, see figure 7 for FY13 scorecard. Please see addendum C for FY12 and FY11 scorecards. Health priority scorecards are developed and reported quarterly to the LG Health Board of Trustees and reported at least annually in the Community Benefit Update newsletter. This newsletter is distributed broadly to the community and posted on the LG Health website.
### Community Health Improvement Scorecard

**2nd Quarter FY 2013**

<table>
<thead>
<tr>
<th>Key Strategic Measures</th>
<th>Stretch FY 12</th>
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<th>8</th>
<th>7</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
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<td># of Healthy Weight Management impressions per quarter (thousand)</td>
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<td>911</td>
<td>917</td>
<td>951</td>
<td>749</td>
<td>700</td>
<td>851</td>
<td>606</td>
<td>563</td>
<td>514</td>
<td>5</td>
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<tr>
<td>% of LGHP patients screened for BMI</td>
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<td>68</td>
<td>59</td>
<td>50</td>
<td>41</td>
<td>59</td>
<td>56</td>
<td>33</td>
<td>30</td>
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<td>Tobacco use</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>% of adults in tobacco dependence treatment services that quit 30 days post intervention</td>
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<td>39</td>
<td>38</td>
<td>37</td>
<td>36</td>
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<td>34</td>
<td>33</td>
<td>32</td>
<td>31</td>
<td>3</td>
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<tr>
<td># of participants completing tobacco dependence treatment services (quarterly)</td>
<td>352</td>
<td>408</td>
<td>588</td>
<td>571</td>
<td>553</td>
<td>338</td>
<td>519</td>
<td>503</td>
<td>289</td>
<td>274</td>
<td>2</td>
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<tr>
<td>% of children participating in school based prevention program who showed increase knowledge</td>
<td>79%</td>
<td>84</td>
<td>85</td>
<td>82</td>
<td>81</td>
<td>80</td>
<td>79</td>
<td>78</td>
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<td>Mental Health</td>
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<tr>
<td>% of LGHP patients screened for depression</td>
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<td>Pending</td>
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*Note: Overall score of 1.0 indicates achievement of goal*

**Quarterly Index**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>YTD</th>
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<td>Stretch</td>
<td>TBD</td>
<td></td>
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</tr>
</tbody>
</table>

**INDEX:** TBD

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Figure 7. LG Health Scorecard for FY13.
**Figure 8. WBH Scorecard for FY13.**

iv. **Service Line Approach**

1. **Service Line Approach**

LGH has five primary service lines.

1. Cardiology
2. Musculoskeletal
3. Oncology
4. Women’s health
5. Neuroscience

Service line executives are responsible for ensuring community-health initiatives within that service line are initiated. Through each service line, primary, secondary, and tertiary prevention interventions are identified to prevent, manage, and treat illness and chronic disease. Each service line establishes departmental goals.
Cardiology

Primary Prevention:
- LGH focuses on the prevention of heart disease for the individual and community through interventions noted in the obesity and tobacco chapters.
- Educates individual/community about heart disease risk.
- Educates individual/community about heart disease prevention.
- LGH is a founding and active member of the Tobacco-Free Coalition and the Lighten Up Lancaster County Coalition. These coalitions gather community partners to raise awareness, provide education, and help our community create policies that encourage healthy weight management and tobacco-free lifestyles.

Secondary Prevention:
- Lancaster General Heart and Vascular Institute performs more diagnostic services and open heart procedures than any hospital in the region.
- Instituted a new Women’s Heart Care Clinic that started Fall 2012 at Women’s and Babies Hospital.
- Owns and operates largest cardiologist practice in the region.

Tertiary Prevention:
- As clients recover from the treatment of heart disease the cardiac rehabilitation team customizes a recovery plan for the individual.
- Clients not only receive physical rehabilitation they also receive education, nutritional and psychological support.
- Through support groups clients discuss continued recovery and on-going prevention.

Musculoskeletal

Primary Prevention:
LG Health focuses on the prevention of injuries throughout the life span.
- Conducts Farm and Family Safety Day: designed with local agricultural and trauma professionals to reduce injuries on the farm.
- Offer Coaches Clinics: designed for coaches and athletes to prevent common sports related injuries.
- Conducts Geriatric Fracture Program: focus on improving patient outcomes and detect risk early to help curb the negative effects of geriatric bone fractures.

Secondary Prevention:
Patients coming to the LG Health Orthopedic Center are treated by a unified team of orthopedic specialists using leading-edge technology and less invasive procedures.
- Total joint replacement patients will receive a home visit and pre-surgical consultation so they can understand what to expect and document their progress.
- The Physical Medicine and Rehabilitation gym is located directly in the total joint replacement nursing unit allowing collaboration on your rehabilitation plan.

Tertiary Prevention:
LG Health offers continued services to those recovering from a musculoskeletal injury. These services include:
- Physical therapy, provide the therapies available for post concussion treatment.
- Exercise classes are geared towards individuals recovering from injury and surgery.
Women’s Health

Primary Prevention:

- Educational lectures provided to at risk populations regarding obesity, cardiovascular health, mental health and injury prevention.
- Lectures for mothers and daughters including relationships and navigating puberty
- Menopause lectures
- Prenatal care is offered through Healthy Beginnings Plus at 6 locations throughout the county.
- Free childbirth, breastfeeding and pregnancy yoga classes are offered to all patients on medical assistance.

Secondary Prevention:

- Comprehensive lactation department for breastfeeding mothers offering inpatient and outpatient consultation.
- Comprehensive childbirth education program with programs for the whole family including sibling, grandparents and father’s boot camp
- The Healthy Woman Program offers free breast and cervical cancer screening to income eligible uninsured women.
- Family Planning Program offers free pap tests, STI testing and contraceptive care to income eligible uninsured women.

Tertiary Prevention:

- Nurse Family Partnership: A comprehensive home visitation program during pregnancy and through the second year of life.
- Support groups for coping with grief and loss of a child or miscarriage
- Breast feeding support group

Oncology

Primary Prevention:

- Through education and prevention, LG Health works to prevent the onset of cancers.
- Fee Immunization for low income uninsured and Medicaid children through the vaccine for children program.
- LifeSkills, an anti-tobacco program, is provided in classrooms throughout Lancaster County.
- LGH is a founding and active member of the Tobacco-Free Coalition and the Lighten Up Lancaster County Coalition. These coalitions gather community partners to raise awareness, provide education, and help our community create policies that encourage healthy weight management and tobacco-free lifestyles.

Secondary Prevention:

- Skin, breast, and cervical cancer screenings are offered throughout the county.
- Inpatient cancer unit, which offers treatment to individuals battling with cancer.
- Nurse navigators for newly diagnosed patients
- Gamma Knife treatment for tumors, lesions, and other brain disorders is offered at LG Health.
- The Ann B. Barshinger Cancer Institute will be opening in the summer of 2013 to offer the newest treatments for cancer patients in a comfortable setting.

Tertiary Prevention:

- Chemotherapy education
- Pain management
- Survivorship program facilitating numerous support groups, pastoral care and mind body classes
## Neuroscience

**Primary Prevention:**

Educates the community through programs and written materials on:
- Neurological impairments and prevent unintentional injury as a result of such impairments
- Memory disorders
- Injury prevention
- Teens about unnecessary head and spine injuries

Offers:
- Vascular screenings for local seniors
- Vascular and fall screenings for at-risk individuals.

**Secondary Prevention:**

- The Neuro Center at LG Health works to detect and treat neurological impairments.
- Provides state-of-the-art care to individuals who seek care and additionally provides noninvasive treatments of certain brain tumors and artery disorders.

Specialty programs include:
- Dizziness and balance program
- Memory disorders program,
- Stroke center and F.A.S.T. track neurological day treatment program,

**Tertiary Prevention:**

- Support programs are provided to individuals through their recovery process.

2. **Department Structure**

The Executive Vice President and Chief Operating Officer for Lancaster General Health provides oversight for community benefit activity. The Community Health and Wellness Department serves as the designated department developing and manages strategies related to community health improvement, however, senior leaders play a vital role in these strategies based on their involvement with service lines. (See addendum D for the Community Health and Wellness Organizational Chart). Community Health and Wellness managers are assigned responsibilities for initiatives within a service line are noted on the organizational chart.

3. **Meeting the Diverse Needs of Our Community**

   a. **General Overview**

   With a population of over 526,000 residents, Lancaster County has seen a 10.4% increase in population between 2000 and 2010,
compared to 3.4% state growth rate\textsuperscript{23}. In 2010, there were approximately 266,000 females in Lancaster County; approximately 210,000 of those females were over the age of 16\textsuperscript{24}. Throughout Lancaster County, there were approximately 7,000 babies born in 2010\textsuperscript{25}. Lancaster County may be best known for being home to the largest group of Amish residents in the country with numbers exceeding 29,000 residents\textsuperscript{26} . Despite its notable rural elements, Lancaster County also has a strong urban component found at the heart of the county in Lancaster City, where the population is young and over 20% of city residents live in poverty. The urban, suburban, and rural areas that make up Lancaster County’s 949 square miles provide a snapshot for the diverse and complex needs of our community.

b. Income

A primary focus of access to care initiatives and services are focused in geographic areas with the highest percentage of poverty. Notably, Lancaster City, Columbia Borough, and rural eastern and southern parts of Lancaster County, as highlighted in figure 9.
Figure 9. Poverty map of Lancaster County.

c. Ethnicity

Ethnic diversity varies greatly when comparing the demographics of Lancaster City to that of the entire county. While 4.4% of all Lancaster County residents are black, 16.3% of Lancaster City residents are black\textsuperscript{27}. Lancaster County has a resident population of 8.9% Latinos, while 39.3% of city residents are Latino\textsuperscript{28}. LG Health has examined this diversity, and continues to do so as the hospital’s priorities are determined. Much of the Latino and African American outreach is focused in Lancaster City and Columbia Borough, whereas outreach focused on Amish and farm safety
is focused on the rural regions of the county. Ethnic diversity is addressed
in each of the health priority chapters.

d. Age

Health concerns and risk vary by age group (see figure 10). LG Health has
identified specific programs and initiatives addressing leading causes of
death, particularly for those older than 35 years of age. LG Health has
focused on the health and safety of children 0-4 years of age through The
Safe Kids Coalition. “Other causes of death” in this age group ranks
number 3. Through programs such as car seat safety checks, child
immunization clinics, and the creation of a Child Death Review Team, LG
Health focuses on educating the community on preventable causes of
death. Programs discussed in more detail, such as HBP and Nurse Family
Partnership (NFP), focus on reducing infant mortality and unintentional
injuries.

The leading causes of death, noted in figure 10 below, are addressed by
our three health priorities- healthy weight management, tobacco use, and
improved mental health.
### 5 Leading Causes of Death, Lancaster County, Pennsylvania

#### 2010, All Races, Both Sexes

#### Age Groups

<table>
<thead>
<tr>
<th>Rank</th>
<th>0-4</th>
<th>5-9</th>
<th>10-14</th>
<th>15-24</th>
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<tr>
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<td>Unintentional Injury</td>
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<td>Unintentional Injury</td>
<td>Unintentional Injury</td>
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<td>2</td>
<td>Congenital malformations, Deformations, &amp; Chromosomal Abnormalities</td>
<td>18</td>
<td>Three Tied&lt;sup&gt;1&lt;/sup&gt; 1</td>
<td>Suicide 7</td>
<td>Suicide 12</td>
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<tr>
<td>3</td>
<td>Other Causes</td>
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<td>Three Tied&lt;sup&gt;1&lt;/sup&gt; 1</td>
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<td>Unintentional Injury</td>
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#### Age Groups

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<td>Cerebrovascular Disease 200</td>
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</tbody>
</table>

<sup>1</sup>0-4: Influenza & Pneumonia; In Situ, Benign, & Uncertain Neoplasms; Homicide; Nephritis, Nephrotic Syndrome & Nephrosis; Septicemia

<sup>2</sup>10-14: In Situ, Benign, & Uncertain Neoplasms; Suicide; Other Causes

<sup>3</sup>15-24: Congenital malformations, Deformations, & Chromosomal Abnormalities; Diabetes Mellitus

<sup>4</sup>25-24: Chronic Liver Disease & Cirrhosis; Malignant Neoplasms

<sup>5</sup>35-44: Diabetes Mellitus; Chronic Liver Disease & Cirrhosis; In Situ, Benign, & Uncertain Neoplasms; Disorders of Biliary Tract

Figure 10. 5 leading causes of death in Lancaster County. See addendum E for what is not included in “Other Causes” of death.

e. Gender

Disease can affect males and females differently, resulting in varying programs and initiatives of LG Health. In Lancaster County, the most recent data indicate that males have a higher:

- Age-adjusted death rate due to cancer
- Age-adjusted death rate due to colorectal cancer
- Age-adjusted death rate due to lung cancer
- All cancer incidence rate
- Colorectal cancer incidence rate
- Lung and bronchus cancer incidence rate
- Oral cavity and pharynx incidence rate
- Age adjusted death rate due to diabetes
- Chance of experiencing a heart attack, coronary heart disease, or stroke
- Age-adjusted death rate due to coronary heart disease
- Age-adjusted death rate due to influenza and pneumonia
- Age-adjusted death rate due to suicide
- Age-adjusted death rate due to falls
- Age-adjusted death rate due to poisonings
- Rate of binge drinking
- Age-adjusted death rate due to drug use
- Age-adjusted death rate due to motor vehicle collisions

In Lancaster County, the most recent data indicate that females have a higher:

- Rate of obesity
- Chlamydia incidence rate
- Gonorrhea incidence rate
- Poor mental health days
- Rate of asthma
- Number of people 65+ below poverty level
- Number of individuals commuting by public transportation

Through development of health priority strategies, we focus on closing the gender gap. Figure 11 identifies the leading causes of death for females in 2010.
10 Leading Causes of Death, Lancaster County, Pennsylvania
2010, All Races, Females

<table>
<thead>
<tr>
<th>Rank</th>
<th>Age Groups</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>All Ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Malignant Neoplasms</td>
<td>92</td>
<td>87</td>
<td>78</td>
<td>79</td>
</tr>
<tr>
<td>2</td>
<td>Diseases of the Heart</td>
<td>31</td>
<td>24</td>
<td>23</td>
<td>25</td>
</tr>
<tr>
<td>3</td>
<td>Two Tied</td>
<td>51</td>
<td>54</td>
<td>57</td>
<td>56</td>
</tr>
<tr>
<td>4</td>
<td>Diabetes Mellitus</td>
<td>97</td>
<td>87</td>
<td>83</td>
<td>83</td>
</tr>
<tr>
<td>5</td>
<td>Intentional Self-Harm (Suicide)</td>
<td>17</td>
<td>14</td>
<td>14</td>
<td>16</td>
</tr>
<tr>
<td>6</td>
<td>Chronic Lower Respiratory Disease</td>
<td>11</td>
<td>9</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>7</td>
<td>Nephritis, Nephrotic Syndrome &amp; Nephrosis</td>
<td>41</td>
<td>41</td>
<td>42</td>
<td>41</td>
</tr>
<tr>
<td>8</td>
<td>HIV Disease</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>9</td>
<td>Septicemia</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
</tr>
</tbody>
</table>

135-44: nontransport accidents; all other causes
135-44: cerebrovascular disease; motor vehicle accidents; in situ, benign & uncertain neoplasms
235-44: disease of the heart; all other causes
335-54: chronic lower respiratory disease; motor vehicle accidents; chronic liver disease & cirrhosis
435-64: chronic lower respiratory disease; nephritis
535-64: cerebrovascular disease; nephritis, nephrotic syndrome & nephrosis; intentional self-harm (suicide); congenital malformations, deformations & chromosomal abnormalities
635-64: nontransport accidents; diabetes mellitus
735-64: influenza & pneumonia; septicemia

Figure 11. Leading causes of death in Lancaster County, females. See addendum E for what is not included in “Other Causes” of death.

f. Geographic Location
Lancaster County is a county with diverse environments. For those residence who do not live in Lancaster City or near a hospital, access to healthcare can be more challenging, especially for those living in the most rural settings. To address this, LG Health developed Lancaster General Health Physicians (LGHP), a multidisciplinary physician practice that uses Lancaster General Health’s resources and system. Physician practices are located all around Lancaster County to provide easily accessible care (see addendum F for map of LGHP primary-care offices). Other healthcare facilities in the County include hospitals, two federally qualified health centers (FQHC), free clinics, and physician groups. Three other hospitals service residence in Lancaster County, Ephrata Community Hospital,
Heart of Lancaster Medical Center, and Lancaster Regional Medical Center. Lancaster County has two other large physician groups in addition to LGHP, Northern Lancaster County Group and Physicians’ Alliance, Ltd. The FQHC’s that are located in Lancaster County are SouthEast Lancaster Health Services, Meadow Creek Family Practice, and Welsh Mountain Medical and Dental Center (see addendum F for location map). The free health clinics in Lancaster County are Hope Within Community Health Center and Water Street Health Services (see addendum F for location map).

To enhance access to care, LG Health has also opened two urgent-care centers (see addendum G for a map of urgent-care locations), three retail clinics to provide convenient care to those in suburban and rural Lancaster County, and nine outpatient centers that offer lab, imaging, and other services (see addendum H for outpatient locations). Programs such as free childhood immunization clinics and farm safety days are held in several areas throughout the county.

F. Historical Perspectives of CHNA

i. History of the Needs Assessment

LG Health began conducting a health needs assessment in the early 1990’s in partnership with many communities organizations.

In 1996, LG Health, in collaboration with Lancaster County Health Partnership, published a report on the health of Lancaster. This report revealed how people perceived health in Lancaster as well as identified ways in which health could be improved. See addendum I for this report.

In 2002, the Lancaster Health Improvement Partnership (LHIP), formerly known as Lancaster County Health Partnership, in collaboration with LG Health, published A
Plan for Creating a Healthy Lancaster Community. This report used Healthy People 2010 goals to assess the current health status of the county. Addendum B lists the members of LHIP.

LG Health has been publishing Morbidity and Mortality reports since 2002. These reports are posted on LG Health’s website in a PDF format to allow community members to easily print or repost the reports on their organizations website. These reports compiled the health statistics data from the Pennsylvania Department of Health into a report that compares cancer data over the past years, to local, state, and national data and to Healthy People 2010 goals.

In 2012, LG Health partnered with LHIP and the Lancaster County Business Group on Health to host a Lancaster County Health Summit. Over 300 individuals attended the summit, representing businesses, faith based organizations, schools, and human service organizations. This health summit presented current data on the health of the County and also invited individuals to listen to experts in healthcare. (Former CHNA documents can be found on the LG Health website at www.lancastergeneralhealth.org/LGH/About-Lancaster-General-Health/Community-Health-Involve/ment/Lancaster-County-Health-Reports.aspx)

ii. Health Priority Selection

1. Process

The process for conducting a CHNA is ongoing and continually undergoes improvements. Since the establishment of LHIP, partners representing diverse populations have joined the discussion. LHIP has developed criteria for the selection of health priorities. Priorities are selected based on the number of lives impacted.

iii. Validation of Priorities

LG Health has worked with The Floyd Institute for Opinion Research at Franklin & Marshall College since 2008 in survey design and administration, data collection and
analysis, program evaluation, and focus groups. The Floyd Institute's expertise covers a wide range of research areas, including healthcare, public policy, education, marketing and advertising, and human behavior. Surveys, reports, and data collected by the Floyd Institute have aided LG Health in determining key health priorities in the County. In addition, Kirk Miller, PhD, Professor of Public Health at Franklin & Marshall College, has served on LHIP since 2008 and had offered his expertise on priority selection through past and current selection processes. See addendum J for other experts that have aided in past and current priority discussion and health needs assessments.

G. Current Health Priorities

i. Establishment of Current Health Priorities

Utilizing the LHIP Community Health Improvement process outlined in this report, programs and initiatives are coordinated within the Community Health & Wellness Department at LG Health (see addendum K for current programs).
III. 2013 CHNA

A. Process

LG Health has made significant strides in the current CHNA process based on what has been learned from past health needs assessments. The assessment uses information from secondary data sources to identify health issues of consequence to the Lancaster community. The data used allows us to observe trends, compare ourselves to other counties in Pennsylvania as well as in the nation. LG Health, with Ephrata Community Hospital, contracted with Healthy Communities Institute for community health data collection.

Healthy Communities Institute (HCI) provides both hospitals with County data on a number of indicators. This information is embedded on the LG Health website and was made publically available in April 2013. HCI provides a community dashboard of indicators, a disparities dashboard, current Lancaster County demographics, as well as a Healthy People 2020 tracker. Under each indicator data is compared to previous years, and if available genders, ages, and races/ethnicities are compared. Under each indicator, available data are compared to other counties in Pennsylvania and to other counties nationally. Such comparisons are user friendly and health status is indicated by a needle located in a green, yellow, or red zone on a dial. The website enables Lancaster County residents to see how the health of Lancaster County compares to others, as well as how it compares to Healthy People 2020 goals for the nation.

HCI updates data on LG Health’s website as it becomes available and notifies LG Health of such. When new data is available, LG Health develops an informational sheet on the changes and a press release is created to share this information with the community.

HCI serves as a data collection agency. LG Health partnered with Franklin & Marshall College’s Floyd Institute to conduct the needs assessment based on this data. The Floyd Institute analyzed the data provided and created a report that described the
findings of the analysis, defined the community’s need, suggested the impact of poor health has on the community, and concluded with policy based recommendations for Lancaster County. See addendum L for the full CHNA report.

When determining healthy priorities, LG Health consulted other community reports for recommendations. One such report is the Lancaster County Building a Model of Prosperity for the 21st Century (see addendum M for this report). This report was developed collaboratively by the Lancaster Chamber of Commerce & Industry, The Lancaster County Community Foundation, United Way of Lancaster County, and The County of Lancaster. Shared prosperity indicators include obesity, open spaces, air quality (tobacco), low birth weight, and access to health care. Strategies outlined in this plan will assist in addressing the indicators discussed in the 21st Century report.

B. Community Input

LG Health worked with a number of community experts to review the needs of Lancaster County to determine priorities of LG Health. These experts represented the diverse community in which we live. Please see addendum J for a list of experts that worked to determine current LG Health priorities, as well as past LG Health priorities. Experts that aided in the CHNA can be found in the CHNA document, addendum L.

C. General Structure of Priorities

In order to have meaningful impact on community health needs, LG Health has selected health priorities. The three key priorities of focus for LG Health were determined by examining the number of lives covered, quality of life, years lost, cost savings by avoiding the issue, and ability to influence the health need. The CHNA Task Force met on three separate occasions to review Lancaster County data, and after careful review and discussion of current health statistics and estimated number of Lancaster County residents affected, LG Health’s Community Health Needs Assessment Task Force identified three key priorities of LG Health:
I. Increase the number of people at a **healthy weight**

II. Reduce the use of **tobacco**

III. Improve **mental health** with a focus on depression and anxiety

**D. Distribution of CHNA**

The full CHNA final report was available to all Lancaster County residents in April 2013 on LG Health’s website ([www.lghealth.org/countyhealthdata](http://www.lghealth.org/countyhealthdata)). This report was attached to the Healthy Communities Institute data, from which the report conclusions were drawn. The report was embedded in PDF format to allow for easy downloading and posting on other community health websites. One thousand postcards were distributed to businesses, community organizations, and faith based organizations, identifying some of the data available and where the report could be found. Hard copies of the CHNA were printed for distribution at meetings and to those without access to the internet or a computer. The LG Health Mission and Community Benefit Committee and the LG Health Board of Trustees also received hard copies of these reports.

If you have difficulties accessing LG Health’s CHNA or would like to request a hard copy, please call LG Health’s Community Health and Wellness Center at (717) 544-3811. Please direct all questions and comments to Alice Yoder, RN MSN, Director of Community Health, at (717) 544-3283 or [amyoder@lghealth.org](mailto:amyoder@lghealth.org).
IV. Lancaster County Health Needs

A. Overview

Currently, Lancaster County is doing a good job at addressing a number of health issues and the statistics reflect this. These indicators appear as “green” on the Healthy Communities Institute (HCI) website. Others are indicators that must be closely watched, and appear “yellow” on the HCI website and will be addressed in section IV-C. Those indicators that are currently “red” on the HCI website will either be addressed as a key priority or as an outstanding health issue. These “red” indicators will be addressed in section IV-D. (See addendum N for the HCI red/yellow/green legend).

B. Successes

Lancaster County is doing well in a number of indicators. The following table lists the indicators that are “green” and programs related to them.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Related Programs/Assets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults with a usual source of health care</td>
<td>Project Access Lancaster County; LGHP; FQHC</td>
</tr>
<tr>
<td>Adults with health insurance</td>
<td>LG Health enrollment specialists; Project Access Lancaster County</td>
</tr>
<tr>
<td>Primary care provider rate</td>
<td>LGHP; FQHC</td>
</tr>
<tr>
<td>Age-adjusted health rate due to cancer</td>
<td>LGHP</td>
</tr>
<tr>
<td>Age-adjusted death rate due to colorectal cancer</td>
<td>LGHP</td>
</tr>
<tr>
<td>Age-adjusted death rate due to lung cancer</td>
<td>Tobacco Initiatives; LGHP</td>
</tr>
<tr>
<td>Age-adjusted death rate due to prostate cancer</td>
<td>LGHP</td>
</tr>
<tr>
<td>Lung and bronchus cancer incidence rate</td>
<td>LGHP</td>
</tr>
<tr>
<td>Oral cavity and pharynx cancer incidence rate</td>
<td>Tobacco Initiatives; LGHP</td>
</tr>
<tr>
<td>Adults with diabetes</td>
<td>Obesity Initiatives; LGHP</td>
</tr>
<tr>
<td>Age-adjusted death rate due to diabetes</td>
<td>Obesity Initiatives; LGHP</td>
</tr>
<tr>
<td>Children with type 2 diabetes</td>
<td>Obesity Initiatives</td>
</tr>
<tr>
<td>Children who are obese; Grades K-6</td>
<td>Obesity Initiatives</td>
</tr>
<tr>
<td>Children who are overweight or obese; Grades K-6</td>
<td>Obesity Initiatives</td>
</tr>
<tr>
<td>Teens who are obese</td>
<td>Obesity Initiatives</td>
</tr>
<tr>
<td>Teens who are overweight or obese</td>
<td>Obesity Initiatives</td>
</tr>
<tr>
<td>Teen birth rate</td>
<td>HBP; NFP; Family Planning Clinic</td>
</tr>
<tr>
<td>Adults who experienced a heart attack, coronary heart</td>
<td>Obesity Initiatives; Tobacco Initiatives</td>
</tr>
<tr>
<td>disease, or a stroke</td>
<td></td>
</tr>
<tr>
<td>Age-adjusted death rate due to coronary heart disease</td>
<td>Obesity Initiatives; Tobacco Initiatives</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Indicator</th>
<th>Related Programs/Assets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults 65+ with influenza vaccination</td>
<td>LGHP; Free Immunization Clinics</td>
</tr>
<tr>
<td>Adults 65+ with pneumonia vaccination</td>
<td>LGHP; Free Immunization Clinics</td>
</tr>
<tr>
<td>Age-adjusted death rate due to HIV</td>
<td>Community Care Medicine; Free Testing</td>
</tr>
<tr>
<td>Age-adjusted death rate due to influenza and pneumonia</td>
<td>LGHP; Free Immunization Clinics</td>
</tr>
<tr>
<td>Lyme disease incidence rate</td>
<td>LGHP</td>
</tr>
<tr>
<td>Babies with low birth rate</td>
<td>NFP, HBP</td>
</tr>
<tr>
<td>Babies with very low birth weight: Singleton births</td>
<td>NFP, HBP</td>
</tr>
<tr>
<td>Mothers who breastfeed</td>
<td>LGHP; WBH Baby Friendly Hospital Initiative</td>
</tr>
<tr>
<td>Mothers who did not smoke during pregnancy</td>
<td>NFP, HBP, Tobacco Initiatives</td>
</tr>
<tr>
<td>Preterm singleton births</td>
<td>NFP, HBP</td>
</tr>
<tr>
<td>Age-adjusted death rate due to suicide</td>
<td>School Based Initiatives</td>
</tr>
<tr>
<td>Poor mental health days</td>
<td></td>
</tr>
<tr>
<td>Dentist rate</td>
<td>Dental Residency Program</td>
</tr>
<tr>
<td>Age-adjusted death rate due to falls</td>
<td>Safe Kids Coalition</td>
</tr>
<tr>
<td>Age-adjusted death rate due to firearms</td>
<td>Safe Kids Coalition</td>
</tr>
<tr>
<td>Age-adjusted death rate due to unintentional injuries</td>
<td>Safe Kids Coalition; Farm Safety Camps</td>
</tr>
<tr>
<td>Age-adjusted death rate due to unintentional poisonings</td>
<td>LGHP</td>
</tr>
<tr>
<td>Children with asthma</td>
<td></td>
</tr>
<tr>
<td>Adults who binge drink</td>
<td>Tobacco Initiatives</td>
</tr>
<tr>
<td>Adults who smoke</td>
<td></td>
</tr>
<tr>
<td>Age-adjusted death rate due to drug use</td>
<td></td>
</tr>
<tr>
<td>Poor physical health days</td>
<td></td>
</tr>
<tr>
<td>Self-reported general health assessment: Poor or fair</td>
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</tr>
<tr>
<td>Unemployed workers in civilian labor force</td>
<td></td>
</tr>
<tr>
<td>Foreclosure rate</td>
<td></td>
</tr>
<tr>
<td>Homeownership</td>
<td></td>
</tr>
<tr>
<td>Renters spending 30% or more of household income on rent</td>
<td></td>
</tr>
<tr>
<td>Median household income</td>
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</tr>
<tr>
<td>Per capita income</td>
<td></td>
</tr>
<tr>
<td>Children living below poverty level</td>
<td></td>
</tr>
<tr>
<td>Families living below poverty level</td>
<td></td>
</tr>
<tr>
<td>People 65+ living below poverty level</td>
<td></td>
</tr>
<tr>
<td>People living 200% above poverty level</td>
<td></td>
</tr>
<tr>
<td>People living below poverty level</td>
<td></td>
</tr>
<tr>
<td>Students eligible for the free lunch program</td>
<td></td>
</tr>
<tr>
<td>Young children living below poverty level</td>
<td></td>
</tr>
<tr>
<td>People 25+ with a bachelor’s degree or higher</td>
<td></td>
</tr>
<tr>
<td>Student-to-teacher ratio</td>
<td></td>
</tr>
<tr>
<td>Daily ozone air quality</td>
<td></td>
</tr>
<tr>
<td>Recognized carcinogens released into air</td>
<td></td>
</tr>
<tr>
<td>Fast food restaurant density</td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Indicator</th>
<th>Related Programs/ Assets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low-income and &gt; 1 mile from a grocery store</td>
<td></td>
</tr>
<tr>
<td>Recreation and fitness facilities</td>
<td></td>
</tr>
<tr>
<td>PBT released</td>
<td></td>
</tr>
<tr>
<td>Violent crime rate</td>
<td></td>
</tr>
<tr>
<td>Age-adjusted death rate due to motor vehicle collisions</td>
<td>Safe Kids Coalition</td>
</tr>
<tr>
<td>Child abuse rate</td>
<td></td>
</tr>
<tr>
<td>Single parent households</td>
<td></td>
</tr>
<tr>
<td>Mean travel time to work</td>
<td></td>
</tr>
<tr>
<td>Workers who drive alone to work</td>
<td></td>
</tr>
<tr>
<td>Workers who walk to work</td>
<td></td>
</tr>
<tr>
<td>Workers commuting by public transportation</td>
<td></td>
</tr>
</tbody>
</table>

Adults with a usual source of health insurance is in the “green” presumably due to access to primary care and initiatives such as Project Access Lancaster County (PALCO). The number of babies born with a low birth weight is low due in part to programs such as LG Health’s HBP and NFP, both programs assist pregnant women in having a healthy pregnancy. The dentist rate is better compared to other US Counties because of initiatives like Dental Access Lancaster County (DALCO). For all indicators in the Prevention and Safety tab of HCI, Lancaster County is in the green. These indicators include age-adjusted death rate due to falls, unintentional injuries, and unintentional poisonings. The trauma and safety initiatives of LGH have played a tremendous role in such successes (see addendum O for all trauma/safety programs of LGH). The programs that are currently in place at LGH will continue to ensure that those cultural indicators that are currently “green” remain in that category.

**Woman Specific**

*Healthy Woman Program*

Lancaster General became a Healthy Woman Program (HWP) provider in 2002 and is the only provider in Lancaster County. The HWP’s goal is to keep mid-life women healthy and in touch with health care through no cost breast and cervical cancer screenings. The program is for low to moderate income, under insured and uninsured women, ages 40 for:

- Clinical Breast Exam
- Pap smear
- Mammogram
- Breast and cervical cancer education
- Follow-up medical care, as appropriate

Screening and diagnostic services are provided annually to over 300 women per year.

**Susan G Komen for the Cure**

In partnership with the Susan G Komen for the Cure Philadelphia, WBH provides awareness and education to over one thousand women per year on breast health. WBH, since 2006, has provided over 350 free mammograms to income eligible women per year. Women who are diagnosed with breast cancer can apply for Gap funding which provides up to $500 per year to assist women with basic health needs such as medication, travel and household expenses.

**Women’s Gatherings**

WBH recognizes that women often make the health care decisions for the family and has targeted health outreach for underserved women. WBH holds quarterly health informational lectures in the homes of Amish women and at faith and community based locations for Latino women. In 2011, WBH educated Latino Health promoters to serve as a liaison to the community. These forums bring health experts on topics such as cancer, stroke, safety and preventive health. Women’s needs are assessed for breast cancer screening and linked to primary care access. Approximately women 300 per year participate in these targeted services.

**Other Programs**

WBH offers a comprehensive childbirth education program including grandparents and sibling class, mother baby support group/weigh station, Safe Haven, Cribs 4 Kids, American Academy of Pediatrics car seat loan program, Happiest Baby on the block program, Infant Massage, and Family Planning program.
C. Precautionary Health Indicators

There are a number of health indicators that the County must keep an eye on. These indicators are “yellow” on the HCl website. The indicators must be monitored to ensure that they do not turn into statistics that are alarming. Additionally, a yellow indicator does not suppose that action needs to be taken. Obesity in Lancaster County is currently a yellow statistic; however, it was selected by LG Health as a key priority. Obesity was selected due to the percentage of adults that are currently obese. Although doing well compared to other Pennsylvania Counties and to the Healthy People 2020 goal, obesity rates in Lancaster County are still at 62% and the major contributor to many chronic diseases in the County and therefore cause for concern. Consequently, obesity has been selected as a key priority of LG Health.

Many “yellow” indicators are currently addressed through initiatives of LG Health. For these indicators to remain in the cautionary status, current programs at LG Health must be continued. Those that are not addressed in some capacity through LG Health initiatives must be closely watched to ensure a change in County health trends does not result in the movement of an indicator into “red” status.

The following indicators have been identified as “yellow” indicators:

- Age-adjusted death rate due to breast cancer
- All cancer incidence rate
- Breast cancer incidence rate
- Cervical cancer incidence rate
- Colorectal cancer incidence rate
- Prostate cancer incidence rate
- Age-adjusted death rate due to cerebrovascular disease (stroke)
- Adults with asthma
- Age-adjusted death rate due to HIV
- Infant mortality rate
- Poor social and emotional support
- Recreation and fitness facilities
- Farmers market density
- Grocery store density
- Households without a car and >1 mile from a grocery store
• SNAP certified stores
• Low income persons who are SNAP participants
• Adults who are obese
• Adults who are overweight or obese
• Households with public assistance
• School dropouts
• Student to teacher ratio

The following “yellow” indicators will be addressed further in the obesity key priorities section:

• Number of adults with asthma
• Recreation and fitness facilities
• Farmers market density
• Grocery store density
• Households without a car and >1 mile from a grocery store
• SNAP certified stores
• Low income persons who are SNAP participants
• Adults who are obese
• Adults who are overweight or obese

The number of adults with asthma “yellow” indicator will also be addressed in the tobacco key priorities section.

Poor social and emotional support “yellow” indicator will be addressed in the mental health key priorities section.

Other Yellow indicators LGH must keep an eye on:

Cancer

Cancer is a “yellow” indicator that LG Health currently addresses with various support groups, screenings, and counseling (see addendum K for current programs) and will continue to do so. Current cancer indicators that are “yellow” are age adjusted death rate due to breast cancer, age adjusted death rate due to colorectal cancer, all cancer incidence rate, breast cancer incidence rate, cervical cancer incidence rate, colorectal cancer incidence rate, and prostate cancer incidence rate. In addressing the incidence of cancer rates in Lancaster County, LG Health educates individuals on cancer risks
and leading a healthy lifestyle to eliminate these risks and hosts a number of cancer screenings. Once an individual is diagnosed with cancer, LG Health’s multidisciplinary team including physicians, nurse navigators, social workers, radiation techs, nutritionists and spiritual counselors guide them through their cancer care. Once acute cancer treatment is completed, the survivorship care team provides support, yoga, mindfulness and exercise programs to continue the health process. Our focus on tobacco use education and obesity has the potential to influence about 70% of cancers. The focus with primary care practices to increase quality measures related to cancer screening should only increase early identifications of many cancers.

HIV

Age is a direct health barrier in death due to HIV. The reported age adjusted death rate due to HIV in Lancaster County is a “yellow” indicator. Comprehensive care medicine at LG Health will continue to care for patients with HIV/AIDS in Lancaster County.

Infant Mortality

Infant mortality rate continues to be one of the most widely used indicators of the overall health status of a community. The leading causes of death among infants are birth defects, pre-term delivery, low birth weight, Sudden Infant Death Syndrome (SIDS), and maternal complications during pregnancy.

Infant mortality rate is a “yellow” indicator. The status of this indicator is not presumed to be caused by the Plain Community (Amish and Mennonite) in Lancaster County, as there are only two deaths above expected number of deaths in this sub-group. All sub-groups and the overall infant mortality rate are well within the confidence intervals reported. WBH currently serves over 1200 low income pregnant women a year in Healthy Beginnings Plus and Nurse Family Partnership and will increase efforts for early identification of mothers who are eligible to participate in these programs to achieve the Healthy People 2020 goal of 6 deaths/1,000 live births.
Figure 12. Scorecard for FY13.

Households with public assistance, school dropouts, and student to teacher ratio

Households with public assistance, school dropouts, and student to teacher ratio are all “yellow” indicators. LG Health will continue to keep an eye on these and related issues and will inform community partners on their current status.

Stroke

Currently, within Lancaster County, the age-adjusted death rate due to stroke is 40.8 deaths per 100,000 population (2010 data). Although the death rate due to stroke has decreased within Lancaster County drastically since 2000, LGH recognizes that the death rate due to stroke in Lancaster County does not meet the Healthy People 2020 target of 33.8 deaths per 100,000 population (age-adjusted, see figure 13).
The age-adjusted death rate due to stroke

Figure 13. The age-adjusted death rate due to cerebrovascular disease (stroke).\textsuperscript{52}

Within Lancaster County, there does not appear to be gender disparities for stroke (see figure 14).

The age-adjusted death rate due to stroke, by gender

Figure 14. The age-adjusted death rate due to cerebrovascular disease (stroke) by gender (2010).\textsuperscript{53}
LG Health works to decrease the incidence of stroke through tobacco cessation and obesity prevention initiatives. The LGH emergency department works to decrease treatment time of a stroke patient once they arrive to the emergency department.

LRH hosts the stroke survivors support group and stroke patients on the risk of recurrent strokes. In addition LRH’s respiratory therapist screens and counsels patients for tobacco use and participates with the Tobacco Free Coalition of Lancaster County.

D. Outstanding Health Issues To Be Addressed

The following indicators are “red” on the HCl website. These indicators were not chosen as priorities for LG Health. Each section outlines where Lancaster County currently stands statistically, what we are currently doing, and why the indicator was not chosen as a priority.

The following indicators have been identified as “red” indicators:

- Children with health insurance
- Colon cancer screening
- Chlamydia incidence rate
- Gonorrhea incidence rate
- Mothers who received early prenatal care
- Annual ozone air quality
- Annual particle pollution
- Households without a vehicle

Children with health insurance

Framing the Issue

State Children’s Health Insurance Program (SCHIP) began in 1997 to provide health insurance to children of low income families who are uninsured\(^{34}\). Since this time, SCHIP has significantly reduced the number of low income children who are uninsured. Health insurance for children is important because it provides regular access to prevention, treatment, disease management, and well-being services\(^{35}\). Uninsured children are less likely to have seen a physician in the past year and are more likely to
have a medical need that remains unmet\textsuperscript{35}. Those with health insurance generally had better health during their youth\textsuperscript{37}.

SCHIP is funded by federal and state governments. Federal funding is determined by the number of low income families in a state and the number of children to those families who are uninsured\textsuperscript{38}. The federal government strives for 100% coverage for children, and encourages states to participate in SCHIP by paying higher rates to those on SCHIP\textsuperscript{39}. SCHIP, however, is not the same program as Medicaid. Generally families that apply for SCHIP coverage have an annual income that is higher than the income level allowed to apply for Medicaid. Federal payout to the states is capped in advanced for the grant-based SCHIP program, whereas Medicaid is an entitlement with no caps on government spending\textsuperscript{40}.

Through this program, each state has the ability to design their CHIP program according to their needs. This allows each state to determine the poverty threshold allowed for individuals to apply for Medicaid. This factor gives states control over the CHIP program. The national SCHIP program allows states to extend coverage to uninsured children not eligible to receive care. In the state of Pennsylvania, CHIP coverage is often free of charge to the child’s family and there are no premiums or copays\textsuperscript{41}. For those families who make above the annual income to qualify for free CHIP, a low cost is associated with care and premiums and copays do apply\textsuperscript{42}. The barrier to insurance for those children who remain uninsured is not that insurance does not exist, but rather there is not complete enrollment in the program by all those who are eligible\textsuperscript{43}.

**Lancaster County**

As of 2011, 85.1%\textsuperscript{44} of children in Lancaster County had health insurance. From 2008-2010, there was an increase in coverage to 83.9%, however this increase is not significant. From 2010-2011, the percentage of children in Lancaster County with health insurance fell from 86.4% to 85.1%.
Figure 15. Children with health insurance.

Disparities

Racial/Ethnic

Racial and ethnic disparities exist in Lancaster County. 82.5% of Asian children have health insurance, 92.2% of African American children have health insurance, 95.8% of Hispanic children have health insurance, and only 82.4% of whites have health insurance (see figure 16). LGH noticed a large percentage of white children are uninsured. Further investigation into this indicated that this is not likely to be due to the Amish/Mennonite population in Lancaster County.
**Figure 16.** Children with health insurance, by race/ethnicity (2011)\(^6\).

### Past Initiatives

LG Health has collaborated with multiple community organizations to increase the number of children in the county with health insurance. In 2001, a program called Reach Out Lancaster was implemented to increase insurance coverage for children eligible for Medicaid or CHIP to break the barriers preventing families from enrolling their children in these programs: misinformation or lack of information and the enrollment process itself (see addendum P for report).

In 2005, LG Health partnered with the Department of Welfare to assist families in completing the CHIP application when they attended our free childhood immunization clinics.

In 2009, LG Health convened all CHIP insurance providers and began a coordinated outreach program in Northern, Southern, Eastern, Western, and Central Lancaster.
County. Through this initiative, enrollment specialists worked with individuals who needed help with the enrollment process. This initiative placed CHIP enrollment specialist at libraries and other public locations throughout Lancaster County (see addendum Q for locations).

Current Initiatives

Currently, LG Health works closely with PALCO. PALCO works with low-income, uninsured people to access medical care in Lancaster County. LG Health also works with DALCO to provide dental care to the low-income, uninsured in Lancaster County. LG Health currently offers free immunizations against childhood diseases to children in Lancaster County who do not have insurance through their ChildProtect program.

Conclusion

LG Health will not focus on increasing the number of children in Lancaster County with health insurance as a key priority. Through the three key priorities of LG Health, children in Lancaster County will receive preventative education and treatment through LG Health initiatives. Although this does not solve the problem of lack of health insurance, LG Health initiatives will prevent a worsening of children’s health in Lancaster County.

The Affordable Care Act (ACA) will help to increase health insurance coverage for children. Beginning in 2014, the ACA will increase the number of families that are eligible for Medicaid, thus increasing the number of children who have health insurance coverage\textsuperscript{47}. This may decrease the number of children enrolled in CHIP, as these children may now be covered under Medicaid. With the ACA, the CHIP federal matching rate will increase by 23% beginning in October of 2015\textsuperscript{48}. LG Health envisions Lancaster County with 100% health insurance coverage for children. If a community organization chooses to focus on CHIP initiatives, LG Health will work with that organization to promote CHIP enrollment.
Colon cancer screenings

Framing the Issue

Colorectal cancer (cancer of the colon or rectum) is the second leading cause of cancer-related deaths in Lancaster County and the United States among cancers occurring in both men and women\(^\text{49}\). The CDC estimates that if all adults aged 50 or older had regular screening tests for colon cancer, as many as 60% of the deaths from colorectal cancer could be prevented\(^\text{50}\). While 90% of new cases and 95% of deaths from colorectal cancer occur in adults aged 50 or older, it is essential for individuals with risk factors (those with a family history of colorectal cancer, inflammatory bowel disease, or heavy alcohol use) to seek regular screening earlier\(^\text{51}\). According to the American Cancer Society, colorectal cancer begins as an adenomatous polyp that is not malignant\(^\text{52}\). The chance of developing cancer depends on the type of polyp.

The Lancaster County behavioral risk factor report revealed that Lancaster County has an equal rate for lower rate for colonoscopy / sigmoidoscopy screening (when compared to state averages), but a higher rate for the home blood stool test. Research suggests reviewing benefits and barriers related to each test with patients and identifying the easiest test for a patient to complete is the best test for them.

Lancaster County

Currently, Lancaster County matches Pennsylvania statics for 53% of adults over the age of 50 who have been screened between 2008-2010. This practice lead to a decreased rate of 24% of adults in Lancaster County and 19% of adults in Pennsylvania having an occult blood screening within the past two years.

The decrease in FOBT may be related to patient preference of alternative options such as colonoscopy or sigmoidoscopy. Lancaster General Health Physicians (LGHP) has expanded patient options and now includes FIT testing in addition to traditional FOBT. FIT testing may prove to increase screening rates as there are no drug or food restrictions, and collecting a stool sample may take less effort. Although other testing
may be perceived as the preferred method, they may be cost prohibitive. Our policy regarding CRC continues to be the best test is the one the patient will complete.

In Lancaster County, the age adjusted death rate due to colorectal cancer is 15.9% (2005-2009 data)\textsuperscript{53}. The goal of LGH is to reach the Healthy People 2020 (HP 2020) goal 14.5% by 2016. The goal of LGHP is to reach 73.7% colorectal cancer screening in adults in Lancaster County over the age of 50, which is the 90th percentile in the Healthcare Effectiveness Data and Information Set (HEDIS). To meet these goals, LG Health will need to provide continued education regarding the importance of CRC screening and reinforce that the best test is the one the patient will complete.

Current Initiatives

Currently, colorectal cancer screening is a LGHP quality indicator and is tracked and measured at the primary care provider level. This is being accomplished through synergistic alignment of physician quality, community health and wellness, and oncology clinical leadership to increase the CRC screening rates and decrease death and mortality related to CRC. This alignment resulted in an increase of 5% in screening rate at the primary care provider level. Although not a key priority, our strategy continues to be to align the health system to address CRC screening rates, morbidity, and mortality for Lancaster County.

Conclusion

LG Health will continue to promote screenings in the primary care provider setting. CRC screening, morbidity and mortality rates will continue to be monitored collaboratively through LGHP quality, community health and the oncology teams to ensure goals are being reached and to identify any barriers to success.
Sexually Transmitted Infection (STI) Incidence rate (Chlamydia and Gonorrhea)

Framing the issue

Chlamydia is four times as common as gonorrhea\textsuperscript{54}. It is the most frequently reported bacterial sexually transmitted disease in the United States and Pennsylvania.\textsuperscript{55} Chlamydia is one of the leading causes of infertility. It makes the woman more susceptible to any infectious disease including HIV and Hepatitis C due to damage to the vaginal mucosa. It has the additional issue of being a “silent” disease with men and women often not recognizing symptoms for many months. During this time they are able to spread the STD to others and are exposed to serious health side effects. Under-reporting of Chlamydia is substantial because most people with Chlamydia are not aware of their infections and do not seek testing.\textsuperscript{56}

Gonorrhea is a STD with serious health implications if left untreated. The most acute problem would be the development of pelvic inflammatory disease.\textsuperscript{57}

Lancaster County

Lancaster County has a Chlamydia incidence rate of 253.0 cases per 100,000 population. Compared with a state average off 172.7 per 100,000 we are considered to be the “worst” category for Chlamydia Incidence Rate.

Lancaster County has one of the highest rates of Gonorrhea per 100,000 people in the state of PA. The average incidence rate in PA is 41.0 per 100,000. Lancaster County is seeing 76.8 cases per 100,000.

LGH Priority

We are currently implementing interventions to educate, treat and decrease the spread of Chlamydia and Gonorrhea. These initiatives are reaching vulnerable populations including low income, high risk populations.
Disparities

Ethnic
In regards to Chlamydia, the black population at 956.1 per 100,000 far exceeds the incidence rate of the white population at 86.3 per 100,000. The next disparity lies in the Hispanic population with 367.2/100,000. The disparity mirrors other high risk behaviors.

Gonorrhea incidence in the black population at 404.5 per 100,000 far exceeds the incidence rate of the white population at 20.4 per 100,000.

Age
Chlamydia is most common among women and men under age 25. The age group of 15-24 years far exceeds the incidence rate at 1,344.1 per 100,000 cases. Followed by the age group 25-34 at 419.7 per 100,000 cases. The ages are consistent with other high risk activities. The possibility of using protection and having limited partners increases with age.

Incidence of gonorrhea is highest among adolescents and young adults. The age group of 15-24 years far exceeds the incidence rate at 321.3 per 100,000 cases. Followed by the age group 25-34 at 186.9 per 100,000 cases. The ages are consistent with other high risk activities. The possibility of using protection and having limited partners increases with age.

Gender
The incidence of Chlamydia in females exceeds males by 361.4 per 100,000 compared to 135.9 per 100,000. This is a consistent ratio seen in all STD’s based on the fact that women experience more trauma to the mucosa during sexual relations.

There is a greater efficiency in transmission of gonorrhea from male to female. Females exceed males by 107.7 per 100,000 compared to 44.5 per 100,000. This is a consistent ratio seen in all STD’s based on the fact that women experience more trauma to the mucosa during sexual relations.
Geographic location

LG Health offers clinics in concentrated areas of poverty which are: Columbia borough, Quarryville, and Lancaster City.

Current LGH Initiatives

Select Programs

Lancaster General has a Family Planning Clinic that treats all teens <18 years old for free. They also provide reduced rates to free care for women and men >18 year olds. The Clinic tests and treats all STD’s and provides free contraceptive medications and supplies and education on safe sex to every person who visits the clinic. 75% of participants are white, 14% are Hispanic, 6% are African American, and 5% are of another race/ethnicity.

LGH Downtown Family Medicine (DFM) tests, treats, and educates patients on STIs. In 2012, a total of 8,222 patients were seen at DFM. Of these patients, 16% were black, 76% were white, 1% were Asian, 5% were other race/ethnicity, and race/ethnicity is unknown for 2% of patients.

Healthy Beginnings Plus (HBP)

The HBP clinic sees over 1,200 women per year to care for pregnant women. All women are medical assistance eligible and all are tested for Chlamydia and treated if necessary. Education for safe sex is provided and free condoms to all pregnant women to protect against further STD exposure. The current wait for an appointment is 2 weeks. All women enrolled in HBP are medical assistance eligible. Currently, 1,200 new mothers are enrolled in the HBP program. The Healthy Beginnings Plus program serves 58% white, 15% African-American, and 27% Latino families.

HBP serves low-income residents of Lancaster County who are either pregnant or have just had a new baby, and are in need of medical services. The families
live in both urban and rural areas of the county. All women in both programs are within 185% of Federal poverty income guidelines.

Outcomes

Through funding from the Pennsylvania Select Program, LGH tested and treated, if positive, over 1,200 low-income, high risk pregnant women and 500 men for Chlamydia in the past year.

Other Community STI Initiatives

Spanish American Civic Association

Currently, the Spanish American Civic Association (SACA) of Lancaster does outreach efforts with targeting Chlamydia and gonorrhea. SACA currently has a public service announcement airing on WLCH 91.3 FM usually four times per day, 7 days per week. SACA efforts and services are also shared on TeleCentro Comcast public access Channel #949 with a prevention programs on STDs and HIV. SACA offers counseling, testing, and treatment for anyone whose results are positive. SACA’s treatment clinic is on Thursday evenings with a physician. Flyers around the community and SACA’s website share testing hours and treatment. SACA provides group interventions around the community for both adults and adolescents to provide them with the awareness of STDs and testing.

Planned Parenthood

Planned Parenthood Lancaster educates the community on the symptoms, protection from, and where to receive help for the treatment of STIs. Planned Parenthood also tests and treats for STIs at their center.

Goals

FY 14: Increase education and prevention program at Healthy Beginnings Plus.

FY 15: Expand the Family Planning Clinic to the Walter L. Aument medical Center in Quarryville. Increase our education and prevention program at Downtown Family Medicine.
FY 16: Expand the Family Planning Clinic to Twin Rose medical Center.

LGH hopes to see the Chlamydia incidence rate in Lancaster County drop to at least the state average of 172.7 per 100,000. LGH hopes to see the Gonorrhea incidence rate in Lancaster County drop to at least the state average of 41 per 100,000.

Conclusion

The cost of expanding our outreach to prevent, test and treat Chlamydia and gonorrhea will result in a negative contribution margin. Counseling and education will be expanded into the county. We will continue to teach prevention, test and treat all patients in the HBP program for Chlamydia and gonorrhea.

Mothers who received early prenatal care

Framing the issue

Babies born to women who do not receive early prenatal care are three times more likely to deliver a low birth weight infant and five times more likely to die than those who have early care⁶¹. Lancaster County has seen a downward trending over the past ten years of patients not receiving early prenatal care.

Lancaster County

Lancaster County is currently considered one of the worst early entry into care percentages in the state. Out of the 67 counties in Pennsylvania, Lancaster County ranks number 62, with a ranking number of 67 indicating the lowest percent of mothers receiving early prenatal care in Pennsylvania. The state of PA averages 71.3% and the Healthy People 2020 goal is 77.9%. Lancaster County has 60.7% of women receiving early prenatal care in the first trimester as compared to 10 years ago when 80.2 percent of women received early prenatal care⁶². There is an adequacy of providers so it appears that lack of knowledge of the importance of prenatal care may be the issue. Although Lancaster County’s percent of mothers who receive early prenatal care is one of the worst in the state, the percent of babies with a low birth weight is lower than the Healthy People 2020
target. In Lancaster County, 7.4% of babies born weighed less than 5 pounds, 8 ounces. The Healthy People 2020 target for this indicator is 7.8% of babies born weighing less than 5 pounds, 8 ounces.

LG Health Priority

Capacity to serve women in their first trimester is not an issue, but rather it appears that education is the issue. The issue may be lack of knowledge of the important protective factors of early care. It may also be lack of knowledge of Medicaid coverage increasing to 185% above the federal poverty income guidelines. Uninsured women may postpone care to due to lack of funds not realizing that they are eligible for coverage.

Disparities

Ethnic
The lowest entry into care is the Black population at 55.1% followed by Asian at 56.8%. The Hispanic population had the best results at 64.1% followed by Whites at 60.7%.

Age
The age group of 40-44 has the highest percentage of late entry at 44.8%. The age group of 15-24 has the second lowest percentage at 52-55%. The age group of 25-34 year olds has the best entry into care at 64-65%. It appears that education needs to be focused on the 15-24 year olds and the 40-44 year olds.

Current LG Health Initiatives

Family Planning Clinic

Lancaster General has a Family Planning Clinic that treats low income women of all ages and provides free pregnancy testing.
Healthy Beginnings Plus (HBP)

As mentioned earlier, the HBP program is provided through Medical Assistance for low income clients who are eligible for medical assistance. The 13 nurses and 9 social workers work in close collaboration to deliver optimal care to every client. They follow the mothers after delivery until the baby is 8 weeks old.

The goal of the program is to prevent pre-term labor and encourage healthy lifestyle changes. We promote the program through health providers and social service organizations in an effort to enroll women in the program during their first trimester.

The HBP clinic sees over 1,200 women per year to care for pregnant women. Appointments are made within two weeks. Currently, 1,200 new mothers are enrolled in the HBP program. The Healthy Beginnings Plus program serves 58% white, 15% African-American and 27% Latino families.

Nurse Family Partnership (NFP)

The NFP Program was developed by David Olds and has over 20 years of research from three scientifically controlled studies. The studies show NFP makes a significant difference in reducing teenage pregnancies, child abuse and welfare dependence. It also leads to significant savings: $5.70 saved for every dollar invested. 63

Nurses with specialized training in relating to first-time parents complete the home visits. Parents enter the program before the 26th week of pregnancy and visits are concluded on the child’s second birthday.

A main focus of the NFP program is early entry into care. All of these women are first time mothers. Forty-five percent of NFP patients enter care in the first trimester. Currently, 125 mothers are enrolled in the NFP program. NFP participants are 48% white, 11% African-American and 41% Latino.
Outcomes
As a result of current LGH initiatives, 82% of women in LG Health-HBP enter care in the first trimester. Forty-five percent of first time mothers in NFP enter care in the first trimester.

Strategies

General goals (3 years: FY14, FY15, FY16)

FY 14: Offer free pregnancy testing and provide education and referral to all patients who come to HBP for a free pregnancy test.

FY 15: Create PSA’s educating people about the importance of early prenatal care.

FY 16: Continue free pregnancy testing and education.

Conclusion
LG Health will continue to connect with social service organizations to increase awareness of the importance of early prenatal care. We will conduct an analysis of our current strategies and identify opportunities to enhance community awareness.

Annual ozone air quality

Framing the Issue

Although nationally ozone air quality has improved, Lancaster County remains a county with hazardous air. Poor air quality is dangerous, causing a number of diseases and complications. Reducing such pollution, through actions such as the strengthening of regulations by the EPA, can extend life expectancy.

According to the American Lung Association, ozone is composed of three oxygen atoms (O₃) and is an extremely reactive gas molecule that attacks lung tissue by chemically reacting with it. Ozone present in the upper atmosphere protects the Earth
from ultraviolet rays, however at the ground level it can cause serious health problems\textsuperscript{67}. The raw ingredients for making ozone are nitrogen oxide and hydrocarbons\textsuperscript{68}. These ingredients are emitted by motor vehicles, busses, fossil fuel burning power plants, chemical plants, gas stations, paint, refineries, and certain other industries\textsuperscript{69,70}. When nitrogen oxide and hydrocarbons come in contact with both heat and sunlight, they combine and form ozone\textsuperscript{71}. Ozone is higher and particularly dangerous in the warmer months because heat is an important factor in the creation of ozone at the ground level\textsuperscript{72}.

Lancaster County’s poor air quality is not entirely a result of the activities of those who work and live in Lancaster County. Poor air quality is also a result of the proximity of significant sources and the prevailing winds from those sources. In addition to the ground level ozone that is produced in the county, ground level ozone travels by wind from nearby cities such as the Baltimore-Washington metro area and large industrial neighbor counties such as York County, as well as from more distant upwind areas such as western Pennsylvania and the Ohio River Valley. Lancaster County is not directly responsible for its poor air quality and cannot change the land or wind patterns; encouraging residents to adopt more environmentally friendly lifestyles may make a subtle difference. Regulations on such industries and emissions are not the responsibility of the County or LG Health, but rather regulations must be made at the State or Federal level.

A scientific review by the National Research Council has found that ozone can shorten life\textsuperscript{73}. According to the 2012 \textit{State of the Air} report by the American Lung Association, those with chronic diseases (such as adult asthma, pediatric asthma, chronic bronchitis, and emphysema), those in poverty, and those who are under the age of 18 or over the age of 65 are at risk from poor ozone air quality\textsuperscript{74}.

Immediate health problems associated with a high value for ozone air quality are: shortness of breath, chest pain when inhaling, wheezing and coughing, increase in asthma attacks, increase in susceptibility to pulmonary inflammation, inflammation and
damage to the airways, increase in difficulty to breathe deeply and vigorously, and increase the need for people with lung diseases to receive medical treatment\textsuperscript{75,76}. The American Lung Association indicates that exposure to a high ozone air quality can alter the lungs’ ability to function and may also affect the heart\textsuperscript{77}. Ground level ozone can reduce lung function and inflame the linings of the lungs\textsuperscript{78}.

**Lancaster County**

Currently Lancaster County is ranked 29 for high ozone days out of 277 metropolitan areas\textsuperscript{79}. Annually, Lancaster County's ozone air quality has a value of 5 (2008-2010 data)\textsuperscript{80}. The American Lung Association assigns grades A-F to counties (A=1; B=2; C=3; D=4; F=5), based on average annual number of days that ozone levels exceeded U.S. standards during the three year measurement period\textsuperscript{81}. Although Lancaster County’s ozone grade is an F, between 2008-2010, Lancaster County had 25.8 fewer days that were classified as high ozone days as it did in 1996\textsuperscript{82}. Both locally and nationally, the annual ozone air quality has decreased in recent years\textsuperscript{83}. This trend can be attributed to the Environmental Protection Agency (EPA) strengthening of regulations on national air quality standards\textsuperscript{84} and state regulations on vehicle emissions\textsuperscript{85}.

**Conclusion**

LG Health does not plan to include air quality and environmental change as a key priority. However, LG Health plans to address chronic diseases through addressing obesity and tobacco. By addressing these key priorities, LG Health will help to reduce the number of individuals in Lancaster County who develop a chronic disease, thus reducing the number of individuals in Lancaster County who are at a higher risk for complications due to poor air quality. LG Health will also include addressing asthma and lung disease in the tobacco key priority and will continue to monitor this indicator. Additionally, LG Health will set up an alert on the health system home page that warns individuals that the air is hazardous to their health on a given day. If this indicator were to change for the worse, LG Health will reassess annual ozone air quality and take appropriate actions.
There are several steps individuals can take within their community for cleaner air. The American Lung Association indicates that individuals can do any of the following to make their air cleaner:\(^6\):

i. Send a message to congress asking them to support cleaner, healthier air and oppose measures to block or delay the cleanup of hazardous air pollutants from coal-fired power plants.

ii. Share why you want cleaner, healthier air in your community.

iii. Drive less often by walking, biking, or using public transportation when you can, limiting vehicle emissions.

iv. Use less electricity by turning off unnecessary lights and purchasing energy efficient appliances.

v. Refrain from burning wood or trash.

vi. Make sure your local school system requires school buses to have filters and other equipment to reduce emissions.

**Annual particle pollution**

**Framing the Issue**

Research has indicated that poor air quality can lead to a number of chronic diseases and even death. According to the 2012 *State of the Air* report published by the American Lung Association, Lancaster County ranks poorly among U.S. communities in annual particle pollution.

One form of air pollution is particle pollution. According to the American Lung Association, particle pollution refers to a mix of very tiny solid and liquid particles that are in the air we breathe\(^7\). Pollution particles are very tiny and cannot be seen, appearing to be invisible pollutants. The larger of the pollution particles (between 2.5 microns and 10 microns in size) can be cleared out of the body through coughing and sneezing\(^8\). Those that are smaller than 2.5 microns (known as PM\(_{2.5}\)) cannot be cleared from the body through natural defense mechanisms\(^9\). Particles less than 0.1 microns are considered ultrafine particles and are small enough to pass through lung tissue into the bloodstream\(^10\). These particles include wind-blown dust, volcano particles, particles from forest fires, particles from all combustion sources, particles from open burning, and particles in the exhaust of diesel engines\(^11\).
Polluted air has been linked to a number of respiratory conditions and those living in communities where particle pollution levels are high have an increased risk of developing these diseases and complications to other diagnoses. Air pollution can cause respiratory infections, heart disease, and lung cancer\textsuperscript{92}. Short-term exposure to particle pollution has been linked to: death from respiratory and cardiovascular causes (including stroke), increased mortality in infants and young children, increased numbers of heart attacks, inflammation of lung tissue in young healthy adults, increased hospitalization for cardiovascular disease, increased emergency room visits for patients suffering from acute respiratory ailments, increased hospitalization for asthma among children, and increased severity of asthma attacks in children\textsuperscript{93}. Year round exposure to particle pollution has also been linked to increased hospitalization for asthma attacks for children living near roads with heavy truck or trailer traffic, slowed lung function growth in children and teenagers, significant damage to the small airways of the lungs, increased risk of dying from lung cancer, and increased risk of death from cardiovascular disease\textsuperscript{94}. The EPA has found that fine particle pollution causes early death, causes cardiovascular harm, is likely to cause respiratory harm, may cause cancer, and may cause reproductive and developmental harm\textsuperscript{95}. The American Lung Association indicates that chronic exposure to particle pollution can shorten life by one to three years\textsuperscript{96}.

The National Institute of Environmental Health Sciences scientists have shown that long-term exposure to air pollutants increases the risk of respiratory illnesses such as allergies, asthma, chronic obstructive pulmonary disease, and lung cancer. Their research has resulted in the development of more stringent air quality standards that promote a higher quality of life, protect the health of children, the elderly and other vulnerable populations, and reduce the costs associated with respiratory disease\textsuperscript{97}. Individuals at risk from developing disease as a result of annual particle pollution are those with pre-existing chronic diseases, those in poverty, and those under the age of 18 or over the age of 65\textsuperscript{98}. Those individuals who currently have a lung disease, have diabetes, have heart disease, are over the age of 65, people with low income, and those who work outside have an increased risk of complications associated with poor
air quality. Infants, children, and teens also have an increased risk. The American Lung Association has indicated that children are at a higher risk for developing complications due to air pollution because their lungs are continuously growing and they are more active outdoors.

The lower levels of air pollution in a community, the better the respiratory and the cardiovascular health of the population will be. However, Lancaster County’s poor air quality is not entirely a result of the activities of those who work and live in Lancaster County. Poor air quality is also a result of the proximity of significant sources and the prevailing winds from those sources. In addition to the air pollution that is produced in the county, pollution travels on the wind from nearby cities such as the Baltimore-Washington metro area and large industrial neighbor counties such as York County, as well as from more distant upwind areas such as western Pennsylvania and the Ohio River Valley. Lancaster County is not directly responsible for its poor air quality and cannot change the land or wind patterns; encouraging residents to adopt more environmentally friendly lifestyles may make a subtle difference.

Lancaster County

Currently, Lancaster County’s annual particle pollution value is 4 (2008-2010 data) on the air quality index. The American Lung Association assigns grades A-F to counties (A=1; B=2; C=3; D=4; F=5), based on number of days that particle pollution exceeded US standards during the three year measurement period. Lancaster County’s annual particle pollution has remained steady at a value of 4 over the last few years. The 2012 State of the Air report indicates that Lancaster County ranks 32 for annual particle pollution out of 277 metropolitan areas and ranks 39 for 24-hour particle pollution out of 277 metropolitan areas. This year, Lancaster’s air pollution improved enough to fall off of the list of most polluted areas. Nationally, the annual PM and the 24-hour PM has declined in recent years. This trend can be attributed to the Environmental Protection Agency (EPA) strengthening of regulations on national air quality standards and state regulations on vehicle emissions.
Conclusion

LG Health does not plan to include air quality and environmental change as a key priority. However, LG Health plans to address chronic diseases through addressing obesity and tobacco. By addressing these key priorities, LG Health will help to reduce the number of individuals in Lancaster County who develop a chronic disease, thus reducing the number of individuals in Lancaster County who are at a higher risk for complications due to poor air quality. LG Health will also include addressing asthma and lung disease as part of the tobacco health improvement plan and will continue to monitor this indicator. If this indicator were to change for the worse, LG Health will reassess annual particle pollution and take appropriate actions.

There are several steps individuals can take within their community for cleaner air. The American Lung Association indicates that individuals can do any of the following to make their air cleaner:\ref{footnote:cleaner_air}

i. Send a message to congress asking them to support cleaner, healthier air and oppose measures to block or delay the cleanup of hazardous air pollutants from coal-fired power plants.

ii. Share why you want cleaner, healthier air in your community.

iii. Drive less often by walking, biking, or using public transportation when you can, limiting vehicle emissions.

iv. Use less electricity by turning off unnecessary lights and purchasing energy efficient appliances.

v. Refrain from burning wood or trash.

vi. Make sure your local school system requires school buses to have filers and other equipment to reduce emissions.

Households without a vehicle

Framing the Issue

Many barriers exist in access to care. One important barrier in receiving preventive care and urgent treatment is transportation. In general, people living in a household without a car make fewer than half the number of journeys compared to those with a car\ref{footnote:car_journeys}. This limits their access to essential local services such as supermarkets,
post offices, doctors’ offices and hospitals. Income is a major factor in car ownership. Most households with above-average incomes have a car while only half of low-income households do.

Lancaster County

In Lancaster County, 9.7% of households are without a vehicle, compared to 8.9% of households in the United States and 11.4% of households in Pennsylvania. Although LG Health cannot work to increase the number of households with a vehicle, the health system is able to bring care closer to all Lancaster County residents, eliminating the barrier of transportation in access to care. The LG Health system of urgent care centers, outpatient centers, express clinics, and primary care practices linked to ambulatory sites extends throughout the entire Lancaster County (see addendums F, G, and H for maps). At these locations, individuals are able to receive care for minor illness or injury and receive preventive care close to home.

Current Initiatives

Although many individuals have a vehicle or access to a vehicle, a number of individuals within Lancaster County rely on public transportation to get to their doctors and to the hospital. The locations of the LG Health Express Clinics and Urgent Care Centers are strategically located close to a bus stop. This allows those individuals who do not have a vehicle to use public transportation for preventive care and acute illnesses.

Conclusion

Pennsylvania, like many states, has faced serious budget challenges over the past several years which have directly reduced funding levels for a variety of health and human service programs. In fiscal year 2010-2011, the Commonwealth instituted several changes to its Medical Assistance Transportation Program that jeopardized patient access to medical appointments and treatment services ranging from routine primary care check-ups to dialysis, chemotherapy, and radiology in some
cases. LG Health joined with its county partners to successfully advocate with the state for additional funds to restore service levels. We continue to work with state and local government officials to monitor and advocate for these resources.
V. Health Priorities Plan

Health Priority: Reduce Obesity
A. **Obesity**

Framing the Issue

This plan sets the strategies for the fourth year LG Health is addressing obesity. It is an extremely complex issue that will take years to stabilize and reverse, therefore the complexity of the strategies reflect this. Much work is needed to address this issue with help from many community partners.

According to the *F as in Fat* 2012 report recently released by the Trust for America’s Health and the Robert Wood Johnson Foundation (RWJF), the obesity epidemic is threatening the success and security of America and most developed nations by deteriorating the health of overweight individuals, increasing national debt, decreasing productivity and plaguing our youth\(^ {113}\).

Best practices in the prevention of obesity recommend evidence-based, comprehensive programs and policy, systems, and environmental changes that address healthy eating and increased physical activity be made available and implemented at all levels of society.

**Why Obesity is a Priority**

Obesity rates for Pennsylvania are slightly lower than the national trend at 28.6\% (+/- 1.3) of adults and is ranked 20\(^ {th}\) in obesity among the 50 states\(^ {114}\). Obesity is defined according to Body Mass Index (BMI) scores which compare body weight, height and sex in order to determine the percent of body fat. A BMI over 30 is considered obese whereas a BMI over 25 signifies overweight.

Recent findings indicate that, on a national level, 64\% of American adult women are overweight or obese, 36\% are obese, and 8\% are extremely obese\(^ {115}\). Compared to their male counterparts, women have a lower percentage for being overweight and obese, yet a higher percentage for extreme obesity. For both sexes, it is commonly known that overweight and obesity incurs an increased risk of high blood pressure, diabetes, and
stroke; however, specific to women, there is an increased risk for breast cancer, endometrial cancer, obstetric and gynecologic complications [i.e. menstrual abnormality, miscarriage, infertility, and difficulty with assisted reproduction], and for women who are pregnant, an increased risk for birth defects and malformed offspring\textsuperscript{16}. It is imperative to give attention to overweight and obese women, as they are the predominant purchasers of food in the household\textsuperscript{17} and are the role models for healthy eating behaviors and decisions within their families, especially for their children.

For its most recent obesity report, the RWJF recruited the National Heart Forum (NHF) to develop a model that showcases the increase of obesity and associated healthcare costs by the year 2030 if obesity continues to grow at the current rate (figure 17). The top figure below shows the predicted obesity rates by state for the year 2030. Conversely, the bottom figure shows the predicted obesity rates by state for the year 2030 if each state were to reduce their average BMI by 5%.

![Maps showing current track and 5% reduction in BMI](image)

**Figure 17.** Projected obesity rates for the year 2030\textsuperscript{18}.

The same study reported that the most recent costs associated with obesity and its related ailments accounted for $147 billion nationally per year\textsuperscript{19}. The link between obesity and the development of chronic disease multiplied by the growing rate of obesity guarantees a 10-20% increase in healthcare rates for all states by the year 2030 which would be anywhere from $48-$66 billion per year\textsuperscript{120}. Healthcare organizations and professionals recognize that
the majority of these costs are preventable, using the $41 billion directly related to childhood obesity as an example\textsuperscript{121}. Economic consequences of obesity do not end at healthcare spending, seeing as the decreased rates of productivity linked to obesity will account for a $390-580 billion loss nationally within the next 18 years\textsuperscript{122}. In addition to the financial burden to our society, obesity has now become a national security issue. As of 2010, the US Department of Defense reported that 27% of America’s young men and women are turned away from joining military services because they are overweight\textsuperscript{123}.

**Cause**

The cause of obesity is complex and multi-faceted. At the core of this issue is the disruption of the energy balance, (i.e. higher caloric intake and decreased physical activity). *F as in Fat* 2012 reported correlations between the states with the highest rates of physical inactivity and least consumption of fruits and veggies with the highest rates of obesity\textsuperscript{124}.

Our society in general has fostered the increase in obesity. The promotion of unhealthy food and beverage choices through visual appeal and low pricing encourages individuals to choose foods that are low in nutritional value and high in fat, sugar, and sodium. A lack of nutrition education and messaging makes our population unknowledgeable about healthy options and susceptible to an array of junk food marketing. Poor nutritional messaging is especially highlighted when it comes to sugar-sweetened beverages. Adults and children are unaware of the negative consequences that soda, juice, and other sugary drinks have on our health. A study by the Harvard School of Public Health found that for each additional sugar-sweetened beverage a child consumes per day, they are at a 60% increased risk for becoming overweight\textsuperscript{125}.

Furthermore, there is a lack of availability of healthy choices that can combat the convenience and low-cost of unhealthy food and beverage choices. A lack of access to these healthy options via fresh markets, convenient stores and concessions is one of the largest barriers to helping individuals maintain a healthy weight.

A deficiency of healthy policies at the community, state and federal levels has allowed this crippling surge of unhealthy trends to occur. Just recently, the USDA released stricter
nutritional guidelines for meals served at schools as a result of the Healthy, Hunger-Free Kids Act. An analysis of state-level legislations that impact obesity found that only two states currently have policies that make clean water cups accessible during the school day.

There is a severe shortage of physical activity in our society. The dependency on vehicular transportation has contributed to overall sedentary lifestyles for most Americans. To compound this issue, communities lack pedestrian and bicycle-friendly features that would encourage these types of activity. Schools continue to eradicate physical education and outdoor play from the daily school schedule. The role of social media is also being recognized as a factor in the obesity epidemic by contributing to physical inactivity.

It is proven that obesity is genetically driven. Children are twice as likely to develop type-2 diabetes and become obese, themselves, if they are born to an obese mother\(^{126}\). Also, eating and exercise habits are nearly set-in-stone by age five. Children that are exposed to predominantly sugary and fatty foods early in life will tend to prefer the same types of foods throughout their lives. Breastfeeding is an additional factor that has been proven to play an important role in preventing obesity in children. Children that are exclusively breastfed have significantly lower rates of obesity than those not breastfed or partially breastfed\(^{127}\). Currently, only 16% of American mothers exclusively breastfeed their children for six months or more\(^{128}\). Improving the nutrition of our infants and children is an area in need of improvement.

**Costs and Health Consequences**

The costs on obesity to the individual and population are extreme and burdensome on many levels. Obesity affects society in relation to the direct costs to the individual as manifested by poor physical and mental health as well as decreased socialization and a decreased overall quality of life\(^{129}\). Obesity results in a higher risk of becoming hospitalized and death, as well as morbidity rates similar to that of smoking, drinking problems, and poverty\(^{130}\). Depending on the race and age of the individual obesity has proven to be related to a 6- to 20-year decrease in life expectancy\(^{131}\). Indirectly the costs relate to the health and fitness of the overall population and the effect on the overall economy and costs
of healthcare\textsuperscript{132}. Chronic diseases such as heart disease, diabetes mellitus, and some cancers are associated with a higher risk for patients who are overweight or obese\textsuperscript{133}. Additional weight related medical problems are menstrual abnormalities, gall bladder disease, and osteoarthritis\textsuperscript{134}. Obese children are now exposed to chronic diseases at young ages that include type-two diabetes, cardiovascular disease as evidenced by hypertension and hypercholesterolemia, and sleep apnea\textsuperscript{135}. Children now face the possibility of not living as long as the previous generation\textsuperscript{136}.

The Risks of Obesity on Women of Child-Bearing Age

With the prevalence of obesity in the United States increasing dramatically over the past couple decades, there has been intent focus on educational wellness programs to reduce this prevalence; however, there also needs to be attention given to women of child-bearing age who are overweight or obese and planning to get pregnant. According to the CDC, one third of women are obese, more than half of pregnant women are obese or overweight, and 8\% of women at a reproductive weight are extremely obese, all of whom are at great risk for complications during pregnancy. For every expectant mother who wants the best health for her child, awareness concerning the complications that obesity incurs during pregnancy needs to be a priority. Obese pregnant women of child-bearing age are predisposed to complications such as: gestational diabetes, preeclampsia, infection, thrombosis, obstructive sleep apnea, overdue pregnancy, labor problems, and/or pregnancy loss\textsuperscript{137}. Compared to women of normal weight, obese women of child-bearing age are more likely to develop diabetes during their pregnancy. With concern to prenatal risks, obesity in the expectant mother is associated with large-for-gestational age infants, thus spawning an increased risk of childhood and adolescent obesity for the child\textsuperscript{138}.

For women who are pregnant, it is important for them to be aware of the potential intrapartum complications that could take place as a result of their obesity. Expectant mothers potentially face challenges with anesthesia management and are at risk for an emergency cesarean delivery. Although the expectant mother potentially faces a handful of operative and postoperative complications during the pregnancy, her obesity also poses
complications for the baby, such as birth defects [i.e. neural tube defects: defects of the brain and spine], preterm birth, injury during the birth due to the baby's large size, death after birth, and childhood obesity. Recent studies indicate that women who are obese before pregnancy or during pregnancy face an increased risk for giving birth to a child with defects. The risk factor differs for each defect; for obese women, the risk of having a child with cardiovascular defects, cleft palate/lip, hydrocephaly, and limb reduction abnormalities was 30%, 20%, 60%, and 30% higher respectively, as compared to pregnant women of a normal weight.

To combat the risks affecting the obese expectant mothers and their children, obese women who are pregnant or planning a pregnancy can turn to recommendations from the CDC concerning the best practices for a healthy pregnancy. Preconception assessment and counseling are strongly encouraged and should include educational awareness about the maternal and fetal risks of obesity on pregnancy. Additionally, obese women who are planning to get pregnant are encouraged to engage in a weight-reduction program, upon consultation with a physician. Within this program, nutrition consultation and an exercise regimen should be offered to these overweight and obese women. At the initial prenatal visit, the physician should record body mass index (BMI) in order to calculate appropriate gestational weight gain; weight, then, should be evaluated continuously throughout the pregnancy. It is important to keep in mind, if an overweight or obese woman decides to undertake a nutritional and exercise regimen prior to pregnancy and during pregnancy, this regimen should be maintained postpartum, and nutritional counseling is recommended prior to attempting another pregnancy.

Where Does Lancaster County Stand

The most recent Community Health Needs Assessment inventoried the county of Lancaster, PA to find that obesity trends are just slightly below the national average for adults. Nationally, about 150 million Americans age 20 and older are overweight or obese (35.7%). Of these individuals, adults aged 40-59 show significantly (more than 10%) higher obesity rates than other age groups. The following chart shows obesity rates for Lancaster, PA compared to the statistics for the state of Pennsylvania and the United States.
While rates for Lancaster County are comparatively low against the state and national averages, LGH recognizes the need for action in the area of obesity as 2/3 of adults in Lancaster County are overweight or obese-putting them and their children at an increased risk for chronic health conditions\textsuperscript{141}. Multiple interventions are focused on the treatment of obesity and helping individuals obtain a healthy weight. However, the majority of programs have been designed for the prevention of weight gain and healthy weight maintenance.

**Figure 18.** Childhood & Adolescent Obesity Rates [Grades K-12] for Lancaster County and Pennsylvania (2006-2011)\textsuperscript{142}. 
**Figure 19.** Adult Obesity in Lancaster County, Pennsylvania, and the United States (2005-2010)\(^{143}\).

**Figure 20.** Adult Female Obesity Rates for Lancaster County, Pennsylvania, and the United States (2002-2010)\(^{144}\). Note: Percentages are of the total female population in Lancaster County, Pennsylvania, and the United States. Lancaster County and Pennsylvania percentages represent the mean and United States percentages represent the median.
Figure 21. Adult Male Obesity Rates for Lancaster County, Pennsylvania, and the United States (2002-2010).<sup>[46]</sup> Note: Percentages are of the total male population in Lancaster County, Pennsylvania, and the United States. Lancaster County and Pennsylvania percentages represent the mean and United States percentages represent the median.

When we look at risk factors for obesity, we see that there is no single indicator to explain the prevalence of this condition. Rather, analyses such as the chart below reiterate that obesity is the result of multiple factors, both medical and behavioral in nature. Research suggests that interventions which target an increase in consumption of fruits and vegetables and an increase in amounts of physical activity are successful in reducing medical conditions as well as body fat.<sup>[46]</sup> LG Health’s efforts in obesity prevention stress the importance of eating fruits and vegetables and getting the recommended amounts of physical exercise.
Figure 22. Prevalence of Risk Factors for Obesity and Chronic Disease among Adults in Lancaster, Pennsylvania and the US (2008-2010)\textsuperscript{47}. 

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**Prevalence of risk factors for obesity and chronic disease among adults**

- **Ever Told They Have Diabetes**
  - Lancaster: 8%
  - Pennsylvania: 9%
  - US: 9%

- **No Leisure Time Physical Activity In The Past Month**
  - Lancaster: 21%
  - Pennsylvania: 25%
  - US: 32.6%

- **Overweight (BMI >25)**
  - Lancaster: 64%
  - Pennsylvania: 64%
  - US: 63.6%

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Figure 23. Prevalence of Risk Factors for Obesity and Chronic Disease Among Females in Lancaster, Pennsylvania and the US, 2008-2010. Note: Percentages are of the total female population in Lancaster County, Pennsylvania, and the United States. Lancaster County and Pennsylvania percentages represent the mean and United States percentages represent the median.
Figure 24. Prevalence of Risk Factors for Obesity and Chronic Disease among Males in Lancaster, Pennsylvania and the US, 2008-2010\textsuperscript{49}. Note: Percentages are of the total male population in Lancaster County, Pennsylvania, and the United States. Lancaster County and Pennsylvania percentages represent the mean and United States percentages represent the median.
Figure 25: Prevalence of Risk Factors for Obesity and Chronic Disease among Adults in Lancaster, Pennsylvania and the US (2009)\textsuperscript{150}.

Disparities

Age

In 2011, ten percent of toddlers (ages 2-5) and 20\% of children (ages 6-11) living in the U.S. were considered obese\textsuperscript{151}. Among U.S. high school students, an average of 13\% are obese. According to the American Heart Association, about 1 in 3 children and adolescents (ages 2-19) are overweight and obese; this statistic is nearly triple the rate from 1980\textsuperscript{152,153}. Additionally, 14.1\% of the high school students claimed that they did not receive 60 minutes or less of exercises during any of the 7 days prior to the administration of the CDC Youth Risk Behavior Surveillance System (YRBSS) survey\textsuperscript{154}. Overweight adolescents have a 70\% chance of
becoming overweight adults. This statistic increases to 80% if 1 or both parents are overweight or obese. For the first time in human history, health experts predict that the younger generation will “live sicker and die younger” than their parents\textsuperscript{155}. Children that are at an unhealthy weight are also subjected to socio-emotional issues such as bullying, rejection, and an increased likelihood of depression\textsuperscript{156}. To address this vulnerable population, LG Health has increased the availability of services geared toward children and adolescents and, in partnership with the LULC, continues to educate adults and implement obesity prevention programs throughout public schools (See initiative and goal section).

\textit{Ethnicity}

Statewide, 25.1% White, 35.6% Black and 27.6% Latino, and 10.7% Asian adults are obese\textsuperscript{157}. We recognize these disparities among ethnicities and know that it is different for children and adolescents. For adolescents (grades 9-12), 11.5% White, 18.2% Black, and 14.1% Hispanic individuals are considered obese. American Indian and Alaskan Native (20.7\%) and Hispanic (17.9\%) children aged 2-4 years have highest rates of obesity\textsuperscript{158}. Low-income neighborhoods, education level and lack of access to fresh produce and recreational space are factors that may contribute to this disparity\textsuperscript{159}.
Figure 26. Obesity rates by race/ethnicity for Lancaster, Pennsylvania, and the US Healthy People 2020 goal (2008-2010)\textsuperscript{100}.

**Gender**

Among adults, there is an interesting trend of obesity by gender for Lancaster County. Obese females make up 31% of the adult population whereas the rate for obese males is 25%. However, when we combine obese and overweight adults, female obesity rates are less than male rates (59% vs. 70%) to account for the average of 64% of Lancastrian adults that are overweight or obese\textsuperscript{161}.

**Menopause**

It is not unusual for women to gain weight as they approach menopause. The weight gain typically begins when women enter their 40s which is approximately when perimenopause the period of time leading up to menopause begins according to Mayoclinic.com. On average women gain one pound per year from perimenopause through the conclusion of menopause. Several studies have shown that menopause plays a role in many midlife women’s transition from pear-shaped to apple-shaped body.
Any excess weight raises health risks. According to the North American Menopause Society most women in North America are overweight in midlife. Any excess weight raises the risk of many diseases, including cardiovascular disease, type 2 diabetes, high blood pressure, osteoarthritis and some types of cancer.

**Income**

Poverty creates an increased susceptibility to obesity. A national study found that obesity rates among individuals that earn less than $15,000/year (33%) are significantly higher than the rates among individuals that earn at least $50,000/year (24.6%)\(^{162}\). Another study found that moving families out of poverty made them 1/5 less likely to become obese or develop diabetes\(^{163}\).

With regard to physical activity, evidence suggests that lower-income families are less likely to have disposable income to spend on health clubs and sports organizations for their children. Also, they are less likely to have parks, community recreation centers, or the safety of letting their children play outside\(^ {164}\). Additionally, the higher cost of fresh produce and other nutritious foods serves as a barrier to healthy eating among low-income families, causing them to gravitate towards cheap, high-calorie foods with limited health benefits. Increasing the access to fresh, affordable produce and green space for safe physical exercise in Lancaster County is a top priority of LG Health in addressing disparities in obesity.

**Current Initiatives**

**LGH**

As a healthcare leader in Pennsylvania, LGH recognizes the role it must play to initiate activities that promote the increase of the number of individuals in our community maintaining a healthy weight. The logic model is a tool that provides a systematic and visual framework to view the relationships between resources, programs, and the measurable impact they have on the community. While
evidence-based, comprehensive programs are proven to be effective at the individual level, the best practice recommendations for population-wide improvements focus on policy, systems, and environmental changes\(^{165}\). The organization has adopted numerous internal and external strategies for addressing obesity at all levels of society as recommended by public health and prevention experts such as the CDC.

**WBH**

WBH primarily focuses on weight during pregnancy and provides menopause education with a focus on weight. WBH also works with Healthy Beginnings Plus (HBP) a multi-disciplinary program for pregnant women that provides childbirth, exercise, nutrition and breastfeeding classes using a staff of nurses, dietitians and social workers from prenatal stages until the infant is eight weeks of age. Over 50% of the women entering care at HBP and NFP had a pre pregnancy BMI >25. Before interventions were implemented, the average weight gain for 95% of women with a high BMI was >20 pounds. After implementing the following interventions (consultation with a dietician, free exercise classes, increased access to fresh fruits and vegetables and motivational interviewing training of staff) the rate of women gaining <20 pounds increased to 36%.

**Logic Models and Socio-Ecological Models**

The following pages include the Logic Model for LG Health’s Healthy Weight Management Initiatives (figure 27) and the Logic Model for LULC (figure 28). The logic model is a tool that provides a systematic and visual framework to view the relationships between our resources, our programs, and the measurable impact they have on our community. The first logic model provides a broad picture of all of the healthy weight management initiatives undertaken by LG Health and the second one provides a more specific break down of the community coalition, LULC, a coalition convened and facilitated by LG Health that has worked to gather leaders and activists around obesity prevention efforts within the
**LGH Healthy Weight Management Logic Model**

**Goal:** To increase the percent of children and adults at a healthy weight in Lancaster County

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Outputs</th>
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<tbody>
<tr>
<td></td>
<td>Clinical BMI intervention</td>
</tr>
<tr>
<td>Physician practices</td>
<td>Employee and worksite wellness programs</td>
</tr>
<tr>
<td>Healthy Team</td>
<td>First Well nutrition awareness program</td>
</tr>
<tr>
<td>Registered Dietitians</td>
<td>Adult &amp; child weight management programs</td>
</tr>
<tr>
<td>Food service staff</td>
<td>1:1 nutritional counseling</td>
</tr>
<tr>
<td>Nurses</td>
<td>Healthy shopping tours</td>
</tr>
<tr>
<td>Health educators</td>
<td>Support groups</td>
</tr>
<tr>
<td>Policy makers</td>
<td>Farm-to-institution</td>
</tr>
<tr>
<td>Engineers and planners</td>
<td>Community engagement</td>
</tr>
<tr>
<td>Translators</td>
<td>Improvements in the built environment</td>
</tr>
<tr>
<td>Evaluators/ statistician</td>
<td>Breastfeeding friendly policies</td>
</tr>
<tr>
<td>Interns and clerks</td>
<td>Healthy food access policies</td>
</tr>
<tr>
<td>Technology</td>
<td>School and community gardens</td>
</tr>
<tr>
<td>Grant funding</td>
<td>Mobile markets</td>
</tr>
<tr>
<td>Worksites</td>
<td>Physical activity policies</td>
</tr>
<tr>
<td>Social media, marketing, and PR support</td>
<td>School wellness programs and policies</td>
</tr>
<tr>
<td>HWM materials, activities &amp; evaluations</td>
<td>Complete streets</td>
</tr>
<tr>
<td>Equipment</td>
<td>Bikeability plan</td>
</tr>
<tr>
<td>Legislation</td>
<td></td>
</tr>
<tr>
<td>Lighten Up Lancaster County Coalition*</td>
<td></td>
</tr>
<tr>
<td>Community partners</td>
<td></td>
</tr>
</tbody>
</table>

**Short Term**

1. Increase awareness of healthy weight management through educational outreach.
2. Increase the number of providers screening for Body Mass Index.
3. Increase number of participants in HWM programs.
4. Increase percent change on pre/post knowledge evaluations and habit inventories.
5. Create and implement policies around healthy food.
6. Increase the number of comprehensive wellness programs in schools and worksites.
7. Increase access to fresh, low-cost fruits and vegetables.
8. Increase the bikeability of Lancaster City and County.

**Intermediate**

1. Increase percent of adults who participate in regular physical activity.
2. Increase percent of adults who consume recommended amounts of fruits and vegetables.
3. Increase percent of children who participate in regular physical activity.
4. Increase percentage of children who consume recommended amounts of fruits and vegetables.

**Long Term**

1. Increase percentage of children who are at a healthy weight.
2. Increase percentage of adults who are at healthy weight.

*See Lighten Up Lancaster County Coalition Logic Model*
Lighten Up Lancaster County Coalition Logic Model

Goal: To increase the percent of youth and adults at a healthy weight in Lancaster County

Inputs
- LGH Healthy Weight Management Team
- Community Partners & Stakeholders
- Registered Dietitians
- Worksites & Workplace Action Team
- Schools & Community Action Team
- Existing legislation, decision makers & Policy Action Team
- Healthy Weight Management materials, equipment & activities
- Marketing/PR Support & Technology
- Social Media
- Planners, evaluators & statistician
- Interns
- Clerks and Volunteers
- Grant funding

Outputs
- Marketing and Media Campaigns
- Website
- E-Newsletter
- Coalition Recruitment and Retention
- Legislative/Advocacy Work
- School Wellness Councils
- Worksite Resources
- Wellness Expos
- Bike Friendly America Program for businesses and community
- Community Outreach
- Crunch (mascot) appearances
- Healthy weight management programs and services

Short Term
1. Increase policies around healthy food options for targeted populations
2. Increase LULC awareness throughout Lancaster County
3. Increase LULC educational presentations/outreach to targeted populations
4. Increase the number of school and community gardens
5. Increase the number of sites that implement healthy vending
6. Increase access to healthy food through farm-to-institution programs
7. Increase number of comprehensive workplace and community wellness programs
8. Increase the use of healthy weight management programs

Outcomes
1. Increase percent of adults who participate in regular physical activity.
2. Increase percent of adults who consume recommended amounts of fruits and vegetables.
3. Increase the percent of children who participate in regular physical activity.
4. Increase the percent of children who consume the recommended amounts of fruits and vegetables.

Intermediate

Long Term
1. Increase percentage of adults who are at a healthy weight.
2. Increase percentage of children who are at a healthy weight.
The Socio-Ecological Model serves as a theoretical framework for tackling obesity on a large scale (see figure 29). This model depicts the various, multi-level strategies while the following section describes the nature and outcomes for each initiative. LG Health offers numerous in-house and outreach programs but has also adopted internal programming and policies to make an impact on the organizational level. Additionally, LG Health and Lighten Up Lancaster are continually advocating for healthy weight related policies where we live, work, and play in order to make healthy choices easier for all individuals.

Figure 29. Socio-Ecological Model for LG Health Healthy Weight Management Initiatives.
Ongoing LG Health programs are continually tracked and evaluated based on the number of people reached (awareness and education), evidence of positive behavior change as measured by Health Habit Inventories (see addendum R), continual monitoring of local and national data related to healthy weight and an increase in local and organizational policies and environmental changes related to nutrition and physical activity. Current programs and initiatives are described below:

INDIVIDUAL

1. Adult Weight Management Program (Healthy Changes. Healthy You.)
This program is designed to help individuals initiate and sustain behavior change using simple techniques from The Beck Diet Solution. The 12-week program is taught by a Registered Dietician and is available for employees and community members. Prior to this new program, the wellness center ran the L.E.A.R.N. program.

<table>
<thead>
<tr>
<th>Service &amp; Target</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PTD</td>
</tr>
<tr>
<td>Adult Weight Management Program* (L.E.A.R.N.)</td>
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</tr>
<tr>
<td>Targeted population: Overweight and obese adults</td>
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</tr>
<tr>
<td>Total number of participants (data collected from 2001-present):</td>
<td></td>
</tr>
<tr>
<td>Outcomes: Positive behavior change as measured by the Health Habit Inventory (began collecting in 2008)</td>
<td>640</td>
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<tr>
<td>Decrease in BMI (began collecting in 2008)</td>
<td>275</td>
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<tr>
<td></td>
<td>233</td>
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</table>

*(Data is for the L.E.A.R.N. program, Healthy Changes, Healthy You. began in January 2013,)*
2. **Healthy Shopping Tours**
15 grocery store tours offered annually in which a registered dietitian teaches community members strategies for making healthy choices such as reading food labels, comparing nutritious value and cost-effective shopping.

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<tr>
<th>Service &amp; Target</th>
<th>Outcomes</th>
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<tr>
<td></td>
<td>PTD</td>
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<tr>
<td><strong>Healthy Shopping Tours</strong></td>
<td></td>
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<tr>
<td><strong>Targeted population:</strong> Total number of individuals on tour</td>
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</tr>
<tr>
<td><strong>Outcomes:</strong> Education</td>
<td>526</td>
</tr>
</tbody>
</table>

3. **One-on-one Nutritional Counseling**
Offer 1:1 healthy weight management counseling for women that are at an increased risk for heart disease. This is a new initiative, outcomes will be available end of FY 14.

<table>
<thead>
<tr>
<th>Service &amp; Target</th>
<th>Outcomes</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>PTD</td>
</tr>
<tr>
<td><strong>One-on-one Nutritional Counseling</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Targeted population:</strong> Overweight or obese women</td>
<td></td>
</tr>
<tr>
<td><strong>Outcomes:</strong> Education, positive behavior change and decrease in BMI</td>
<td>0</td>
</tr>
</tbody>
</table>
4. Diabetes and Nutrition Center
A team of Certified Diabetes Educators including Registered Dietitians and Registered Nurses provide medical nutrition therapy for patients with diabetes and its co-morbid states including but not limited to obesity. Services are provided for patients ranging in age from infancy through adulthood.

<table>
<thead>
<tr>
<th>Service &amp; Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes and Nutrition Center</td>
</tr>
<tr>
<td><strong>Targeted population:</strong> Individuals, both children and adults with diabetes, co-morbidities related to nutrition and/or with elevated BMIs</td>
</tr>
<tr>
<td><strong>Outcomes:</strong> Education, goal attainment and decrease in BMI</td>
</tr>
</tbody>
</table>

5. Bariatric Physician Specialists
The department offers two effective, physician-directed clinical pathways for clinical weight management: bariatric surgery and medical management of obesity. Active support groups, educational classes and seminars are held regularly to increase patient knowledge of nutrition, exercise and behavioral health and increase patient compliance to a healthier lifestyle. All patients have use of the bariatric-exclusive exercise department and a fully equipped kitchen for healthy cooking demonstrations and on-going educational presentations and support groups.

<table>
<thead>
<tr>
<th>Service &amp; Target</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bariatric Physician Specialists</td>
<td>PTD</td>
</tr>
<tr>
<td><strong>Targeted population:</strong> Obese adults</td>
<td>212</td>
</tr>
<tr>
<td><strong>Number of bariatric surgeries performed:</strong></td>
<td>212</td>
</tr>
<tr>
<td><strong>Additional outcome measurements:</strong> Education, decrease in BMI, and decrease in obesity related co-morbidities.</td>
<td></td>
</tr>
</tbody>
</table>
In addition to the above programs, LGH created and disbursed materials to encourage physical activity and healthy eating on an individual and family level, such as:

1. **Lancaster on the Move**: Partnership with the Lancaster County Park and Recreation Commission provides a guide to free and low-cost places to be physically active in Lancaster County.

2. **Lancaster City on the Move Directory to Physical Activity Resources**: A smaller guide to free and low-cost physical activity opportunities within Lancaster City.

3. **Healthy Cookbooks**:
   - *The Lighter Side of Lancaster: Traditional Recipes Made Healthier*
   - *Cooking Healthy: Latino Style*
   - *Cocinar Saludable al Estilo Latino*
   - *African American Favorite Traditional Recipes Made Healthy, Tasty and Easy*
INTERPERSONAL

1. **Weight Management Program for Children and Teens (ShapeDown)**
   This is a family-based program for overweight and obese children and adolescents (ages 7-17) that was initially developed by the University of California. It targets overweight, nutrition and activity in both child and parent/guardians. A team of health experts teach the entire family how to eat more nutritiously and make exercise a fun part of the daily routine. Classes take place in a group setting.

<table>
<thead>
<tr>
<th>Service &amp; Target</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PTD</td>
</tr>
<tr>
<td>Weight Management Program for Children and Teens (ShapeDown)</td>
<td></td>
</tr>
<tr>
<td><strong>Targeted population:</strong> Overweight and obese children aged 7-17 and their families</td>
<td></td>
</tr>
<tr>
<td>Total child participants</td>
<td>324</td>
</tr>
<tr>
<td><strong>Outcomes:</strong> Positive behavior change</td>
<td></td>
</tr>
<tr>
<td>Exercise</td>
<td>165 (92%)</td>
</tr>
<tr>
<td>Healthy Food Choices</td>
<td>164 (91%)</td>
</tr>
<tr>
<td>Portion Control</td>
<td>155 (86%)</td>
</tr>
<tr>
<td>Emotional Overeating</td>
<td>148 (82%)</td>
</tr>
<tr>
<td>Decrease in BMI</td>
<td>139</td>
</tr>
</tbody>
</table>
2. Adult Weight Management Support Group (Healthy Changes Healthy You Maintenance)
This support group meets monthly with a Registered Dietitian to continue learning and receiving interpersonal support to help maintain weight loss. Prior to this new program, the wellness center ran L.E.A.R.N. maintenance.

<table>
<thead>
<tr>
<th>Service &amp; Target</th>
<th>Outcomes</th>
<th>PTD</th>
<th>FY12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Weight Management Support Group (Healthy Changes, Healthy You Maintenance)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Targeted population:</strong> Adult weight management program graduates</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total number of different individuals who attended a class</strong></td>
<td></td>
<td>63</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Outcomes:</strong> Education and awareness (Data beginning 3/12)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. **Weight Management Program for Obese Pregnant Women (New Beginnings):** This program for obese pregnant women was developed based on guidelines from the American College of Obstetricians and Gynecologists (ACOG), which recommends that obese pregnant women gain no more than 15 lbs during pregnancy. The focus of the program is to serve as an intervention to promote a healthier lifestyle and decrease the risk of gestational diabetes for overweight mothers and children in the community. Using a team of nurses and dietitians, it also educates on the benefits of breastfeeding and how to encourage healthy weight in infants and toddlers.

<table>
<thead>
<tr>
<th>Service &amp; Target</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Weight Management Program for Obese Pregnant Women (New Beginnings)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Targeted population:</strong> Obese pregnant women</td>
<td>63 plus 7 pending</td>
</tr>
<tr>
<td><strong>Outcomes:</strong> Education, weight gain of &lt;15lb and initiation of breastfeeding</td>
<td>26</td>
</tr>
</tbody>
</table>

4. **Healthy Beginnings Plus:** A multi-disciplinary program for pregnant women that provides childbirth, exercise, nutrition and breastfeeding classes using a staff of nurses, dietitians and social workers from prenatal stages until the infant is eight weeks of age.

<table>
<thead>
<tr>
<th>Service &amp; Target</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Healthy Beginnings Plus</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Targeted population:</strong> Low-income, pregnant women</td>
<td></td>
</tr>
<tr>
<td><strong>Outcomes:</strong> Education, awareness</td>
<td>17,350</td>
</tr>
</tbody>
</table>

| FY12                              |
|-----------------------------------|----------|
| 1,356                             |          |
5. **Nutrition Program for Preschoolers (Color Me Healthy)**

This program targets preschool and daycare workers to integrate curriculum on healthy eating and activity in the classroom. The entire program includes educational programs for schools, including use of the new Department of Education Nutrition Curriculum, informational seminars on healthy eating and physical activity targeted to needs of at-risk populations.

<table>
<thead>
<tr>
<th>Service &amp; Target</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition Program for Preschoolers (Color Me Healthy)</td>
<td>PTD</td>
</tr>
<tr>
<td><strong>Targeted population:</strong> Preschool children, daycare workers, at-risk early childhood populations and community members</td>
<td>60</td>
</tr>
<tr>
<td>Number of individuals educated at a training:</td>
<td></td>
</tr>
<tr>
<td><strong>Outcomes:</strong> Education and awareness (Data beginning 3/12)</td>
<td></td>
</tr>
</tbody>
</table>

**ORGANIZATIONAL**

To address obesity at the practice level, the United States Preventative Services Task Force (USPSTF) recommends screening all patients for BMI and referring patients with an elevated BMI to appropriate intervention services. To encourage providers and nurses to discuss obesity with their patients, LGH is continually training physicians, nurses and staff on techniques surrounding behavior change and weight management such as Motivational Interviewing. Additionally, all new employees receive sensitivity training via CBL on obese patients. The organization has recently launched a **Body Mass Index Pilot Study**. Using the patient database, EPIC, an electronic tool has been designed to trigger a Best Practice Advisory (BPA) for patients with an elevated BMI. Physicians and nurses use sensitive interviewing techniques to discuss the patient’s weight and assist in a referral process to engage clients in an appropriate weight management programs. Patients also have the option of receiving practice-based intervention. The series of counseling sessions has been designed by the wellness team and uses tools such as the 5 A’s of Behavior Change Model and SMART goal-setting, following the Medicare guidelines for reimbursement of obesity care services. A successful pilot study will show an increase in the number of
patients being screened, counseled and referred. The study is currently in its first phase, focusing on adults at one practice site. Phase two of the study will integrate tools and training on addressing obesity in children. Within the first two weeks of the study, referrals to weight management services have shown a significant increase.

Also taking place on the organizational level is a multitude of LGH employee wellness programs.

1. Employee Wellness Program (MyHealthyLiving)
This wellness program is offered to all LGH employees and their spouses. It encourages healthy actions toward behavior change in five key areas of health. LG Health employees are offered a Health Risk Assessment (HRA) and biometric screenings. In addition to a healthcare benefits incentive, participants are given access to 24-hour WebMD health coaching that helps set goals for achieving weight loss.

<table>
<thead>
<tr>
<th>Service &amp; Target</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PTD</td>
</tr>
<tr>
<td><strong>Employee Wellness Program (MyHealthyLiving)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Targeted population:</strong> All LGH employees, spouses and domestic partners</td>
<td></td>
</tr>
<tr>
<td>HRA Completions</td>
<td></td>
</tr>
<tr>
<td><strong>Outcomes:</strong> Awareness, participation in wellness programs and positive behavior change</td>
<td>65%</td>
</tr>
</tbody>
</table>
2. Healthy Hospital Food Initiative (Eat Well for Life)
The food options made available to employees and clients can greatly impact their diet and long-term health. The Eat Well for Life program aims to improve the quality of the food options available to all individuals and provides nutritional information for all food served. The colored flags below indicate the health of an item as defined by our dietitian guidelines.

<table>
<thead>
<tr>
<th>Service &amp; Target</th>
<th>Outcomes</th>
<th>PTD</th>
<th>FY12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Hospital Food Initiative (Eat Well for Life)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Targeted population: Customers, patients, employees and community members</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Red flagged food</td>
<td></td>
<td>38.5%</td>
<td>40%</td>
</tr>
<tr>
<td>Yellow flagged food</td>
<td></td>
<td>31%</td>
<td>27%</td>
</tr>
<tr>
<td>Green flagged food</td>
<td></td>
<td>30.5%</td>
<td>33%</td>
</tr>
<tr>
<td>Outcomes: Awareness</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Baby Friendly Hospital Initiative: This initiative focuses on the promotion and accommodation of breastfeeding by improving hospital practices in maternity care to supporting breastfeeding.

As the obesity epidemic is threatening the health and success of countless Americans, it is unsurprising that overweight and obese trends in women can yield a harmful impact for pregnancy and expectant child development. Aside from maintaining a healthy eating regimen and moderate levels of activity, a recent study in BMC Public Health indicates that breastfeeding is protective of obesity and overweight in early childhood development. Expectant mothers are encouraged to breastfeed their children, as children who are breastfed for 6+ months are 36% less likely to be overweight and 49% less likely to become obese compared to children who are not breastfed. Additionally, there is an inverse relationship between duration of breastfeeding and risk of obesity, such that for each
month a mother breastfeeds her child [up to 9 months], the odds of obesity and overweight for that child decreases by 4%\textsuperscript{167}. Ultimately, the long-term impact observed on children who are breastfed as infants indicates that these infants had a lower weight gain in the first year of life, and therefore a lower overweight risk at 7 years of age. Thus, the effect of weight gain in infancy may allow a child to remain on a favorable BMI track for life. Aside from its influence on weight, breastfeeding provides ideal nutrition for infants, giving the infant a perfect mixture of vitamins, protein, and fat. Moreover, breast milk contains antibodies, which are vital for allowing the infant to fight off viruses and bacteria. Whether breastfed or not, it is vital for parents to teach healthy lifestyle habits to their children during development and adolescence; however, breastfeeding during infancy can serve as a preliminary, strongly influential factor in catapulting children on the track for healthy living throughout their lives.

“Mothers who give birth at Baby-Friendly hospitals and birthing centers are more likely to initiate exclusive breastfeeding and more likely to sustain breastfeeding at six months and one year of age, perhaps because of the institutional support for breastfeeding at these facilities. Adherence to the Ten Steps to Successful Breastfeeding, is associated with increased rates of breastfeeding around the world. In the United States, new mothers exposed to at least six of the Ten Steps were 13 times more likely to continue breastfeeding at 6 weeks postpartum when compared to mothers who had not been exposed to any of the Ten Steps during their birthing hospitalization. Additionally, adherence to the Ten Steps decreases racial, ethnic, and socio-cultural disparities in breastfeeding rates in U.S. hospitals.\textsuperscript{168}"

“Because the process of attaining Baby-Friendly designation compels facilities to examine, challenge and modify longstanding policies and procedures, the process also strengthens the organization by enhancing leadership skills, increasing staff competence, and improving patient satisfaction. Although the hospital is not, and should not be, the only place a mother receives support for breastfeeding, hospitals provide a unique and critical link between the breastfeeding support provided prior to and after delivery.\textsuperscript{169}"

In order to establish and promote a philosophy on breastfeeding that is congruent with the recommendations and breastfeeding policy statements published by the American
Academy of Pediatrics (AAP), American College of Obstetricians and Gynecologists (ACOG), and American Academy of Family Physicians (AAFP), Association of Women’s Health, Obstetrics, and Neonatal Nurses (AWHONN) Women’s and Babies Hospital is working towards a designation for a Baby Friendly Hospital Initiative with a goal of obtaining designation by June 30, 2013. This initiative and change in policy will work to advance the health and well being of the communities we serve.

Women’s and Babies will uphold the WHO International Code of Marketing of Breast milk substitutes by offering education and materials that promote human milk rather than other infant food or drinks. Additionally, we will refuse to accept or distribute free or subsidized supplies of breast milk substitutes, nipples, pacifiers, other feeding devices, free gifts, non scientific literature, materials, equipment, money or support for breastfeeding education or events from manufactures of breastmilk substitutes, bottles, nipples and pacifiers. Within this initiative no pregnant women, mothers, or families are given marketing materials or samples or gift packs by the facility that consist of breastmilk substitutes, bottles, nipples, pacifiers, or other infant feeding equipment or coupons for the above items.

The policies and procedures of the hospital will change to reflect these new standards. The hospital will measure success based on their current initiated and engagement breastfeeding rates.

<table>
<thead>
<tr>
<th>Service &amp; Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Baby Friendly Hospital Initiative</strong></td>
</tr>
<tr>
<td><strong>Targeted population:</strong> Customers, patients, employees and community members</td>
</tr>
<tr>
<td><strong>Outcomes:</strong> Education and behavior change</td>
</tr>
</tbody>
</table>
3. Physical Activity Programs (Walking Trails, Clubs and Maps)
Maps have been developed with detailed distance information to promote physical activity among employees throughout LGH sites. Maps utilize specially designed walking trails and are available electronically for use.

<table>
<thead>
<tr>
<th>Service &amp; Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Activity Programs (Walking Trails, Clubs and Maps)</td>
</tr>
<tr>
<td><strong>Targeted population:</strong> Employees and community members</td>
</tr>
<tr>
<td><strong>Outcomes:</strong> Positive behavior change</td>
</tr>
</tbody>
</table>

**COMMUNITY**

1. The Lighten Up Lancaster County Coalition
To take action against obesity in Lancaster County, LG Health convened a community coalition called the LULC. We recognized that one organization is not able to fight this epidemic alone. LULC was established in 2007 with the overall goal of increasing the percentage of adults and children who are at a healthy weight in Lancaster County. LULC has launched a number of different countywide programs and initiatives and serves as a support for community organizations and events that promote the coalition’s mission. The operational plan (see addendum S) explains targeted populations and outcomes. LULC has formed the following action teams to address different sectors of the county:

- School and Community
- Workplace
- Policy

a. **Social Media Marketing and Outreach:** In keeping with the societal changes around media and information gathering an integrative and resourceful website and newsletter have been developed for healthy weight advocacy, education and advertising. LULC also holds active Facebook, Twitter and LinkedIn accounts for community interaction.
b. **Incentive Wellness Programs (Workplace Award and Apple Award):** LULC’s self-developed competition serves as a tool for formally recognizing and rewarding workplaces or schools that excel in wellness areas.

c. **Access to Fresh Produce:** LULC and LG Health are responsible for the implementation of programs to increase access to fresh and healthy produce for at-risk populations including a mobile produce market for the Spanish American Civic Association (SACA) and the establishment of school and community gardens, particularly within Lancaster City. This coalition worked with City Council to pass an ordinance making it possible for produce vendors to sell their products on public property. Also, Community Supported Agriculture (CSA) programs in which farmers sell shares of their seasonal harvest are being developed for multiple institutions across the county. LULC is currently working on the development of a CSA program to assist workplaces with connecting their employees to fresh produce. Finally, LULC and LiveWell Lancaster are working to implement Farm-to-School programs within Lancaster County public schools. The results of these efforts will show increased consumption of fruits and vegetables for individuals living in Lancaster.

d. **Coalition for a Bicycle Friendly Lancaster:** Coalition members recently started a Coalition for a Bicycle Friendly Lancaster (CBFL). LULC and the CBFL are advising and working closely with city officials to improve the bikeability of Lancaster City. In April, Lancaster City Council passed a resolution that would provide that a city employee complete the League of American Bicyclists’ Bicycle Friendly Community Application, thus establishing a baseline of the current state of biking in Lancaster City. The city was recently given an honorable mention recognition and valuable technical assistance from the League to further this initiative. LG Health also completed the Bicycle Friendly Business Application and was recognized with an honorable mention, thus recognizing ways in which LG Health encourages employees and clients to use active transportation. This coalition, with the support
of Dream Ride Projects and the Lancaster League of American Bicyclists, continues to encourage bicycling throughout the city. Outcomes of this initiative will include increased physical activity among adults and an increase in access to healthy food and recreational spaces.

e. **Community Education Sessions**: LULC, with the support of LG Health staff, facilitates nutrition education sessions at churches, such as San Juan Bautista Catholic Church, to promote healthy eating and stress the importance of fruit and vegetable consumption. These sessions help to increase awareness in the community, and specifically target at-risk, Latino, or low-income populations.

f. **Incentive Programs (Maintain Your Weight)**: Together with Lighten Up Lancaster, this program is offered to employees from Thanksgiving to the first week of January, providing practical, healthy recipes, tips for de-stressing and staying physically active throughout the holiday season.

g. **Collaboration with Community Partners**: LULC partners with a variety of community organizations and businesses to provide specific programs that aid in addressing obesity in Lancaster County. The coalition emphasizes the importance of working together and helping each other to remove barriers and provide additional support. These partners include:

- The American Heart Association
- The American Cancer Society
- Local school districts
- Lancaster City Recreation Center and County Recreation Centers
- YWCA of Lancaster
- Women, Infant, and Children (WIC)
- Power Packs
- State Representative’s offices
- Lancaster League of American Bicyclists
- Lancaster County Business Group on Health
- Lancaster County Solid Waste Management Authority (LCSWMA)
- Engle Publishing
- Susquehanna Bank
- Friendship Community
• Hands on House
• Girls on the Run
• Local legislators
• Local businesses

2. Corporate Wellness

Our corporate health team provides comprehensive wellness programming to many clients across the county. Provided in these services are biometric screenings, health screenings, and educational sessions. Best practices recommend comprehensive wellness programs as a way to keep employee populations maintaining a healthy weight, therefore decreasing the overall healthcare costs of an organization.

3. Save-A-Lot

LG Health plans to assess the feasibility of partnering with a Save-A-Lot grocery store in Lancaster city. LG Health recognizes that in order to change the eating habits of the community and thereby change the health of the individuals we serve, people must have equitable access to these nutritious foods and educational opportunities.

POLICY

LGH is a regular participant in advisory health councils throughout the community to assist in planning and implementing the necessary policies related to obesity where we live, work, learn and play. This approach requires LG Health and its partners to be actively involved in community organizational, educational, and recreational facilities as advisors and leaders on making healthy policy changes that will impact the prevalence of obesity. As we facilitate the work of LULC and LiveWell Lancaster, LG Health holds representation on 12/16 school wellness councils in the county to advise and encourage healthy practices within the public school system. On the public level, LG Health and its partners strive to implement policy, systems, and environmental changes related to healthy weight management as recommended by the CDC best practices.

Changes in the built environment, system operations and legislation are expected to result in more individuals that adopt healthy habits because everyday choices that affect our
weight will become the social norm in addition to being convenient and affordable for all. LG Health also believes that disparities in obesity are best addressed through population-wide impacts because they influence outcomes across all sectors of the environment. Lighten Up Lancaster has organized efforts around advocacy for active living communities and the increase of healthy food access within our municipalities, townships, and boroughs and serves as a resource for healthy program and policy initiatives. Initiatives that display these efforts include:

1. **LiveWELL Lancaster County: **LiveWELL Lancaster County works with LULC to identify policies which can be modified or introduced in schools, businesses, and the community at large that impact nutrition and activity. Currently, LULC has partnered with LiveWell Lancaster County, to review the county-wide policy scan for over 60 municipalities, townships and boroughs in order to measure the current number of wellness policies in Lancaster County. Strategic initiatives are in place to increase the number of policies related to healthy weight management in coming years.

2. **The Coalition for a Bicycle Friendly Lancaster: **As noted previously, this coalition (created by the Lighten Up Lancaster Coalition) advocates for changes in the built environment that encourage the use of bicycles and other methods of active transportation by increasing safety and awareness of motorist. The developments of bike lanes, sharrows, sidewalks, etc. are the expected result of this coalition’s efforts in addition to local legislation to ensure the safety of bicyclists/pedestrians

3. **Healthy Vending: **Convenient access to healthy food and beverages is vital to maintaining a healthy weight. LiveWell Lancaster has developed a toolkit to teach businesses and organizations how to switch their vending machines to include all healthy and nutritious items. Success in this initiative will be measured by the increase in number of entities that adopt healthy vending policies.

4. **Farm-to-Institution: **Within the heartland of Lancaster County, there are many partners who are interested in convening local farmers and food purveyors around the topic of
purchasing local fresh fruits and vegetables. LG Health and LiveWell Lancaster have initiated a working task force on assessing the feasibility of future farm-to-institution programs. With the assistance of the CDC technical assistance team, this task force will be armed with resources that have been implemented at a national level to increase the utilization of local food items in our workplaces and schools.

Strategies & Goals

LG Health’s strategic approach to Healthy Weight Management is planned using national, state and local data and engages community stakeholders to utilize evidenced-based best practices around policy, systems, and environmental changes. This is demonstrated by the convened community coalition, LULC.

Decisions related to community health improvement are prioritized so that the greatest needs are addressed and impact is tracked. Our work is organized out of our overall mission of LULC to increase the number of adults and children maintaining a healthy weight in Lancaster County. This mission is accomplished by our goals to increase the number of individuals who are physically active and making healthy food choices. We accomplish these goal by targeting our interventions within our sectors of where we live, work, and play (schools, communities and workplaces). Our strategic initiatives within each sector are designed to increase awareness, educate individuals, promote behavior change, and implement policy change to make the healthy choice the easy choice.

Additional ways to measure our progress beyond the national and state data mentioned below is the LiveWELL Lancaster County policy scan and scorecard. The recent CDC policy scan (see addendum T) was designed to provide a baseline assessment of the current level of policies in each sector. The community health scorecard (see addendum U) is an internally developed document to track and measure outcomes and impressions for all internal and external healthy weight management initiatives.
### Broad Community Goals

<table>
<thead>
<tr>
<th>Goal</th>
<th>Indicator</th>
<th>Target</th>
<th>2012</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase the percent of adults who report no leisure time physical</td>
<td>Percent of adults who report no leisure time physical activity in the past month**</td>
<td>32.6%**</td>
<td>21%</td>
<td>16%</td>
</tr>
<tr>
<td>activity in the past month</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase the percent of adults who eat more fruits and vegetables</td>
<td>Percent of adults who eat greater than 5 fruits and vegetables per day*</td>
<td>57.5%*</td>
<td>29%</td>
<td>30%</td>
</tr>
<tr>
<td>Increase the percent of adults at a healthy weight</td>
<td>Percent of adults who are obese</td>
<td>30.6%</td>
<td>28%</td>
<td>27%</td>
</tr>
<tr>
<td>Increase the percent of children classified as healthy weight</td>
<td>Percent of children who are obese</td>
<td>15.7%</td>
<td>15.1%</td>
<td>14%</td>
</tr>
<tr>
<td>Increase the percent of patients who initiate breastfeeding</td>
<td>Percent of mothers who initiate breastfeeding</td>
<td>81.9% (2010)</td>
<td>82.6%</td>
<td>Maintain or Increase</td>
</tr>
<tr>
<td>Increase the percent of patients who deliver &gt;37 weeks</td>
<td>Percent of HBP mothers who deliver &gt;37 weeks</td>
<td>95%</td>
<td>94%</td>
<td>95%</td>
</tr>
</tbody>
</table>

*Target based on Healthy People 2020  
**Target based on Healthy People 2010

### LG HWM Scorecard

<table>
<thead>
<tr>
<th>Score Card</th>
<th>FY 13 Goal</th>
<th>FY 14 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Healthy Weight Management impressions per quarter (thousand)</td>
<td>700</td>
<td>750</td>
</tr>
<tr>
<td>% of LGHP patients screened for BMI</td>
<td>85</td>
<td>90</td>
</tr>
</tbody>
</table>
Goals

LGH Goals

The goals presented in the chart below provide the measurable indicators needed to show progress in the reduction of obesity. These goals require collaboration among many community members and organizations by means of our county-wide coalition, Lighten Up Lancaster. Goals selected follow the SMART goal model by being specific, measurable, attainable, realistic and timely. As we continue to closely follow the CDC research and best practices we will evaluate how to effectively continue the work on these goals. We will continually need to assess and reassess what policies, systems and environmental changes should be the target for 2015-2016. The following chart summarizes the baseline data and goals for Lancaster County.

<table>
<thead>
<tr>
<th>Goal</th>
<th>Indicator</th>
<th>FY12</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase awareness raising campaign of obesity epidemic</td>
<td>Number of impressions via Facebook, Twitter, Linked In, LULC website hits, newsletters sent and blog followers</td>
<td>700,000</td>
<td>750,000</td>
<td>775,000</td>
<td>800,000</td>
</tr>
<tr>
<td>Increase the number of healthy weight program participants</td>
<td>Number of clients who have completed a Healthy Changes, Healthy You class, Shopping Tour, Shapedown</td>
<td>191</td>
<td>250</td>
<td>300</td>
<td>350</td>
</tr>
<tr>
<td>Increase the percentage of clients screened for BMI at LGHP practices</td>
<td>Percent of clients who are screened with recent height and weight at each visit</td>
<td>n/a</td>
<td>90</td>
<td>92</td>
<td>94</td>
</tr>
<tr>
<td>Increase the proportion of health care providers who routinely counsel and refer for healthy weight management services</td>
<td>Number of referrals to wellness services</td>
<td>64</td>
<td>250</td>
<td>350</td>
<td>450</td>
</tr>
<tr>
<td>Goal</td>
<td>Indicator</td>
<td>FY12</td>
<td>2014</td>
<td>2015</td>
<td>2016</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>Increase the number of school districts educated on best practices</td>
<td>Number of school districts that attend trainings on best practices and school</td>
<td>10</td>
<td>14</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>of wellness councils</td>
<td>wellness policy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase the proportion of school gardens</td>
<td>Number of school buildings that have gardens</td>
<td>24</td>
<td>28</td>
<td>32</td>
<td>40</td>
</tr>
<tr>
<td>Increase the number of workplaces that complete the Well Work Place</td>
<td>Number of workplaces that complete the Well Work Place award</td>
<td>26</td>
<td>50</td>
<td>60</td>
<td>70</td>
</tr>
<tr>
<td>Award</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase the number of employees and community members who have</td>
<td>Percent of businesses that have farmer to institution policies and practices</td>
<td>n/a</td>
<td>60</td>
<td>150</td>
<td>200</td>
</tr>
<tr>
<td>access to fresh fruits and vegetables at worksite</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase the number of workplaces that utilize healthy policies and</td>
<td>Percent of businesses that have 50% healthy options in vending machines</td>
<td>27%</td>
<td>30%</td>
<td>40%</td>
<td>50%</td>
</tr>
<tr>
<td>practices</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase the number of sites that have completed the Bicycle</td>
<td>Percent of townships, municipalities, boroughs, workplaces and Universities</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>Friendly Community Program</td>
<td>that have received recognition from the National League of Bicyclists</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal</td>
<td>Indicator</td>
<td>FY12</td>
<td>2014</td>
<td>2015</td>
<td>2016</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>Increase the number of emergency food providers that are educated about healthy food practices for people receiving the emergency food</td>
<td>Number of food banks, community meals and other emergency food provider sites that are trained in healthy food practices and policy</td>
<td>0</td>
<td>5</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Increase the percentage of women that initiate breastfeeding at WBH</td>
<td>Birth records on feeding maintained by the Breastfeeding Support Center.</td>
<td>92%</td>
<td>93%</td>
<td>94%</td>
<td>95%</td>
</tr>
<tr>
<td>Increase the percentage of HBP patients with a BMI ≥ 30 who gain ≤ 20 pounds</td>
<td>Measurements obtained in EMR for HBP patients.</td>
<td>33%</td>
<td>35%</td>
<td>37%</td>
<td>39%</td>
</tr>
<tr>
<td>Obtain and maintain Baby Friendly Hospital Designation.</td>
<td>Designation by Baby-Friendly USA.</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

**Recommendations**

Because of the rapid growth in numbers of overweight and obese individuals, obesity has been formally recognized as a health epidemic by the international experts in disease, the Centers for Disease Control (CDC). It is difficult to define the best practices for fighting obesity because it is a large-scale, population health issue and the behavioral nature of the disease is problematic for measuring outcomes. Rather than recommending evidence-based practices, health leaders such as the CDC and the Institute of Medicine (IOM) recommend multi-sector, comprehensive strategies for addressing obesity, such as:

- Restricting availability of unhealthy food and increasing availability of healthy food and beverage choices in public venues.170,171
• Improving community-based mechanisms for purchasing food from farms\textsuperscript{172}.
• Increased support for breastfeeding within communities\textsuperscript{173}.
• Enhancing support for walking and bicycling through infrastructure and policy\textsuperscript{174,175,176}.
• Participation “in community coalitions or partnerships to address obesity”\textsuperscript{177,178}.
• Outreach to obese pregnant mothers\textsuperscript{179}.

Aside from the above community strategies, organizations, clinicians and local governments are recommended to:

• Encourage all patients to prevent/avoid weight gain and also advise a 5-10% reduction in overweight patients to significantly improve health\textsuperscript{180,181}.
• Develop cost-effective prevention, health education and counseling programs targeting obesity for the individual and community-based settings\textsuperscript{182,183}.
• Implement policies that promote healthy choices and active lifestyles\textsuperscript{184,185}.
• Fund preventative programming/infrastructure to make physical activity and healthy eating the convenient and routine choice\textsuperscript{186}.

LG Health is measuring the progress made within the organization and out in the community using a number of tools. We recognize that as a healthcare leader in our community, health and obesity prevention must be a community benefit priority. The CDC recognized our efforts and as of September 2011 awarded us the Community Transformation Grant, a community five year grant that will work to increase physical activity, healthy eating, decrease tobacco use and work to link our community to preventative health services. This program, now titled LiveWell Lancaster, in partnership with established community coalitions has worked to survey each municipality in the county about their current local policies related to food, physical activity, etc. Through the year 2016, we will be evaluating the increase in obesity-related policy changes throughout the county. In addition, the organization uses the CDC’s Behavioral Risk Factor Surveillance System (BRFSS) to conduct its Community Health Needs Assessment every two years. More detailed outcomes will be discussed with their respective program descriptions.

Resources

Resources required for the implementation of our strategic approach as per the operational plan require funding and technical assistance. LG Health has devoted staff and budget (as
noted below) to implement these health priority initiatives. LiveWell Lancaster has and will continue to provide technical assistance to support Lighten Up Lancaster and other initiatives as needed. In addition to dollars allocated for these initiatives by LG Health, the community health and wellness center staff research grant opportunities for LGH obesity initiatives.

A Healthy Weight Management Coordinator within the Department of Community Health and Wellness is responsible for overseeing both internal and external healthy weight management initiatives as well as collaborating with health system partners within the health system such as our Bariatric and Cardiovascular service lines and the pilot primary care practice manager and physicians to organize initiatives around the obesity priority.

**Barriers & Risks**

The risks for implementing obesity prevention and intervention projects as described within are minimal. All initiatives are developed for the benefit of the community and designed to increase healthy behaviors. However, there are several barriers that may impede the success of our initiatives including community buy-in, patient buy-in, and overall participant compliance with weight loss program goals.

**Conclusion**

The causes and effects of obesity are numerous and complex. It is critical to the success of our organization in addressing the need for obesity prevention and intervention to understand the factors that contribute to this health condition and the projected consequences if this need goes unmet. As a leader in healthcare, it is our responsibility and purpose to increase awareness and knowledge of these consequences and to encourage and empower individual toward positive behavior changes that will decrease their risk for obesity and its associated health risks.

In addition to the continual development and implementation of best practice objectives at all levels of the socioecological model, LG Health is committed to continual acts of
community benefit to increase awareness and create policy, systems, and environmental changes to decrease obesity trends. Together with a variety of internal and external partners, LGH has unique access to all groups within the community including disparate and high-risk populations, to address healthy weight management.
Health Priority:
Reduce Tobacco Use
B. Tobacco

Framing the Issue

LG Health began working with community partners to address tobacco use in Lancaster County in 2000. Since that time, many strategies have been developed with much success locally and nationally. The strategies in this plan reflect the advancement of initiatives and the years of partnership addressing this issue.

According to Healthy People 2020, tobacco use is the single most preventable cause of disease, disability, and death in the United States, and more deaths are caused each year by tobacco use than by all deaths from human immunodeficiency virus (HIV), illegal drug use, alcohol use, motor vehicle injuries, suicides, and murders combined. In 2009, an estimated 20.6% of all American adults age 18 and older—46.6 million people—smoked, and every day another 850 young people age 12 to 17 began smoking on a daily basis.

As a result of widespread tobacco use, approximately 443,000 Americans die from tobacco-related illnesses, such as cancer and heart disease, each year. An estimated 49,000 of these deaths are the result of secondhand smoke exposure. For every person who dies from tobacco use, another 20 suffer from at least one serious tobacco-related illness. For women and men alike, tobacco use poses a heavy burden on the U.S. economy and medical care system. Each year, cigarette smoking costs more than $193 billion in medical care costs, while secondhand smoke costs an additional $10 million. Tobacco use is thus one of the Nation’s deadliest and most costly public health challenges. Figure 30 illustrates the number of deaths from multiple chronic illnesses that are linked directly to cigarette smoking.
Figure 30. The number of deaths from multiple chronic illnesses that are linked directly to cigarette smoking.

Decisions related to community health improvement are made strategically to address the greatest needs of the community. Health indicators and program outreach are tracked to identify impact. The death and disability resulting from tobacco use continue to keep tobacco control a top health priority for LG Health.

Why Tobacco is a key priority
In Lancaster County, the percentage of current adult smokers is decreasing from 24% in 2001 to 13% in 2010 (see figure 31), but education and cessation services need to continue to bring rates in line with the Healthy People 2020 target.
Figure 31. Percent of adult smokers\textsuperscript{190}.

Although cigarette use among youth is decreasing (see addendum V for youth tobacco trends), it continues to be a national problem. According to draft guidelines issued by the US Preventive Services Task Force (USPSTF), health care providers are being urged to intervene and educate youth to prevent teen smoking\textsuperscript{191}. 
Figure 32. Percent of females who smoke. Note: Percentages are of the total female population in Lancaster County, Pennsylvania, and the United States. Lancaster County and Pennsylvania percentages represent the mean and United States percentages represent the median.

Figure 33. Percent of males who smoke. Note: Percentages are of the total male population in Lancaster County, Pennsylvania, and the United States. Lancaster County and Pennsylvania percentages represent the mean and United States percentages represent the median.
**Figure 34.** 30 day use of cigarettes, 12th grade\(^{104}\).

**Figure 35.** 30 day use of cigarettes, 10th grade\(^{105}\).
30 day use of cigarettes, 8th grade

![Graph showing percent (%) of 30 day use of cigarettes for 8th grade from 2003 to 2011 for Lancaster, PA, and US.]

Figure 36. 30 day use of cigarettes, 8th grade.\textsuperscript{190}

Emerging tobacco products such as candy flavored cigarillo’s, hookahs and snus, along with e-cigarettes containing nicotine, coupled with advertising strategies targeting youth are of particular concern. To achieve continued success in preventing the initiation and use of tobacco products among adolescents, we need to continue strategic evidence-based school prevention programs, close the loophole on tobacco taxes, and monitor enforcement of convenience stores.

Targeted Populations/Disparities Overview

Mental Health

People with mental illness smoke at rates almost twice as high as the general population (41 percent versus 22.5 percent, respectively). Nearly half the cigarettes smoked in the United States (44-46 percent) are consumed by people with co-occurring psychiatric or addictive disorders. The smoking prevalence rates are even
higher (60-80 percent) for those who are diagnosed with depression, bipolar disorder, or schizophrenia. Sixty percent of people with lifetime depression are either current or former smokers; as many as 70% of people with bipolar disorder smoke; and up to 88% of people with schizophrenia are current smokers. See figure 37. The effects of this rampant tobacco use are staggering. Individuals with serious mental illness carry a disproportionate level of tobacco-related morbidity and mortality and, on average, are dying 25 years prematurely with the chief causes being chronic, tobacco-related diseases.197.

![Figure 37. Smoking Prevalence among Adults by Lifetime Mental Illness](image)

Lesbian, Gay, Bisexual, Transgender (LGBT)

LGBT are 40-70% more likely to smoke than non-LGBT, which is one of the highest smoking rates even of all the disproportionately affected subpopulations. LGBT adolescents are taking up smoking at an alarming rate, in a recent national study 45% of females and 35% of males reporting same-sex attraction or behavior smoked. In comparison, only 29% of the rest of the youth smoked. American Cancer Society estimates that over 30,000 LGBT people die each year of tobacco related diseases. Several factors such as higher levels of social stress and direct targeting of LGBT consumers by the tobacco industry may be related to higher prevalence rates of tobacco use among some LGBT people199.
Pregnant Women

Women who smoke during pregnancy put themselves and their unborn babies at risk for other health problems. The dangers of smoking during pregnancy include premature birth (being born too early), certain birth defects, and infant death. Smoking can also cause problems with the placenta—the source of the baby’s food and oxygen during pregnancy. According to the 2008 Pregnancy Risk Assessment and Monitoring System (PRAMS) data from 29 states—approximately 13% of women reported smoking during the last three months of pregnancy. Of women who smoked three months before pregnancy, 45% quit during pregnancy. Among women who quit smoking during pregnancy, 50% relapsed within six months after delivery.200

In 2005, 16.6% of female teens age 15-19 have smoked during pregnancy and 18.6% of women aged 20-24 have smoked during pregnancy.201 Neonatal health-care costs attributable to maternal smoking has been estimated at $366 million per year. Smoking can be very harmful to the baby, accounting for 20% to 30% of low-birth weight, 14% of preterm deliveries and about 10% of all infant deaths.202 The odds of a child developing asthma are twice as high among children whose mothers smoke more than ten cigarettes a day.203

Smoking makes it harder for women to get pregnant. If a woman becomes pregnant and continues to smoked during pregnancy, she puts herself and her child at risk for additional health problems related to cigarette smoke. Women who smoke during pregnancy are more likely to have a miscarriage and babies are more likely to be born prematurely or at a low birth weight.204 Women who smoke during pregnancy are more likely to have an ectopic pregnancy, bleeding, placental issues, and even stillbirths.205 Smoking can lead to an increased risk of Sudden Infant Death Syndrome (SIDS) and babies are more likely to have birth defects, such as a cleft lip or palate.206
Women & Babies Hospital

The Healthy Beginnings Plus and Nurse Family Partnership team encourages moms who smoke to consider quitting or decreasing their use of tobacco products. Goals are set and reviewed at every visit with all providers including midwife/physician, nurse and social worker. Incentives are set up at the start of the goal and are given as the client meets her goals. WBH utilize the department of health smoking cessation 5 A’s: ask, advise, assess, assist, and arrange. This form is placed on every patients chart and tracked at every visit. WBH stages the readiness for change using Prochaska’s stages of change. Through tobacco cessation efforts with pregnant women, WBH works to decrease the second hand smoke exposure of newborns. 1400 women have been screened.

All HBP and NFP patients are screened for smoking at the intake of their pregnancy and every trimester. We utilize the American Academy of Pediatrics’ 5 A’s assessment. All staff have been trained in motivational interviewing and we utilize incentives to encourage sustained behavioral changes. We have a success rate of 19% of our mothers stop smoking during pregnancy and 45% decrease smoking.

Ethnic, Age, Gender, Socio-economic

According to the CDC Morbidity and Mortality Weekly Report on September 9, 2011, in 2010, an estimated 19.3% (45.3 million) of U.S. adults were current cigarette smokers; of these, 78.2% (35.4 million) smoked every day, and 21.8% (9.9 million) smoked some days. Prevalence was higher among men (21.5%) than women (17.3%). Adults aged 25-44 years (22.0%) and 45–64 years (21.1%) had the highest prevalence among age groups. Among racial/ethnic populations, non-Hispanic American Indians/Alaska Natives had the highest prevalence (31.4%), followed by non-Hispanic whites (21.0%) and non-Hispanic blacks (20.6%). Smoking prevalence generally decreased with increasing education and was higher among adults living below the poverty level (28.9%) than among those at or above the poverty level (18.3%).
Females

According to the American Lung Association and the Centers for Disease Control and Prevention (CDC), cigarette smoking kills an estimated 173,940 women in the United States\textsuperscript{206}. Smoking is directly responsible for 80% of lung cancer deaths in women in the United States each year; women who have smoked are 13 times more likely to die from chronic obstructive pulmonary disease (COPD) than women who have never smoked\textsuperscript{209}.

Perimenopausal Women

Smoking brings on menopause faster-as much as two years earlier in heavier smokers. Women smokers are likely to have hot flashes more frequently and more severely than nonsmokers. At and after menopause, your risks of other conditions rises, and smoking increases the risk even more, including:

- Heart disease
- Stroke
- Breast cancer

Current Initiatives

Tobacco-Free Coalition of Lancaster County

Established in 2000, the Tobacco-Free Coalition of Lancaster County is a group dedicated to decreasing tobacco use, illness, and death related to tobacco use in our community. LG Health, one of the founders of the coalition currently serves as chair for the coalition. The coalition identifies needs and raises county awareness about tobacco issues, organize local volunteers to participate in regional events, engage local business leaders, insurers and legislators, and link residents of Lancaster County to prevention and cessation resources. The mission of the coalition is to prevent young people from using tobacco, provide resources for people to quit their tobacco use, eliminate tobacco-smoke pollution and educate legislators regarding tobacco. The goals of the coalition include:

1. Preventing young people from using tobacco.
2. Providing resources for people to quit using tobacco.
3. Eliminating tobacco smoke pollution.
4. Educating legislators regarding tobacco control issues.

Tobacco-Free Coalition of Lancaster County has launched a number of different countywide programs and initiatives and serves as a support for community organizations and events that promote the coalition’s mission. The operational plan (see addendum W) explains targeted populations and outcomes.

The Tobacco-Free Coalition of Lancaster County includes concerned community members and organizations throughout the county who provide tobacco prevention and cessation programs:

- American Cancer Society
- American Lung Association
- Community Members
- Compass Mark
- Council on Drug and Alcohol Abuse
- Ephrata Community Hospital
- Lancaster General Hospital
- YWCA of Lancaster

**SouthEast Pennsylvania Tobacco Free (SET-Free) Coalition**

LG Health participates in quarterly regional SET-Free meetings, and regional meetings for TDT, Prevention and Behavioral Health TDT meetings. South East PA Control Project (SEPA TCP) aims to network and engage professionals in regional tobacco control.
1. Outpatient Individual and Group Cessation Counseling

Clients attend multi-session programs to develop a personalized quit plan. Free Nicotine Replacement Therapy (NRT) is provided as grant funding allows.

<table>
<thead>
<tr>
<th>Service &amp; Target</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Tobacco Dependence Treatment (TDT)</strong></td>
<td><strong>PTD</strong></td>
</tr>
<tr>
<td><strong>Targeted population:</strong> Adult tobacco users in Lancaster County (Program start date: 2000)</td>
<td>2072</td>
</tr>
</tbody>
</table>

2. Inpatient Tobacco Cessation Counseling

Inpatient tobacco users are met with for brief interventions and education regarding their tobacco use, its impact on their health/medical condition, and to assess readiness to develop a quit plan.

<table>
<thead>
<tr>
<th>Service &amp; Target</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Tobacco Cessation Counseling</strong></td>
<td><strong>PTD</strong></td>
</tr>
<tr>
<td><strong>Targeted population:</strong> Hospitalized Individuals identified as tobacco users (Program start date: 2002)</td>
<td>14,998</td>
</tr>
</tbody>
</table>
INTERPERSONAL

1. Life Skills (school based program)

An evidence-based spiral, prevention curricula which addresses all of the most important factors leading adolescents to use tobacco and one or more drugs. Topics include: self esteem, decision making, advertising, stress, communication skills, social skills, and assertiveness.

<table>
<thead>
<tr>
<th>Service &amp; Target</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PTD</td>
</tr>
<tr>
<td>Life Skills (school based program)</td>
<td></td>
</tr>
<tr>
<td>Targeted population: students in grades 3 - 8</td>
<td>66,038 students</td>
</tr>
<tr>
<td>(Program start date: 2002)</td>
<td></td>
</tr>
</tbody>
</table>

ORGANIZATIONAL

1. Employee Wellness Program Assistance

This wellness program is offered to all LG Health employees and their spouses. It encourages healthy actions toward behavior change in five key areas of health. In addition to a healthcare benefits incentive, participants are given access to 24-hour WebMD health coaching that helps set goals for achieving a tobacco free life.

2. Healthcare Provider Electronic Referral for Tobacco Dependence Treatment

Research has shown that brief clinical interventions by health care providers are effective at increasing quit attempts. LG Health is continually training physicians, nurses and staff on techniques surrounding behavior change and tobacco dependence treatment. Following the clinical practice guidelines of the 5 A’s (Ask, Advise, Assess, Assist, Arrange) staff assess tobacco use at every visit. This information is collected and documented in patients’ electronic health record. Patients are given appropriate education and services based on their readiness. Practice based counseling, referrals and pharmacotherapy provided are
tracked and reported monthly. Referrals for group and individual programs are sent through the electronic health record. Patients are assessed again for services and enrolled in group, individual or telephonic counseling. Currently the project has been rolled out to all LGHP groups and two non LGHP physician groups. A paper fax is in place for non LGHP practices.

<table>
<thead>
<tr>
<th>Service &amp; Target</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PTD</td>
</tr>
<tr>
<td>Health Care Provider Referral</td>
<td></td>
</tr>
<tr>
<td>Targeted population: patients throughout Lancaster County</td>
<td>1229</td>
</tr>
</tbody>
</table>

PUBLIC POLICY

1. Tobacco Free Green Spaces (Young Lungs At Play)

Local municipalities are encouraged to strengthen or adopt a tobacco-free policy for parks and play areas. This public health initiative is promoted by the PA Department of Health, Clean Air Council and the Health Promotion Council.

<table>
<thead>
<tr>
<th>Service &amp; Target</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PTD</td>
</tr>
<tr>
<td>Young Lungs At Play (YLAP)</td>
<td></td>
</tr>
<tr>
<td>Targeted population: local municipalities (n=61)</td>
<td>14</td>
</tr>
</tbody>
</table>
2. Worksite Tobacco Policy

Provide technical assistance to employers in Lancaster County to discuss implementation and/or strengthening tobacco-free worksite policies and hiring practices.

<table>
<thead>
<tr>
<th>Service &amp; Target</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worksite Tobacco Policy</td>
<td>PTD</td>
</tr>
<tr>
<td><strong>Targeted population:</strong> companies located in Lancaster County</td>
<td>2</td>
</tr>
</tbody>
</table>

3. Educational Legislative Visits

Educate legislators on the health and financial benefits of supporting tobacco control including closing the loop hole for taxes on other tobacco products, strengthening Clean Indoor Air Act exemptions and protecting prevention and cessation funding.

<table>
<thead>
<tr>
<th>Service &amp; Target</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational Legislative Visits</td>
<td>PTD</td>
</tr>
<tr>
<td><strong>Targeted population:</strong> Legislators</td>
<td>14</td>
</tr>
</tbody>
</table>
LG Health Tobacco Scorecard

<table>
<thead>
<tr>
<th>Score Card</th>
<th>FY ’13 Goal</th>
<th>FY ’14 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of adults in tobacco dependence treatment services that quit 30 days post intervention.</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td># of participants completing tobacco dependence treatment services per quarter.</td>
<td>336</td>
<td>336</td>
</tr>
<tr>
<td>% of children participating in school based prevention program who showed increase knowledge</td>
<td>80%</td>
<td>80%</td>
</tr>
</tbody>
</table>

Future Strategies/ Initiatives

Goals

The goals presented in the table below provide the measurable indicators needed to show progress in the reduction of tobacco use. These goals require collaboration among many community members and organizations by means of our county-wide coalition, Tobacco Free Lancaster County, and our regional coalition, South East Tobacco Free (SET-FREE). Goals selected mirror those identified in “A Strategic Plan for a Comprehensive tobacco Control Program in Pennsylvania (2012-2017)”, a coordinated effort between the Pennsylvania Department of Health (DOH), key partners and other stakeholders in tobacco prevention and control in Pennsylvania. Targets have been projected through the year 2016 based on the Healthy People 2020 guidelines, the Behavioral Risk Factor Surveillance Survey (BRFSS), the Youth Tobacco Survey (YTS), and policy scans conducted by the Ware Institute at Franklin and Marshall College. The following chart summarizes the baseline data and goals related to tobacco for Lancaster County.
<table>
<thead>
<tr>
<th>Goal</th>
<th>Indicator</th>
<th>FY13</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintain the number of students that have received the LifeSkills program</td>
<td>Number of students that received evidence-based tobacco programming                                                                                                                                       6,200</td>
<td>6,300</td>
<td>6,400</td>
<td>6,500</td>
<td></td>
</tr>
<tr>
<td>Increase the number of clients who have completed a (4 or more outpatient sessions) comprehensive tobacco cessation program</td>
<td>Number of clients who have completed 4 or more tobacco cessation classes or individual counseling sessions                                                                                              214</td>
<td>230</td>
<td>245</td>
<td>260</td>
<td></td>
</tr>
<tr>
<td>Increase the proportion of health care providers who routinely advise patients about cessation services and provide follow-up</td>
<td>Number of referrals for TDT from healthcare providers (total providers = 20)                                                                                                                                  1000</td>
<td>1100</td>
<td>1200</td>
<td>1300</td>
<td></td>
</tr>
<tr>
<td>Increase the number of municipalities that have written policies supporting the Young Lungs at Play initiative (YLAP)</td>
<td>Number of townships, municipalities and boroughs that have adopted a tobacco free park policy (total = 61)                                                                                                   18</td>
<td>28</td>
<td>42</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>Increase the percent of worksites that have comprehensive tobacco policies</td>
<td>Percent of 150 business in Lancaster County with tobacco-free worksite policies                                                                                                                            21%</td>
<td>25%</td>
<td>35%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>Increase cessation resources and services provided to community partners who work with targeted/disparate populations (pregnant women, mental health, LGBT)</td>
<td>Number of trainings with community partners serving targeted/disparate populations                                                                                                                          0</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Increase the percentage of clients who are quit at 30 days</td>
<td>Percent of clients who report being quit at 30 days                                                                                                                                                    38%</td>
<td>39%</td>
<td>40%</td>
<td>41%</td>
<td></td>
</tr>
<tr>
<td>Goal</td>
<td>Indicator</td>
<td>FY13</td>
<td>2014</td>
<td>2015</td>
<td>2016</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>Educate youth on tobacco industry influences and practices</td>
<td>Number of youth who complete trainings on tobacco industry influences and practices</td>
<td>25</td>
<td>35</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Increase the number of media messages promoting tobacco free living</td>
<td>Number of media stories, Facebook likes, media stories and youth-created advocacy/prevention videos</td>
<td>19</td>
<td>50</td>
<td>100</td>
<td>150</td>
</tr>
<tr>
<td>Increase number of families protected by smoke-free multi-unit housing policies</td>
<td>Policy passed by City Housing Authority</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Increase the percentage of HBP patients who quit smoking in pregnancy</td>
<td>Measured by self reporting in the monthly visit report in the EMR</td>
<td>19%</td>
<td>22%</td>
<td>24%</td>
<td>26%</td>
</tr>
</tbody>
</table>

**Logic Models and Socio-Ecological Models**

The following page includes the Logic Model for LG Health’s tobacco use (see figure 38). The logic model is a tool that provides a systematic and visual framework to view the relationships between our resources, our programs and the measurable impact they have on our community. Logic models are reviewed and updated periodically to ensure maximum effectiveness.
Lancaster General
Tobacco Use Logic Model

MISSION:
To increase the percent of tobacco free children and adults in Lancaster County by 2016.

INPUTS
(Resources needed: staff, time, materials, etc.)
- Community Partners
- Equipment and Educational materials (C.O. monitors)
- Evaluators/ statisticians
- Grant Funding
- Health Care Providers
- Marketing/PR Support
- Municipality Officials
- Prevention Educators
- School District Administrators
- School Teachers
- Tobacco Free Coalition of Lancaster Coalition
- Translators
- Technology

OUTPUTS
Activities
- Services/programs provided
- What we do and who we reach

What We Do
- Chair Tobacco Free Coalition of Lancaster County
- Community Awareness Campaign (Great American Smoke Out)
- Individual Tobacco Dependence Treatment
- Inpatient Tobacco Dependence Treatment
- Group Tobacco Dependence Treatment
- Health Care Provider Training (Ask, Advise, Refer)
- Legislative Educational Visits
- Life Skills Classes
- Municipality Education (Young Lunges at Play)
- Work site Technical Assistance
- Regional Coalition Steering Committee

OUTCOMES - IMPACT
(Results/changes of program)
Short Term  Intermediate  Long Term

Knowledge
1. Increase number of individuals who participate in individual and group tobacco dependence treatment.
2. Increase number of professionals who counsel, refer and prescribe medication for nicotine addiction.
3. Increase percentage of clients returning for tobacco prevention and cessation services.
4. Increase the number of policy makers educated regarding dangers of tobacco smoke pollution.

Behavior Change
1. Increase percentage of adults who report no tobacco use.
2. Increase percentage of children who report no use of tobacco products.
3. Increase number of adults and children protected from tobacco smoke pollution.
The Socio-Ecological Model serves as a theoretical framework for tackling reduction of tobacco use on a large scale. This model depicts the various, multi-level strategies while the following section describes the nature for each initiative. As you will see, LGH offers numerous in-house and outreach programs but has also adopted internal programming and policies to make an impact on the organizational level. (See figure 39).

Figure 39. Socio-Ecological Model for LG Health Tobacco Control Initiatives

Conclusion

The costs and consequences of tobacco dependence are numerous and complex. It is critical to the success of our organization in addressing the need for tobacco prevention and cessation to understand the factors that contribute to this addiction and the projected
consequences if this need goes unmet. As a leader in healthcare, it is our responsibility and purpose to increase awareness and knowledge of these consequences and to encourage and empower individuals toward positive behavior changes that will decrease their risk for tobacco-related chronic illnesses and premature death.

In addition to the continual development and implementation of best practice objectives at all levels of the socio-ecological model, LG Health is committed to continual acts of community benefit to increase awareness and create policy, systems and environmental changes to decrease trends of tobacco use. Together with a variety of internal and external partners, LG Health has unique access to all groups within the community including disparate and high-risk populations.
Health Priority: Improve Mental Health
C. Mental Health

Framing the Issue

This is the first year LG Health will set out to strategically develop a plan related to mental health needs in Lancaster County. As with tobacco use and obesity, the first year will be exploratory. We will learn from our partners and the community to locally develop a plan that will have a meaningful impact on mental health in Lancaster County.

Mental illness refers to mental disorders that impact the mood, thinking, or behavior of an individual and is often times associated with distress and impaired functioning, thus interrupting daily life and leading to social impairment. Although in the 1999 Surgeon General’s report Mental Health: A Report of the Surgeon General, Americans were encouraged to address mental health as a public health concern, mental health is often times viewed as an issue separate from public health. Society views public health as the physical health of an individual, ignoring the holistic well-being of an individual. There is evidence to suggest a connection between mental health and chronic disease or injury. Tobacco use is twice as likely in an individual suffering from mental illness and injuries are two to six times higher, than an individual in the general population.

Chronic diseases are also thought to increase the chances that an individual will develop a mental illness, such as depression. Depression is more common among patients suffering from chronic diseases and who have unhealthy lifestyles. The mental health of an individual is also certain to impact the recovery of a patient from illness. Depression affects about one third of all menopausal women and varies in severity.

WBH recognizes the importance of frequent screening for perinatal depression. This is why we have implemented the use of the Edinburgh Postnatal Depression Scale (EPDS) and the PHQ-9 at HNP and NFP. Every patient is screened a minimum of two times, at 28 weeks of pregnancy and again post partum. Of the 1,200 women screened this year, 27% scored high enough to require referral to the PCP and counseling. Over 75% of the women who scored positive during pregnancy received treatment before the baby was born and did not score positive for depression after the birth.
Although mental health indicators related to suicide, poor mental health days, and poor social or emotional support in Lancaster County are not worse than State or National data, it is necessary that LG Health address mental health due to the linkage between chronic disease and mental health. Through addressing mental health, we will address obesity and tobacco use, both key priorities of LG Health.

Costs and Health Consequences

Anxiety and depression, two common mental health illnesses, have the potential to impact an individual’s ability to function as a productive member of society. In 2004, the World Health Organization (WHO) indicated that depression was the third most important cause of diseases burden worldwide<sup>217</sup>. Anxiety disorders (panic disorders, generalized anxiety disorder, phobias) are the most common type of mental health disorder in the general population<sup>218</sup>. Mental health disorders have the ability to prevent individuals from taking part in healthy behaviors and can affect the treatment and recovery of chronic disease<sup>219</sup>. Poor mental health has the potential to impact individuals physically as well as mentally.

According to the CDC, poor mental health leads to more disability in the United States than any other disease<sup>220</sup>. In 2002 the economic burden due to poor mental health was $300 billion<sup>221</sup>. A study estimates that the annual cost of anxiety disorders during the 1990’s in the United States was $42.3 billion<sup>222</sup>.

Why is mental health a priority?

In 2008, a panel from the CDC recommended an increase in the nation’s capacity to address not only physical, but also mental health of individuals and the connection between the two<sup>223</sup>. This task force also found that there is a gap in the care of mental health as a public health issue. The task force determined that there is a lack of understanding in the public health profession of the link between mental health and the other illnesses and chronic diseases that the public health professionals are seeking to address<sup>224</sup>. The task force indicated that it is not only the responsibility of the public health professionals to understand the importance of addressing mental health and how to do so, but it is also the
responsibility of the mental health professionals to understand the impact mental health can have on chronic disease, treatment of such diseases, and persistence of illness\textsuperscript{225}.

Monitoring mental health is important not only because mental health is associated with an increase in chronic disease, but because those who suffer from poor mental health are less likely to adhere to their treatment for illness and seek medical care for illness\textsuperscript{226}.

**Where does Lancaster County Stand?**

Since the 1990s, LGH has been conducting Community Health Needs Assessments. Community health indicators over the past few years have not included many mental health indicators. Utilization data are available; however, data does not exist to understand the extent of need within Lancaster County. Through focusing on mental health and working with community partners, LG Health plans to increase the mental health indicators included in future Community Health Needs Assessments.

Currently, in Lancaster County, 8\% of adults report they rarely or never get the social and emotional support that they need (2008-2010)\textsuperscript{227}. This percentage shows an increase from 6\% in 2007-2009\textsuperscript{228}.

![Adults who rarely or never get the social or emotional support they need](image)

*Figure 40.* Adults in Lancaster County who report they rarely or never get the social and emotional support that they need\textsuperscript{229}. *Note: A HP2020 goal has not been set for this indicator.*
Figure 41. Females who report they rarely or never get the social and emotional support that they need\textsuperscript{30}. Note: Percentages are of the total female population in Lancaster County, Pennsylvania, and the United States.

Figure 42. Males who report they rarely or never get the social and emotional support that they need\textsuperscript{31}. Note: Percentages are of the total male population in Lancaster County, Pennsylvania, and the United States.
Between the years of 2008-2010, 31% of adults stated that their mental health was not good for one or more days in the past month\textsuperscript{232} (see figure 43). This percentage has remained generally stable since 2003.

**Figure 43.** Adults in Lancaster County who stated that their mental health was not good for one or more days in the past month\textsuperscript{233}. Note: A HP2020 goal has not been set for this indicator.
Figure 44. Females in Lancaster County who stated that their mental health was not good for one or more days in the past month. Note: A HP2020 goal has not been set for this indicator.

Figure 45. Males in Lancaster County who stated that their mental health was not good for one or more days in the past month. Note: A HP2020 goal has not been set for this indicator.
In 2010, the age-adjusted death rate due to suicide was 8.9 deaths per 100,000 population\textsuperscript{236}. This number has fluctuated, increasing to as high as 11.7 deaths per 100,000 population and decreasing to as few as 6.6 deaths per 100,000 population\textsuperscript{237}. (See figure 46).

**Death rate due to suicide**

![Graph showing suicide rates](image)

**Figure 46.** Age-adjusted death rate due to suicide\textsuperscript{238}.
Figure 47. Age-adjusted death rate due to suicide, females.\(^{239}\)
Figure 48. Age-adjusted death rate due to suicide, males240.

Targeted Population/Disparities Overview

Ethnic, racial, gender, and socioeconomic disparities exist in mental health outcomes241,242. By addressing the root causes of these disparities, through numerous public health interventions and collaboration with organizations that address such disparities, the public health field can improve the mental health and complications in physical health due to poor mental health in individuals243.
Age

Between the years of 2008-2010, 7% and 6% of 18-44 year olds and 45-64 year olds, respectively, reported they rarely or never get the social and emotional support that they need\textsuperscript{244}. However, 13% of those that are over the age of 65 reported they rarely or never get the social and emotional support that they need\textsuperscript{245}. (See figure 49).

![Bar chart showing adults by age who rarely or never get the social or emotional support they need]

Figure 49. Adults, by age, who reported that they rarely or never get the social and emotional support they need (2008-2010)\textsuperscript{246}.

Between the years of 2008-2010, 38%, 27% and 19% and 6% of 18-44 year olds, 45-64 year olds, and 65+ year olds, respectively, reported that their mental health was not good one or more days in the past month\textsuperscript{247}. (See figure 50).
Adults, by age, who stated that their mental health was not good for one or more days in the past month

**Figure 50.** Adults, by age, who reported that their mental health was not good one or more days in the past month (2008-2010).248

**Gender**

The CDC reports that nationally, women are more likely to report suffering from depression during their lifetime than men, 11.7% and 5.6% respectively.249 Anxiety disorders are more commonly found in women than in men.250

In Lancaster County, between the years of 2008-2010, 6% and 9% of females and males, respectively, reported they rarely or never get the social and emotional support that they need.251 (See figure 51).
Adults, by gender, who rarely or never get the social or emotional support they need

<table>
<thead>
<tr>
<th>Gender</th>
<th>Overall</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lancaster</td>
<td>8%</td>
<td>9%</td>
<td>6%</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>8%</td>
<td>9%</td>
<td>7%</td>
</tr>
</tbody>
</table>

**Figure 51.** Adults, by gender, who reported that they rarely or never get the social and emotional support they need (2008-2010).252.

In Lancaster County, between the years of 2008-2010, 36% and 25% of females and males, respectively, reported that their mental health was not good one or more days in the past month.253. (See figure 52).

Adults, by gender, who stated that their mental health was not good for one or more days in the past month

<table>
<thead>
<tr>
<th>Gender</th>
<th>Overall</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lancaster</td>
<td>31%</td>
<td>25%</td>
<td>36%</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>34%</td>
<td>29%</td>
<td>39%</td>
</tr>
</tbody>
</table>

**Figure 52.** Adults, by gender, who reported that their mental health was not good one or more days in the past month (2008-2010).254.
In Lancaster County in 2010, the age adjusted death rate per 100,000 population due to suicide was 6.3% and 11.6% of females and males, respectively. (See figure 53).

**Death rate, by age, due to suicide**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Suicide Deaths/100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>8.9 (Lancaster) 11.7 (Pennsylvania)</td>
</tr>
<tr>
<td>Male</td>
<td>11.6 (Pennsylvania) 19 (Pennsylvania)</td>
</tr>
<tr>
<td>Female</td>
<td>6.3 (Lancaster) 4.8 (Pennsylvania)</td>
</tr>
</tbody>
</table>

*Figure 53. Age-adjusted death rate due to suicide by gender (2010)*.

**Ethnic**

The CDC reports that nationally, lifetime percentages of depression are highest among whites at 6.52%, followed by blacks (4.57%) and Hispanics (5.17%).

**Environmental Scan**

Addendum X lists the organizations that provide mental health services to Lancaster County residents. Such services include behavioral therapy, drug and alcohol counseling, support groups, inpatient programs, pastoral care and outpatient programs. Although there appears to be an extensive availability of programs and services, there are nowhere near enough resources for individuals suffering from debilitating poor mental health. Patients who have been recommended to seek help from a counselor or a psychiatrist are often times told they cannot receive an appointment for weeks-to-months, long past the time of
initial need. Many times this is too long for people in need. A mental health community based organization is currently conducting a gap analysis inventory to be published by July 1, 2013. This gap analysis/assessment with delve down features as to the specific mental health needs in our community. We will use this information to develop our implementation plan.

Current Initiatives

LGH worked with other community organizations to host a mental health summit in 2008. At this summit, participants were asked to provide input on the mental health concerns for Lancaster County, identified visions for the future of mental health in Lancaster County, and identified resources available and barriers to creating such a future. See addendum Y for the 2008 Mental Health Summit Final Report. Community partners volunteered to take the lead on next steps of the Summit.

As a result of the Summit, LG Health increased the number of support groups to improve the recovery from illness and for helping individuals cope with living with a chronic disease. For a list of current support groups held at LG Health, please see addendum Z.

Currently, WBH works with women to handle feelings of depression during and after pregnancy. WBH’s HBP has published a pamphlet the help mothers to understand the signs and symptoms of perinatal and postpartum depression and what to do if feeling depressed. Website resources are provided as well as the phone number for a crisis intervention hotline. See addendum AA for this pamphlet.

LGH provides support groups on multiple health related conditions. Our mindfulness based stress reduction programs are facilitated by a psychologist and focus on increasing resiliency skills to cope with mental or physical health concerns. The Ann B Barshinger Cancer Institute will be initiating a “distress thermometer” for all cancer patients upon opening in July 2013. The distress thermometer findings will be incorporated into the patient’s electronic health record. The Oncology Clinical Support team will evaluate, interpret and respond to concerns identified.
The Lancaster Rehab Hospital provides a stroke survivor support group and connect with local organizations such as the amputee support team to assist patients and families as they adapt to mental, emotional and physical changes that may occur post traumatic injury or health event.

Domestic violence is a public health issue. It impacts more women than heart disease, diabetes or cancer. It results in a wide variety of acute physical injuries; obstetrical, gynecological, and mental health conditions; and frequent stress-related complaints due to ongoing or past violence. Domestic violence frequently occurs during pregnancy, with homicide as the leading cause of death among pregnant women and in the year after giving birth.

WBH and LGH have the opportunity to help to prevent domestic violence, and assist victims. WBH’s domestic violence program includes community education projects, training for medical staff on identifying and sensitively responding to victims in a safe and confidential setting, and a domestic violence employee awareness and assistance policy.

LG Health is a member of LHIP, a coalition with membership including the executive director of Mental Health America in Lancaster County. Through this coalition, LHIP informs participating members of community trends related to the mental health status of Lancaster County residents. As a result of the information gained, LG Health has plans to, in conjunction with other mental health providers, help drive an expanded focus on mental health issues.

Future Strategies and Initiatives

There is a great opportunity for a unified approach to treating mental health and physical health particularly in the primary care setting258. LG Health plans to convene community partners to determine how to best collaborate to enhance policies and systems changes that impact mental health in Lancaster County. According to research, effective mental health coalitions bring public health professionals with experience in chronic disease, both mental health and primary care providers, as well as other community advocates to the table259.
LG Health plans to pilot integrating counseling services at LGHP practices. These physician practices are a promising avenue to address mental health, since 93% of Lancaster County adults (2008-2010 data) have a usual source of health care\(^\text{200}\).

**Logic Model and Socio-Ecological Model**

A logic model will be built in collaboration with community partners.

The mental health Socio-Ecological Model (figure 54) serves as a framework of avenues for addressing poor mental health in Lancaster County. LGH offers in-house and outreach programs but has also adopted internal programming and policies to make an impact on the organizational level. LG Health will work with community partners to determine the needs of the County and identify opportunities for improvement.

![Diagram](image)

**Figure 54.** Socio-Ecological Model for LG Health Mental Health Initiatives.
Goals

1. Convene community partners by June 2014.
2. Establish baseline of providers who screen and refer patients with anxiety and depression by April 2014.
3. Build a mental health logic model with community partners by June 2014.
4. Explore the feasibility of integrated mental health services in LGHP by December 2013.

Conclusion

Through working with community partners, there is an opportunity to have a significant impact on mental health in Lancaster County. Through an array of comprehensive interventions, we hope to reduce the burden of mental health issues, e.g. missed work, domestic violence, substance abuse, or deteriorating mental health towards acute inpatient care in Lancaster County.

Through the convening of partners to discuss mental health in Lancaster County, LG Health and partners will more clearly identify the mental health needs of the county and opportunities for improvement.
D. Summary of Planned Initiatives

The table below identifies LG Health initiatives. More information on priority initiatives can be found in Chapter V, Health Priorities Plan.

**Obesity**- Increase the number of people at a healthy weight

<table>
<thead>
<tr>
<th>Initiative</th>
<th>LGH</th>
<th>WBH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop multimedia materials to distribute through print, video, radio campaigns to raise awareness of obesity epidemic.</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Provide healthy weight programs for adults and youth.</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Provide technical assistance to health care providers to increase the percentage of clients screened for BMI.</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Participate in school wellness councils.</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Coordinate school garden initiatives.</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Link farmers and worksites together to increase access to fresh fruits and vegetables through our farm to institution initiatives.</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Link vendors and school cafeteria administration together for collaborative buying to increase the number of schools that provide healthy food choices.</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Educate policy makers to increase the number of municipalities participating in the Bicycle Friendly Community Program.</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Educate emergency food providers about healthy food practices for people receiving the emergency food.</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Educate new mothers on the benefits of breastfeeding at WBH.</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>Educate HBP patients with a BMI ≥ 30 on the importance of gaining ≤ 20 pounds.</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>Developed Lancaster on the Move guides in partnership with Lancaster County Park and Recreation Commission to link people to free and low-cost places to be physically active.</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Develop, print, and distribute healthy cookbooks created with our community: <em>The Lighter Side of Lancaster, Cooking Healthy: Latino Style, Cocinar Saludable al Estilo Latino, African American Favorite Traditional Recipes Made Healthy, Tasty and Easy</em>.</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Coordinate a Healthy Vending initiative to increase healthy vending choices in organizations across the county.</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Continue to facilitate the growth of Lighten Up Lancaster County Coalition.</td>
<td>✔</td>
<td></td>
</tr>
</tbody>
</table>
### Tobacco - Reduce the use of tobacco

<table>
<thead>
<tr>
<th>Initiative</th>
<th>LGH</th>
<th>WBH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educate school students on tobacco prevention practices through the CDC best practice program, LifeSkills.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Provide and or refer inpatient, outpatient, group and individual, tobacco cessation program.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Provide technical assistance to increase the proportion of health care providers who routinely advise patients about cessation services and provide follow-up.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Educate policy makers to increase the number of municipalities that have written policies supporting tobacco free parks and playground initiative, Young Lungs at Play (YLAP).</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Collaborate with local employers to increase the percent of worksites that have comprehensive tobacco policies.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Provide cessation resources and services to community partners who work with targeted/disparate populations (pregnant women, mental health, LGBT).</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Increase the percentage of clients who quit at 30 days.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Educate youth on tobacco industry influences and practices.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Develop media messages promoting tobacco free living.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Collaborate with policy makers to increase number smoke-free multi-unit housing policies.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Provide education to increase the percentage of HBP patients who quit smoking in pregnancy.</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

### Mental Health - Improve mental health with a focus on depression and anxiety

<table>
<thead>
<tr>
<th>Initiative</th>
<th>LGH</th>
<th>WBH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide mindfulness based stress reduction groups to adults coping with stress and or chronic illness.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Educate patients on the benefits of participation in breast cancer related exercise programs.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Build a mental health logic model with community partners.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Explore the feasibility of integrated mental health services in provider practices.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Provide support groups for health related conditions including pregnancy, cancer, stroke and injury.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Initiate a distress thermometer for oncology patients.</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>
Access to Care/ Health Disparities Related

<table>
<thead>
<tr>
<th>Initiative</th>
<th>LGH</th>
<th>WBH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaborate with primary care providers to increase the percentage of women patients who are screened for breast and cervical cancer.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Provide screenings and treatment for sexually transmitted diseases.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Conduct breast and cervical cancer screenings through the Healthy Woman Program.</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Provide immunizations for post partum women and low income children.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Provide the Nurse Family Partnership and Healthy Beginnings program for low income at risk women.</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Facilitate Farm and Family Safety Day camps to reduce injury.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Facilitate educational lectures and linkages to health screenings in the homes of Amish women.</td>
<td></td>
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<tr>
<td>Facilitate educational health lectures for women and linkages to screenings in churches and community organizations.</td>
<td>✓</td>
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<tr>
<td>Provide foundational support and facilitate a children’s advocacy center for Lancaster County which provides forensic interviews and non-invasive specialized medical examinations to children with allegations of sexual abuse.</td>
<td>✓</td>
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<tr>
<td>Provide education lectures, ministerium guide and screen patients for domestic violence.</td>
<td>✓</td>
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<tr>
<td>Facilitate the Dental Access of Lancaster County (DALCO) program linking low income uninsured residents with volunteer dentists.</td>
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<tr>
<td>Convene the Child Death Review Team to identify trends and opportunities for preventing child hood deaths.</td>
<td></td>
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<tr>
<td>Facilitate car seat technician trainings and car seat safety checks to reduce injury and death related of children from motor vehicle accidents.</td>
<td></td>
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<tr>
<td>Continue to provide initial health physical for new refugees within one month of arrival to Lancaster County.</td>
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<tr>
<td>Continue partnership with the Lancaster City &amp; County Medical Society to standardize treatment and control of hypertension and cholesterol.</td>
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Lancaster Rehabilitation Hospital (LRH)

<table>
<thead>
<tr>
<th>Initiative</th>
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<tbody>
<tr>
<td>Increase the percentage of patients screened for BMI and referred for services.</td>
</tr>
<tr>
<td>Screen and refer patients to group and individual, tobacco cessation program.</td>
</tr>
<tr>
<td>Provide stroke survivor support group.</td>
</tr>
<tr>
<td>Participation in Farm and Family Safety Days to reduce injury.</td>
</tr>
<tr>
<td>Financially sponsor American Heart and Stroke Foundation Lancaster County Heart Walk as well as encourage employee participation.</td>
</tr>
</tbody>
</table>
VI. Implementation and Monitoring Plan

LG Health will continue to monitor all indicators on the LG Health HCl web-based system. A newsletter will be published approximately every other month and disseminated to the community, through the LG Health website and community partners, as new data becomes available. LG Health will take a dynamic approach in addressing health in Lancaster County and will address health issues that may have a detrimental impact on the community. Through the process of continuously monitoring county health indicators, LG Health is prepared to be nimble in addressing the community’s needs. LG Health has previously acted when such situations have arisen, such as through flu clinics, refugee clinics, lead screenings, and in CHIP outreach, and will continue to monitor opportunities for community health improvement.

LG Health will implement strategies related to three priorities: tobacco, obesity, and mental health. LG Health worked with community organizations and experts to develop LG Health’s implementation plan. The Lancaster County CHNA was conducted in collaboration with Ephrata Community Hospital, however LG Health’s Implementation Plan for Lancaster County was written solely by LG Health’s three hospitals for Lancaster County initiatives. With the help of these experts (see addendum J for entire list of experts), LG Health’s community health and wellness center will track progress towards goals using a scorecard. Goal progress will be reported quarterly to LG Health’s Mission & Community Benefit Committee and partner coalitions.

Priority plans will be updated at least annually and presented to Mission and Community Benefit for approval. LG Health’s Mission and Community Benefit Committee will reevaluate LG Health priorities every three years.

This report is available in PDF format to allow for easy downloading and posting on other community health websites. If you have difficulties accessing LG Health’s implementation plan or would like to request a hard copy, please call LGH’s Community Health and Wellness Center at (717) 544-3811. Please direct all questions and comments to Alice
Yoder, RN MSN, Director of Community Health, at (717) 544-3283 or amyoder@lghealth.org.
VII. Conclusion

Lancaster County, like many other communities around the nation, is impacted by the poor health of its residents. LG Health will use a logic model and the socio-ecological model to demonstrate that all issues in Lancaster County are interrelated, and that one simple change can have a tremendous impact on the communities’ health. Through education of the community, larger sustainable changes can be accomplished. All initiatives implemented will be data-driven, evidence-based, and collaborative whenever possible.

LG Health will implement plans to address priorities: obesity, tobacco, and mental health initiatives. Through these initiatives, LG Health will help to build a healthier Lancaster County.

LG Health is committed to the residents of Lancaster County. All initiatives of LG Health will be guided by LG Health’s Mission to “advance the health and well-being of the communities we serve” and Vision to “deliver on the promise of a healthier future.” Through collaboration with other hospitals in the health system and community coalitions, LG Health will work to improve the health of all Lancaster County residents.
Lancaster General Health | Community Health Improvement Plan 2013-2016

References


Lancaster General Health | Community Health Improvement Plan 2013-2016


139 Committee on Obstetric Review. (2013) Obesity in Pregnancy. The American College of Obstetricians and Gynecologists, 549. Retrieved from...


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Addendum A: Mission & Community Benefit Charter

CHARTER OF THE MISSION & COMMUNITY BENEFIT COMMITTEE
OF
LANCASTER GENERAL

Membership

Members of the Mission & Community Benefit Committee shall be appointed annually by the Chairperson of the Board of Directors in consultation with the Chairperson of the Mission & Community Benefit Committee. Membership shall be composed of at least six (6) Trustees from the Boards of Trustees of the corporation and its affiliates, and one physician. Committee meetings will be attended by members of the staff on an as-needed basis.

Charge of the Mission & Community Benefit Committee

The Mission & Community Benefit Committee shall assist the Board of Trustees in fulfilling its oversight responsibility related to the corporation’s mission and community benefit activities. These activities include but are not limited to taking such actions as are necessary to increase the availability and access all members of the community to health and wellness services provided by Lancaster General and other community resources, irrespective of their ability to pay.

Responsibilities of the Mission & Community Benefit Committee

For purposes of this charge, community benefit is defined as programs or activities that provide treatment and/or promote health and healing as a response to identified community needs. They are not provided for marketing purposes.

The Mission & Community Benefit Committee is responsible for the following matters:

1. Establish health priorities and the tenure of each. Review strategies, implementation plans, and budgets for each primary health priority.

2. Assist with developing and fostering community collaborations that support identified community health needs.
3. Monitor community health data and needs, and recommend organizational response.

4. Establish community sponsorship guidelines and monitor related expenditures.

5. Review community benefit activities and expenditures on a quarterly basis, and report on such to the Board of Trustees at least annually.

6. Monitor access to care trends and issues, and recommend strategies to address concerns that are identified.

7. Provide guidance on corporate citizenship responsibilities and activities in areas of health education, volunteerism, advocacy, community development, and sponsorship that relate to Lancaster General’s mission.

8. Seek information from management, physicians, employees, and members of the community at large for the purpose of fulfilling its duties.

9. Make regular reports to the Board of Trustees, and make recommendations on actions that support the mission and community benefit responsibilities of the corporation.

10. Oversee any strategic issues contained in the Strategic Plan of the Corporation related to the mission of the Corporation which have been delegated to the Committee by the Board of Trustees.
### Addendum B: Lancaster Health Improvement Partnership Members (as of 12/2012)

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan Baily</td>
<td>Mental Health America</td>
</tr>
<tr>
<td>Trisha Banker</td>
<td>County of Lancaster</td>
</tr>
<tr>
<td>Steve Batchelor</td>
<td>Ephrata Community Hospital</td>
</tr>
<tr>
<td>Jeff Blystone</td>
<td>Pennsylvania Department of Health</td>
</tr>
<tr>
<td>Zoe Bracci</td>
<td>Albright Life</td>
</tr>
<tr>
<td>Eboni Bryant</td>
<td>Community Transformation Grant-LGH</td>
</tr>
<tr>
<td>Jacqueline Burch</td>
<td>Lancaster County Office of Aging</td>
</tr>
<tr>
<td>Ken Culton</td>
<td>Pennsylvania Department of Health</td>
</tr>
<tr>
<td>Gail Dennis</td>
<td>Lancaster General Health</td>
</tr>
<tr>
<td>Susan Eckert</td>
<td>Partnership for Public Health</td>
</tr>
<tr>
<td>Colleen Elmer</td>
<td>Water Street Health Services</td>
</tr>
<tr>
<td>Steve Fuhs</td>
<td>Pennsylvania Department of Health</td>
</tr>
<tr>
<td>Moira Gaul</td>
<td>Susquehanna Valley Pregnancy Services</td>
</tr>
<tr>
<td>Vicki Gillmore</td>
<td>Masonic Villages/Lanc. Senior Services</td>
</tr>
<tr>
<td>Beth Good</td>
<td>Community Volunteer</td>
</tr>
<tr>
<td>Esther Good</td>
<td>River of Life Health Center</td>
</tr>
<tr>
<td>Phil Goropoulos</td>
<td>Alder Health</td>
</tr>
<tr>
<td>Rick Kastner</td>
<td>Lancaster County Drug &amp; Alcohol Commission</td>
</tr>
<tr>
<td>Melody Keim</td>
<td>Lancaster County Community Foundation</td>
</tr>
<tr>
<td>Jim Kelly</td>
<td>Community Volunteer</td>
</tr>
<tr>
<td>Dave Koser</td>
<td>Lancaster County Community Foundation</td>
</tr>
<tr>
<td>Carol Kuntz</td>
<td>Compass Mark</td>
</tr>
<tr>
<td>Mary Levasseur</td>
<td>Tobacco-Free Coalition-LGH</td>
</tr>
<tr>
<td>Janeen Maxwell</td>
<td>Holleran</td>
</tr>
<tr>
<td>Lisa McCracken</td>
<td>Holleran</td>
</tr>
<tr>
<td>Kirk Miller</td>
<td>Franklin &amp; Marshall College</td>
</tr>
<tr>
<td>Brenda Pittman</td>
<td>Lancaster Emergency Management Assoc.</td>
</tr>
<tr>
<td>Jamie G. Quinn</td>
<td>American Cancer Society</td>
</tr>
<tr>
<td>Bonnie Reid</td>
<td>AmeriHealth Mercy Health Plan</td>
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<tr>
<td>Sean Reynolds</td>
<td>St. Joseph Health Ministries</td>
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<tr>
<td>Lisa Riffanacht</td>
<td>Project Access Lancaster County</td>
</tr>
<tr>
<td>Karen Schloer</td>
<td>Boys &amp; Girls Club</td>
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<tr>
<td>Jim Schmucker</td>
<td>Lancaster County Business Group on Health</td>
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<tr>
<td>Kelly Schobor</td>
<td>Lancaster City &amp; County Medical Society</td>
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<tr>
<td>Stacy Schroder</td>
<td>Masonic Villages/ Lancaster Senior Services</td>
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<td>Beth Schwartz</td>
<td>Lighten Up Lancaster County/ LGH</td>
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<td>Cynthia Sears</td>
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<tr>
<td>Hillda Shirk</td>
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<td>Cheri Simoni</td>
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<td>Susan Sines</td>
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<tr>
<td>Donita Sturgis</td>
<td>Hope Within Ministries</td>
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<tr>
<td>Joanne Sullivan</td>
<td>Pennsylvania Immunization Coalition</td>
</tr>
<tr>
<td>Lauren Thomas</td>
<td>United Health Care</td>
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<tr>
<td>Terri Trimble</td>
<td>Welsh Mountain Health Centers</td>
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<tr>
<td>Sandra Valdez</td>
<td>Spanish American Civic Association (SACA)</td>
</tr>
<tr>
<td>Sharon Wasnesuski</td>
<td>CAP-WIC</td>
</tr>
<tr>
<td>Allison Weber</td>
<td>Spanish American Civic Association (SACA)</td>
</tr>
<tr>
<td>Tamara Wurst</td>
<td>Family Health Council of Central PA</td>
</tr>
<tr>
<td>Alice Yoder</td>
<td>Lancaster General Health</td>
</tr>
<tr>
<td>Berwood Yost</td>
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### Key Strategic Measures

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<th>Measure</th>
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<th>9</th>
<th>8</th>
<th>7</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Raw Score</th>
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<td># of Healthy Weight Management Impressions per quarter (thousand)</td>
<td>NA</td>
<td>700</td>
<td>650</td>
<td>600</td>
<td>550</td>
<td>500</td>
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<td>% of participants who show a positive change in habit inventory scores after completing Healthy Weight Management programs</td>
<td>92%</td>
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<td>98</td>
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<td>95</td>
<td>94</td>
<td>92</td>
<td>88</td>
<td>84</td>
<td>80</td>
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<td># of participants in Healthy Weight Management programs</td>
<td>199</td>
<td>95</td>
<td>90</td>
<td>85</td>
<td>80</td>
<td>75</td>
<td>63</td>
<td>50</td>
<td>40</td>
<td>30</td>
<td>9</td>
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<tr>
<td>% of adults who are quit 3 months post cessation services.</td>
<td>58%</td>
<td>99</td>
<td>89</td>
<td>79</td>
<td>69</td>
<td>59</td>
<td>49</td>
<td>39</td>
<td>29</td>
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<tr>
<td># of participants in smoking cessation services.</td>
<td>169</td>
<td>92</td>
<td>82</td>
<td>72</td>
<td>62</td>
<td>52</td>
<td>42</td>
<td>32</td>
<td>22</td>
<td>12</td>
<td>5</td>
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<tr>
<td>% of in-patients who are smoke free 3 months post discharge.</td>
<td>56%</td>
<td>98</td>
<td>88</td>
<td>78</td>
<td>68</td>
<td>58</td>
<td>48</td>
<td>38</td>
<td>28</td>
<td>18</td>
<td>6</td>
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<tr>
<td># of in-patients who receive cessation consults</td>
<td>1941</td>
<td>275</td>
<td>265</td>
<td>255</td>
<td>245</td>
<td>235</td>
<td>225</td>
<td>215</td>
<td>205</td>
<td>195</td>
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<td>% of Lifeskills participants who showed increase knowledge</td>
<td>67%</td>
<td>80</td>
<td>77</td>
<td>74</td>
<td>71</td>
<td>69</td>
<td>66</td>
<td>63</td>
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<td># of children participating in Lifeskills (Annualized)</td>
<td>6057</td>
<td>6500</td>
<td>6400</td>
<td>6300</td>
<td>6200</td>
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<td>5800</td>
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<tr>
<td>% of Level 1 / 2 visits in Fast Care</td>
<td>20.50%</td>
<td>15</td>
<td>16</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>22</td>
<td>25</td>
<td>28</td>
<td>30</td>
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### Quarterly Index

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<tr>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>YTD</th>
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<tr>
<td>Total</td>
<td>56</td>
<td>50</td>
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### Access to Care

- **Note:** Overall score of 1.0 indicates achievement of goal

INDEX: 1.1
## Lancaster General Health
### Community Health Improvement Scorecard
#### 4th Quarter FY 2012

### Key Strategic Measures

<table>
<thead>
<tr>
<th>Metric</th>
<th>FY 11</th>
<th>Goal</th>
<th>Threshold</th>
<th>Raw Score</th>
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<td># of Healthy Weight Management Impressions per quarter (thousand)</td>
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<td>356</td>
<td>308</td>
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<td>% of participants who show a positive change in 2 habit inventory scores after completing Healthy Weight Management programs</td>
<td>NA</td>
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<td># of participants in Healthy Weight Management programs</td>
<td>285</td>
<td>313</td>
<td>148</td>
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<tr>
<td>% of adults in tobacco dependence treatment services that quit 30 days post intervention</td>
<td>NA</td>
<td>56</td>
<td>36</td>
<td>28</td>
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<tr>
<td># of participants completing tobacco dependence treatment services. (quarterly)</td>
<td>260</td>
<td>285</td>
<td>255</td>
<td>245</td>
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<tr>
<td>% of children participating in school based prevention program who showed increase knowledge</td>
<td>5900 Children</td>
<td>76</td>
<td>64</td>
<td>60</td>
</tr>
<tr>
<td>% of Level 1 / 2 visits in Fast Care</td>
<td>22%</td>
<td>19</td>
<td>28</td>
<td>30</td>
</tr>
</tbody>
</table>

### Quarterly Index

<table>
<thead>
<tr>
<th>Quarter</th>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>YTD</th>
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<td>Goal</td>
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<td>1.5</td>
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<td>Stretch</td>
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<td>1.4</td>
<td>1.4</td>
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</table>

**Note:** Overall score of 1.0 indicates achievement of goal

**INDEX:** 1.5
Addendum E: “Other Causes” of Death Exceptions

“Other Causes” of death includes all causes of death except:

- Heart disease
- Cancer
- Stroke
- Chronic Lower Respiratory Disease
- Unintentional Injury
  - Non-transport accidents
  - Motor vehicle accidents
  - Other transport accidents
- Diabetes Mellitus
- Influenza & Pneumonia
- Nephritis, Nephrotic Syndrome & Nephrosis
- Septicemia
- Alzheimer’s Disease
- Suicide
- Chronic Liver Disease & Cirrhosis
- In Situ, Benign & Uncertain Neoplasms
- Parkinson’s Disease
- Essential Hypertension & Hypertensive Renal Disease
- Atherosclerosis
- Homicide
- Perinatal Conditions
- HIV Disease
- Congenital Malformations, Deformations & Chromosomal Abnormalities
- Anemias
- Pneumoconiosis
- Disorders of Biliary Tract & Pancrease
- Nutritional Deficiencies
- Peptic Ulcer
- Multiple Sclerosis
- Cholelithiasis & Other Disorders of Gallbladder
- Hernia
- Epilepsy
Addendum F: LGH Primary Care Locations

Primary Care Locations

Travel Distance (Miles)

Lancaster General

Legend

Type
- Orange (FQHC)
- Green (Free)
- Blue (Primary Care)

0-5 Miles
6-10 Miles
11-15 Miles
16-20 Miles
A Plan for Creating a Healthy Lancaster Community

Support for this Lancaster Health Improvement Partnership project has been provided by:

Lancaster Community Health Plan
Lancaster General Hospital
Lancaster Osteopathic Health Foundation
Lancaster Regional Medical Center
St. Joseph Health Ministries
## Introduction

Access to Care
Improve access to comprehensive, high-quality health care services

Cancer
Prevention, early detection and early intervention
Breast, lung, and colorectal cancer, reducing disparities

Cognitive Development
Promote a physical and emotional environment that provides for the greatest possible intellectual development in infants and growing children

Environmental Quality
Promote healthy environments

Heart Disease and Stroke
Prevention, detection, and treatment of risk factors leading to cardiovascular disease and stroke, reducing disparities

Immunization
Prevent infectious disease through immunization

Injury and Violence
Reduce injuries, disabilities, and deaths due to unintentional injuries and violence

Mental Health
Improve mental health and ensure access to appropriate, quality mental health services

Nutrition and Overweight
Reduce child and adult obesity

Physical Activity
Promote regular physical activity

Responsible Sexual Behavior
Promote sexually responsible behavior

Substance Abuse
Reduce substance abuse to protect the health, safety, and quality of life for all, especially children

Tobacco Use
Prevent and reduce tobacco use

## Appendix

A—Team, Mission, and Goals
B—Definitions of Determinants of Health
C—2010 Major Data Sources
D—Baselines for Age-Adjusted Mortality Objectives
E—Glossary

Acknowledgments
The Lancaster Health Improvement Plan has been written with all citizens of the community in mind. We have attempted to write a plan that has something to say to anyone interested in improving their own health, that of their family, or their community. This plan should be of particular interest to health care providers and policy-makers. For some, data is important—we have that. Others want to know what they can do for themselves or whom they can call—we have that too. Still others want to know where they can research programs that are achieving good results in other communities—that also has been made available. We believe that information on health that provides the keys to higher quality of life can and should be accessible to everyone.

Lancaster Healthy Communities (LHC) is a voluntary association of individuals, community leaders, institutions, and agencies. We support a civic movement to create “A whole community enabling all of its people to be healthy, to live healthy lifestyles, and to reach their full potentials.” We’ve been such a movement since 1998, convening public forums that promote community dialogue around planning, community problem-solving, and providing information concerning a variety of issues. We believe that facilitated dialogue is critical to understanding community values—those elements of community life that everyone holds dear and that define who we are—linking us to our past and providing the key to decision-making for a sustainable future. We promote and facilitate collaboration in the community as the best way to utilize and share human and fiscal resources. We promote facilitative leadership skills. We attempt to base our work on information gathered about the current way the community works so that we can more adequately take aim at that which needs to be changed—or does not.

LHC convened Lancaster Health Improvement Partners as the SHIP Action in August of 2000 to focus on what we considered traditional health issues. We recruited a chair, Alice Yoder, Director of Community Health for Lancaster General Hospital, who facilitated a small group from the LHC Coordinating Committee in putting together a recruitment plan that identified potential community partners. This group also provided materials on Healthy People (HP) 2010 and PA SHIP for orientation purposes. We convened a diverse group from across the county that met monthly. We found that having a diversity of viewpoints and disciplines was valuable because different kinds of questions were asked than those that might have surfaced from just health care professionals. These questions surfaced because there were no set assumptions being made by a majority of us as experts in any one field. Many questions were those we believe the general public would have asked.

We began by introducing the team to Healthy People 2010 and the proposed PA Department of Health State Health Improvement Plan (SHIP) for background information on national and state planning efforts. LHC is committed to building on existing resources. We asked, however, that the group decide on their own mission and goals after reading the materials.

The team decided to continue meeting and established a Mission, Goals, and Working Agreements (see Appendix, p. 1). The team accepted the challenge from the Department of Health to begin a local health planning process based on Healthy People 2010 work. This document reflects that decision as it addresses the goal to develop and publicize health improvement priorities.
Before we go much further, it is important that we address in some detail Healthy People 2010. Healthy People 2010 was developed by citizens from throughout the Nation, in a multiyear process that was coordinated by the U.S. Department of Health and Human Services (HHS). For two decades, HHS had used Healthy People objectives to improve the health of the American people. Healthy People 2010 is the third set of health promotion and disease prevention objectives.

The impact of HP 2010 has been more keenly felt because its promotion has coincided with the federal government’s charge to change state health planning processes. They were the initial force behind local health planning and mandated local health planning efforts as the key to developing state plans. By forcing that perspective on planning, more community efforts have looked at HP 2010 as a resource or guide to local work.

HP 2010 has inspired activity on the part of states, local communities, agencies, institutions, and individuals. It is asking us as a nation to focus attention on key health issues in a way that heightens our awareness of prevention strategies and to identify the root causes of illness and what determines health. It asks us to cross disciplines and bring an integrated approach to improving health outcomes.

In 1999, the PA Department of Health (DOH) chose seven pilot partners including LHC to begin experimenting with a new way of planning to meet the state’s health priorities. The idea was to have local groups set their own priorities and develop a local plan that the state could then support. These local priorities would then be incorporated into a state plan. The keys to validating the local plan were community input by a variety of participants and the use of credible information and data in setting local priorities. This process, known as SHIP (State Health Improvement Plan) has since expanded. Local partners were encouraged to use HP 2010 objectives within their plans as DOH modeled how they might be used in their own planning.

Developing community focus was not as easy as it sounded. In many communities, the process required rival institutions and agencies to sit down for the first time to talk about issues. Complicating the process further was the issue that these groups would be asked to share local data the institutions or programs had collected for themselves in order to gain an upper hand in the local health care or human service market. Trust-building skills became important.

Lancaster Healthy Communities was uniquely situated in that we had the full cooperation of the five county hospitals from our inception (Community Hospital of Lancaster, Ephrata Community Hospital, Lancaster General Hospital, LGH—Susquehanna Division, and Lancaster Regional Medical Center). In fact, LHC was the brainchild of our hospitals, and they have remained our primary funding sources. Additionally, we were already organized to collect data through our work on a Local Community Indicator Project (LCIP) and had some experience with convening groups for the purpose of studying difficult issues through collaborative structures.

LHC sent representatives to three committees at the PA Department of Health. The charge to those committees was to lend guidance in drawing up a plan that might shape partnering criteria from the state’s perspectives. In addition, these groups served to represent the needs of Pennsylvania’s communities and shared what they believed communities needed from the state to better undertake health planning in the way it was being envisioned in our home areas. Our representatives were Alice Yoder (Community Partners Committee), Rick Kastner (Program Committee), and Dr. John Hahn and Sean Flaherty (Data Committee). These groups met until 2001, when a new state organizational plan was implemented and the current planning process began.

The Department of Health has provided matching funds for our Healthy Communities work and LHIP process. They have provided data support and made research opportunities available. They are convening Regional SHIP meetings so that we can meet with our peer counties to study regional issues. Furthermore, they have been supporting national efforts to educate partners and the public about Healthy People 2010.
Healthy People 2010 builds on initiatives pursued over the past twenty years to achieve two overarching goals: (1) to increase the quality and years of healthy life and (2) to eliminate health disparities. A health disparity is a gap in the health status of different groups of people, in which one group is healthier than the other group or groups. Like its predecessors, Healthy People 2010 was developed through a broad consultation process, built on the best scientific knowledge and designed to measure programs over time.

Healthy People 2010 contains a comprehensive set of 467 health objectives in 28 focus areas for the nation to achieve over the first decade of the century.

<table>
<thead>
<tr>
<th>Healthy People 2010: 28 Focus Areas</th>
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<tbody>
<tr>
<td>1. Access to Quality Health Services</td>
</tr>
<tr>
<td>2. Arthritis, Osteoporosis, Chronic Back Conditions</td>
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<tr>
<td>3. Cancer</td>
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<tr>
<td>4. Chronic Kidney Disease</td>
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<tr>
<td>5. Diabetes</td>
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<tr>
<td>6. Disability and Secondary Conditions</td>
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<td>7. Educational and Community-Based Programs</td>
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<td>8. Environmental Health</td>
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<td>9. Family Planning</td>
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<td>10. Food Safety</td>
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<td>11. Health Communication</td>
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<tr>
<td>12. Heart Disease and Stroke</td>
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<tr>
<td>13. HIV</td>
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<tr>
<td>14. Immunization and Infectious Diseases</td>
</tr>
<tr>
<td>15. Injury and Violence Prevention</td>
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<tr>
<td>16. Maternal, Infant, and Child Health</td>
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<td>17. Medical Product Safety</td>
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<tr>
<td>18. Mental Health and Mental Disorders</td>
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<tr>
<td>19. Nutrition and Overweight</td>
</tr>
<tr>
<td>20. Occupational Safety and Health</td>
</tr>
<tr>
<td>21. Oral Health</td>
</tr>
<tr>
<td>22. Physical Activity and Fitness</td>
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<tr>
<td>23. Public Health Infrastructure</td>
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<td>24. Respiratory Diseases</td>
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<tr>
<td>25. Sexually Transmitted Diseases</td>
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<tr>
<td>26. Substance Abuse</td>
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<tr>
<td>27. Tobacco Use</td>
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<tr>
<td>28. Vision and Hearing</td>
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</tbody>
</table>

The determinants of health—individual biology and behavior, physical and social environments, policies and interventions, and access to quality health care (see Appendix, p. 3)—have a profound effect on the health of individuals, communities, and the nation. An evaluation of these determinants is an important part of developing any strategy to improve health. For example, individual behaviors and environmental factors are responsible for about 70 percent of all premature deaths in the United States. Developing and implementing policies and prevention strategies that effectively address these determinants of health can reduce the burden of illness, enhance quality of life, and increase our longevity.

Important ideas around determinants of health influenced the selection of the Leading Health Indicators by HP 2010. The process was led by an interagency work group within the U.S. Department of Health and Human Services. Individuals and organizations provided comments at national and regional meetings or via mail and the Internet. A report by the Institute of Medicine, National Academy of Sciences, provided several scientific models on which to support a set of indicators (Leading Health Indicators For Healthy People 2010).

The ideas that impacted the selection were:

- Multiple factors, both internal and external, impact individual and population risk factors including the role of medical care. These risk factors include physical environment, social environment, genetic assets of the individuals, prosperity, individual behaviors, Individual biology, health and function, disease, and finally health care systems and overall well-being.
It is important to move health policy beyond simply health care policy to include social, political, and environmental policies as well as characteristics and behaviors inherent in individuals and societies. Relationships among the various determinants are important because they can suggest very different mandates for community intervention to achieve community health.

- Many determinants of health have different magnitudes of effect at different stages in life (e.g. in very young children, family factors seem to have a greater impact than personal behaviors).

- Health and disease status are a result of cumulative factors as well as the effects of factors at certain critical periods of one’s life. It is possible to predict future health status based on early experiences and, therefore, to develop preventive measures and more effective health promotion activities.

Even though each person may begin with different health assets, by understanding their impact we can intervene meaningfully and strategically to improve a person’s quality of life in the future.

- The general population: Individuals, in collaboration with public and private health professionals should take action to promote health and prevent disease in themselves and others.

Individuals and non-health care audiences should be targeted and measures should emphasize public and community activities and personal behaviors as well as clinical changes and practice.

What are the Leading Health Indicators?

Healthy People 2010’s 467 objectives can be mind-boggling to those attempting to do local planning with limited local resources. Understanding this, those guiding Healthy People 2010 asked a great number of well-informed people to identify a set of health priorities that reflect 10 major public health concerns in the United States. These 10 Leading Health Indicators are intended to help everyone more easily understand the importance of health promotion and disease prevention. What was hoped was that motivating individuals to act on just one of the indicators can have a profound effect on increasing the quality and years of healthy life and on eliminating health disparities—for the individual, as well as the community overall.

Locally, we have used the Leading Health Indicators targeted by HP 2010 as our base for local priorities. We have also included other indicators on which to focus concern as dictated by the local data. We have looked at the 467 target outcomes set by HP 2010 to help gauge our performance but also to set our own standards. HP 2010 offers a simple but powerful idea: Provide health objectives in a format that enables diverse groups to combine their efforts and work as a team.

How did LHIP decide on the local focus areas?

LHIP members agreed we would initially look at existing data that was well accepted by local providers and practitioners. We then developed a process for studying the data within a geographic and peer county context. We believed that we needed to compare ourselves to similar communities and places where we knew something of their assets and resources. We felt it important to look to communities within Pennsylvania because of similar definitions in data collection and funding streams for local assets. We developed a formal partnership with Franklin & Marshall College that insured that faculty and students would help gather, present, and analyze data.

First, we looked at data from HRSA, The Department of Health, The State of the Child and the Behavioral Risk Factor Surveillance Survey. We compared local results with Healthy People 2010’s 467 objectives.
2010 goals, national and state trends, and with geographically adjacent and demographically peer counties in Pennsylvania (as defined by HRSA, these are counties with a similar demographic makeup.) Once we studied this data and determined the areas we believed needed further research, we asked experts to join in our analysis. Often we were motivated to look at additional data sources because of the sheer lack of local data and information on an issue, and yet these issues were highlighted as a national or state priority. One such issue was mental health. We also had an epidemiologist evaluate our work. The epidemiologist looked at PHC4 data as well as our sources. As a result, other areas of concern were then highlighted for deeper investigation.

The local expert groups were asked to answer a set of questions within their groups. They were asked to review the HP 2010 indicators for local relevance. They then met with us to review the work we had all done in studying the data. These experts brought targeted information to the table that was culled through their field experience or research. We examined community resources and programs. We researched best practices in other communities. Once the report was in draft form, it was shared again with experts before the final draft was printed.

HP 2010 Leading Health Indicators were deemed useful because they would help communities and organizations to focus attention on a small number of key health and social issues. In that way, they would motivate actions that would change the basic factors that really impact and influence our personal and community health. In having this happen from community to community or institution to institution, one would be able to influence the health of the county.

Finally, we chose indicators based on leading indicators proposed by HP 2010 and the National Institute of Medicine study groups that put together the original lists from which the HP 2010 indicators were chosen. We diverged from HP 2010 by including Heart Disease and Stroke, Cancer Prevention and Screening, and Cognitive Development. Local data strongly supported that additional attention be paid to these areas to improve local health status. These indicators reflected the four enabling goals that are set out by Healthy People 2010: 1) promote healthy behaviors, 2) promote a healthy community, 3) prevent and reduce disease and disorders, and 4) improve systems for personal and public health.

We asked the following questions in choosing specific measures for the indicators and goals:

- Is data available?—Many HP 2010 measures are not immediately useful for Lancaster because there is no data collection in place for the information at the local level. HP 2010 has recommended some measures that they believe are important, but which they recognize are not available and need development nationally, statewide, and locally.
- What is the local context for the issue?—The measures have to reflect the demographics and geography of the local area. For example, we in Lancaster would not measure the incidence of an infectious disease or illness that is prevalent in desert regions.
- Will the information motivate action?—If the community is doing very well in the Lead Indicator and it is not a major community concern, why expend extra time and resources to collect additional data at the expense of other issues? What matters most and requires attention now?
- Are we able to find ways to measure progress for diverse populations? Often the data on the overall population of the county may be very good, but there are pockets of incidence that account for a vast majority of incidence. For example, research has shown that poor and ethnic populations often have higher incidences of teen pregnancy, infant mortality, and tuberculosis.
mortality, and deaths due to lack of early detection of illness or access to care. How do we research those assumptions in our own communities?

- Will measures taken over time reflect actions? If we act on this data, can we make improvements and are there proven actions (personal behavior, access to services, implementation of new policies or programs) that can change the direction of the indicator? Why measure something that you cannot change?

Leading Indicators with the greatest impact generally link to many different health and community issues requiring work and collaboration by many sectors of the community. Consequently, by having a wide variety of agencies, organizations, diverse population groups, and community institutions focusing on a small number of indicators, we not only have a greater impact on the community selected issues but, by acting together, we also reinforce a strong community identity.

“The Leading Health Indicators are intended to help everyone more easily understand the importance of health promotion and disease prevention and to encourage wide participation in improving health in the next decade. Developing strategies and action plans to address one or more of these indicators can have a profound effect on increasing the quality of life and the years of healthy life and on eliminating health disparities—creating healthy people in healthy communities.” Healthy People 2010 Leading Health Indicators Report.

The availability and comparability of data for national, state, and local monitoring of Healthy People objectives vary considerably. Some data, especially vital statistics, are readily available at national, state, county, and some municipal levels. The standardization of vital statistics data contributes to its comparability. Mortality and natality data are readily accessible and generally comparable. However, vital statistics data provide only a limited perspective on health status, risk behaviors, and access to health care. Morbidity and risk factor data are required to monitor a very large proportion of the current and proposed Healthy People objectives. Data for these objectives come from a wide range of household surveys, environmental hazard data, and other sources. These are not usually available at the local level, either county or municipal.

Many of the national Healthy People objectives are monitored using data from the National Health Interview Survey (NHIS). Some of these objectives are monitored at state and some local levels using data from the Behavioral Risk Factor Surveillance System (BRFSS). Details of these surveys (for example, design and sampling) can be found at the PA Department of Health or Centers of Disease Control (CDC) Web sites. It should be noted that both differences in the data collection methods (household interview versus telephone interview) and wording of questions used to monitor the same objectives can affect the comparability of the information collected. Additionally, some objectives monitored with identical questions in both the NHIS and the BRFSS (e.g., firearm storage) are only included periodically in a specific rotating module of the BRFSS or supplements to the NHIS. Not all states use these modules or the year of the “rotation” may not coincide with national data from the NHIS. This limits comparability between national and state data.

Other national Healthy People objectives are monitored using composite data sources (e.g., General Estimates System, National Water Quality Trends Report). The national data from these systems are aggregated from data collected at state or local levels. Unlike the vital statistics data (which include all births and deaths), several of these systems are samples of events that use somewhat different data collection and analysis methods between states or between communities. This affects the quality and comparability of national, state, and local data.

For yet other Healthy People objectives, state and local jurisdictions were unable to monitor progress. This prompted the development of Priority Data Needs under Healthy People 2000, which identified sources of state and local data that could be used to track important
health issues, such as adult immunization and access to primary health care. The availability of data for the Leading Health Indicators may be somewhat limited at the state level and it represents a substantial challenge for measurement at the local level.

When possible, LHIP accepted HP 2010 goals. However, it was difficult for us to set specific targets for areas for which we had no local data. In those areas, our goals always included finding ways to begin tracking local data. Often we maintained the indicator but chose local measures for which we either had data or that we believed we could collect in the near future. Those local measures might also reflect an aspect of a focus area that was a greater problem for us here in Lancaster than nationally. Or we may have been doing better than the national rate but believed we should do even better given the long-term risks associated with the problem. An example of this category is teen pregnancy. Another area of concern is the availability of data on sub-populations, so that disparity can be measured. We often had anecdotal information from local experts on pockets of poor health outcomes. But we had no corroborating data. One population that was often mentioned was the Amish population.

Target-Setting Methods For HP 2010

The framework of Healthy People 2010 has proposed to “eliminate health disparities” as one of the two primary goals for the next decade. To support this goal of eliminating health disparities, a single national target that is applicable to all select populations has been set for each measurable, population-based objective. Three guiding principles were used in setting targets for the measurable, population-based objectives:

- For objectives that address health services and protection (e.g., access to prenatal care, health insurance coverage, etc.), the targets have been set so that there is an improvement for all racial/ethnic segments of the population (i.e., the targets are set “better than the best” racial/ethnic subgroup shown for the objective). Data points for at least two population groups under the race and ethnicity category are needed to use “better than the best” as the target-setting method.

- For objectives that can be influenced in the short term by policy decisions, lifestyle choices, and behaviors (e.g., physical activity, diet, smoking, suicide, alcohol-related motor vehicle deaths, etc.), the target-setting method is also part of the “better than the best” group.

- For objectives that are unlikely to achieve an equal health outcome in the next decade, regardless of the level of investment (e.g., occupational exposure and resultant lung cancer), the target represents an improvement for a substantial proportion of the population and is regarded as a minimum acceptable level. Implicit in setting targets for these objectives is the recognition that population groups with baseline rates already better than the identified target should continue to improve.

The specific method for developing the target is described under each objective in Healthy People 2010. Beyond this general guidance, the lead agency work groups that developed the objectives determined the exact target levels. The work groups used various methods for arriving at the target levels, including retention of the year 2000 target, computation of a statistical regression using current rates to project a target, knowledge of the programs currently in place and expected change, and expert judgment.
The following target-setting methods have been used:

- Better than the best.
- __ percent improvement.
- “Total coverage” or “Total elimination” (for targets like 100 percent, 0 percent, all States, etc.).
- Consistent with ________________ (another national program, e.g., national education goals).
- Retain year 2000 target (the Healthy People 2000 target has been retained).

**Assessing Progress**

- Most objectives are tracked by a single measure. For these objectives, progress will be assessed by the change from the baseline measure toward the target. Some objectives seek to increase positive behaviors or outcomes, while others are stated in terms of decreasing negative behaviors or outcomes.
- A number of objectives contain multiple measures. Progress will be assessed separately for each measure. For these objectives, therefore, the progress may be mixed if some measures are progressing toward the target and others are regressing.
- For some objectives, precise measures that match the objective are not available. In these cases, similar proxy measures may be used to track progress. The tracking data and methods for assessing progress will be reviewed during the mid-course review in 2005, and a determination will be made at that time whether any changes will be made.

Each chapter has been organized in the following manner:

- Focus Area Definition
- HP 2010 Goals and Measures
- Local Goals and Measures
- Background and Local Context
- Researched Practices
- Local Recommendations
- Local Assets
- What Businesses, Institutions and Individuals Can Do
- Related HP Objectives

In conclusion, we encourage the readers of this Health Improvement Plan to focus initially on those Indicators and goals that impact them most personally. While an overall view of the health needs of Lancaster County is helpful in understanding the work ahead of us all, progress begins with individual health improvement and choices. Personal ownership fuels the energy and commitment to community action. The Lancaster Health Improvement Partnership has great confidence in the promise of this collaborative effort to inspire real action to improve our quality of life. Knowledge empowers each individual to have a significant positive impact on their own health as well as that of the community.
Access to Care

Improve access to comprehensive, high-quality health care services

Financial Barriers—Health insurance and poverty

Structural Barriers—Availability of professional services

Personal Barriers—Education, literacy and cultural
Access to Care

Goal: Better than the best

### HP 2010 Measures and Local Measures

<table>
<thead>
<tr>
<th>1-1</th>
<th>Increase the proportion of persons with health insurance.</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Target: 100 percent.</td>
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<tr>
<td></td>
<td>Baseline: 83 percent of persons under age 65 years were covered by health insurance in 1997 (age adjusted to the year 2000 standard population).</td>
</tr>
<tr>
<td></td>
<td>Target-setting method: Total coverage.</td>
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<tr>
<td></td>
<td>Data source: National Health Interview Survey (NHIS), CDC, NCHS.</td>
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<th>1-4</th>
<th>Increase the proportion of persons who have a specific source of ongoing care.</th>
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<tr>
<td></td>
<td>Baseline: Varies by population.</td>
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<tr>
<td></td>
<td>Target-setting method: Better than the best.</td>
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<td></td>
<td>Data source: National Health Interview Survey (NHIS), CDC, NCHS.</td>
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<th>16-6</th>
<th>Increase the proportion of pregnant women who receive early and adequate prenatal care.</th>
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<tbody>
<tr>
<td></td>
<td>Target-setting method: Better than the best.</td>
</tr>
<tr>
<td></td>
<td>Data sources: Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPH; National Health Interview Survey (NHIS), CDC, NCHS; National Vital Statistics System (NVSS); CDC, NCHS, PA Vital Statistics (PAVS).</td>
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<tr>
<th>7-1</th>
<th>Percentage of population ages 18–24 who have completed high school.</th>
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<tr>
<td></td>
<td>Target-setting method: Better than the best.</td>
</tr>
<tr>
<td></td>
<td>Baseline: 85 percent of persons aged 18 to 24 years had completed high school in 1998.</td>
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</table>
There are four components of the health care system: clinical preventive care, primary care, emergency services, and long-term and rehabilitative care. Together with health care delivered by specialists and care received in hospital settings, these are the major components of the continuum of care. Access to quality health care and this continuum of care depends strongly on having health insurance, a higher income level, and a regular primary care provider or other source of ongoing health care (Weissman, J.S., and Epstein, A.M. “The insurance gap: Does it make a difference?” Annual Review of Public Health 14:243–270, 1993).

When looking for ways to measure access, some have employed the use of clinical preventive services, such as early prenatal care or screening procedures. Children's access to care as well as mother's prenatal care is important because early intervention can greatly reduce the impact of illness on future health status. It can even prevent lifelong chronic illness and disability. But there are many reasons a community may not be able to access care. Barriers are financial, structural, and personal.

Financial barriers include not having health insurance, not having enough health insurance to cover needed services, or not having the personal financial ability to cover services outside a health plan or insurance program. The lack of health insurance coverage creates significant social, structural, system, and personal barriers to the receipt of appropriate health care services in appropriate settings at appropriate times.

- It reduces the ability of individuals to access regular preventive care, screenings, timely diagnostic procedures and adequate care in managing chronic conditions.
- It hampers the health care system's attempts to manage costs due to the inefficient or inappropriate use of services like the emergency room in place of primary care.

Persons with health insurance are more likely to have a primary care provider (PCP) and to have received appropriate preventive care such as a recent Pap test, immunization, or early prenatal care. (Partnership for Prevention. Results From the William M. Mercer Survey of Employer Sponsored Health Plans. Washington, DC: the Partnership, 1999.) Adults with health insurance are twice as likely to receive a routine checkup as adults without health insurance. Evidence suggests that lack of insurance over a long period of time significantly increases the risk of premature death and that death rates among uninsured hospitalized patients are significantly higher than among insured patients (Reinhardt, U.E. Coverage and access in health care reform. New England Journal of Medicine 330:1452–1453, 1994).

Most individuals and families in the United States receive access to health insurance through their employers. At one time, employers assumed all of the costs of insuring employees and even their families. But as health care costs have climbed, the structure of insuring and paying for health benefits as well as the availability of a benefit variety has changed. Co-payment of insurance premiums and also per visit co-pays are more usual than unusual. An employee pays extra to include family members under a health insurance plan. Eye, dental, and pharmaceutical coverage is extra and again sometimes not offered. Furthermore, employees are often required to join HMOs rather than maintaining fee-for-service plans. Those in low wage jobs are often not offered health benefits and the vulnerability of their job market makes attempts at consistent coverage almost futile. The federal government mandates that certain employers make health insurance coverage available after an employee leaves a job if they were entitled to coverage as an employee. But availability does not mean real access to coverage as COBRA benefits are often well beyond the financial reach of the employee and family. Private health insurance requires that about one-third of total medical costs be picked up by the consumer in the form of deductibles, premiums, and co-payments. Many states have moved to very strict low income or medical disaster eligibility standards for their public systems for those under 65.
In 1997, 83 percent of all persons under age 65 years had health insurance. In 1998, 87 percent of persons of all ages had a usual source of health care. Also in that year, 83 percent of pregnant women received prenatal care in the first trimester of pregnancy.

The Department of Health Policy and Management at Johns Hopkins School of Public Health and Hygiene in Baltimore, Maryland, conducted a study that examined the association between type of health insurance coverage and quality of primary care. They found that the experience of primary care varies according to insurance status. The insured are able to obtain better primary care than the uninsured, and the privately insured are able to obtain better primary care than the publicly insured (Medicaid and Medicare). Those insured through fee-for-service coverage experienced better longitudinal care and fewer access barriers than those insured through health maintenance organizations (HMOs). They concluded that while expanding insurance coverage is important for establishing access to care, efforts are needed to enhance the quality of primary health care, particularly for the publicly insured.

And while legislatures balance their state budgets by cutting back eligibility for Medicaid, a study from the National Health Interview Survey (NHIS), demonstrated that Medicaid expansions that increase the proportion of a state's population eligible for Medicaid lead to increases in enrollment, enhanced utilization of medical services, and lower child death rates (Currie, J., and Gruber, J. "Health insurance eligibility, utilization of medical care, and child health." Quarterly Journal of Economics 111(2):431–466, 1996.) Another study showed that among those without insurance, chronically ill persons are even less likely than those with acute conditions to get health care services they need (Hafner-Eaton, C. "Physician utilization disparities between the uninsured and insured: Comparisons of the chronically ill, acutely ill, and well non-elderly populations." Journal of the American Medical Association 269:787–792, 1993.) Policy-makers should closely monitor the quality of primary care provided by HMOs. Here in Lancaster County as elsewhere in PA, Health Choices is being implemented for those on Medicaid. It is important that we as a community monitor the provider networks that are being assembled to meet our communities' needs.

Extensive epidemiological literature documents the unquestionable correlation between income and health. Those at the lowest end of the income spectrum, those with total family incomes at or below the federal poverty level, have significantly greater burdens of illness and poorer disease outcomes.

Pennsylvania has had relatively high insurance coverage rates although we are slipping in employee-based coverage as are many states. Lancaster County has maintained high employment and, unlike many locations, has not lost manufacturing jobs (that usually include health benefits) at the same rate as other areas in the US and the state. The current national economic downturn is just beginning to affect our local economy as we have a strong balanced economic base. The state of PA, however, is facing a large budget deficit like most states and the federal government. This usually does not bode well for health care either for poor consumers or providers who often face cuts in reimbursement fees.
1-1 Increase the proportion of persons with health insurance.

Target: 100 percent.
Baseline: 83 percent of persons under age 65 years were covered by health insurance in 1997 (age adjusted to the year 2000 standard population).
Target-setting method: Total coverage.
Data source: National Health Interview Survey (NHIS), CDC, NCHS.

### Persons Under Age 65 Years, 1997

<table>
<thead>
<tr>
<th>Health Insurance Percentage</th>
<th>Percent</th>
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<tbody>
<tr>
<td><strong>TOTAL</strong> 83</td>
<td></td>
</tr>
<tr>
<td><strong>Race and ethnicity</strong></td>
<td></td>
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<tr>
<td>American Indian or Alaska Native 62</td>
<td></td>
</tr>
<tr>
<td>Asian or Pacific Islander 81</td>
<td></td>
</tr>
<tr>
<td>Asian 81</td>
<td></td>
</tr>
<tr>
<td>Native Hawaiian and other Pacific Islander 80</td>
<td></td>
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<tr>
<td>Black or African American 80</td>
<td></td>
</tr>
<tr>
<td>White 84</td>
<td></td>
</tr>
<tr>
<td>Hispanic or Latino 66</td>
<td></td>
</tr>
<tr>
<td>Cuban 79</td>
<td></td>
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<tr>
<td>Mexican American 61</td>
<td></td>
</tr>
<tr>
<td>Puerto Rican 81</td>
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<tr>
<td>Not Hispanic or Latino 85</td>
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</tr>
<tr>
<td>Black or African American 80</td>
<td></td>
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<td>White 86</td>
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<tr>
<td><strong>Gender</strong></td>
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<tr>
<td>Female 84</td>
<td></td>
</tr>
<tr>
<td>Male 81</td>
<td></td>
</tr>
<tr>
<td><strong>Family income level</strong></td>
<td></td>
</tr>
<tr>
<td>Poor 66</td>
<td></td>
</tr>
<tr>
<td>Near poor 69</td>
<td></td>
</tr>
<tr>
<td>Middle/high income 91</td>
<td></td>
</tr>
<tr>
<td><strong>Geographic location</strong></td>
<td></td>
</tr>
<tr>
<td>Within MSA 83</td>
<td></td>
</tr>
<tr>
<td>Outside MSA 80</td>
<td></td>
</tr>
<tr>
<td><strong>Disability status</strong></td>
<td></td>
</tr>
<tr>
<td>Persons with disabilities 83</td>
<td></td>
</tr>
<tr>
<td>Persons without disabilities 83</td>
<td></td>
</tr>
<tr>
<td><strong>Sexual orientation</strong></td>
<td>DNC</td>
</tr>
<tr>
<td><strong>Select populations</strong></td>
<td>DNA</td>
</tr>
<tr>
<td>Age groups</td>
<td>DNA</td>
</tr>
<tr>
<td>10 to 24 years</td>
<td>DNA</td>
</tr>
<tr>
<td>10 to 14 years</td>
<td>DNA</td>
</tr>
<tr>
<td>15 to 19 years</td>
<td>DNA</td>
</tr>
<tr>
<td>20 to 24 years</td>
<td>DNA</td>
</tr>
</tbody>
</table>

DNA = Data have not been analyzed. DNC = Data are not collected.
DSU = Data are statistically unreliable. MSA = Metropolitan statistical area.
Note: Age adjusted to the year 2000 standard population.
Until recently, HMO’s had low penetration in our market, meaning that they were not the normal form of insurance. Instead, a fee-for-service system dominated medical expense reimbursement. The use of HMO’s is climbing and carries serious ramifications. Lancaster County is now a medium-level managed-care penetration area. There is increased tension between providers and insurers, patients and insurers, and a growing discontent with not being able to choose one’s source of care. Other issues include higher employee co-pay for premiums for eye, dental, and pharmaceutical coverage, if this coverage is offered at all. Coverage for behavioral health services is very limited throughout PA, where the issue of parity of coverage for Drug and Alcohol Services and Mental Health Services is an often-revisited political battle in Harrisburg. But many major employers do offer Employee Assistance Programs (EAP) to employees in order to help manage personal behavior issues within the work environment.

### Health Insurance Coverage Status and Type of Coverage by State—Children Under 18: 1987 to 2000

(Numbers in thousands. People as of March of the following year covered by private or government health insurance.)

<table>
<thead>
<tr>
<th>State/Year</th>
<th>All People</th>
<th>Private or Gov’t Health Insurance</th>
<th>Private Insurance</th>
<th>Employment-based</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>United States:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2000 c/</td>
<td>72,553</td>
<td>64,148</td>
<td>51,193</td>
<td>70.6</td>
</tr>
<tr>
<td>1999 r/</td>
<td>72,325</td>
<td>63,180</td>
<td>50,606</td>
<td>70.0</td>
</tr>
<tr>
<td>1999</td>
<td>72,325</td>
<td>62,302</td>
<td>49,822</td>
<td>68.9</td>
</tr>
<tr>
<td>1998</td>
<td>72,022</td>
<td>60,949</td>
<td>48,627</td>
<td>67.5</td>
</tr>
<tr>
<td>1997 2/</td>
<td>71,682</td>
<td>60,939</td>
<td>47,968</td>
<td>66.9</td>
</tr>
<tr>
<td>1996</td>
<td>71,224</td>
<td>60,670</td>
<td>47,219</td>
<td>66.3</td>
</tr>
<tr>
<td>1995</td>
<td>71,148</td>
<td>61,353</td>
<td>47,021</td>
<td>66.1</td>
</tr>
<tr>
<td>1994 3/</td>
<td>70,509</td>
<td>60,505</td>
<td>46,266</td>
<td>65.6</td>
</tr>
<tr>
<td>Pennsylvania:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2000 c/</td>
<td>2,993</td>
<td>2,848</td>
<td>2,408</td>
<td>80.5</td>
</tr>
<tr>
<td>1999 r/</td>
<td>2,866</td>
<td>2,646</td>
<td>2,263</td>
<td>79.0</td>
</tr>
<tr>
<td>1998</td>
<td>2,955</td>
<td>2,687</td>
<td>2,201</td>
<td>74.5</td>
</tr>
<tr>
<td>1997 2/</td>
<td>2,940</td>
<td>2,699</td>
<td>2,210</td>
<td>75.2</td>
</tr>
<tr>
<td>1996</td>
<td>2,939</td>
<td>2,725</td>
<td>2,332</td>
<td>79.3</td>
</tr>
<tr>
<td>1995</td>
<td>3,055</td>
<td>2,782</td>
<td>2,279</td>
<td>74.6</td>
</tr>
<tr>
<td>1994 3/</td>
<td>2,979</td>
<td>2,649</td>
<td>2,099</td>
<td>70.5</td>
</tr>
</tbody>
</table>
The reliance on the Medicare system by Lancaster’s significant elderly population poses many access issues. Many elderly cannot afford Medi-gap insurance plans that cover services or medical supplies not covered by Medicare. Those suffering from chronic illnesses and conditions that require long-term care are most financially vulnerable. PA is one of the top two states for wrapping support services around our senior population. However, the crisis in financing pharmaceutical benefits and long-term care needs has yet to be addressed systematically at any level. As a community, we need to be mindful of our systemic and personal responses to the needs of our parents, grandparents, and neighbors as they face these health challenges.
CHIP is Pennsylvania’s program to provide quality health insurance for children of working families who otherwise could not afford it. It is not a welfare program. As of September of 2000, the following benefits are available through CHIP: Immunizations, Routine Check-ups, Diagnostic Testing, Prescription Drugs, Dental, Vision, Hearing Services, Emergency Care, Maternity Care, Mental Health Benefits, Up to 90 Days Hospitalization in any Year, Durable Medical Equipment, Substance Abuse Treatment, Partial Hospitalization for Mental Health Services, Rehabilitation Therapies, and Home Health Care.

The following factors are considered for a child’s eligibility for CHIP:
- Must not be eligible for Medicaid or have any other health insurance
- Must be under age 19
- Must be a U.S. citizen or lawful alien
- Must be a Pennsylvania resident for at least 30 days, except for a newborn
- The family’s income is below the following levels based on federal poverty guidelines released February 2001. Family income is adjusted to allow for a monthly deduction of $90 from earnings and a deduction for day care.

<table>
<thead>
<tr>
<th>Number of People in Family, including Parents</th>
<th>*Maximum Income for Free Program</th>
<th>*Maximum Income for Subsidized Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$17,180</td>
<td>$20,187</td>
</tr>
<tr>
<td>2</td>
<td>23,220</td>
<td>27,284</td>
</tr>
<tr>
<td>3</td>
<td>29,260</td>
<td>34,381</td>
</tr>
<tr>
<td>4</td>
<td>35,300</td>
<td>41,478</td>
</tr>
<tr>
<td>5</td>
<td>41,340</td>
<td>48,575</td>
</tr>
<tr>
<td>6</td>
<td>47,380</td>
<td>55,672</td>
</tr>
<tr>
<td>7</td>
<td>53,420</td>
<td>62,769</td>
</tr>
<tr>
<td>8</td>
<td>59,460</td>
<td>69,866</td>
</tr>
</tbody>
</table>

### Children Enrolled in Medicaid (MA)

<table>
<thead>
<tr>
<th>State</th>
<th>All-County Mean</th>
<th>Lancaster</th>
<th>Chester (G)</th>
<th>York (G)</th>
<th>Berks (P)</th>
<th>Dauphin (G)</th>
<th>Lebanon (G)</th>
<th>Lehigh (P)</th>
<th>Northampton (P)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998 Rate per 100 children under 19</td>
<td>23.6</td>
<td>N/A</td>
<td>11.5</td>
<td>8.1</td>
<td>13.2</td>
<td>18.0</td>
<td>23.2</td>
<td>16.6</td>
<td>19.2</td>
</tr>
</tbody>
</table>

### Children Enrolled in Children’s Health Insurance Program (CHIP)

<table>
<thead>
<tr>
<th>State</th>
<th>All-County Mean</th>
<th>Lancaster</th>
<th>Chester (G)</th>
<th>York (G)</th>
<th>Berks (P)</th>
<th>Dauphin (G)</th>
<th>Lebanon (G)</th>
<th>Lehigh (P)</th>
<th>Northampton (P)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999 Rate per 100 children under 19</td>
<td>2.3</td>
<td>N/A</td>
<td>1.1</td>
<td>1.7</td>
<td>1.2</td>
<td>1.2</td>
<td>1.4</td>
<td>0.8</td>
<td>1.6</td>
</tr>
</tbody>
</table>

### Children Receiving TANF/AFDC

<table>
<thead>
<tr>
<th>State</th>
<th>All-County Mean</th>
<th>Lancaster</th>
<th>Chester (G)</th>
<th>York (G)</th>
<th>Berks (P)</th>
<th>Dauphin (G)</th>
<th>Lebanon (G)</th>
<th>Lehigh (P)</th>
<th>Northampton (P)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998 Rate per 100 children under 18</td>
<td>9.7</td>
<td>5.7</td>
<td>3.1</td>
<td>2.4</td>
<td>3.7</td>
<td>6.6</td>
<td>9.4</td>
<td>3.6</td>
<td>6.3</td>
</tr>
</tbody>
</table>
Poverty

The federal government uses set levels of income to define poverty. It often seems to have little relationship to what we may know is enough to be self-sufficient in a community. But such standards must be set. People who live at or below poverty are not, as the myth suggests, living high off the government dole. Living at these income levels is debilitating and difficult and presents individuals and families with innumerable obstacles to any quality of life and health. For a family of four, the average Federal poverty level weighted for family composition was $16,813 in 1998. A family of four making $33,626 is 200% of poverty or middle income. Many state programs use the federal standard of poverty as their own thresholds for programs.

Poverty levels
Poor (below the Federal poverty level)
Near poor (100–199%) of the Federal poverty level)
Middle and high income (200% or more of the Federal poverty level)

When measured against other areas of the state and nation, our overall economic health is very good. Our poverty rates for the county are low. But pockets of poverty do exist that are predominantly minority, single mothers, and elderly. Additionally, there is rural

### Poverty Thresholds for 2001 by Size of Family and Number of Related Children Under 18 Years (in dollars)

<table>
<thead>
<tr>
<th>Size of Family Unit</th>
<th>Weighted Average Thresholds</th>
<th>Related Children Under 18 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None</td>
<td>One</td>
</tr>
<tr>
<td>One person (Unrelated Individual)</td>
<td>9,039</td>
<td></td>
</tr>
<tr>
<td>Under 65 years</td>
<td>9,214</td>
<td>9,214</td>
</tr>
<tr>
<td>65 years and over</td>
<td>8,494</td>
<td>8,494</td>
</tr>
<tr>
<td>Two persons</td>
<td>11,569</td>
<td></td>
</tr>
<tr>
<td>Householder under 65 years</td>
<td>11,920</td>
<td>11,859</td>
</tr>
<tr>
<td>Householder 65 years and over</td>
<td>10,715</td>
<td>10,705</td>
</tr>
<tr>
<td>Three persons</td>
<td>14,128</td>
<td>13,583</td>
</tr>
<tr>
<td>Four persons</td>
<td>18,104</td>
<td>18,267</td>
</tr>
<tr>
<td>Five persons</td>
<td>21,405</td>
<td>22,029</td>
</tr>
<tr>
<td>Six persons</td>
<td>24,195</td>
<td>25,337</td>
</tr>
<tr>
<td>Seven persons</td>
<td>27,517</td>
<td>29,154</td>
</tr>
<tr>
<td>Eight persons</td>
<td>30,267</td>
<td>32,606</td>
</tr>
<tr>
<td>Nine persons or more</td>
<td>36,286</td>
<td>39,223</td>
</tr>
</tbody>
</table>

Source: [http://www.census.gov/hhes/poverty/threshld/thresh01.html](http://www.census.gov/hhes/poverty/threshld/thresh01.html)

### Percent of Population Below the Poverty Level in 1999: 2000 Census

<table>
<thead>
<tr>
<th>Area</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>12.4</td>
</tr>
<tr>
<td>PA</td>
<td>11.0</td>
</tr>
<tr>
<td>Lancaster</td>
<td>7.8</td>
</tr>
<tr>
<td>York</td>
<td>6.7</td>
</tr>
<tr>
<td>Berks</td>
<td>9.4</td>
</tr>
<tr>
<td>Chester</td>
<td>5.2</td>
</tr>
<tr>
<td>Dauphin</td>
<td>9.7</td>
</tr>
<tr>
<td>Northampton</td>
<td>7.9</td>
</tr>
<tr>
<td>Lehigh</td>
<td>9.3</td>
</tr>
<tr>
<td>Lebanon</td>
<td>7.5</td>
</tr>
</tbody>
</table>

Source: Census 2000 Demographic Profiles
poverty related to agriculture and older industries where low wages are still the norm. We have a significant number of families that might be classified as working poor. These are individuals or families wherein too much money is earned to be part of a public system, but where the employee cost of the health care benefits offered by employers is too expensive. Sometimes the benefits are not offered at all or are only offered to the employee and not to his or her family. And it is not unusual to find that dental and eye coverage is optional or prohibitive. Rural poverty presents its own issues with regard to access to care including transportation and services.

In addition, the Amish and Old Order Mennonite populations, known as the Plain Sects of Lancaster County, do not carry insurance for cultural reasons. They pay all expenses out of pocket. Transportation is a challenge because they do not use automobiles, which increases the need for access to local services. Education and preventive services must be promoted within the community, and their acceptance is based on building trust with specific providers over time. Cultural and social beliefs and customs present unique challenges to improving and even measuring their health status.

Although poverty negatively impacts the health status of all groups, the effects of poverty on children persist throughout life. Even when individuals experience greater affluence at later stages in life, as children they were more likely to have experienced poor nutrition and housing, decreased access to enrichment and basic educational programs, and significantly lower access to health care services. As a result, they will experience acute and chronic health conditions at significantly higher rates and of greater severity. Additionally, racial and ethnic minorities are overrepresented among the nation’s poor, directly affecting the disparity in health status for these groups. Data from the U.S. Department of Labor supplemented by state and local economic indicators and Vital Statistics may provide information about this indicator. (Source: Institute of Medicine)

Contracted by the State of PA, Health Choices has begun rolling out a care system in Lancaster County for Medicaid clients (mandatory on April 1, 2002). Its emergence replaces Lancaster Community Health Plan (LCHP), a local non-profit managed-care plan that provided services on a fee-for-service basis with a comprehensive network of physicians who accepted a fee for providing a regular place of care for Medicaid consumers. Putting together such a network is the challenge faced by Health Choices. Children’s Health Insurance Plan, known as CHIP, is a state and federal program to insure children who do not qualify for Medicaid but have no health care benefits. These children are often from working families who cannot afford health insurance for any number of reasons. There are income eligibility standards that must be met. Many counties have special programs in place to increase enrollment in this program. Lancaster has such a partnership, called Reach Out Lancaster. This “Reaching Out” effort has been successful in increasing enrollment in many areas across the state.
**Source of Ongoing Care**

**Description**

Ongoing care can be defined as having a medical home. There is a provider who maintains a consumer's medical record and is able to treat that person with some continuity. A relationship is established between the consumer and the care provider that is compatible with cultural and medical needs so that together they not only manage illness but also manage wellness. The goal is to improve quality of life and to share information that enables both the provider and consumer to prevent illness by intervening effectively and quickly when necessary. Primary care physicians, neighborhood clinics, hospital clinics, home visitors, and even parish nurses can be ongoing sources of care that can head off major illness by providing access to and information about preventive and screening services.

More than 40 million Americans do not have a particular doctor's office, clinic, health center, or other place where they usually go to seek health care or health-related advice. Even among privately insured persons, a significant number lack a usual source of care or report difficulty in getting needed care due to financial constraints or insurance problems. People aged 18 to 24 years were the most likely to lack a usual source of ongoing primary care. Only 80 percent of individuals below the poverty level and 79 percent of Hispanics had a usual source of ongoing primary care (HP 2010).

A study by the Center for Studying Health System Change, in Washington, D.C., conducted a cross-sectional survey of households during 1996 and 1997 with a nationally representative sample of 14,271 low-income persons. They wanted to (1) examine the effects of managed care on the likelihood of low-income persons having a usual source of care and a usual physician; and (2) examine the association between usual source of care and access. They looked at the usual source of care, usual physician, managed-care enrollment, and managed-care penetration. They found that:

- When there is high managed-care penetration in the community there will be a lower likelihood of having a usual source of care for uninsured persons (54.8% vs. 62.2% in low penetration areas).

- When there is high managed-care penetration in the community there is lower likelihood of having a usual physician (60% vs. 72.8%).

- Managed care has only marginal effects on the likelihood of having a usual source of care for privately insured and Medicaid beneficiaries.

- Having a usual physician substantially reduces unmet medical needs for the insured but less so for the uninsured.

They concluded that having a usual physician can be an effective tool in improving access to care for low-income populations, although it is most effective when combined with insurance coverage. However, the effectiveness of managed care in linking more low-income persons to a medical home is uncertain, and may have unintended consequences for uninsured persons.

Access and availability to primary care is a major issue due to shortages in family practitioners, nurses, office and medical support staffing, mental health professionals, some

---

**Access to Quality Health Services**

(By race and ethnicity, United States, 1997)

<table>
<thead>
<tr>
<th>Race</th>
<th>Persons under age 65 years with health insurance coverage</th>
<th>Persons with a regular source of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian or Alaska Native</td>
<td>62%</td>
<td>86%</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>81%</td>
<td>84%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>80%</td>
<td>84%</td>
</tr>
<tr>
<td>Native Hawaiian and other Pacific Islander</td>
<td>80%</td>
<td>84%</td>
</tr>
<tr>
<td>White</td>
<td>84%</td>
<td>84%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>66%</td>
<td>78%</td>
</tr>
<tr>
<td>Cuban</td>
<td>79%</td>
<td>89%</td>
</tr>
<tr>
<td>Mexican American</td>
<td>61%</td>
<td>75%</td>
</tr>
<tr>
<td>Puerto Rican</td>
<td>81%</td>
<td>88%</td>
</tr>
<tr>
<td>Not Hispanic</td>
<td>86%</td>
<td>87%</td>
</tr>
</tbody>
</table>

*Age adjusted to the year 2000 standard population.

Source: CDC, NCHS, National Health Interview Survey (NHIS), 1997.
specialists, and dental professionals. Minority and ethnic populations, elderly and children, and rural populations particularly feel the lack of availability of professionals and services. Mental health professionals are particularly at a premium for all populations, but especially for children.

In 1998, 87 percent of persons of all ages had a usual source of health care. People aged 18 to 24 years were the most likely to lack a usual source of ongoing primary care. Only 80 percent of individuals below the poverty level and 79 percent of Hispanics had a usual source of ongoing primary care. In 1998, 83 percent of pregnant women received prenatal care in the first trimester of pregnancy.

**1-4 Increase the proportion of persons who have a specific source of ongoing care.**

<table>
<thead>
<tr>
<th>Target and baseline:</th>
<th>1998</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective Increase in Persons With Specific Source of Ongoing Care</td>
<td>Baseline*</td>
<td>Target</td>
</tr>
<tr>
<td>1–4a All ages</td>
<td>87</td>
<td>96</td>
</tr>
<tr>
<td>1–4b Children and youth aged 17 years and under</td>
<td>93</td>
<td>97</td>
</tr>
<tr>
<td>1–4c Adults aged 18 years and older</td>
<td>85</td>
<td>96</td>
</tr>
</tbody>
</table>

*Age adjusted to the year 2000 standard population.

**Target-setting method:** Better than the best.

**Data source:** National Health Interview Survey (NHIS), CDC, NCHS

From the 1998 National Health Interview Survey:
- Is there a place that you usually go when you are sick or need advice about your health?
- What kind of place is it: a clinic, doctor's office, emergency room, or some other place?
  - (a) Hospital emergency room
  - (b) Urgent care/walk-in clinic
  - (c) Doctor's office
  - (d) Clinic
  - (e) Health center facility
  - (f) Hospital outpatient clinic
  - (g) HMO (Health Maintenance Organization)/Pre-paid group
  - (h) Military or other VA healthcare
  - (i) Some other place

**Expected Periodicity—Annual.**

**Comments:** A specific source of primary care includes responses (b) through (i) listed above. A hospital emergency room (a) is not included as a specific source of primary care. Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents.

**Data source:** National Health Interview Survey (NHIS), CDC, NCHS.

### Specific Source of Ongoing Care

#### Population by Age Group, 1998

<table>
<thead>
<tr>
<th>Race and ethnicity</th>
<th>1-4a. All Ages</th>
<th>1-4b. Aged 17 Years and Under</th>
<th>1-4c. Aged 18 Years and Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian or Alaska Native</td>
<td>82</td>
<td>89</td>
<td>79</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>84</td>
<td>89</td>
<td>81</td>
</tr>
<tr>
<td>Asian</td>
<td>84</td>
<td>89</td>
<td>82</td>
</tr>
<tr>
<td>Native Hawaiian and other Pacific Islander</td>
<td>83</td>
<td>90</td>
<td>82</td>
</tr>
<tr>
<td>Black or African American</td>
<td>86</td>
<td>91</td>
<td>84</td>
</tr>
<tr>
<td>White</td>
<td>88</td>
<td>95</td>
<td>86</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>79</td>
<td>86</td>
<td>76</td>
</tr>
<tr>
<td>Cuban</td>
<td>86</td>
<td>95</td>
<td>82</td>
</tr>
<tr>
<td>Mexican American</td>
<td>75</td>
<td>83</td>
<td>72</td>
</tr>
<tr>
<td>Puerto Rican</td>
<td>86</td>
<td>90</td>
<td>85</td>
</tr>
<tr>
<td>Native Hawaiian and other Pacific Islander</td>
<td>83</td>
<td>90</td>
<td>82</td>
</tr>
<tr>
<td>Cuban</td>
<td>86</td>
<td>95</td>
<td>82</td>
</tr>
<tr>
<td>Mexican American</td>
<td>75</td>
<td>83</td>
<td>72</td>
</tr>
<tr>
<td>Puerto Rican</td>
<td>86</td>
<td>90</td>
<td>85</td>
</tr>
<tr>
<td>Not Hispanic or Latino</td>
<td>89</td>
<td>95</td>
<td>87</td>
</tr>
<tr>
<td>Black or African American</td>
<td>86</td>
<td>91</td>
<td>85</td>
</tr>
<tr>
<td>White</td>
<td>89</td>
<td>96</td>
<td>87</td>
</tr>
</tbody>
</table>

#### Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>1-4a. All Ages</th>
<th>1-4b. Aged 17 Years and Under</th>
<th>1-4c. Aged 18 Years and Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>91</td>
<td>93</td>
<td>90</td>
</tr>
<tr>
<td>Male</td>
<td>84</td>
<td>94</td>
<td>81</td>
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</table>

#### Family income level

<table>
<thead>
<tr>
<th>Family income level</th>
<th>1-4a. All Ages</th>
<th>1-4b. Aged 17 Years and Under</th>
<th>1-4c. Aged 18 Years and Older</th>
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</thead>
<tbody>
<tr>
<td>Poor</td>
<td>80</td>
<td>88</td>
<td>77</td>
</tr>
<tr>
<td>Near poor</td>
<td>82</td>
<td>90</td>
<td>79</td>
</tr>
<tr>
<td>Middle/high income</td>
<td>91</td>
<td>97</td>
<td>88</td>
</tr>
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</table>

#### Geographic location

<table>
<thead>
<tr>
<th>Geographic location</th>
<th>1-4a. All Ages</th>
<th>1-4b. Aged 17 Years and Under</th>
<th>1-4c. Aged 18 Years and Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>87</td>
<td>93</td>
<td>85</td>
</tr>
<tr>
<td>Rural</td>
<td>89</td>
<td>95</td>
<td>87</td>
</tr>
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</table>

#### Disability status

<table>
<thead>
<tr>
<th>Disability status</th>
<th>1-4a. All Ages</th>
<th>1-4b. Aged 17 Years and Under</th>
<th>1-4c. Aged 18 Years and Older</th>
</tr>
</thead>
</table>

#### Sexual orientation

<table>
<thead>
<tr>
<th>Sexual orientation</th>
<th>1-4a. All Ages</th>
<th>1-4b. Aged 17 Years and Under</th>
<th>1-4c. Aged 18 Years and Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>DNC</td>
<td>DNC</td>
<td>DNC</td>
<td></td>
</tr>
</tbody>
</table>

#### Select populations

<table>
<thead>
<tr>
<th>Age groups</th>
<th>1-4a. All Ages</th>
<th>1-4b. Aged 17 Years and Under</th>
<th>1-4c. Aged 18 Years and Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 to 24 years</td>
<td>DNA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>10 to 17 years</td>
<td>91 (1997)</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>18 to 24 years</td>
<td>72 (1997)</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

DNA=Data have not been analyzed. DNC=Data are not collected. DSU=Data are statistically unreliable. NA=Not applicable. Note: Age adjusted to the year 2000 standard population.
aged 17 years and under have a specific source of ongoing care. CHIP has helped increase this percentage.

- The usual source of care can vary among groups according to their age, race and ethnicity, and health insurance coverage.

<table>
<thead>
<tr>
<th>1-4c Percent of Adults with Specific Source of Ongoing Care</th>
<th>PA 2001</th>
<th>National Baseline 1998</th>
<th>2010 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Adults</td>
<td>88</td>
<td>85</td>
<td>96</td>
</tr>
<tr>
<td>Male Adults</td>
<td>83</td>
<td>81</td>
<td>96</td>
</tr>
<tr>
<td>Female Adults</td>
<td>93</td>
<td>90</td>
<td>96</td>
</tr>
<tr>
<td>Non-Hispanic White Adults</td>
<td>89</td>
<td>87</td>
<td>96</td>
</tr>
<tr>
<td>Non-Hispanic Black Adults</td>
<td>82</td>
<td>85</td>
<td>96</td>
</tr>
<tr>
<td>Urban Adults</td>
<td>88</td>
<td>85</td>
<td>96</td>
</tr>
<tr>
<td>Rural Adults</td>
<td>87</td>
<td>87</td>
<td>96</td>
</tr>
</tbody>
</table>

Source: http://webserver.health.state.pa.us/health/lib/health/HP2010-FA01PA.pdf

- Young children and elderly adults aged 65 years and older are most likely to have a usual source of care.

- Adults aged 18 to 64 years are not as likely to have a usual source of care. Young adults aged 18 to 24 years are the least likely of any age group.

- Hispanic persons are the least likely to have a usual source of care. Some 24 percent of the adult Hispanic population (and 28 percent of the Mexican American population) lack a usual source of care. 15 percent of African Americans lack a usual source of care.

- Some 88 percent of persons with a usual source of care use an office-based provider, and 11 percent use a hospital outpatient department or clinic. African Americans and Hispanics are more likely to use hospital-based providers (including hospital clinics and outpatient departments) as their usual source of care.

- Uninsured persons under age 65 years are more likely to lack a usual source of care (38 percent) than those who have either public or private insurance. When compared with their counterparts who have private health insurance, uninsured people under age 65 years are 2.6 times more likely to lack a usual source of care.

A usual source of primary care helps people clarify the nature of their health problems and can direct them to appropriate health services, including specialty care. (Starfield, B. “Primary Care: Balancing Health Needs, Services and Technology.” New York, NY: Oxford University Press, 1998.) Primary care also emphasizes continuity, which implies that individuals use their primary source of care over time for most of their health care needs. Greater continuity has been observed for individuals with shorter appointment waits, insurance, and access to more after-hours care (Forrest, C.B., and Starfield, B. “Entry into primary care and continuity: The affects of access.” American Journal of Public Health 88:1334, 1998.) Other advantages of primary care are that a primary care provider deals with all common health needs (comprehensiveness) and coordinates health care services, such as referrals to specialists. Evidence suggests that first-contact care provided by an individual's primary care provider leads to less costly medical care. (Forrest, C.B., and Starfield, B. The effect of first-contact care with primary care clinicians on ambulatory health care expenditures. Journal of Family Practice 43:40-48, 1996.)

Many of the risk factors for high-risk pregnancies and children born at low birth weight or with birth defects can be mitigated or prevented with good preconception and prenatal care. An early start in life is very important to good long-term health outcomes. A woman who has an ongoing source of care is more likely to get preconception and prenatal care. She is more likely to understand women's health issues and know the dangers of risky behavior to her baby. Preconception screening and counseling is an opportunity to identify and mitigate risk factors before pregnancy begins, including daily folic acid consumption (a protective factor) and cessation of alcohol or tobacco use (a risk factor). Fetal death often is associated with maternal complications of pregnancy, such as problems with amniotic fluid levels and blood disorders. Rates of fetal mortality are 35 percent greater than average in women who use tobacco during pregnancy and 77 percent higher in women who use alcohol.
During preconception counseling, health care providers can refer women for medical and psychosocial or support services for any risk factors identified. Counseling needs to be culturally appropriate and linguistically competent. These issues are of particular importance to those populations that have an unusually high risk for maternal and infant health problems.

- The 1997 infant mortality rate among African American infants was 2.3 times that of white infants. Although infant mortality rates have declined within both racial groups, the proportional discrepancy between African Americans and whites remains largely unchanged. (Hoyert, D.L.; Kockanck, K.D.; and Murph, S.L. “Deaths: Final data for 1997.” National Vital Statistics Report 47(19), 1999.)

- The rate of maternal mortality among African Americans is 20.3 per 100,000 live births, nearly four times the white rate of 5.1 per 100,000. African American women continue to be three to four times more likely than white women to die of pregnancy and its complications.

- Rates of Low Birth Weight babies for white women have risen from 5.7 percent of births in 1990 to 6.5 percent in 1998. Among African Americans, the LBW rate has declined slightly in the 1990s but remains twice as high as that of whites—13 percent in 1998. Puerto Ricans also are especially likely to have LBW infants. (Ventura, S.J.; Martin, J.A.; Curtin, S.C.; et al. “Births: Final data for 1997.” National Vital Statistics Report 48(3), 2000.)

- African Americans also are more likely to have other risk factors, such as young maternal age, high birth order (that is, having many live births), less education, and inadequate prenatal care.

**16-6 Increase the proportion of pregnant women who receive early and adequate prenatal care.**

<table>
<thead>
<tr>
<th>Target and baseline: Objective Increase in Maternal Prenatal Care</th>
<th>1998 Baseline</th>
<th>2010 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of Live Births</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16-6a. Care beginning in first trimester of pregnancy</td>
<td>83</td>
<td>90</td>
</tr>
<tr>
<td>16-6b. Early and adequate prenatal care</td>
<td>74</td>
<td>90</td>
</tr>
<tr>
<td>Target setting method: Better than the best.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Data source: National Vital Statistics System (NVSS), CDC, NCHS.

Prenatal care should begin early and continue throughout pregnancy, according to accepted standards of periodicity. The American College of Obstetricians and Gynecologists recommends that women receive at least 13 prenatal visits during a full-term pregnancy. (American College of Obstetricians and Gynecologists [ACOG]. Manual of Standards in Obstetric-Gynecologic Practice. 2nd ed. Chicago, IL: ACOG, 1965.) The Adequacy of Prenatal Care Utilization Index (APNCU) measures two dimensions of care: the adequacy of initiation of care and the adequacy of the use of prenatal services once care has begun (by comparing actual use to the recommended number of visits based on the month of initiation of care and the length of the pregnancy). (Kotelchuck, M. “An evaluation of the Kessner Adequacy of Prenatal Care Index and a proposed Adequacy of Prenatal Care Utilization Index.” American Journal of Public Health 84:1414–1420, 1994.)

These dimensions are combined to classify each woman's prenatal care history as inadequate, intermediate, adequate, or adequate-plus. The baseline rates presented above include all women who received either adequate or adequate-plus care.
The use of timely, high-quality prenatal care can help to prevent poor birth outcomes and improve maternal health by identifying women who are at particularly high risk and taking steps to mitigate risks, such as the risk of high blood pressure or other maternal complications. Interventions targeted at prevention and cessation of substance use during pregnancy may be helpful in further reducing the rate of preterm delivery and low birth weight. (AAP, Committee on Substance Abuse. "Drug-exposed infants." Pediatrics 96 (2):364-367, 1995.) Prenatal care is more likely to be effective if women begin receiving care early in pregnancy.

Since 1990, the proportion of infants whose mothers entered prenatal care in the first trimester increased 8.8 percent, from 76 percent to 83 percent. Among African Americans, this proportion grew 19 percent, and among Hispanics, 22 percent. (National Center for Health Statistics (NCHS). Health, United States, 1999. Hyattsville, MD: U.S. Department of Health and Human Services, 1999.)

The risk of poor birth outcomes is greatest among the youngest mothers (aged 15 years and under). Clearly, therefore, continued work is needed to educate women, particularly young women, about the need to begin prenatal care early in pregnancy.

The likelihood of early entry into prenatal care rises with age.

Increases in early entry into prenatal care have been concentrated in those populations whose perinatal illness and disability rates and mortality rates are highest and who are most likely to have low incomes. These increases are in part due to:

✔ Increased access to Medicaid coverage for pregnancy-related services.


The continuum of care is possible when all four components of the health care system (clinical preventive care, primary care, emergency services, and long-term and rehabilitative care) are working together and seamlessly with community support services. The public health system educates people about prevention and addresses the need to eliminate disparities by working to provide access to preventive services for everyone. It ensures the availability of primary care through direct funding of clinics and providers or by providing public insurance. It coordinates emergency services systems and oversees long-term and rehabilitative care. Communities committed to the continuum of care, and access to it for all, address cultural and socio-economic factors by supporting wrap-around services such as transportation, translation, visiting nurse, and school nurse services. Major changes in the structure of the U.S. health care system, including the increasing influence of market forces, changes in

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### LIVE BIRTHS

<table>
<thead>
<tr>
<th></th>
<th>Early Care</th>
<th>Adequate Care</th>
</tr>
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<tbody>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother's race and ethnicity</td>
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<td></td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>69</td>
<td>57</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>83</td>
<td>74</td>
</tr>
<tr>
<td>Asian</td>
<td>86</td>
<td>76</td>
</tr>
<tr>
<td>Native Hawaiian and other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>75</td>
<td>67</td>
</tr>
<tr>
<td>Black or African American</td>
<td>73</td>
<td>67</td>
</tr>
<tr>
<td>White</td>
<td>85</td>
<td>76</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>74</td>
<td>66</td>
</tr>
<tr>
<td>Not Hispanic or Latino</td>
<td>85</td>
<td>76</td>
</tr>
<tr>
<td>Black or African American</td>
<td>73</td>
<td>67</td>
</tr>
<tr>
<td>White</td>
<td>88</td>
<td>79</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th><strong>Mother's education level</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than high school</td>
<td>68</td>
<td>61</td>
</tr>
<tr>
<td>High school graduate</td>
<td>81</td>
<td>74</td>
</tr>
<tr>
<td>At least some college</td>
<td>91</td>
<td>82</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Select populations</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother's age groups</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 15 years</td>
<td>48</td>
<td>48</td>
</tr>
<tr>
<td>15 to 19 years</td>
<td>69</td>
<td>64</td>
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<tr>
<td>20 to 24 years</td>
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<td>70</td>
</tr>
<tr>
<td>25 to 29 years</td>
<td>86</td>
<td>77</td>
</tr>
<tr>
<td>30 to 34 years</td>
<td>89</td>
<td>79</td>
</tr>
<tr>
<td>35 years and older</td>
<td>88</td>
<td>79</td>
</tr>
</tbody>
</table>

DNA=Data have not been analyzed. DNC=Data are not collected. DSU=Data are statistically unreliable.

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Our Public Health System
payment and delivery systems, and welfare reform, have significant implications for vulnerable and at-risk populations. In light of these systems changes, federal, state, and local public health agencies must redouble their efforts to address access barriers and reduce disparities for these populations (HP 2010—Tracking Healthy people 2010).

**Lancaster County** has been blessed with a good health care delivery system. Year after year our hospitals and services have consistently been highly rated for services and for cost. We have five hospitals in the county. Three are non-profit: Ephrata Community Hospital (Ephrata Borough), Lancaster General Hospital (Lancaster City and the Health Campus that includes the Mother and Baby Hospital in East Hempfield Township) and Susquehanna Division of Lancaster General Hospital (Columbia). There are two for-profit institutions; Community Hospital of Lancaster (Lancaster Township with a new hospital to be built in Warwick Township), and Lancaster Regional Medical Center (Lancaster City). We have two Federally Qualified Health Clinics that were founded to provide medical and dental services to those underserved areas of the county: Welsh Mountain Health and Dental Services (Welsh Mountain Area in eastern end of county) and Southeast Lancaster Health Services (Lancaster City). The transition of the two hospitals from non-profit to for-profit resulted in the establishment of two community-oriented health foundations: Osteopathic Health Foundation and St. Joseph Health Foundation.

---

**Lack of Early Prenatal Care**

<table>
<thead>
<tr>
<th>State</th>
<th>All County Mean</th>
<th>Lancaster</th>
<th>Chester (G)</th>
<th>York (G)</th>
<th>Berks (P)</th>
<th>Dauphin (G)</th>
<th>Lebanon (G)</th>
<th>Lehigh (P)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994–1996 Rate per 100 Births</td>
<td>16.9</td>
<td>16.4</td>
<td>21.4</td>
<td>14.5</td>
<td>13.9</td>
<td>21.2</td>
<td>16.4</td>
<td>23.2</td>
</tr>
<tr>
<td>Overall Relative Performance</td>
<td>*</td>
<td>***</td>
<td>***</td>
<td>*</td>
<td>**</td>
<td>*</td>
<td>***</td>
<td></td>
</tr>
<tr>
<td>UrbnCntyAvg = 17.1</td>
<td></td>
<td>**</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>MxdCntyAvg = 16.7</td>
<td></td>
<td>*</td>
<td>***</td>
<td>***</td>
<td>*</td>
<td>*</td>
<td></td>
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</tr>
<tr>
<td>RuralCntyAvg = 16.8</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

*** Performs much better than average   ** Performs better than average   * Performs worse than average   * Performs much worse than average

**Lack of Early Prenatal Care by Race**

<table>
<thead>
<tr>
<th>State</th>
<th>Lancaster</th>
<th>Chester (G)</th>
<th>York (G)</th>
<th>Berks (P)</th>
<th>Dauphin (G)</th>
<th>Lebanon (G)</th>
<th>Lehigh (P)</th>
<th>Northampton (P)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996 Rate per 100 Births</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>32.9</td>
<td>21.9</td>
<td>35.2</td>
<td>33.6</td>
<td>36.4</td>
<td>24.4</td>
<td>N/A</td>
<td>30.5</td>
</tr>
<tr>
<td>Caucasian</td>
<td>12.9</td>
<td>21.1</td>
<td>11.7</td>
<td>11.2</td>
<td>20.1</td>
<td>11.6</td>
<td>N/A</td>
<td>12.1</td>
</tr>
<tr>
<td>Hispanic</td>
<td>29.4</td>
<td>18.2</td>
<td>35.4</td>
<td>25.9</td>
<td>43.0</td>
<td>16.3</td>
<td>N/A</td>
<td>25.6</td>
</tr>
<tr>
<td>AfrAm/Caucasian</td>
<td>2.6</td>
<td>1.0</td>
<td>3.0</td>
<td>3.0</td>
<td>1.8</td>
<td>2.1</td>
<td>N/A</td>
<td>2.5</td>
</tr>
<tr>
<td>Hispanic/Caucasian</td>
<td>2.3</td>
<td>0.9</td>
<td>3.0</td>
<td>2.3</td>
<td>2.1</td>
<td>1.4</td>
<td>N/A</td>
<td>2.1</td>
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</table>

**Lack of Early Prenatal Care City-County Profile**

<table>
<thead>
<tr>
<th>Lancaster</th>
<th>Chester (G)</th>
<th>York (G)</th>
<th>Berks (P)</th>
<th>Dauphin (G)</th>
<th>Lebanon (G)</th>
<th>Lehigh (P)</th>
<th>Northampton (E) (P)</th>
<th>Northampton (B) (P)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996 Rate per 100 Births</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>14.9</td>
<td>N.C.C</td>
<td>25.1</td>
<td>34.3</td>
<td>22.2</td>
<td>N.C.C</td>
<td>19.9</td>
<td>15.4</td>
</tr>
<tr>
<td>County**</td>
<td>22.9</td>
<td>N.C.C</td>
<td>10.0</td>
<td>13.4</td>
<td>11.4</td>
<td>N.C.C</td>
<td>8.1</td>
<td>10.9</td>
</tr>
<tr>
<td>City/County</td>
<td>0.7</td>
<td>N.C.C</td>
<td>2.5</td>
<td>2.6</td>
<td>1.9</td>
<td>N.C.C</td>
<td>2.5</td>
<td>1.4</td>
</tr>
</tbody>
</table>

*Less than 5 lbs., 9 oz. or 2500 grams   **Excluding municipality  N.C.C. = No Central City
County/City = Lancaster: Lancaster; York: York; Dauphin: Harrisburg; Lebanon: N.C.C.; Berks: Reading; Chester: N.C.C.; Lehigh: Allentown; Northampton: Bethlehem, Easton

Local Context

Lancaster County has been blessed with a good health care delivery system. Year after year our hospitals and services have consistently been highly rated for services and for cost. We have five hospitals in the county. Three are non-profit: Ephrata Community Hospital (Ephrata Borough), Lancaster General Hospital (Lancaster City and the Health Campus that includes the Mother and Baby Hospital in East Hempfield Township) and Susquehanna Division of Lancaster General Hospital (Columbia). There are two for-profit institutions; Community Hospital of Lancaster (Lancaster Township with a new hospital to be built in Warwick Township), and Lancaster Regional Medical Center (Lancaster City). We have two Federally Qualified Health Clinics that were founded to provide medical and dental services to those underserved areas of the county: Welsh Mountain Health and Dental Services (Welsh Mountain Area in eastern end of county) and Southeast Lancaster Health Services (Lancaster City). The transition of the two hospitals from non-profit to for-profit resulted in the establishment of two community-oriented health foundations: Osteopathic Health Foundation and St. Joseph Health Foundation.
Our health care providers have collaborated with each other and with community organizations to provide many different kinds of outreach services in the community. They have opened primary care clinics in underserved neighborhoods. They have attempted to put clinics in two city elementary schools until insurance issues made them prohibitive. They had representatives on local coalitions focused on specific issues such as family violence, children’s safety, healthy mothers and babies, and teen pregnancy. When managed care came to Lancaster County, local providers did their best to establish networks that did not dictate exclusivity. For example, many local doctors could practice at more than one hospital. This has changed.

But many issues are changing the local picture. These are national, state, and local in scope. Critical issues are:

- The loss of practicing doctors due to prohibitive malpractice insurance costs and HMO operating procedures, which limits a doctor's ability to manage patient care.
- The inability to staff positions critical to good care such as nurses, emergency and lab technicians, physician's assistants, and case managers.
- The lack of dentists, psychiatrists, and psychologists (particularly child). In addition, the number of students studying such professions is low, suggesting an increasing shortage of these specialists.
- A lack of minority representation in all of the health fields.

Two issues facing physicians, consumers, and local health care systems are tort reform and managed care. Physicians are choosing to leave primary care and specialty services (particularly OB/GYN), or moving to other states to practice because of the high rates for malpractice insurance in PA. Tort reform has yet to be dealt with systemically in many states and...
at the federal level for a variety of political reasons. But when an entire country is facing a shortage of physicians, it is not hard for PA doctors to find another community to serve.

Yet other physicians are frustrated by conflicts with insurers over the quality of care they are able to provide their patients. There is a strong belief that insurers are driving medical decisions rather than patients and physicians. Local examples often involve a change in an insurance carrier or drug formularies. An example of this is a case that took several years of trial and error for the doctor and patient to find the right medication to meet the needs of both the person’s diabetes and mental illness. The new insurers had a set of drug protocols that the physicians had to follow and would not approve the drugs that the patient and doctor had painstakingly settled upon. Going back to the old drugs resulted in less than optimum care, but the physician and patient were powerless. There are many examples that frustrate patients and physicians. A dialogue about who has the final decision on care options is long overdue.

Many areas of professional care cannot recruit or retain practitioners. The loss of OB/GYNs and nurses has been well publicized. But the area of mental health providers must be highlighted. Local experts have been concerned for many years about our inability to recruit enough child psychiatrists and psychologists to serve those currently identified as being in need of services. Reports and hearings have, for years, been peppered with families’ sad stories of severely depressed or emotionally disturbed children not receiving services in a timely way, or at all. Waiting lists exist at every level, and many patients in outpatient care wait many weeks and months between appointments, flying in the face of accepted best practice and treatment.

The ability to recruit ethnically and racially competent professionals is greatly hindered by a national shortage. The personal affects on individuals and families are all around us.

Our large institutions are facing issues as well. It is no longer unusual for those entering a local hospital to be faced with a long wait before seeing a health care provider. Every staffing level is short, from the nurses who provide floor care, to the support staff that prepares a room, to those who move the waiting patient from place to place within the hospital areas. Hospitals must increasingly utilize expensive agency nursing to fill in staffing shortages. Although we are blessed with strong local training programs for all of these critical support positions at Harrisburg Area Community College, Millersville University, Lancaster General, and even Hershey Medical School and Center, the regional and national competition for these workers is fierce. Higher wages, signing bonuses, or negotiated assignment hours all play a role in where these highly needed workers choose to go. The health care employment section regularly has advertisements from outside the area, including Maryland and New Jersey. It is not speculation that this is going to drive up health care costs—it IS driving health care costs and access to care.

Additionally, when the health care community was planning for the changes managed care would bring, they projected a lesser demand on certain services. It was widely believed that there would be less need for critical care (hospital beds, emergency services, etc.) because managed care would find people a regular source of ongoing care that would result in less admissions of a critical nature. Less hospital space would be needed and more prevention or diagnostic programs, services, and facilities would be demanded. Hospitals reallocated, remodeled, and built space accordingly. Those assumptions have not proven to be true as cited earlier in the study by the Center for Studying Health System Change. In fact, as communities get a higher penetration of managed care, the guarantee of an ongoing source of care goes down. Lancaster has moved from low to moderate penetration in ten years. We are still seeing a demand for hospital beds, and it is less unusual for a hospital to be diverting patients to another hospital because they are no longer able to take in more patients.

We are seeing that providing access to care is increasingly difficult with fewer professionals and support staff. Also, it is increasingly difficult to manage costs as the demand for services continues to increase. If costs continue to increase, insurers will raise premiums,
which will exclude another round of employees. Coverage is not only critical to the individual's health but also critical to hospital reimbursement. This vicious cycle is further complicated by the fact that we are not isolated or in a contained market. We are competing in a much larger arena than Lancaster County. There are some important consumer questions we must keep in mind. How have critical health care issues affected the patients' view of the care they receive and their faith in the future of our health care system? How powerless do they feel as consumers within that system?

Lancaster is fortunate to have two Federally Qualified Community Health Centers. These two organizations partner with local hospitals to increase their capacity to serve clients and to improve their ability to draw on professional staff. Both have an ongoing relationship with local residency programs, which enables them to provide high-quality care. They have both been able to access federal funding to expand care beyond the Medicaid population, to the working poor and uninsured who are able to access care on a sliding-fee basis. Dental and medical services are provided, although it is increasingly difficult to find dental professionals. Additionally, Welsh Mountain provides mental health services to its consumers as well as immunization outreach programs to the rural and Plain communities.

An evaluation of community health centers' ability to mitigate health status disparities simply by providing access to a regular and usual source of care was undertaken by researchers at Johns Hopkins, School of Hygiene and Public Health. This is a major focus of HP 2010. Researchers used comprehensive site-level data, patient surveys, and medical record reviews from a variety of studies. They concluded that safety net community health centers have reduced racial/ethnic, income, and insurance status disparities in access to primary care and important preventive screening procedures. In addition, the centers have reduced low birth weight disparities for African American infants. Evidence suggests that health centers are successful in reducing and eliminating health access disparities by establishing themselves as their patients' usual and regular source of care. This relationship portends well for reducing and eliminating health status disparities.

Racial and ethnic minorities make up about 25 percent of the U.S. population. Their representation among health professionals, however, is in the range of 10 percent. Several studies have shown that minority health professionals are more likely to serve areas with high proportions of underrepresented racial and ethnic groups and to practice in or near designated health care shortage areas (Cooper-Patrick, L.; Gallo, J.; Gonzales, J.; et al. “Race, gender, and partnership in the patient-physician relationship.” Journal of the American Medical Association 282:583-589, 1999.) Several strategies need to be given attention, such as providing financial assistance for underrepresented racial and ethnic group students to pursue health care degrees, encouraging mentor relationships, promoting the early recruiting of students before they graduate from high school, and increasing the number of racial and ethnic group faculty and administrative staff members in schools that train health care professionals. Increasing cultural competency among all health workers and increasing the number of lay health workers from underrepresented racial and ethnic groups is a good interim step.
Description

As with poverty, level of educational attainment is highly correlated with a wide range of social and behavioral risk factors and poor health outcomes. Education level affects a person's ability to understand how their own behavior can influence their health, how the health care delivery system works, and how to use the health care delivery system to maximize personal benefit. In addition to the independent effects of education on health, educational level is also related to income and employment opportunities, with lower incomes associated with lower rates of high school completion and more restricted job opportunities. A person's income is directly related to their ability to learn new skills in a changing economy. Good jobs are those that provide health insurance benefits and that include pharmaceutical, vision, dental, and mental health coverage. Jobs at the lower end of the pay scale are also less likely to provide health care benefits to employees and families. Data on high school graduation rates can be obtained from the PA Department of Education or the U.S. Department of Education.

Data

Functional literacy is necessary for adults to participate fully as citizens of the community and as parents and workers. Unfortunately, a large percentage of our citizenry do not possess the minimum skills that are necessary to be self-sufficient. Functional illiteracy makes holding a well-paying job nearly impossible, which lowers the likelihood of receiving employee health benefits and keeps many people in poverty. According to the Lancaster-Lebanon Literacy Council, as reported in Measure Up Lancaster, in 1990, of the approximately 311,000 adults living in Lancaster County:

- 100,000 needed some form of basic adult education service
- 90,000 were functionally illiterate.
- 38,000 read at less than a 9th grade reading level
- 3,100 read at less than a 5th grade reading level

The inability to read has been associated with increased risks for social, physical, and mental health problems. If one cannot read, how are they to be able to properly follow any written instructions they receive from their physicians? This is extremely dangerous for those suffering chronic illnesses such as diabetes or asthma.

This problem is unlikely to go away any time soon without direct intervention. It seems to pass from generation to generation. Many skills supporting literacy are learned in the home, prior to children entering kindergarten. If parents cannot help their children master basic skills at home, they are at a severe disadvantage when they do reach kindergarten and elementary school.

Consensus is growing regarding the value of a range of preventive services, but providers identify lack of time and reimbursement as specific barriers to more consistent delivery of counseling about behavioral risk factors such as diet and exercise. (American College of Preventive Medicine. 1998 National Prevention in Primary Care Study. Washington, DC: the College, 1998.) Computerized or manual tracking systems, patient and clinician reminders, guidelines, and patient information materials can help providers improve delivery of necessary preventive care. (HHS. Clinician’s Handbook of Preventive Services. 2nd ed. Washington, DC: HHS, 1998.)

Systems interventions that can increase delivery of health care include:

✔ Offering clinical preventive services among standard covered benefits
✔ Providing feedback on performance to providers and practices
✔ Offering incentives for improved performance
✔ Developing and implementing systems to identify and provide outreach to patients in need of services.

Significant progress in the delivery of clinical preventive services (CPS) is unlikely without appropriate data systems which allow providers and administrators to identify services and populations most in need of better delivery.

To be effective, preventive care must be linked to systems to ensure appropriate follow-up services or counseling for patients identified through risk assessment or screening.

Increasing the number and proportion of members of underrepresented racial and ethnic groups who are primary care providers.


The following groups provide tools to evaluate different parts of the health care system:

✔ The National Committee for Quality Assurance (NCQA), a managed-care accreditation group, led a collaborative effort to develop the Health Plan Employer Data and Information Set (HEDIS), a widely used tool for evaluating health plan performance. (NCQA. Health Plan Employer Data and Information Set [HEDIS 3.0] Washington, DC: NCQA, 1997.)
✔ The Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) has developed performance measures.
✔ AHRQ has developed the Consumer Assessment of Health Plans Survey (CAHPS), an instrument to assess consumer experiences with health plans. AHRQ also has developed the Healthcare Cost and Utilization Project (HCUP), which makes available state and nationwide estimates of hospital use. These data can be used with the HCUP Quality Indicators to provide measures of ambulatory-care-sensitive conditions, which can uncover potential problems in access to primary care services.
✔ Quality monitoring systems tend to emphasize measures that focus on delivery rates for clinical preventive services because access to and use of these services are important indicators of the quality of health care providers and of delivery systems.
Local Assets

The complementary National Report on Healthcare Quality will explore methods for integrating the data from these quality-monitoring systems with population-based data collected by the public sector.


Benchmark: Increase the percentage of students who graduate from high school

Proven Programs
- Perry Preschool Project

Promising Programs
- Communities In Schools
- I Have a Dream
- Quantum Opportunity Program
- Teen Outreach Program

Healthy Beginnings Plus
Community Hospital of Lancaster—(717) 239-4141
Ephrata Community Hospital—(717) 738-6695
Lancaster General Medical Center—(717) 290-4305
Lancaster Regional Medical Center—(717) 291-8388
SouthEast Lancaster Health Services—(717) 299-6371
Walter L. Aument Family Health Center—(717) 290-5098

Healthy Kids Helpline
1-800-986-5437

Blue Chip (Insurance for Kids)
1-800-543-7101

All Area Hospitals offer special programs to reduce health costs:
- Community Hospital of Lancaster—(717) 397-3711
- Ephrata Community Hospital—(717) 733-0311
- Lancaster General Hospital—(717) 290-5511
- Lancaster General Hospital–Susquehanna Division—(717) 684-2841
- Lancaster Regional Medical Center—(717) 291-8211
- The Women's and Babies Hospital—(717) 290-3700

Local Assets
### Additional Resources

Robert Wood Johnson Foundation funded the Georgetown University Institute for Health Care Research and Policy to write *A CONSUMER GUIDE FOR GETTING AND KEEPING HEALTH INSURANCE* for each state and the District of Columbia.  
http://www.healthinsuranceinfo.net/

The Official U.S. Government Site for People with Medicare:  
http://www.medicare.gov/

CHIP—Pennsylvania’s program to provide quality health insurance for children of working families who otherwise could not afford it:  
http://www.insurance.state.pa.us/html/chip.html

The EMPLOYER QUALITY PARTNERSHIP provides this site to help employees, employers, and the self-employed understand the issues and the resources for navigating the Health Care System:  
http://www.eqp.org/

### What You Can Do

**Businesses and Institutions**

- Provide health insurance, including mental health coverage, for your employees.
- Educate employees on how to best utilize their coverage and stress the importance of primary care physicians.
- Encourage legislators to provide blanket health care coverage for all children without eligibility barriers.
- Look at all issues affecting the health care system when lobbying legislators for change—those include Tort Reform, Insurance and HMO regulation, and Tuition Reimbursement for students entering the broad range of health professions.

**Schools**

- Educate parents on how to enroll their children in medical assistance if they are eligible.
- Encourage pregnant mothers to seek prenatal care early in their pregnancy.
- Provide support to students who may be at risk for dropping out of school. Do whatever you can to help them stay in school and receive their diploma.
- Provide a strong school nurse program.
- Encourage students to consider the medical arts and a wide variety of health professions from an early age and provide clubs and mentoring programs to encourage that choice.
Individuals
- Mentor a young person and encourage them to finish high school and move on to additional education.
- Have a primary care physician, and encourage friends and family members to have one as well. Proper use of primary care physicians can greatly reduce the number of unnecessary visits to the emergency room, particularly among the chronically ill, and can be a great source of health education materials.
- If you are pregnant, seek prenatal care early in your pregnancy and encourage others to do the same. There are services available even if you are uninsured and think you cannot afford to pay for care.
- Write to elected officials to encourage them to support legislation that will improve the health care system.
- When considering a career change, consider health care.

- How can we continue to find areas of collaboration among competing county health care providers that will result in increasing access to quality care.
- How do we best influence our political leaders to put together a comprehensive package of health care provisions that would include tort reform, insurance regulation, and tuition reimbursement for those entering the health professions.
- What can we do to help our young people further their education?
- How can we monitor the quality and accessibility of services, particularly within the underserved populations of Lancaster?
- Is there a way to better demonstrate to taxpayers and legislators that providing medical assistance to a larger number of people will actually be more cost-effective in the long run?

Clinical Preventive Care
1-1 Persons with health insurance
1-2 Health insurance coverage for clinical preventive services
1-3 Counseling about health behaviors
1-3a Physical activity or exercise
1-3b Diet and nutrition
1-3c Smoking cessation
1-3d Reduced alcohol consumption
1-3e Childhood injury prevention: vehicle restraints and bicycle helmets
1-3f Unintended pregnancy
1-3g Prevention of sexually transmitted diseases
1-3h Management of menopause

Primary Care
1-4 Source of ongoing care
1-4a All ages
1-4b Children and youth aged 17 years and under
1-4c Adults aged 18 years and older
1-5 Usual primary care provider
1-6 Difficulties or delays in obtaining needed health care
1-7 Core competencies in health provider training
1-8 Racial and ethnic representation in health professions
1-8a American Indian or Alaska Native—Health professions
1-8b Asian or Pacific Islander—Health professions
1-8c Black or African American—Health professions
1-8d Hispanic or Latino—Health professions
1-8e American Indian or Alaska Native—Nursing
1-8f Asian or Pacific Islander—Nursing
1-8g Black or African American—Nursing
1-8h Hispanic or Latino—Nursing
1-8i American Indian or Alaska Native—Medicine
1-8j Asian or Pacific Islander—Medicine
1-8k Black or African American—Medicine
1-8l Hispanic or Latino—Medicine
1-8m American Indian or Alaska Native—Dentistry
1-8n Asian or Pacific Islander—Dentistry
1-8o Black or African American—Dentistry
1-8p Hispanic or Latino—Dentistry
1-8q American Indian or Alaska Native—Pharmacy
1-8r Asian or Pacific Islander—Pharmacy
1-8s Black or African American—Pharmacy
1-8t Hispanic or Latino—Pharmacy
1-9 Hospitalization for ambulatory-care-sensitive conditions
1-9a Pediatric asthma
1-9b Uncontrolled diabetes
1-9c Immunization-preventable pneumonia or influenza

Emergency Services
1-10 Delay or difficulty in getting emergency care
1-11 Rapid prehospital emergency care
1-12 Single toll-free number for poison control centers
1-13 Trauma care systems
1-14 Special needs of children
1-14a On-line medical direction
1-14b Guidelines

Long-Term Care and Rehabilitative Services
1-15 Long-term care services
1-16 Pressure ulcers among nursing home residents

Arthritis, Osteoporosis, and Chronic Back Conditions
2-2 Activity limitations due to arthritis
2-3 Personal care limitations
2-6 Racial differences in total knee replacement
2-7 Seeing a health care provider
2-11 Activity limitations due to chronic back conditions

Cancer
3-10 Provider counseling about cancer prevention
3-11 Pap tests
3-12 Colorectal cancer screening
3-13 Mammograms

Diabetes
5-1 Diabetes education
5-4 Diagnosis of diabetes
5-11 Annual urinary microalbumin measurement
5-12 Annual glycosylated hemoglobin measurement
5-13 Annual dilated eye examinations
5-1. Annual foot examinations
5-16 Aspirin therapy

Disability and Secondary Conditions
6-7 Congregate care of children and adults with disabilities
6-10 Accessibility of health and wellness programs

Educational and Community-Based Programs
7-2 School health education
7-3 Health-risk behavior information for college and university students
7-5 Work site health promotion programs
7-7 Patient and family education
7-8 Satisfaction with patient education
7-12 Older adult participation in community health promotion activities

Family Planning
9-1 Intended pregnancy
9-2 Birth spacing
9-3 Contraceptive use
9-5 Emergency contraception
9-6 Male involvement in pregnancy prevention
9-10 Pregnancy prevention and sexually transmitted disease (STD) protection
9-11 Pregnancy prevention education
9-13 Insurance coverage for contraceptive supplies and services

Health Communication
11-2 Health literacy
11-6 Satisfaction with health care providers’ communication skills

Heart Disease and Stroke
12-1 Coronary heart disease (CHD) deaths
12-15 Blood cholesterol screening

HIV
13-8 HIV counseling and education for persons in substance abuse treatment
13-9 HIV/AIDS, STD, and TB education in State prisons
13-10 HIV counseling and testing in State prisons

Immunization and Infectious Diseases
14-5 Invasive pneumococcal infections
14-22 Universally recommended vaccination of children aged 19 to 35 months
14-23 Vaccination coverage for children in day care, kindergarten, and first grade
14-24 Fully immunized young children and adolescents
14-25 Providers who measure childhood vaccination coverage levels
14-26 Children participating in population-based immunization registries
14-27 Vaccination coverage among adolescents
14-28 Hepatitis B vaccination among high-risk groups
14-29 Influenza and pneumococcal vaccination of high-risk adults

Injury and Violence Prevention
15-7 Nonfatal poisonings
15-8 Deaths from poisoning
15-10 Emergency department surveillance systems
15-12 Emergency department visits
15-19 Safety belts
15-20 Child restraints
15-21 Motorcycle helmet use
15-23 Bicycle helmet use
15-24 Bicycle helmet laws

**Maternal, Infant, and Child Health**
16-1 Fetal and infant deaths
16-2 Child deaths
16-3 Adolescent and young adult deaths
16-17 Prenatal substance exposure
16-18 Fetal alcohol syndrome
16-20 Newborn bloodspot screening
16-22 Medical homes for children with special health care needs
16-23 Service systems for children with special health care needs

**Medical Product Safety**
17-3 Provider review of medications taken by patients
17-5 Receipt of oral counseling about medications from prescribers and dispensers

**Mental Health and Mental Disorders**
18-6 Primary care screening and assessment
18-7 Treatment for children with mental health problems
18-8 Juvenile justice facility screening
18-9 Treatment for adults with mental disorders
18-10 Treatment for co-occurring disorders
18-11 Adult jail diversion programs
18-12 State tracking of consumer satisfaction
18-13 State plans addressing cultural competence
18-14 State plans addressing elderly persons

**Nutrition and Overweight**
19-1 Healthy weight in adults
19-2 Obesity in adults
19-3 Overweight or obesity in children and adolescents
19-4 Growth retardation in children
19-17 Nutrition counseling for medical conditions
19-18 Food security

**Oral Health**
21-7 Annual examinations for oral and pharyngeal cancers
21-10 Use of oral health care system
21-11 Use of oral health care system by residents in long-term care facilities
21-13 School-based health centers with oral health component
21-14 Health centers with oral health service components
21-15 Referral for cleft lip or palate
21-16 Oral and craniofacial state-based surveillance system
21-17 Tribal, State, and local dental programs

**Physical Activity and Fitness**
22-12 School physical activity facilities
22-13 Work site physical activity and fitness
22-14 Community walking
22-15 Community bicycling

**Public Health Infrastructure**
23-1 Public health employee access to the Internet
23-2 Public access to information and surveillance data
23-3 Use of geocoding in health data systems
23-8 Competencies for public health workers
23-9 Training in essential public health services
23-10 Continuing education and training by public health agencies
23-12 Health improvement plans
23-13 Access to public health laboratory services
23-14 Access to epidemiology services

Respiratory Diseases
24-6 Patient education
24-7 Appropriate asthma care
24-11 Medical evaluation and follow-up

Sexually Transmitted Diseases
25-11 Responsible adolescent sexual behavior
25-13 Hepatitis B vaccine services in STD clinics
25-14 Screening in youth detention facilities and jails
25-15 Contracts to treat nonplan partners of STD patients
25-16 Annual screening for genital chlamydia
25-17 Screening of pregnant women
25-18 Compliance with recognized STD treatment standards
25-19 Provider referral services for sex partners

Substance Abuse
26-18 Treatment gap for illicit drugs
26-20 Treatment of injection drug use
26-21 Treatment gap for problem alcohol use
26-22 Hospital emergency department referrals

Tobacco Use
27-5 Smoking cessation by adults
27-7 Smoking cessation by adolescents
27-8 Insurance coverage of cessation treatment

Vision and Hearing
28-1 Dilated eye examinations
28-2 Vision screening for children
28-10 Vision rehabilitation services and devices
28-11 Newborn hearing screening, evaluation, and intervention
28-13 Rehabilitation for hearing impairment
28-14 Hearing examination
28-15 Evaluation and treatment referral
Cancer

Prevention, Early Detection, and Early Intervention

Breast, Lung, and Colorectal Cancer

Reducing Disparities
All Cancer

Goal: Reduce the number of new cancer cases as well as the illness, disability, and death caused by cancer.

**HP 2010 Measures and Local Measures**

<table>
<thead>
<tr>
<th>HP 2010 Measures and Local Measures</th>
</tr>
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<tbody>
<tr>
<td><strong>3-1 Reduce the overall cancer death rate.</strong></td>
</tr>
<tr>
<td>Target-setting method: 21 percent improvement</td>
</tr>
<tr>
<td>Data source: National Vital Statistics System (NVSS), CDC, NCHS</td>
</tr>
<tr>
<td><strong>3-2 Reduce the lung cancer death rate.</strong></td>
</tr>
<tr>
<td>Target setting method: 22 percent improvement.</td>
</tr>
<tr>
<td>Data source: National Vital Statistics System (NVSS), CDC, NCHS</td>
</tr>
<tr>
<td><strong>3-3 Reduce the breast cancer death rate.</strong></td>
</tr>
<tr>
<td>Target: 22.3 deaths per 100,000 females</td>
</tr>
<tr>
<td>Baseline: 27.9 breast cancer deaths per 100,000 females occurred in 1998.</td>
</tr>
<tr>
<td>Target-setting method: 20 percent improvement</td>
</tr>
<tr>
<td>Data source: National Vital Statistics system (NVSS), CDC, NCHS</td>
</tr>
<tr>
<td><strong>3-5 Reduce the colorectal cancer death rate.</strong></td>
</tr>
<tr>
<td>Target: 13.9 deaths per 100,000 population</td>
</tr>
<tr>
<td>Baseline: 21.2 colorectal cancer deaths per 100,000 population occurred in 1998 (age adjusted to the year 2000 standard population).</td>
</tr>
<tr>
<td>Target-setting method: 34 percent improvement</td>
</tr>
<tr>
<td>Data source: National Vital Statistics System (NVSS), CDC, NCHS</td>
</tr>
<tr>
<td><strong>3-10 Increase the proportion of physicians and dentists who counsel their at-risk patients about tobacco use cessation, physical activity, and cancer screening.</strong></td>
</tr>
<tr>
<td>This indicator is developmental. Complete operational definitions have not been specified.</td>
</tr>
<tr>
<td>Target-setting method: Better than the best.</td>
</tr>
<tr>
<td>Data sources: Survey of Physicians’ Attitudes and Practices in Early Cancer Detection, NIH, NCI; National Ambulatory Medical Care Survey (NAMCS), CDC, NCHS; Survey of Current Issues in Dentistry, American Dental Association</td>
</tr>
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The 2002 local BRFSS survey will provide more accurate information regarding local people’s behaviors related to cancer screening and prevention activities. This will guide future indicator choices.
National statistics indicate a disturbing rise in the incidence of cancer over the past ten years. More than any other, this disease strikes a chord of resignation and helplessness in individuals and families dealing with its human toll. According to the Centers for Disease Control and Prevention, cancer is the second leading cause of death behind heart disease. However, considerable good news is imbedded in this statistic. Much of the apparent rise in incidence has to do with improved early detection techniques and effective interventions. While the incidence rate appears to be increasing, the death rate is decreasing.

More people are living longer with cancer. Clinical trials have demonstrated that mammography screening can reduce breast cancer deaths by 20 to 39 percent in women aged 50 to 75 years. Detection and removal of precancerous polyps through sigmoidoscopy and colonoscopy is key to colorectal cancer survival. With the introduction of the prostate-specific antigen test in 1992, early detection and intervention occurs much more frequently in diagnosing prostate cancer.

Studies indicate that communities and individuals have greater control over the likelihood of contracting the most common cancers through improved dietary habits, increased physical activity, and elimination of self-destructive habits such as smoking and over exposure to the sun.

According to the American Cancer Society, nearly one third of the more than 500,000 annual U.S. cancer deaths are attributable to diet and physical activity behaviors. For example, physical activity decreases the amount of exposure of breast tissue to circulating estrogen thus reducing risk for breast cancer. The risk of colon cancer is similarly reduced because physical activity accelerates the movement of food through the digestive system, reducing the time that the lining of the bowel is exposed to potentially cancer-causing substances. Obesity significantly increases the risk of breast cancer and colorectal cancer. Even if the individual is not obese, a diet high in fat and low in fruits and vegetables is a strong risk factor. In addition, cigarette smoking causes 87% of all lung cancer.

A very disturbing trend nationally and echoed in every community with racial/ethnic diversity is a much higher rate of mortality from these cancers in the black and Hispanic communities. This seems to indicate that not everyone is being reached with cancer prevention and early detection strategies and screenings. This disparity has prompted, since April 2000, several action task forces initiated by both the Centers for Disease Control and Prevention and the National Cancer Institute to address the issue. When seeking to reduce cancer death rates, each community must evaluate resources and interventions especially directed toward its racially diverse populations. Socioeconomics plays a role in the availability of cancer interventions. The higher the income and education level for any individual, regardless of race or ethnic background, the greater the likelihood that individual will survive cancer. Without special attention to the issue of disparity, no community can hope to effectively reduce its cancer death rate.
The key to success in achieving locally adopted HP 2010 target objectives appears to be in the areas of early detection, intervention, prevention, and elimination of disparity in cancer death rates.

All cancers combined are the second leading cause of death in the United States. During 2000, an estimated 1,220,100 persons were expected to be diagnosed and 552,200 persons were expected to die from cancer. One-half of the new cases of cancer occur in people aged 65 and over. Lung and bronchus, prostate, female breast, and colon and rectum were the most common cancers for all racial and ethnic populations in the United States and together they accounted for approximately 54 percent of all newly diagnosed cancers. Four in ten people diagnosed with cancer in a given year are expected to be alive five years after diagnosis. This rate means that the chance of a person recently diagnosed with cancer being alive in five years is 60 percent of the chance of someone not diagnosed with cancer. Commonly, these five-year survival rates are used to monitor progress in the early detection and treatment of cancer. All persons who are living five years after diagnosis, whether in remission, disease free, or under treatment, are included.

Causes of cancer incidence are as varied as the types of cancers. Environmental pollutants, exposure to chemicals, chronic infections such as Hepatitis B, tobacco use, overexposure to UV rays, and various personal health issues such as obesity and lack of physical activity, play a role in the rise of cancer incidence. Because this health issue is complex, and because interventions for the five most common cancers carry implications for the others, we will focus on the most common. According to the American Cancer Society, other less common cancers in descending order of their contribution to total cancer deaths include: Non-Hodgkins’ Lymphoma (4.4 per cent of deaths), Liver and intrahepatic bile duct (2.3 percent of deaths), Esophagus (2.2 percent of deaths), Melanoma (1.4 percent), Acute Myeloid Leukemia (1.3 percent), and Soft Tissue including Heart (0.7).

In addition to the staggering human toll, the financial burden of cancer is substantial. The overall annual costs for cancer are estimated at $107 billion, with $37 billion for direct medical costs, $11 billion for costs of illness (low productivity due to illness), and $59 billion for costs of death (lost productivity due to death).

Uterine/cervical, colorectal, and breast cancers, besides being among the most prevalent cancers in this country, are also more likely to be cured if they are detected early. Early detection tends to prevent long-term illness or death. This indicator reflects whether or not individuals are able or willing to avail themselves appropriately of screening examinations. Furthermore, it reveals the ability of the health care system to provide screening exams in addition to the effectiveness of the health care delivery system in ensuring that individuals are scheduled at the proper intervals for these examinations. Information about the stage of disease at the time of diagnosis would best be provided by a locally-based cancer registry but may be supplemented by the National Hospital Discharge Survey. Attitudes and behaviors concerning screening can be measured through the Behavioral Risk Factor Surveillance Survey.

Physicians are also encouraged to be more aggressive in certain cancer screenings and prevention counseling. Although the indicator is in development, the following table provides some guidelines for local areas and institutions interested in promoting these activities among their provider population.
Increase the proportion of physicians and dentists who counsel their at-risk patients about tobacco use cessation, physical activity, and cancer screening.

<table>
<thead>
<tr>
<th>Target and baseline:</th>
<th>1988</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective</td>
<td>Baseline</td>
<td>Target</td>
</tr>
<tr>
<td>Increase in Counseling About Tobacco Use Cessation, Physical Activity, and Cancer Screening (unless noted)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3-10a. Internists who counsel about smoking cessation</td>
<td>50</td>
<td>85</td>
</tr>
<tr>
<td>3-10b. Family physicians who counsel about smoking cessation</td>
<td>43</td>
<td>85</td>
</tr>
<tr>
<td>3-10c. Dentists who counsel about smoking cessation</td>
<td>59 (1997)</td>
<td>85</td>
</tr>
<tr>
<td>3-10d. Primary care providers who counsel about blood stool tests</td>
<td>56</td>
<td>85</td>
</tr>
<tr>
<td>3-10e. Primary care providers who counsel about proctoscopic examinations</td>
<td>23</td>
<td>85</td>
</tr>
<tr>
<td>3-10f. Primary care providers who counsel about mammograms</td>
<td>37</td>
<td>85</td>
</tr>
<tr>
<td>3-10g. Primary care providers who counsel about Pap tests</td>
<td>55</td>
<td>85</td>
</tr>
<tr>
<td>3-10h. Primary care providers who counsel about physical activity</td>
<td>22 (1995)</td>
<td>85</td>
</tr>
</tbody>
</table>

Smoking cessation, adoption of healthy diets, increased physical activity, and increased cancer screening can all contribute to reduced numbers of cancer deaths. Experts recommend that providers screen patients for breast, cervical, and colorectal cancers and counsel patients to prevent or reduce tobacco use, promote physical activity, and promote a healthy diet. Provider counseling should be conducted in a linguistically and culturally appropriate manner.

Research studies comparing the effects of both education and income on the tendency of women to avail themselves of screening exams for breast and cervical cancer show that both higher income and higher education result in greater prevalence. A study reported by the Journal of the National Cancer Institute in April of 2002 concluded that a lower income status is more important than race in determining the quality of medical care for women with breast cancer. The study used a cancer registry in Detroit to identify women with breast cancer and then searched for those included who were also on Medicaid, a program that provides medical care for the poor. Researchers found that women on Medicaid were 41 percent more likely to be diagnosed with late-stage breast cancer and 44 percent less likely to receive radiation, a key part of therapy. Women on Medicaid were three times more likely to die of the disease than were non-Medicaid patients. It seems likely that if one doesn’t receive regular care prior to diagnosis, one is more likely to be in a late stage of the disease when diagnosed. Furthermore, analysis provided by the Behavioral Factor Surveillance Survey (BRFSS) in the state of Pennsylvania, 1993–1997, showed that increased household income led to a higher prevalence of screening through mammography, clinical breast exam, and Pap smear.

Five-year survival rates in colorectal cancer for the 1989–94 period are 64 percent in whites and 52 percent in African Americans. Early detection and treatment also play a key role in improving survival rates.
role in these survival rates. Dr. Otis Brawley of the Winship Cancer Institute of Emory University, in an article in the Journal suggests that “rather than speaking in racial/ethnic terms of black and white population, it is more appropriate to speak in socio-economic terms of the ‘haves’ and ‘have nots’. This focus would rightfully bring other socio-economically deprived populations that include whites, Hispanics, Native American, and Asians into the discussion.”

Recent Trends

Some progress is being made in the protracted fight against deaths caused by the major cancers. Cancer death rates for all sites combined decreased an average of 0.6 percent a year from 1990–1996. This decrease occurred after rates had increased by 0.4 percent per year from 1973 to 1990. Death rates for male lung, female breast, prostate, and colorectal cancers decreased significantly during the 1990–1996 period.

Lung cancer is the number one cause of cancer death among men and women in all racial and ethnic groups. This cancer is linked to smoking and smoking cessation trends led to a 1.9 percent decrease per year in men from 1992 to 1998. Unfortunately, for women, death from lung cancer increased at a rate of 0.8 percent per year in the same time period.

Female breast cancer is one of a dozen cancers with an upward statistical trend, showing a 1.2 percent per year increase in incidence from 1992 to 1998. Since increases are limited to early stage breast cancer (I and II), this trend may be related to increased screening, particularly with mammograms. Other factors, such as an increase in obesity, may have contributed to the increase. Breast cancer death rates decreased 1.6 percent annually from 1989 to 1995 and then more rapidly, at a rate of 3.4 percent per year between 1995 and 1998. Again, early detection and better screening and treatment probably contribute to these rates of decrease.

Data on colorectal cancer shows a decline in new cases and death rates in white males and females, stable new cases in African Americans, and a continued rise in death rates in African American males. Five-year survival rates for 1989 to1994 were 64 percent in whites and 52 percent in African American males. Early detection and treatment play a key role in these survival rates.

Local Context

In Lancaster County, the overall cancer mortality rate (age-adjusted 116 per 100,000) is lower than that of the state overall, most referent areas, and the HP 2010 objective of 159 per 100,000. The site-specific, age-adjusted cancer incidence rates indicate that breast, lung, and colorectal cancers are the leading causes of cancer in the county. Again, the rates for these cancers are below those reported for the state overall and each reference county. However, the death rate from breast cancer is higher than the state, each surrounding county, and considerably higher than the HP 2010 objective of 22.2/10,000 cases. Two of the three cancers most prevalent in Lancaster County, breast and colorectal, both have effective screening technologies to provide early detection, which greatly increases survival rate.

Breast Cancer

In 2002, the American Cancer Society estimates:
- 11,000 new cases of breast cancer will be diagnosed among women in Pennsylvania.
- 2,200 women will die of breast cancer in Pennsylvania.

In 1998, the Behavioral Risk Factor Surveillance System of the U.S. Department of Health and Human Services monitored Lancaster County for risk factors contributing to premature death. Results revealed that 75.1 percent of Lancastrians eat very few fresh fruits and vegetables. The same group is also sedentary, the highest risk factor for premature death. It is ironic that an area referred to statewide as the “Garden Spot” would have residents whose consumption of the local bounty is scarce. The BRFSS data for Lancaster also indicates that 57 per cent of adults report being overweight, 21 percent use cigarettes, 14.5 percent report acute drinking, and 3 percent reporting chronic drinking. The local 2002 BRFSS will provide more accurate information regarding at-risk behaviors.
Lancaster County reflects, along with the rest of the nation, a trend toward higher percentages of obesity and, tragically, much greater rates of obesity in its children. Weight issues are generally regarded to be a personal vanity problem and possibly a mobility problem. The public seems largely unaware of their heightened risk for the most prevalent cancers as a result of their dietary habits. They know that cigarettes can cause lung cancer, but they are blissfully unaware that super-sizing their fast food choices and eating saturated fats will put them on the fast track to a cancer diagnosis.

Against the backdrop of this local dietary landscape stand the American Cancer Society’s new guidelines (February 2002) that stress adopting a diet with a wide variety of healthy foods that are primarily plant-based.

Attitudes toward physical exercise are best exemplified by the changing curriculum in Lancaster County schools and public schools across the nation regarding physical education. Over the past ten years, in the face of educational reform calling for heavy emphasis on “the basics,” the state has permitted school districts to greatly reduce physical education time. The importance of physical activity in leading a full and healthy life is not being emphasized by the actions of community institutions. In addition, pedestrian activity is discouraged in the county by the presence of farmland and the tendency of drivers within cities to disregard the rights of those on foot. Furthermore, rapid population growth over the past 25 years has rendered the available parks and trails for exercise inadequate to the needs of the local populace.

Mortality/incidence ratios for Lancaster County from the Pennsylvania Department of Health report, *Cancer Incidence and Mortality*, 1994–1998, indicates that the ratio among white women is commensurate with the state level. The ratio for black women is considerably higher. Furthermore, the gap is greater than Lancaster’s peer counties, neighbors, and the state. Clearly, this is a great area of concern in reaching the goal of reduced death rates locally. This report will present the most prevalent cancers in the community—breast, lung, and colorectal—in this order, starting with the cancer showing the most disparity.

Possible disparities regarding the health status of lesbian women and possible barriers to access to health service by lesbians has been identified by the Institute of Medicine as a research priority. Better local research and tracking statistics would allow us to know to what degree this group is contributing to the unacceptably high cancer death rate.
Disparities

- Cancer death rates vary by gender, race, and ethnicity.
- Lung cancer deaths among males have declined since 1990 while female lung cancer deaths have continued to rise.
- The four leading cancer sites for the five racial/ethnic populations (Caucasian, African American, Asian/Pacific Islanders, Native American/Alaskan Native, and Hispanic) are: lung and bronchus, prostate, female breast, and colorectal.
- African Americans are 34 percent more likely to die of cancer than whites and more than two times more likely to die of cancer compared to the other ethnic/racial populations.
- African American women are more likely to die of breast cancer and colon cancers than are women of any other racial/ethnic group.
- African American men have the highest death rates of colon, rectum, lung, and prostate cancers.
- Hispanics have higher rates of cervical, esophageal, gallbladder, and stomach cancers than those of non-Hispanic whites.
- New cases of female breast and lung cancer are increasing among Hispanics, who are diagnosed at later stages and have lower rates of survival than non-Hispanic whites.

Researched Best Strategies

Evidence suggests that several types of cancer can be prevented and that the prospects for surviving cancer continue to improve. The ability to reduce cancer death rates depends, in part, on the existence and use of various types of resources. First, it is essential to make certain that culturally and linguistically appropriate information on prevention, early detection, and treatment is provided for everyone in a culturally diverse population. Collaboration with acknowledged leaders within the racially/ethnically diverse community is critical to the success of this endeavor. Best means for reaching the public can only be ascertained in this way. Screening techniques, such as mammography and colonoscopy, are under-utilized.

Secondly, means or systems must exist for providing all people with access to state-of-the-art preventive services and treatment. Where suitable, participation in clinical trials also should be encouraged.

Third, continued progress in research must be fostered. Genetic information is emerging as a result of new research that can be used to improve the effectiveness of both clinical and preventive medical services. Vital research on the causes of cancer (including genetic and environmental) needs to translate biologic and epidemiological findings into effective prevention and control programs for use by government and community agencies.

Fourth, a national cancer surveillance system that collects information across the entire life cycle could be used to target populations with prevention and early detection initiatives, to focus research, and to improve access to treatment and palliative care for all cancer patients and survivors.

In addition, every five years, the American Cancer Society works with experts in the fields of nutrition, physical activity, and cancer prevention to review current scientific evidence in order to develop recommendations regarding the relationship between diet, activity, and cancer risk. The Society’s 2002 guidelines for prevention of cancer include for the first time recommended changes within workplaces, schools, and communities to ensure that Americans have opportunities to be physically fit and eat healthfully. Changes are needed in school curricula toward a greater emphasis on health and physical activity; in workplaces, policies need to be initiated that support activity; and in government, zoning and urban planning must consciously provide and promote activity. Recommended healthy diet guidelines (higher consumption of fresh fruits and vegetables, eating whole grains, limiting saturated fats), are well established but need to be aggressively promoted by doctors, dentists, and all civic and social service organizations. Tobacco reduction programs (tobacco smoking is responsible for 30 percent of all cancer deaths) and other prevention programs such as sunscreen education to prevent melanoma and immunization against Hepatitis B to prevent infection must be supported and expanded.
Finally, central to the success of cancer prevention strategies nationwide is reducing racial/ethnic/gender disparities across diverse populations by disseminating information and treatment to all people to increase survival, improve quality of life, and decrease mortality. Training programs are needed to increase the diversity of scientists in biomedical research and to enhance existing careers.

Businesses and Institutions
- Actively support local, state, and national initiatives such as the American Cancer Society's Relay for Life by fielding teams and supporting walkers.
- Provide the ACS’ educational materials on diet, activity, and preventive screenings for employees and reinforce reminders of the value of proactivity in the face of cancer risk.
- Accommodate the workplace needs of cancer survivors as employees with an attitude that emphasizes their continuing value to the work environment.
- Build incentives into smoking cessation programs.
- Encourage workplace weight reduction programs such as those offered by Weight Watchers, providing space, time, and incentives for those who succeed.
- Sponsor and support health fairs provided by area churches and other community agencies as a means to promote cancer-preventing lifestyle choices.

Individuals
- Smoke less or quit smoking.
- Exercise a minimum of 30 minutes per day.
- Participate in a weight-loss regimen if you are overweight.
- Know and follow the American Cancer Society's researched guidelines for prevention of cancer through dietary food choices.
- Know and commit to the recommended screening and early detection programs for your age and gender.
- Take an active role in your health and that of your children in partnership with a family physician.
- Research and know the risk factors for cancer that are particular for you through family health history and environmental factors (workplace exposure, air and water quality where you live, secondhand tobacco smoke.) Do what you can to avoid unnecessary exposure.

Breast Cancer

<table>
<thead>
<tr>
<th>3-3 Reduce the breast cancer death rate.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target:</strong> 22.3 deaths per 100,000 females</td>
</tr>
<tr>
<td><strong>Baseline:</strong> 27.9 breast cancer deaths per 100,000 females occurred in 1998 (age adjusted to the year 2000 standard population).</td>
</tr>
<tr>
<td><strong>Target-setting method:</strong> 20 percent improvement</td>
</tr>
<tr>
<td><strong>Data source:</strong> National Vital Statistics System (NVSS), CDC, NCHS</td>
</tr>
</tbody>
</table>

Breast cancer is the most common cancer among women in the United States. An estimated 184,000 new cases were expected to be diagnosed in 2000, with 40,800 deaths. These numbers account for 15.2% of the cancer deaths among women (Landis and Bolden, 2000, 2398–2424). When approximately one out of every nine women has received a breast cancer diagnosis, the human toll impacts nearly every family in this country. These women are...
mothers, daughters, spouses, and valued members of the work force at every level. Even when they survive, the impact of their disability during cancer treatment and sometimes continuing afterward requires families and workplaces to support them and compensate for the loss of their considerable services.

The need to identify causes of breast cancer is intensified by a rising incidence rate over the past ten years. Because the rises are in early stage cancers (I and II), some of that increase might be attributable to better early detection technologies. Furthermore, women may be becoming more vigilant in getting scheduled mammography and clinical breast examinations performed by a health professional and in performing their own breast self-examinations. Risk factors for breast cancer that cannot be changed include gender, age, race, inherited genetic factors, a family history of breast cancer, previous occurrence, previous breast irradiation, and lengthy lifetime menstruation (early at age 12 to after age 50). Awareness of these factors can motivate a woman and her physician to be more aggressive in utilizing detection measures and in avoiding the risk factors that are lifestyle related.

No woman likes to hear that she may have participated in causing her own breast cancer. This message is not emphasized post-diagnosis out of sheer compassion and respect for the struggles that are about to ensue. More women, however, need to know and be firmly reminded by their health care professionals that lifestyle choices can result in a breast cancer diagnosis. The most controllable of these choices involve obesity, fat consumption, alcohol consumption, and physical inactivity. According to the American Cancer Society, research studies have repeatedly and clearly shown that healthful choices in these areas reduce the risk of breast cancer.

According to the Pennsylvania Department of Health’s report, Cancer Incidence and Mortality, 1994–98, Lancaster County has a lower than average incidence of breast cancer when compared to both its peer counties and the state as a whole. What is alarming is that it has a higher than average death rate from breast cancer.
A closer look at the available statistical information would shed more light on precisely where within this group the death rate is the highest.

According to the Census 2000 Redistricting Data, Lancaster County's population was 5.7% Hispanic or Latino of any race, 2.8% African American or Black, and 1.4% Asian (State and County QuickFacts, http://www.census.gov). These were the largest racial/ethnic groups after whites. We know from the national data that the breast cancer death rate among black women is higher than among white women. The Pennsylvania Department of Health statistics find that this is especially true in Lancaster County.

There are no available data of the same sort for Hispanic women specific to this county, though we know that nationwide they too are diagnosed at later stages and are more likely to die from breast cancer even though their incidence rate is lower. Since Hispanics constitute the largest racial/ethnic minority in Lancaster County, more research must be done to discover how the community is faring in terms of death rate and the availability of appropriate medical care, including utilization of early detection methods.

Other data available concerning state and national trends in health-related behaviors can be projected on local minority groups in the absence of current local statistics. One of the top risk factors for breast cancer for all women is obesity. The Pennsylvania Department of Health’s new *Special Report on Minority Health*, April 2002, points out that 20 percent of white non-Latinos, 32 percent of black non-Latinos, and 19 percent of Latinos are obese. However, the report cites a national study in 1996 that reported that 33 percent of all Hispanic women were overweight. Of even greater concern is the fact that between 1986 and 1998, the national percentage of black and Hispanic children who were overweight increased by 120 percent, while the rate for white children increased 50 percent. Greater disparity is very probable for the future both in Lancaster County and throughout the country.

Being overweight is a well-established breast cancer risk, especially for postmenopausal women. Since the incidence of breast cancer is highest in this group, attention to healthful diet and weight loss must be presented as being as important as early detection strategies. Physical activity is an integral part of this picture.

Following the American Cancer Society's guidelines for early detection of breast cancer improves the chances that breast cancer can be diagnosed early and treated successfully. All women should be aware of these guidelines, and means should be provided for all women to...
follow them. Women aged 40 or older should have a mammogram each year. Between the
ages of 20 and 39, women should have a clinical breast exam by a health professional every
three years; after 40, every year. Women aged 20 and older should perform breast self-exami-
nation every month and should be taught how to properly conduct this exam.

Information concerning risk factors that can be controlled and the effectiveness of
early detection techniques in reducing the death rate must be presented to racial/ethnic minority
groups in a culturally sensitive, language appropriate format. Directly involving the leadership in these groups from the outset is the only effective way to connect with the women who most need to hear the message.

**Businesses and Institutions**
- Conduct an evaluation of availability of health resources located along lines of public
  transportation and proximate to low income and racial/ethnic groups most in need of
  improved adherence to early detection guidelines.
- Seek practical means to insure that geographical issues do not prevent recommended care.
- With the help of local leaders in minority communities, create health fairs and educa-
tion sessions within the community that are culturally sensitive and designed to inform
women of risk factors in a way that motivates them to become personally responsible
for those factors they can control.
- Investigate the availability of regular preventive care to women at high risk of breast
cancer to prevent late diagnosis and ensure survival.
- Local physicians and other health care providers recommit themselves to using blunt
  messages to women regarding the top risk factors, obesity and lack of physical activity.
- Seek financial supporters within the community for a media campaign directed
  toward women regarding the connection between weight loss and reduced breast can-
cer risk. The only message being heard right now is from the pharmaceutical company
  selling preemptive Tamoxifen.

**Individuals**
- Know and follow the age appropriate guidelines for mammography and clinical
  breast exam.
- Learn and perform breast self-exam monthly.
- Exercise a minimum of 30 minutes per day.
- Maintain a healthy weight by reducing calories, eating at least five fruits and
  vegetables daily, using whole grains, and eliminating saturated fats.
- Avoid alcohol consumption.
- Do not smoke.
- Educate yourself regarding your risk factors not subject to intervention (family
  history, reproductive history, age).

**National Cancer Institute:** [http://www.cancer.gov](http://www.cancer.gov)
**American Cancer Society:** [http://www.cancer.org](http://www.cancer.org)
**Susan G. Komen Breast Cancer Foundation:** [http://www.komen.org](http://www.komen.org)
**The Breast Cancer Network:** [http://www.breastcancer.net](http://www.breastcancer.net)
**The Y-Me Breast Cancer Organization:** [http://www.y-me.org](http://www.y-me.org)
Lung Cancer

“When you can’t breathe, nothing else matters.” This logo heads the American Lung Association’s home page on its Web site. Lung cancer is the most tragic of the cancers because, in most cases, it is totally preventable. Yet it is the leading cancer killer among both men and women, with an estimated 164,100 new cases and 156,900 deaths in this country in 2000. (American Lung Association, 2002, “What is Lung Cancer,” para. 1) Furthermore, early detection is very difficult, treatment does not lead to remission, and the only way to reduce this horrendous death toll is through aggressive prevention campaigns. Use of tobacco is responsible for all but 13% of lung cancer cases. Cigarettes contain over 4,000 different chemicals, most of which are proven carcinogens. The second leading cause of lung cancer in the United States today is radon, an odorless gas that seeps up through the soil and into the cracks in the foundations of homes and buildings. Our modern buildings are more airtight than ever before, making the risks much greater. The Environmental Protection Agency estimates that approximately 1 in 15 homes has indoor radon levels unacceptably high. Radon causes 12 percent of all lung cancer deaths. (American Lung Association, 2002, “What Causes Lung Cancer?,” para. 4).

Lung cancer is deadly because, in its early stages, it does not cause symptoms. When symptoms such as chronic cough, hoarseness, shortness of breath, weight loss, and coughing up blood, do occur, the cancer is often advanced. As indicated by Pennsylvania Department of Health studies, more men die of lung cancer than women, with African American men having the highest mortality of any group.

As is the case with female breast cancer, Lancaster County has an equivalent or lower lung cancer incidence than its peers and the state. However, we again show a significantly higher ratio of deaths to incidence. This takes place in a statistical environment in Pennsylvania reported by the Centers for Disease Control and Prevention where the age-adjusted mortality rate, based on the 2000 standard population, per 100,000 population, is 46.8 for whites and 79.8 for blacks. Centers for Disease Control and Prevention Surveillance Report, states that we clearly have some work to do as a community in getting the message out to those who are not choosing to hear at the current levels of communication. Tobacco use levels are too high and radon detection and remediation is occurring too infrequently.

Lung Cancer

In 2002, the American Cancer Society estimates:

- 8,700 new cases of lung cancer will be diagnosed among men and women in Pennsylvania.
- 8,000 men and women will die of lung cancer in Pennsylvania.

The average annual age-adjusted mortality rates for lung cancer deaths per 100,000 persons, by race, 1995-1999.
In its TIPS Report (Tobacco Information and Prevention Source), the Centers for Disease Control and Prevention points out that African American men are 50% more likely than white men to develop lung cancer and have a higher rate of mortality. (Centers for Disease Control and Prevention, 1998, African Americans and Tobacco, para. 4). There is no reason to think that Lancaster County's incidence/mortality rate contains anything but a similar disproportionate burden carried by African American men.
Businesses and Institutions

- Follow guidelines regarding smoking cessation strategies through the workplace provided in the “Tobacco Use” chapter.
- Be aware and informed regarding workplace air quality and the risks of airborne pollutants in increasing the risks of lung cancer.
- Contribute to community coalitions looking for media sponsors for campaigns against smoking.
- Field an employee-driven team for the annual Relay for Life events in our area to raise awareness and build cooperative attitudes. New team kits are available at the American Cancer Society.

Individuals

- Smoke less, and then quit.
- Seek help to quit through support groups and medical interventions.
- Don’t allow others to smoke in your home and patronize no-smoking establishments.
- Know the warning signs for lung cancer if you smoke. Work in partnership with your family physician to monitor your lungs while you are in the process of quitting.
- Have your home tested for radon and, if the levels are unacceptably high, contract for the interventions that will reduce the effect of this silent killer.

Colorectal Cancer

3-5 Reduce the colorectal cancer death rate.

Target: 13.9 deaths per 100,000 population
Baseline: 21.2 colorectal cancer deaths per 100,000 population occurred in 1998 (age adjusted to the year 2000 standard population).
Target-setting method: 34 percent improvement
Data source: National Vital Statistics System (NVSS), CDC, NCHS

<table>
<thead>
<tr>
<th>Total Population, 1998</th>
<th>Colorectal Cancer Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rate per 100,000</td>
</tr>
<tr>
<td>TOTAL</td>
<td>21.2</td>
</tr>
<tr>
<td>Race and ethnicity</td>
<td></td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>13.3</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>13.7</td>
</tr>
<tr>
<td>Asian</td>
<td>DNC</td>
</tr>
<tr>
<td>Native Hawaiian and other Pacific Islander</td>
<td>DNC</td>
</tr>
<tr>
<td>Black or African American</td>
<td>28.2</td>
</tr>
<tr>
<td>White</td>
<td>20.8</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>12.8</td>
</tr>
<tr>
<td>Not Hispanic or Latino</td>
<td>21.7</td>
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<tr>
<td>Black or African American</td>
<td>28.9</td>
</tr>
<tr>
<td>White</td>
<td>21.1</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>18.2</td>
</tr>
<tr>
<td>Male</td>
<td>25.4</td>
</tr>
<tr>
<td>Education level (aged 25 to 64 years)</td>
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</tr>
<tr>
<td>Less than high school</td>
<td>10.4</td>
</tr>
<tr>
<td>High school graduate</td>
<td>12.0</td>
</tr>
<tr>
<td>At least some college</td>
<td>7.5</td>
</tr>
</tbody>
</table>

DNA=Data have not been analyzed. DNC=Data are not collected. DSU=Data are statistically unreliable. Note: Age adjusted to the year 2000 standard population.

Colorectal cancer is the second leading cause of cancer-related deaths in the United States. Risk factors that cannot be controlled include a family history of colorectal cancer, familial syndromes for this cancer, a past history of colorectal cancer, a history of intestinal polyps or chronic inflammatory bowel disease, and aging (90 percent of cases diagnosed are in people over age 50). Risk factors associated with controllable behaviors include a diet high in fat, especially from animal sources, and low in fiber from
lack of fruits, vegetables, and whole grains and legumes. Physical inactivity and obesity increase the risk of colorectal cancer, as does smoking. Early detection through the use of yearly Fecal Occult Blood Tests at age 50 and sigmoidoscopy every five years after age 50 is the best defense against colorectal cancer. These methods detect polyps that develop into cancer. Removing them before they grow results in a total cure.

The age-adjusted death rate from colorectal cancer in Lancaster County is significantly higher than the rate of its peer counties and the state, even though its incidence rate is lower. This discrepancy, as with breast cancer mortality rates, sends a strong message to the community that perhaps we are failing in the effort to get across the message that this cancer can be completely cured through early detection. While our unhealthy eating habits and lack of exercise put us at the same level of incidence statewide, it is apparent that too few of us are following guidelines for early detection and prevention.

**Colorectal Cancer**

In 2002, the American Cancer Society estimates:
- 8,700 new cases of colorectal cancer will be diagnosed among men and women in Pennsylvania.
- 3,300 men and women will die of colorectal cancer in Pennsylvania.

### Local Context

<table>
<thead>
<tr>
<th>Cancer of the Colon, 1994–1998</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age-Adjusted Mortality</strong>*</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Lancaster</td>
</tr>
<tr>
<td>Peers**</td>
</tr>
<tr>
<td>Neighbors**</td>
</tr>
<tr>
<td>State</td>
</tr>
</tbody>
</table>

*per 100,000 of population; age-adjustment to 1970 standard million population

** weighting for Peer and Neighbor aggregations by number of cases

### Total Deaths

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
<th>Male</th>
<th>Female</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lancaster</td>
<td>242</td>
<td>267</td>
<td>497</td>
<td>533</td>
<td>.49</td>
<td>.50</td>
</tr>
<tr>
<td>Peers</td>
<td>501</td>
<td>560</td>
<td>1,284</td>
<td>1,339</td>
<td>.39</td>
<td>.42</td>
</tr>
<tr>
<td>Neighbors</td>
<td>808</td>
<td>869</td>
<td>1,861</td>
<td>1,990</td>
<td>.43</td>
<td>.44</td>
</tr>
<tr>
<td>State</td>
<td>7,176</td>
<td>7,933</td>
<td>16,551</td>
<td>18,119</td>
<td>.43</td>
<td>.44</td>
</tr>
</tbody>
</table>


### Overall Population

<table>
<thead>
<tr>
<th></th>
<th>Pennsylvania</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>24.7</td>
<td>21.7</td>
</tr>
<tr>
<td>White</td>
<td>24.2</td>
<td>21.3</td>
</tr>
<tr>
<td>Black</td>
<td>32.1</td>
<td>29.0</td>
</tr>
<tr>
<td>Hispanic</td>
<td>11.8</td>
<td>12.9</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>10.3</td>
<td>13.3</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>–</td>
<td>13.5</td>
</tr>
</tbody>
</table>

Source: American Cancer Society Facts and Figures, 2002. Estimates exclude more than a million cases of basal and squamous cell skin cancers and in situ cancers, except urinary bladder, that will be diagnosed in 2002. Lung cancer rates include bronchus cancer.

State death totals were rounded to nearest 100. Hyphens represent suppression of rates when there were 75,000 or fewer persons in the denominator or 20 or fewer deaths in the numerator.
As is indicated by the research of the National Center for Health Statistics, the pattern again repeats itself. African Americans in the state of Pennsylvania are more likely to die of colon cancer than whites (mortality rate per 100,000 21.8 for whites, 32.6 for blacks (Centers for Disease Control and Prevention, wonder, compressed mortality). This pattern is reflected nationally.

**Businesses and Institutions**
- With the help of local leaders in minority communities, create health fairs and education sessions that are culturally sensitive and designed to inform about the prevalence of colorectal cancer and the strategies to prevent death.
- Local churches, through congregation nurses and pastors, can help initiate health education courses under the title of responsible stewardship of the body. Preventable cancer such as colorectal can be a cornerstone.
- Workplaces can provide information to employees by willingly distributing pamphlets and materials regarding fecal occult tests, sigmoidoscopies, and colonoscopies for all employees over 50.
- Local physicians and health care providers can recommit themselves to providing blunt messages about lifestyle preventions such as proper diet and exercise along with the early detection tests.
- Community leaders can contact the Centers for Disease Control for their “Screen for Life—National Colorectal Cancer Action Campaign,” which provides materials that are reproducible and easily adapted for education of the general public. State-specific data is available through this program.

**Individuals**
- Eat foods high in fiber and low in fat.
- Exercise a minimum of thirty minutes daily.
- Investigate and be aware of family genetic risk factors.
- Take a proactive role with your family doctor to assure that you get a yearly Fecal Occult Blood Test after age 50, a sigmoidoscopy every five years, and a colonoscopy every ten years.
- Do not allow lack of knowledge and misplaced modesty to prevent you from taking advantage of these life-saving early detection strategies.
Additional Questions

- Are there any connections between our cancer rates in Lancaster County and the use of pesticides and herbicides particularly in light of the high number of households using on-site well water as a drinking source?
- How do we increase the availability of affordable fresh fruits and vegetables to everyone, including urban poor?
- How do we encourage more restaurants and workplace food vending machine providers to include a wider variety of freshly cooked vegetables, fresh fruit, and low-fat items on their menus?
- How do we encourage the parents of young families that are on the go, to avoid high-fat-content fast food as a way of teaching children to eat healthily for a lifetime?
- How do we help people make the connection between lack of physical activity and poor diets to increased cancer risk?

Local Assets

Cancer Research Trials
Lancaster General Hospital
Contact: Becky Ayers
Phone: (717) 290-5965
E-mail: RKAyers@LancasterGeneral.org

Breast Care Center and Breast Support Groups
Lancaster General Hospital
Contact: Teresa Smink
Phone: (717) 290-3206

Saint Joseph Health Ministries
The Life Enhancement Center
832 Marietta Avenue
Lancaster, PA 17603
Executive Director, Jennifer Thompson
Coordinator, Barbara Landis, RN
Phone: (717) 239-1196
web site: www.sjhm.org

Lancaster General Cancer Center
Lancaster General Hospital
Contact: Melanie McCurdy
Phone: (717) 290-3112
E-mail: MAMccurd@LancasterGeneral.org

Lancaster General Gamma Knife Center
Lancaster General Hospital
Contact: Melanie McCurdy

Cancer Registry
Lancaster General Hospital
Contact: Judy George
Phone: (717) 290-4072
E-mail: JAGeorge@LancasterGeneral.org

American Cancer Society
Local Programs and Services
Phone: (717) 397-3744

American Cancer Society
Cancer Support Resources
314 Good Drive
Lancaster, PA 17603
(717) 397-3744

Breast Care Center and Breast Cancer Support Groups
Lancaster General Hospital
Contact: Teresa Smink
Phone: (717) 290-3206
E-mail: TESmink@LancasterGeneral.org

The Life Enhancement Center
St. Joseph Health Ministries
832 Marietta Avenue
Contact: Barbara Landis, RN
Phone: (717) 239-1196
E-mail: barbaralandis@chi-east.org

American Lung Association of Pennsylvania
630 Janet Avenue
Lancaster, PA 17601
(717) 397-5203

St. Joseph Health Ministries
Life Enhancement Center
Lung Cancer Community
828 Marietta Avenue
Lancaster, PA 17603
Contact person: Barbara Landis, RN
(717) 239-1196
Objective Number and Short Title

Cancer
3-1 Overall cancer deaths
3-2 Breast cancer deaths
3-3 Colorectal cancer deaths
3-4 Prostate cancer deaths
3-12 Colorectal cancer screening
3-13 Mammograms

Weight Status and Growth
19-2 Obesity in adults
19-3 Overweight or obesity in children and adolescents

Fruit and Nutrient Consumption
19-5 Fruit intake
19-6 Vegetable intake
19-7 Grain product intake
19-8 Saturated fat intake
19-9 Total fat intake

Other Resources

Association of Cancer On-line http://www.acor.org
University of Pennsylvania Cancer Center http://www.med.upenn.edu
CDC's Screen for Life program http://www.cdc.gov/cancer/screenforlife

Minority Health Resource Center (800) 444-6472
Salud Hispana (717) 396-1155
South East Lancaster Health Services (717) 299-6371


Schools, Work sites, and Nutrition Counseling
19-16 Work site promotion of nutrition education and weight management
19-17 Nutrition counseling for medical conditions

Physical Activity in Adults
22-1 No leisure time physical activity
22-2 Moderate physical activity

Physical Activity in Children and Adolescents
22-6 Moderate physical activity in adolescents
22-8 Physical education requirements in schools
22-9 Daily physical education in schools

Access
22-13 Work site physical activity and fitness
22-14 Community walking

Prevention Research
23-17 Population-based prevention research

Tobacco Use in Population Groups
27-1 Adult tobacco use
27-2 Adolescent tobacco use

Cessation and Treatment
27-5 Smoking cessation by adults
27-6 Smoking cessation by adolescents

Exposure to Secondhand Smoke
27-10 Exposure to environmental tobacco smoke

Educational and Community-Based Programs
7-2 School health education
7-5 Work site health promotion programs
7-6 Participation in employer-sponsored health promotion activities
7-9 Health care organization sponsorship of community health promotion activities
7-10 Community health promotion programs
7-11 Culturally appropriate and linguistically competent community health promotion programs
Cognitive Development

Promote a physical and emotional environment that provides for the greatest possible intellectual development in infants and growing children.
Prenatal

Goal: Reduce the number of babies whose cognitive development in utero is threatened by poor nutrition, smoking, and lack of prenatal care of their mothers.

HP 2010 Measures and Local Measures

16-6 Increase the proportion of pregnant women who receive early and adequate prenatal care.
- Care beginning in first trimester of pregnancy
- Early and adequate prenatal care
- Target-setting method: Better than the best
- Data source: National Vital Statistics System (NVSS), CDC, NCHS

16-12 Increase the proportion of mothers who achieve a recommended weight gain during their pregnancies.
- Potential data source: National Vital Statistics System (NVSS), CDC, NCHS

16-14 Reduce the occurrence of developmental disabilities.
- Mental retardation
- Cerebral palsy
- Autism spectrum disorder
- Epilepsy
- Target-setting method: 5 percent improvement
- Data source: Metropolitan Atlanta Developmental Disabilities Surveillance Program (MADDSP), CDC, NCEH

16-16 Increase the proportion of pregnancies begun with an optimum folic acid level.
- Target-setting method: Better than the best
- Data source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS
- Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women.
  - a. Alcohol
  - b. Binge drinking
  - c. Cigarette smoking†
  - d. Illicit drugs
- Target-setting method: Better than the best for 16-17a and 16-17c; complete elimination for 16-17b and 16-17d
- Data sources: National Household Survey on Drug Abuse, SAMHSA for 16-17a, 16-17b, and 16-17d; National Vital Statistics System, CDC, NCHS for 16-17c.

16-18 Reduce the occurrence of fetal alcohol syndrome (FAS).
- Potential data source: Fetal Alcohol Syndrome Network (FASNnet), CDC, NCEH

19-13 Reduce anemia among low-income pregnant females in their third trimester.
- Target: 20 percent improvement
- Baseline: 29 percent of low-income pregnant females in their third trimester were anemic (defined as hemoglobin <11.0 g/dL) in 1996.
- Target-setting method: Better than the best
- Data source: Pregnancy Nutrition Surveillance System, CDC, NCCDPHP

19-14 Reduce iron deficiency among pregnant females.
- Potential data source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS
Cognitive development, the ability of infants and young children to grow intellectually and relate to their environment, is critical to their future health and well-being. It includes the way that children think, reason, and solve problems. Each child depends, in turn, on the prenatal health of his or her mother to begin to create the conditions needed to allow maximizing of potential cognitive growth. While some of the factors affecting cognitive development are purely biological in nature, many other factors are socio-demographic. That is, optimal cognitive development can be profoundly hindered by environmental negatives such as physical and emotional neglect or abuse. Physical neglect can begin in utero in the case of mothers whose diets are inadequate or who participate in risk behaviors such as alcohol and drug abuse or cigarette smoking. These behaviors result in low birth weight babies and babies born with Fetal Alcohol Syndrome, both proven to negatively affect cognitive development. Poverty, lack of insurance, single parenthood, and the age of the mother may influence whether or not the mother receives good prenatal medical care. Prenatal care for the mother lowers the risk of giving birth to low birth weight babies who have been proven to have long-term cognitive delays. (O’Callaghan, Burns, and Gray, “School Performance in Extreme Low Birth Weight Children: A Controlled Study.” Dev Med Child Neurol. 1996:38: 917.)

### 16-6a Increase the proportion of pregnant women who begin prenatal care in the first trimester of pregnancy.

**Target and baseline:**

**Objective** Increase in Maternal Prenatal Care  
1998 Baseline: 2010 Target

<table>
<thead>
<tr>
<th></th>
<th>Percent of Live Births</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>16-6a</strong></td>
<td>Care beginning in first trimester of pregnancy</td>
</tr>
<tr>
<td><strong>16-6b</strong></td>
<td>Early and adequate prenatal care</td>
</tr>
</tbody>
</table>

**Target-setting method:** Better than the best  
**Data source:** National Vital Statistics System (NVSS), CDC, NCHS
### Live Births, 1998

<table>
<thead>
<tr>
<th>Live Births, 1998</th>
<th>Maternal Prenatal Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>16-6a First Trimester</td>
</tr>
<tr>
<td></td>
<td>16-6b Early and Adequate</td>
</tr>
<tr>
<td>Percent</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>83</td>
</tr>
</tbody>
</table>

#### Mother’s race and ethnicity

<table>
<thead>
<tr>
<th></th>
<th>16-6a First Trimester</th>
<th>16-6b Early and Adequate</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian or Alaska Native</td>
<td>69</td>
<td>57</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>83</td>
<td>74</td>
</tr>
<tr>
<td>Asian</td>
<td>86</td>
<td>76</td>
</tr>
<tr>
<td>Native Hawaiian and other Pacific Islander</td>
<td>75</td>
<td>67</td>
</tr>
<tr>
<td>Black or African American</td>
<td>73</td>
<td>67</td>
</tr>
<tr>
<td>White</td>
<td>85</td>
<td>76</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>74</td>
<td>66</td>
</tr>
<tr>
<td>Not Hispanic or Latino</td>
<td>85</td>
<td>76</td>
</tr>
<tr>
<td>Black or African American</td>
<td>73</td>
<td>67</td>
</tr>
<tr>
<td>White</td>
<td>88</td>
<td>79</td>
</tr>
</tbody>
</table>

#### Mother’s education level

<table>
<thead>
<tr>
<th></th>
<th>16-6a First Trimester</th>
<th>16-6b Early and Adequate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than high school</td>
<td>68</td>
<td>61</td>
</tr>
<tr>
<td>High school graduate</td>
<td>81</td>
<td>74</td>
</tr>
<tr>
<td>At least some college</td>
<td>91</td>
<td>82</td>
</tr>
</tbody>
</table>

#### Mother’s disability status

<table>
<thead>
<tr>
<th></th>
<th>16-6a First Trimester</th>
<th>16-6b Early and Adequate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mothers with disabilities</td>
<td>DNC</td>
<td>DNC</td>
</tr>
<tr>
<td>Mothers without disabilities</td>
<td>DNC</td>
<td>DNC</td>
</tr>
</tbody>
</table>

#### Select populations

<table>
<thead>
<tr>
<th></th>
<th>16-6a First Trimester</th>
<th>16-6b Early and Adequate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 15 years</td>
<td>48</td>
<td>48</td>
</tr>
<tr>
<td>15 to 19 years</td>
<td>69</td>
<td>64</td>
</tr>
<tr>
<td>20 to 24 years</td>
<td>78</td>
<td>70</td>
</tr>
<tr>
<td>25 to 29 years</td>
<td>86</td>
<td>77</td>
</tr>
<tr>
<td>30 to 34 years</td>
<td>89</td>
<td>79</td>
</tr>
<tr>
<td>35 years and older</td>
<td>88</td>
<td>79</td>
</tr>
</tbody>
</table>

DNA=Data have not been analyzed. DNC=Data are not collected. DSU=Data are statistically unreliable.

### 16-06a Percent of live births to mothers who began prenatal care in the first trimester, 1998–2000

- **HP 2010 target:** 90%
- **1998 national baseline:** 83%

<table>
<thead>
<tr>
<th>PA</th>
<th>Lancaster</th>
<th>Berks</th>
<th>Chester</th>
<th>Dauphin</th>
<th>Lebanon</th>
<th>Lehigh</th>
<th>Northampton</th>
<th>York</th>
</tr>
</thead>
<tbody>
<tr>
<td>85.1</td>
<td>80.7</td>
<td>73.5</td>
<td>876</td>
<td>85.6</td>
<td>80.2</td>
<td>879</td>
<td>88.6</td>
<td>878</td>
</tr>
</tbody>
</table>

### 16-06b Percent of live births to mothers who received early and adequate prenatal care, 1998–2000

- **HP 2010 target:** 90%
- **1998 national baseline:** 74%

<table>
<thead>
<tr>
<th>PA</th>
<th>Lancaster</th>
<th>Berks</th>
<th>Chester</th>
<th>Dauphin</th>
<th>Lebanon</th>
<th>Lehigh</th>
<th>Northampton</th>
<th>York</th>
</tr>
</thead>
<tbody>
<tr>
<td>71.8</td>
<td>54.0</td>
<td>69.4</td>
<td>670</td>
<td>72.3</td>
<td>72.1</td>
<td>69.1</td>
<td>66.4</td>
<td>76.0</td>
</tr>
</tbody>
</table>

The rate of early prenatal care in Lancaster County is lower than the average for the state and most reference counties, and considerably lower than the Healthy People 2010 objective of 90%. Breakdown by race and ethnicity indicates that all groups are below the HP 2010 objective. According to the Pennsylvania Department of Health's Health Status...
Indicators, in 1998 Lancaster County had 8.73 percent occurrence of no prenatal care during the first trimester, which is significantly higher than the Pennsylvania state average of 3.8 percent. It is important that the community determine which pregnant women are not seeking early prenatal care and make a concerted effort to get the message out that this is a high-risk behavior. The patterns in national statistics suggest that lack of prenatal care clusters in younger women, in those with less education, and in certain ethnic groups.

A careful look at the issues and circumstances that impact single mothers under the age of 20 also sheds light on at-risk behaviors of all pregnant women in the area of prenatal and postnatal cognitive development for their children.

According to a study published in *Adolescence* magazine in the spring of 2000 (Sommer, Kristen S., “Prenatal Maternal Predictors of Cognitive and Emotional Delays in Children of Adolescent Mothers”), children of adolescent mothers are at increased risk for intellectual and social-emotional problems. (Statistics referred to in this discussion come from that study unless otherwise indicated.) Infants of adolescent mothers performed less well than infants of adult mothers on the Bayley developmental scales at eight months of age, the Stanford Binet at four years, and the WISC at seven years. (Marecek, J., *Economic, social and psychological consequences of adolescent childbearing: an analysis of data from the Philadelphia Collaborative Perinatal Project*. NICHD, 1979). Adolescent mothers often have inadequate readiness for parenting and, as a result, have unrealistic expectations concerning their child’s development. They tend to overestimate or underestimate motoric and linguistic skills. One-year-old infants of adolescent mothers had fewer vocalizations than did infants of adult mothers.

Some of the prenatal factors that put the children of adolescent mothers at greater risk for developmental delays would also do so for the children of adult women. Lack of prenatal medical care leads to nutritional deficits—not enough weight gain, less than the required 400 mcg. of folic acid daily, and inadequate calcium consumption—result in poor birth outcomes. The incidence of spina bifida (a birth defect characterized by a congenital cleft in the spine) and neural tube defects (abnormal development of the brain and precursor of the spinal cord) could be cut in half with adequate folic acid consumption (Healthy People 2010, *Maternal, Infant, and Child Health*). In general, low birth weight babies (LBW) and extremely low birth weight babies (ELBW) are at much greater risk for cognitive delays. Both adolescent mothers and adult mothers have a much higher probability of giving birth to LBW and ELBW babies when they smoke, consume alcohol, or use “street” drugs. Absence of good prenatal care means a lack of information about how these behaviors affect the growth and cognitive development of a child. Mothers need help in order to stop these activities before pregnancy occurs or immediately after.
According to the Pennsylvania Department of Health, in 1996 Lancaster County had a higher than the state average birth rate for children born to single mothers under 20. While the Caucasian rate was similar between the state and the county (7.3 per 100,000 for the state and 7.4 for the county), among Hispanics the state rate was 22.4 per 100,000 and county was 27.5. Among African American single mothers below 20, the state average was 22.8 while the County average was 29.4. In the same year, low birth weight statistics showed the Lancaster County Hispanic community as having a higher incidence of low birth weight babies at 11.3 per 100,000 births compared to the state average of 9.5 for the same group. Both Caucasian and African American communities in Lancaster had a lower than state average incidence of low birth weight babies at 5.2 and 9.3 respectively. According to the Pennsylvania Department of Health, in 1998 the percentage of babies born to Caucasian mothers under 18 was 2.9 for the state and 2.6 for Lancaster County. The percentage born to Hispanic mothers under 18 was 10.9 for the county and 10.7 percent for the state. Nationally, the low birth weight incidence for white women has risen from 5.7 percent in 1990 to 6.5 percent in 1998. According to Healthy People 2010, among African Americans, the LBW rate has declined slightly in the 1990's but is twice as high as whites at 13 percent in 1998. Puerto Ricans, the Hispanic subgroup most prevalent in Lancaster County, are especially likely to have low birth weight babies. (Ventura, S.J., Anderson, R.N., Martin, J.A.; et al. Births: Final Data for 1998. National Vital Statistics Report 48(3), 2000.)

Neonatal

Goal: Reduce the number of infants put at high risk for developmental delay due to low birth weight, insensitive home environment, and poor parenting skills resulting in little stimulation or challenge.

HP 2010 Measures

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-19</td>
<td>Increase the proportion of mothers who breastfeed their babies.</td>
</tr>
<tr>
<td>16-23</td>
<td>Service systems for children with special health care needs.</td>
</tr>
</tbody>
</table>

Target-setting method: Better than the best

Data sources: Mothers’ Survey, Ross Products Division, Abbott. Title V Block Grant Application form 13, HRSA, MCHB

NOTE: In addition to these HP 2010 measures, goals should include parenting skill classes available to all adolescent mothers and to all parents experiencing difficulty providing a positive environment for young children.

Impact of Low Birth Weight and Extremely Low Birth Weight

<table>
<thead>
<tr>
<th>ID</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-10</td>
<td>Reduce low birth weight (LBW) and very low birth weight (VLBW).</td>
</tr>
</tbody>
</table>

Target and baseline:

<table>
<thead>
<tr>
<th>Objective</th>
<th>Reduction in Low and Very Low Birth Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-10a Low birth weight (LBW)</td>
<td>7.6</td>
</tr>
<tr>
<td>16-10b Very low birth weight (VLBW)</td>
<td>1.4</td>
</tr>
</tbody>
</table>

Target-setting method: Better than the best

Data source: National Vital Statistics System (NVSS), CDC, NCHS
### 16-10a Percent of infants born at low birth weight (LBW), 1998–2000

**HP 2010 target:** 5.0  
**1998 national baseline:** 7.6

<table>
<thead>
<tr>
<th>Live Births, 1998 (unless noted)</th>
<th>Maternal Prenatal Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>16-10a Low Birth Weight</td>
</tr>
<tr>
<td></td>
<td>Percent</td>
</tr>
<tr>
<td>TOTAL</td>
<td>7.6</td>
</tr>
<tr>
<td><strong>Mother's race and ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>6.8</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>7.4</td>
</tr>
<tr>
<td>Asian</td>
<td>7.2</td>
</tr>
<tr>
<td>Native Hawaiian and other</td>
<td>6.5</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td></td>
</tr>
<tr>
<td>Black or African American</td>
<td>13.0</td>
</tr>
<tr>
<td>White</td>
<td>6.5</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>6.4</td>
</tr>
<tr>
<td>Not Hispanic or Latino</td>
<td>7.8</td>
</tr>
<tr>
<td>Black or African American</td>
<td>13.2</td>
</tr>
<tr>
<td>White</td>
<td>6.6</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>7.0 (1997)</td>
</tr>
<tr>
<td><strong>Mother's education level</strong></td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
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</tr>
<tr>
<td>At least some college</td>
<td>6.5</td>
</tr>
<tr>
<td><strong>Mother's disability status</strong></td>
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</tr>
<tr>
<td>Mothers with disabilities</td>
<td>DNC</td>
</tr>
<tr>
<td>Mothers without disabilities</td>
<td>DNC</td>
</tr>
<tr>
<td><strong>Select populations</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Mother's age groups</strong></td>
<td></td>
</tr>
<tr>
<td>Under 15 years</td>
<td>13.1</td>
</tr>
<tr>
<td>15 to 19 years</td>
<td>9.5</td>
</tr>
<tr>
<td>20 to 24 years</td>
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<tr>
<td>25 to 29 years</td>
<td>6.7</td>
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<tr>
<td>30 to 34 years</td>
<td>7.0</td>
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<tr>
<td>35 years and older</td>
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</table>

### Live Births, 1998 (unless noted)

<table>
<thead>
<tr>
<th>PA</th>
<th>Lancaster</th>
<th>Berks</th>
<th>Chester</th>
<th>Dauphin</th>
<th>Lebanon</th>
<th>Lehigh</th>
<th>Northampton</th>
<th>York</th>
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<tr>
<td>78</td>
<td>5.6</td>
<td>7.1</td>
<td>6.0</td>
<td>8.9</td>
<td>6.5</td>
<td>8.6</td>
<td>9.0</td>
<td>7.9</td>
</tr>
</tbody>
</table>

### 16-10b Percent of infants born at very low birth weight (VLBW), 1998–2000

**HP2010 target:** 0.9  
**1998 national baseline:** 1.4

<table>
<thead>
<tr>
<th>PA</th>
<th>Lancaster</th>
<th>Berks</th>
<th>Chester</th>
<th>Dauphin</th>
<th>Lebanon</th>
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<tr>
<td>1.6</td>
<td>1.2</td>
<td>1.5</td>
<td>1.1</td>
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<td>1.2</td>
<td>1.7</td>
<td>1.4</td>
<td>1.6</td>
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</tbody>
</table>
Low birth weight is defined as a weight of 5.5 pounds or under due to shorter gestation or to various maternal risk behaviors. Extremely low birth weight is defined as 3.3 pounds or less at birth. Both groups of infants are at higher risk for long-term illness, developmental delays, and disability.

Between 1997 and 1999 in Lancaster County, one in 21 babies was born to either of these categories. (The State of the Child in Pennsylvania: a 2002 Guide to Child Well Being in Pennsylvania). While this figure overall is better than the state average, the statistical study as a whole found that 63% of LBW babies were born in urban areas, so it is logical to assume that the rate of these births is higher in Lancaster City. Both at the state level and nationwide, the rate of LBW and ELBW births is worsening, in part due to an increase in multiple births due to fertility treatments. Nationally, African American women under the age of 15 without a high school education are the most likely to give birth to an LBW child.

A study reported in the New England Journal of Medicine (Hack et al., Jan. 17, 2002) followed a group of 233 LBW and ELBW people from birth until they reached their 20’s. Marie C. McCormick, M.D., of the Harvard School of Public Health observed, “This is one of our first opportunities to look at the long-term issues facing these . . . babies as they approach adulthood. It is not surprising that they continue to have lower IQ scores and other evidence of learning problems . . . ” IQ scores averaged five points lower for the LBW group (87 vs. 92). Fewer of the young adults graduated from high school than their normal weight counterparts (74% vs. 83%) and very low birth weight men were significantly less likely to be enrolled in colleges or universities (30% vs. 53%). However, this was not true of the women. The follow-up of these children does show that they do not “outgrow” the problems associated with low birth weight.

**Breastfeeding**

Epidemiological research has shown that human milk and breastfeeding of infants provide advantages to general health, growth, and development while significantly reducing risk for a large number of acute and chronic diseases (American Academy of Pediatrics, Policy Statement, “Breastfeeding and the Use of Human Milk” [RE9729]). *Pediatrics*, vol. 100, 6, pp. 1035–1039. Breastfeeding has been related to possible enhancement of cognitive development. A study conducted to clarify risk factors in development during the first two years examined the relationship between breastfeeding and cognitive development. A significant difference was found on the Mental Development Index of Bayley Scales at ages one and two years favoring breastfed children over bottlefed children (Morrow-Tlucak M., Haude, R.H., Ernhart, C.B. “Breastfeeding and cognitive development in the first two years of life.” *Social Science Medicine*, 26:635–639, 1988). In 1997, the American Academy of Pediatrics issued a mandate to pediatricians to “promote and support breastfeeding enthusiastically.”
Impact of Maternal IQ, Parenting Skill, and Social Support

Intellectual and linguistic delays in developing young babies were most directly correlated to the mother's performance IQ, parenting skill, and social support from an extended family, regardless of the mother's age. However, research has shown that many adolescent mothers function in a low-average to mildly mentally handicapped range of intelligence (Sommer, et al., "Cognitive Readiness and Adolescent Parenting," Developmental Psychology, 1993). Results of the Sommer study also showed that the maternal Performance IQ was a more important predictor than the maternal Verbal IQ.

School, day care, child care, and home environments that provide little stimulation and challenge can produce children with cognitive-intellectual delays in early and middle childhood. In this way, the IQ and preparedness of the mother has both a direct (genetic) impact on the child and an indirect impact. Cognitive readiness in the parent is defined in terms of knowledge about child development, parenting styles, and parenting attitudes. Young mothers less prepared to parent than adult mothers have more stress and more authoritarian parenting styles. (Camp, "Maternal characteristics of adolescent mothers and older mothers of infants." Psychological Reports, 77, 1152-1154, 1995.) Cognitive readiness of the parent is related to children's intelligence and language development because more prepared mothers utilize their knowledge and child-caring experience to help themselves become more competent teachers of their children. Young children of inexperienced, adolescent mothers were found to be overly conforming and uncommunicative and, as they grew older, became resentful of authority, exhibiting aggressiveness, impulsiveness, and distractibility. (Marecek, J. "Economic, social and psychological consequences of adolescent childbearing: An analysis of data from the Philadelphia Collaborative Perinatal Project." Final Report to NICHD 1979.)

This combination of traits becomes a challenge for classroom teachers attempting to move these children along in a group toward normal and expected educational goals. The alienation that results for the child who does not really understand why he or she cannot adjust to the school environment only compounds the developmental delay. These children need special understanding and early diagnosis of cognitive and adjustment delays in order for the school system to best provide for them in a way that helps to prevent frustration and failure.

Social support for young mothers and for those with little formal education is paramount in the prevention of an ongoing cycle of poor cognitive development in young children. This support should give cognitive guidance, social reinforcement, tangible assistance, and emotional support to both parent and child. (Nath, P.S., Borkowski, J.G., Whitman, T.L., Schellenbach, C.J. "Understanding adolescent parenting: The dimensions and functions of social support." Family Relations, 40, 411-420. 1991.) The Lancaster City School District has in place a parenting program that supports and educates young parents who are enrolled in the high school. An onsite childcare program allows young mothers to continue their high school education while learning how to best parent their children. However, there are many more young parents outside the school system who need to be reached. Churches and other community organizations must provide the vital contact with these young families. Programs such as the Bridge Program at St. John's Episcopal Church in Lancaster City “adopt” young single mothers, providing not only material needs but mentoring support and a feeling of personal belonging to a larger group in a lifelong commitment to her and her child. Programs like this are to be encouraged throughout the community. Other means of social support include support expected from the primary partner, from friends, and from the grandmother, and extended family, and siblings.

Interestingly, gender significantly interacted with social support from partner and friends to predict the Stanford-Binet IQ score for the child. In each case, social support was unrelated to outcomes for boys, but significantly, and positively, related to outcomes for girls. The more an adolescent mother expected her partner and friends to provide support, the higher her daughter scored on cognitive development. (Sommer, "Prenatal Maternal Predictors of Cognitive and Emotional Development," Adolescence, Spring 2000). The social support issue is complex. Support from partner and friends was the only consistently positive type of support while, in contrast, support from siblings and extended family were consis-
tently negative. Support from the grandmother can sometimes hinder the emergence of good parenting skills in the adolescent mother. Counseling and support of these young families needs to concentrate on reducing conflicts within the extended family for the sake of the cognitive and emotional development of the child. And reports indicate that increasing numbers of children are being raised by grandparents.

**Early Childhood**

Goal: To reduce risk factors for continued cognitive delay through food insufficiency, childhood abuse, lead poisoning, lack of quality day care, and lack of quality programs for special-needs children

According to the American Academy of Pediatrics, research on children's cognitive and developmental problems shows that they do not have single causes nor do risks have specific outcomes. Rather risk factors are additive, and the more risks a child has, the worse the outcomes of all types. (Alaimo, K., “Food Insufficiency and American School-Aged Children's Cognitive, Academic, and Psychosocial Development.” *Pediatrics*, July 2001.) Duration of poverty, school and neighborhood influences, personality traits of the child, and parental characteristics have been demonstrated to be associated with children's development. (Duncan, J., Brooks-Gunn J. *Consequences of Growing Up Poor*, Russell Sage Foundation, New York, 1997.)

**Food Insufficiency**

The results of a study reported in the American Academy of Pediatrics' *Pediatric Journal* in July 2001, demonstrated that family food insufficiency is associated with school-aged children's academic and psychosocial development. They support a growing body of research on the negative consequences of food insecurity and hunger on American children. Studies previously conducted by U.S. Nutrition programs such as the Special Supplemental Food Program for Women, Infants, and Children, Head Start, and the School Lunch and Breakfast Programs have shown small, but significant benefits of food supplementation in cognition, academic achievement, and school absence. (Hicks L., Langham R., Takenaka, J. “Cognitive and health measures following early nutritional supplementation: a sibling study.” *American Journal of Public Health* 72:1110–1118.) A child’s height at the time of the study was used as an indicator of past nutrition status. An association was detected between food insufficiency and lower reading scores in children with fewer other risk factors. Furthermore, we know that low academic achievement in younger ages and grade failure is a predictor of low long-term education achievement. (Baydar N., Brooks-Gunn J., Furstenberg F., “Early Warning Signs of functional illiteracy: predictors in childhood and adolescence.” *Child Development* 64:815–829, 1993.) It is important, however, to realize that ensuring food sufficiency without addressing other risk factors affecting cognitive development may not lead to measurable improvements.

- Between 1990 and 1996, the number of children born to young, single mothers increased in the county by 26.2 percent, much higher than the state increase, which was only 7.4 percent. As we have previously noted, these children are at much higher risk for cognitive and developmental delay.
- In Lancaster County in 1997, 7.8% of the county population was living in poverty. This figure includes 15,300 children under the age of 18, a rate of 11.8%. This is lower than the average for the state of Pennsylvania's rate of 16.6 percent.
- Many poor children are concentrated in urban areas. The public schools in the Lancaster District see the majority of children affected by the multiple risk factors imposed by poverty, including low birth weight, lead poisoning, child abuse and neglect, hunger, learning disabilities, and high incidence of school drop-outs.
Child Abuse

A recent report of the National Research Council and Institute of Medicine of the National Academies (Committee on Integrating the Science of Early Childhood Development. From Neurons to Neighborhoods: The Science of Early Childhood Development. National Academy Press, 2000), provided extensive evidence that childhood experience has a substantial impact on brain development. In studies during the past decade, child maltreatment was consistently associated with impaired cognitive ability within a childhood population. (Kaplan, et al. “Child and adolescent abuse and neglect research: a review of the past 10 years.” American Academy of Child and Adolescent Psychiatry, 38:1212–1222, 1999.) It was found also that among ELBW infants who were followed to 4.5 years of age, a referral to child protective services was more significant in predicting cognitive outcome than severe intraventricular hemorrhage, chronic neonatal lung disease, or low socioeconomic status. Young, single, poorly educated mothers were more likely to experience severe stress and, consequently, were more likely to be reported for child maltreatment.

In Lancaster County, between 1990 and 2000, substantiated cases of child abuse or neglect rose from 140 to 193, an increase of 29 percent, while the rate statewide declined by as much (United Way, Lancaster County 2000 Child Care Report). Even though the total number of cases is better than the state average, the problem is increasing as the severity of abuse of children seems worse. This also increases the severity of the impact on the cognitive development of these unfortunate children.

Lead Poisoning

| 8-22 | Increase the proportion of persons living in pre-1950s housing that has been tested for the presence of lead-based paint. |

Target: 50 percent  
Baseline: 16 percent of persons living in homes built before 1950 reported in 1998 that their homes had been tested for the presence of lead-based paint (age adjusted to the year 2000 standard population).  
Target-setting method: Better than the best  
Data source: National Health Interview Survey (NHIS), CDC, NCHS

Lead poisoning is one of the most common pediatric health problems in the United States—and is entirely preventable. Almost 60 million American homes currently contain lead paint and 14 million children younger than seven years of age live in the houses with the highest concentrations of lead (Linakis J., “Childhood lead poisoning, though preventable, still devastates lives.” Brown University Child and Adolescent Behavior Letter, April 2000). Unacceptable levels of lead exposure are measured by micrograms of deciliters found in the blood. The Centers of Disease Control’s current standard for risk in children is 10:g/dl. As an environmental toxin, lead has some unique qualities. Being an element, once lead has been introduced into the environment it is there forever. The most familiar sources are paint and car exhaust, but lead was a component of some pesticides prior to 1988 and may be present in the soil. Lead can still be found in ceramic ware, sealants of cans, and ethnic cosmetics.
Lead has a variety of effects on various organs of the body. One of the most long-lasting effects is on the neuropsychiatric function. Comparatively minor elevations in lead levels at two years of age are associated with significant impairments in intellectual and academic performance. Recent studies have been careful to adjust for variables such as parental intelligence, socioeconomic status, education, and home environment; the studies and have found that the detrimental effect on IQ remained significant (Bellinger D., Needleman H.L., “Low-level lead exposure, intelligence and academic achievement: a long-term follow-up study.” Pediatrics. 90:855–861, 1993).


Despite these successes, due in part to professional and public campaigns to spread the word, much needs to be done. Risk is not spread evenly throughout all population groups. Furthermore, an analysis of childhood blood lead data collected by state surveillance programs found that prevalence of elevated blood lead levels varied from state to state and county to county, indicating that lead poisoning is still a problem at the local level (Binns, “Targeted screening for elevated blood lead levels: populations at high risk.” Pediatrics, December 2001). An important risk factor for lead poisoning is low socioeconomic status, a criterion for Medicaid eligibility. Based on data from NHANES III, Phase 2 (1991–1994), among the estimated 890,000 children with elevated blood lead levels, 60 percent (535,000) were on Medicaid. Even though the Centers of Medicare and Medicaid Services now mandate that children enrolled in Medicaid receive blood lead screening, an estimated 81 percent of Medicaid children had not been screened for lead poisoning (US General Accounting Office, “Medicaid: Elevated Blood Lead Levels in Children.” GAO Publ. No. CAO-HEHS-98-78, 1998).

Locally, the Childhood Lead Poison Program of Harrisburg, Pinnacle Health along with clinics and individual doctors are charged with lead paint investigation. A staff person of the CLPP works out of the Lancaster City office several days a week and is notified if anything higher than 15:gd/l is recorded. The state of Pennsylvania’s CLPP projects systematically perform blood lead screening tests on children under the age of 6, focusing on those estimated to have the highest risk of being lead poisoned. CLPP projects also provide the following: referral for diagnostic services and medical treatment, investigation of lead hazards in the homes of lead-poisoned children, technical assistance to property owners and local health officials regarding the remediation of lead-based paint hazards, and community, professional, and parent education regarding lead poisoning. The CDC recommends that all children between the ages of 1 and 2 years be tested since lead exposure can come from outside the home. However, not every child is being tested. Private practice doctors who do not see a high-risk population do not think it necessary to test even though middle and upper class families may live in old, remodeled homes. Overall, pediatricians attempt to screen about one-half of their patients aged 9–24 months for lead poisoning: pediatricians report screening an average of 52% of their 9–12 month olds, 48% of their 13–14 month olds, and 37% of their patients aged 25–36 months (American Academy of Pediatrics, Lead Screening Practices of Pediatricians, Division of Health Policy Research, 2002). A finger stick can show the presence of lead but to determine actual blood lead levels necessitates a visit to the hospital. Many parents will not follow through. The Amish community is at special risk with their high exposure to older buildings and sanding and repainting old buggies.

This year there were 18 cases in Lancaster County with BLL greater than 20:gd/l. The number is higher for those above 15. When a child shows levels above 15:gd/l, a staff member visits the home with an informational packet and cleaning kit, and then retests after three months to make sure that levels are declining. Although there have been some programs for landlords in Lancaster City, organized by the city, there is currently no capacity to educate
parents. In June of this year, the city conducted an education program for safe work practices for contractors and landlords. Grant money is available from the Environmental Protection Agency for lead poisoning education.

It is the municipality’s responsibility to facilitate an abatement process, assess any other housing code violations, and do follow-up on both. Lancaster City has an extensive ordinance governing this procedure. Lead paint must be treated as seriously as any other housing violation. They enforce the federal Residential Lead-Based Paint Hazard Reduction Act of 1992 and work under its regulation, managing lead-based paint hazards in housing and imposing control standards for federally assisted housing. The Act also authorizes grants to cities and states to help fund primary prevention.

**Day Care and Early Childhood Cognitive Development**

Cognitive development and early literacy are an important part of a young child’s readiness for school. Early success depends in part on four skills to be demonstrated by 3 to 5 year olds as reported by their parents: the ability to recognize letters, to count to 20 or higher, to write his or her name, and to read or pretend to read (National Education Goals Panel. *Reconsidering Children’s Early Development and Learning: Toward Common Views and Vocabulary*. Washington, DC, 1995).

Between 1993 and 1999, 3 to 5 year olds able to exhibit three or four cognitive/literacy school readiness skills increased slightly from 35 to 39 percent. A variety of risk factors can make a profound difference in a child’s readiness.

- Children who live in poverty are much less likely to exhibit these skills. Since 1993 the percentages have increased for children above the poverty threshold (from 40 to 45 percent) and decreased for children below the poverty threshold (from 23 to 19 percent.) (Child Trends Databank, Early School Readiness, www.childrens databank.org.)

- The mother’s educational level is directly related to the likelihood that a child will demonstrate 3 or 4 of the readiness skills, ranging from 15 percent of children of mothers who did not complete high school to 57 percent of mothers with graduate/professional training or degrees.

- As the data indicates in the chart above, children who are white, non-Hispanic, or “other” are more likely to have three or four readiness skills than children who are either Hispanic or black, non-Hispanic.

- In addition, in 1999, 41 percent of young children whose mother’s home language was English had three to four skills compared to 14 percent of those whose mother’s home language was not English.
In 2001, 61 percent of children from birth to age six spent time in nonparental child care. There is no conclusive evidence that childcare is either better or worse for children than being cared for solely by a parent. However, many researchers have found that high-quality day care is more beneficial for children's cognitive, language, and social development than low-quality day care (National Research Council and Institute of Medicine. From Neurons to Neighborhoods: The Science of Early Childhood Development. Committee on Integrating the Science of Early Childhood Development, 2000).

Over 15,000 children in Lancaster County will need regulated childcare this year, as opposed to relative care, a nanny, or care from an unregulated provider (United Way, Lancaster County Child Care 2000, The Climate). 15,300 children living in poverty in the county will not be able to afford quality childcare. Quality childcare is defined as care which goes beyond the minimum standards set by the Pennsylvania Department of Public Welfare for the operation of childcare centers and group day care homes. High-quality programs are rooted in the community they serve, center around developmentally appropriate practices, promote close communication with the children's families, recognize and celebrate their cultural diversity, and employ teachers and assistants who are well-trained and well compensated (Eithiel, N. Ed., Reflections of NAEYC Accreditation: Lessons Learned and Goals for the Future, Washington, DC, National Association for the Education of Young Children, 1997).

In Lancaster County, there are 121 childcare centers, 19 group day care homes, and 135 registered family day care homes. In addition, the state of Pennsylvania allows the legal operation of some unregulated childcare. An estimated 30 percent of the county's children are in unregulated childcare.

National accreditation by one of the five nationally recognized organizations is one reliable measure of the quality of a program. It is voluntarily pursued by a childcare program and involves visits by a panel of professionals. Of the 203 centers in Pennsylvania that are accredited by the National Association for the Education of Young Children (NAEYC), only six are located in Lancaster County. Park City Child Care Center is the only one geographically available to most city residents. Statewide, the number of programs accredited is less than 10 percent. Financial concerns create barriers to accreditation. The process itself costs between $425 and $1,200, and costs are associated with qualified staffing and structural improvements. Our local county affiliate of the NAEYC will assist programs by paying for half of their application and accreditation fees.

Other features of high-quality, early childhood programs include:
- Children's school readiness and success as it relates to pre-school experiences.
- High-quality staff where several caregivers have advanced or continued education.
- Low staff-child ratios.
- High retention rate.
- Partnerships between day care centers and schools.

Quality and safety cannot be measure in unregulated day care and relative care. The number of unregulated providers in Lancaster County is increasing due to the increase in demand. These providers, because they care for too few children, may have no basic health and safety standards and are not required to undergo criminal or child abuse background checks (Galinsky, E., Howes, C., Kontos, S., and Shinn, M., “The Study of Children in Family Child Care and Relative Care: Highlights of Findings.” Work and Family Institute, 1994). It is estimated that the number of children in unregulated care, with relatives, or who are latchkeys could be as high as 4,000. The number of children receiving subsidy money who are in unregulated care is about 19.5 percent of the subsidized population of Lancaster County (Child Care Information Service [CCIS], Community Action Program, Lancaster, PA).

In the face of these discouraging statistics, we must realize that the quality of early childhood experiences in day care has a decisive and long-lasting effect on how children develop, both academically and socially. School readiness is positively correlated to high-
quality childcare experiences. Knowledge about how the brain functions indicates that environment is as important to early brain development as heredity. By the age of three, the brains of children are two and a half times more active than the brains of adults, and they remain that way throughout the first decade of life (Shore, R., *Rethinking the Brain: New Insights into Early Development*, Families and Work Institute, 1997). In the area of cognitive development, quality childcare and early childhood experience needs to be much more than just custodial care.

Another issue to be considered in childhood cognitive development through quality day care is the growing need for facilities for children with special needs. Between 1996–97 and 1999–2000, the School District of Lancaster saw an increase of 25.4 percent expenditure on special education. Many special-needs children are in the system and many more are on the way. Generally poor quality day care arrangements have helped to contribute to the staggering 10.3 percent dropout rate in the city schools, far higher than any other county districts (Pennsylvania Partnership for Children, *The State of the Child in Pennsylvania, School District Profiles*, p. 234). The benefits of inclusive early childhood programs for young children with disabilities include socialization as a key factor. However, the ability of programs to provide responsive care to these children depends on the quality of the program—and there is wide variance—rom programs that are excellent to those that can actually harm children.

### Children Enrolled in Head Start

<table>
<thead>
<tr>
<th></th>
<th>State</th>
<th>All County Mean</th>
<th>Lancaster</th>
<th>Chester (G)</th>
<th>York (G)</th>
<th>Berks (P)</th>
<th>Dauphin (G)</th>
<th>Lebanon (G)</th>
<th>Lehigh (P)</th>
<th>Northampton (P)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate per 100 eligible children 3–4, 1999</td>
<td>476</td>
<td>N/A</td>
<td>45.6</td>
<td>49.7</td>
<td>39.7</td>
<td>42.6</td>
<td>46.9</td>
<td>58.9</td>
<td>40.8</td>
<td>49.7</td>
</tr>
</tbody>
</table>

### Regulated Childcare Capacity

<table>
<thead>
<tr>
<th></th>
<th>State</th>
<th>All County Mean</th>
<th>Lancaster</th>
<th>Chester (G)</th>
<th>York (G)</th>
<th>Berks (P)</th>
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<th>Lebanon (G)</th>
<th>Lehigh (P)</th>
<th>Northampton (P)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spaces per 100 children under 14 in need, 1998</td>
<td>88.0</td>
<td>66.0</td>
<td>78.7</td>
<td>110.9</td>
<td>73.1</td>
<td>86.1</td>
<td>110.7</td>
<td>80.7</td>
<td>108.6</td>
<td>113.5</td>
</tr>
</tbody>
</table>

Pennsylvania remains one of nine states that fails to invest in preschool; therefore, quality options for parents are slim, especially for low-income parents. Lacking access to quality preschool, too many at-risk kids start school at an unfair advantage, without the basic tools of learning that are critical to acquiring new knowledge and succeeding in school (Pennsylvania Partnerships for Children, *From Building Blocks to Books: Learning from Birth through 8 in Pennsylvania*, p. 25). Head Start is the federal government’s child development and school readiness program for low-income children from birth to age 5. Eligible children come from families whose income is 100 percent of poverty or below, but eligibility does not guarantee admission. Only 28,895 children of the 56,895 eligible in Pennsylvania were served in 2002, despite an 80% increase in federal funding from 1989 to 2002. Clearly, the risk factors of poverty and babies born to single adolescent mothers are outstripping the ability of programs to keep up with the need. Many young children are not being cared for in the existing system.
Optimal cognitive development in babies and young children depends both on biological/genetic factors such as nutritional status during pregnancy and mother's IQ, and on environmental/nurturing factors such as parenting skill, exposure to lead, and access to quality day care.

- Early and continued prenatal care is paramount to protecting and guaranteeing optimal conditions for brain development in unborn children. All mothers must be educated in nutritional care for their children before birth, especially in maintaining adequate levels of iron in the blood and the requisite 400 mcg of folic acid daily for prevention of spina bifida, neural tube disorders, and other neurological problems.

- Compliance throughout pregnancy should be monitored. Women must give themselves the best possible chance to carry their babies full term. High-risk behaviors such as cigarette smoking, poor nutrition, and drug and alcohol use may lead to low or extremely low birth weight babies, a condition dangerous to proper development of the brain.

- Communities, churches, and schools must work together to provide information to adolescents about the high risk for developmental delays in children born to single mothers under 20. Adolescent girls in some cultural traditions and from families with low socioeconomic status often see childbirth as a way to obtain attention and medical care for themselves along with an increase in their intrinsic value within their own family. They are largely unaware of the risks they expose their unborn children to through poverty, unstable home life, and lack of parenting skill.

- Parenting classes are needed for adolescent mothers and for parents mistreating their children as a result of stress, poverty, or lack of knowledge about developmental issues. Parents should recognize that they are their children's first teachers in school readiness behaviors like counting, recognizing colors, writing their own name, and pretending to read. Children should be read to at home.

- All children between the ages of 1 and 2 years should be tested for blood lead levels. This is especially true of children on Medicaid who are more likely to live in older homes with flaking paint. Blood lead levels can become elevated in high traffic areas also. Any reading of 10:µg/dl or above should trigger an immediate intervention response.

- Nutrition programs such as the Special Supplemental Food Program for Women, Infants and Children; Head Start; and the School Lunch and Breakfast Programs should continue to be funded and available to all families of children who have experienced hunger. Community food banks and programs like the Water Street Rescue Mission and Brightside Baptist Church's hot meals must reach out to those not being reached by other programs.

- Regulated, high-quality childcare must be made available especially to children at risk for developmental delays through other factors. Every effort must be made to assist daycare providers to aspire to and achieve national accreditation for their programs.

- Every effort should be made by communities to influence Congress and state legislatures to fully fund Head Start.
The ARC of Lancaster County
(717) 299-5561

Child Care Information Services
(717) 393-4004

Child Care Management Agency
(800) 937-4546

Child Lead Poisoning Prevention Program
(717) 291-4708

Children and Youth Social Service Agency
(717) 299-7925

Community Hospital of Lancaster
Childbirth Educator
(717) 394-2377

CONTACT Kids/Teen Line
(717) 394-2000

Family Service
(Counseling, Teen Pregnancy/ Parenting Classes)
(717) 397-5241

Head Start
(717) 299-7301

Healthy Beginnings Plus
Community Hospital of Lancaster— (717) 239-4141
Ephrata Community Hospital— (717) 738-6695
Lancaster General Medical Center— (717) 290-4305
Lancaster Regional Medical Center— (717) 291-8388
SouthEast Lancaster Health Services— (717) 299-6371
Walter L. Aument Family Health Center— (717) 290-5098

Homeless Student Project
School District of Lancaster
(717) 396-6829

Lancaster County Coalition for the Prevention of Teen Pregnancy
(717) 290-3203

Lancaster General Health Campus
Childbirth Education
(717) 290-3138

Lancaster Regional Medical Center
Family Health Center
(717) 291-8388

Lancaster-Lebanon IU#13
(717) 569-7331

Mental Health/Mental Retardation Program
(717) 393-0421

Plain Sect
Maternal, prenatal, and infant care
(717) 687-9407
Addendum I: A Plan for Creating a Healthy Lancaster Community

S. June Smith Center  
(At-risk and developmentally delayed children)  
(717) 299-4829

Schreiber Pediatric Rehab Center  
(717) 393-0425

Southeast Lancaster Health Services  
(717) 299-6371

The Special Kids Network  
1-800-896-4550

Success by 6  
(717) 394-0731

United Way LINC  
(717) 291-6462 for day care resources and preschool programs

Welsh Mountain Family Planning  
(717) 354-4711

WIC  
(Women, Infant, Children)  
1-800-732-0018

Additional Resources

National Child Care Information Center (NCCIC)  
http://nccic.org  
1-800-616-2242

National Lead Information Center  
http://www.epa.gov/lead/nlic.htm  
1-800-424-LEAD (1-800-424-5323)

National Center for Education in Maternal and Child Health  
http://www.ncemh.org  
1-703-524-7802

National Maternal and Child Health Clearinghouse (NMCHC)  
http://www.nmchc.org  
1-888-434-4MCH (1-888-434-4624)

National Women’s Health Information Center (NWHIC)  
http://www.4woman.gov  
1-800-994-9662

What You Can Do

- Educate employees and clients on the importance of proper prenatal care.
- Provide full or partial day care vouchers available as a benefit for employees. Help make quality day care affordable to everyone.
- Provide prenatal services which are convenient for teens (after-school hours, fast service, drop-ins available, close to schools, etc).
- Provide greater opportunities for prenatal visits in the homes of the Plain sect (nurse practitioners and midwives).
- Encourage Primary Care Providers to talk to child-bearing-age women about nutrition during annual checkups.
Schools
- Educate students about the importance of proper nutrition.
- Send materials home to families regarding proper nutrition and helping them to eat properly on a budget.
- Provide quality pre-Kindergarten programs to help better prepare young children with the skills they need to succeed in the early years of grade school.
- Provide workshops and evening classes for parents on healthy eating and cooking healthy.
- Help pregnant teens to understand the importance of proper checkups as well as the importance of receiving their diploma.
- Help connect children and teens with medical assistance if they qualify.
- Talk about the medical risks of parenting in health class.

Individuals
- If you suspect you may be pregnant, go to the doctor immediately.
- Eat a healthy diet and exercise regularly.
- Mentor young people.
- Teach your daughters about the importance of maintaining a balanced diet.

- How can we better serve low-income and/or minority women who are less likely to receive proper pre- and post-natal care and who are at higher risk for complications?
- How do we account for the difference in county and city early prenatal visits?
- In what ways can we do a better job of educating women of the Plain community on the importance of seeking proper prenatal care?
- How can our community work together to provide medical coverage of prenatal care and testing to all women living in Lancaster County?
- How do we put together an effective campaign to convince lawmakers of the importance of full funding for Head Start?
- How do we discuss the role of family planning on cognitive development issues in a rational atmosphere of respect?
Environmental Quality

Promote healthy environments
**Air Quality**

Goal: Better than the best

**HP 2010 Measures**

8-1a Reduce the proportion of persons exposed to air that does not meet the U.S. Environmental Protection Agency’s health-based standards for ozone.

27-10 Reduce the proportion of nonsmokers exposed to environmental tobacco smoke.

*Target-setting method:* Consistent with the Clean Air Act (Public Law 101-549)

*Data source:* Aerometric Information Retrieval System (AIRS), EPA, OAR. U.S. Environmental Protection Agency, Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey

**Local Measures**

1. Reduce total number of days annually designated “Code Orange” under the 8-hour standard for ground-level standards for ground-level ozone.

2. Reduce total number of days annually designated “Code Red” under the 8-hour standard for ground-level standards for ground-level ozone.

*Target-setting method:* Consistent with the Clean Air Act

*Data source:* Source: U.S. Environmental Protection Agency, Office of Air Quality Planning and Standards

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**Water Quality**

Goal: Better than the best

**HP 2010 Measures**

8-5 Increase the proportion of persons served by community water systems who receive a supply of drinking water that meets the regulations of the Safe Drinking Water Act.

*Target:* 95 percent

*Baseline:* 85 percent of persons served by community water systems received drinking water that met SDWA (Public Law 93-523) regulations in 1995.

*Target-setting method:* Consistent with EPA’s strategic plan

*Data sources:* Potable Water Surveillance System (PWSS) and Safe Drinking Water Information System (SDWIS), EPA. The Environmental Protection Agency or the PA Department of Environmental Protection may have data that can be used to track this indicator. Local data directly correlating disease and illness and poor local air and water quality has yet to be collected.

**Local Measures**

1. Increase the proportion of persons served by community water systems who receive a supply of drinking water that meets the regulations of the Safe Drinking Water Act.

2. Increase the number of municipalities with local ordinances requiring testing of existing on-lot wells.

*Target-setting method:* Consistent with EPA’s strategic plan

*Data sources:* Same as above and Lancaster Conservation District and Lancaster County Planning Commission
Environmental factors play a central role in human development, health, and disease. Broadly defined, the environment, including infectious agents, is one of three primary factors that affect human health. The other two are genetic factors and personal behavior.

Human exposures to hazardous agents in the air, water, soil, and food and to physical hazards in the environment are major contributors to illness, disability, and death worldwide. Furthermore, deterioration of environmental conditions in many parts of the world slows sustainable development. Poor environmental quality is estimated to be directly responsible for approximately 25 percent of all preventable ill health in the world, with diarrheal diseases and respiratory infections heading the list. Ill health resulting from poor environmental quality varies considerably among countries. Poor environmental quality has its greatest impact on people whose health status already may be at risk.

The Centers for Disease Prevention and Control associated air pollution in the United States with 50,000 premature deaths and an estimated $40 billion to $50 billion in health-related costs annually. Poor air quality accounts for increased emergency room visits and exacerbates a wide range of respiratory ailments including asthma, chronic obstructive pulmonary disease, and certain allergic reactions. For example, asthma can be triggered or worsened by exposure to ground-level ozone and ETS (Environmental Tobacco Smoke). The overall death rate from asthma increased 57 percent between 1980 and 1993, and for children it increased 67 percent.

There are economic consequences linked to poor air quality. Federal Transportation funding may be reduced unless conditions are mitigated and tougher vehicle inspection and gasoline station regulations may be enforced.

There are many compounds responsible for air pollution. In 1997, despite continued improvements in air quality, approximately 120 million people lived in areas with unhealthy air based on established standards for one or more commonly found air pollutants, including ozone. In 1996, a disproportionate number of Hispanics and Asian and Pacific Islanders lived in areas that failed to meet these standards compared with whites, African Americans, and American Indians or Alaska Natives.

Ozone ($O_3$) is a naturally occurring constituent of the part of the upper atmosphere known as the stratosphere. The presence of this ozone is important, because it absorbs UV light from the sun, and hence decreases the risk of skin cancer. The same chemical, ozone, is also formed in the lower atmosphere, the troposphere, the air that we breathe. It is produced especially on hot, sunny, stagnant summer days when the air pollutants, nitrogen oxides (NOx), and volatile organic compounds (VOCs) have been emitted in large amounts and “cook” in the atmosphere. As it happens, the same chemical, ozone, that protects us from UV light, is also a powerful respiratory irritant, and is bad to breathe. That’s why we teach school children the motto: “Ozone: Good Up High; Bad Nearby!” Ground-level ozone is an invisible pollutant.

Ground-level ozone is an invisible pollutant formed when two types of pollutants react in the presence of heat and sunlight. These pollutants are:

- Volatile organic compounds or VOCs, including solvent vapors and unburned fuel.
- Sources include unburned fuel from cars, trucks, other vehicles, and yard equipment, as well as vapors from paints and industrial processes such as printing and de-greasing.
- Nitrogen oxides resulting primarily from processes that burn a fuel such as coal, oil, motor fuel, or natural gas. Important sources during the ozone season (locally, May through September, when temperatures are highest and the amount of sunlight is greatest) include diesel engines and fossil-fuel-burning electric power plants.
At outdoor levels, ozone is invisible and odorless, but it can still sear the lungs and make it difficult to breathe. Ground-level ozone concentrations are measured in parts per billion (ppb). A monitor exceeds the 8-hour ozone standard when it records a concentration of 85 ppb or above (averaged over 8 hours); it exceeds the 1-hour standard when a single (hourly) reading is 120 ppb or higher.

- During a code orange day, when the 8-hour reading falls in the 85 to 104 ppb range, the air is considered unhealthy for children, the elderly, and people with heart or respiratory ailments; people in these groups should avoid prolonged outdoor activity.

- On a code red day, the eight-hour reading falls in the 105 to 124 ppb range. In this case the air is unhealthy for all persons; everyone should avoid prolonged outdoor activity.

- Even more serious advisories regarding outdoor activity are offered for days when the 8-hour reading exceeds 124 ppb (code purple), but such events are rare; the highest 8-hour reading ever recorded for Lancaster County was 121 ppb in July of 1997.

It is important to remember that ozone action alerts are weather-based predictions of the possibility or likelihood of Code Orange or Code Red days. Although they are usually accurate and should be taken seriously, they may or may not result in an 84 ppb exceedance.

In 1997, the EPA issued a National Ambient Air Quality Standard based on 8-hour readings. There were challenges to the implementation of this standard. But, in March of 2002, the District of Columbia Circuit Court decision removed all remaining legal challenges to the 1997 standard and that the EPA intends to move forward with its usage.

The fourth highest 8-hour readings in each of three calendar years are combined to produce a three-year-average score. A county is in non-attainment of the EPA's 8-hour attainment standard when its monitor's three-year-average score is 85 ppb or higher. Another (earlier established) attainment standard is based on 1-hour readings, with an ozone threshold value of 120 ppb. An area meets the yearly standard when there is no more than one day with an hourly reading above the 120 ppb threshold. The area is in non-attainment of the 1-hour attainment standard when it fails to meet the yearly standard in any one of three consecutive years.

When the EPA's 1-hour attainment standard was implemented following the passage of the Clean Air Act Amendments in 1990, Lancaster County was identified as being in non-attainment of the standard, owing to its having experienced three ground-level ozone readings of 120 ppb or greater in 1988 (see the table). In the early 1990s, a limited number of exceedance days brought the county into temporary attainment of the standard, but, as the table makes clear, the county has been in a non-attainment status since 1997.

The table also makes clear that Lancaster County has never been in attainment of the 8-hour standard, which has only been calculable since 1997 (beginning with the three-year period 1995–97). The Clean Air Network's Smogwatch 2000, using the EPA's 8-hour attainment standard for the 1997–99 period, ranked U. S. metropolitan areas on the quality of their air. The Lancaster Metropolitan Area's 3-year average (non)attainment score of 101 ppb placed the county in a tie for 15th in Smogwatch's ranking of the "Top 50 Dirty Metropolitan Areas" (and 3rd among Pennsylvania metropolitan areas). Using a related but somewhat different criterion—the total number of days during the period with 8-hour readings of 85 ppb or more—Smogwatch identified Lancaster's 66 such days as being the 14th highest among metropolitan areas across the nation and the highest in Pennsylvania.

Note: A metropolitan area is a county or an integrated cluster of counties with at least one "central city." The Lancaster Metropolitan Statistical Area (MSA), named for its central city, Lancaster, consists of all of Lancaster County. Similarly, the Reading MSA consists of all of Berks County; the Harrisburg-Lebanon-Carlisle MSA, named for its three central cities, consists of the entirety of Dauphin, Cumberland, Lebanon, and Perry counties. Ozone levels
for Lancaster County, the Lancaster MSA, are measured by one monitor, which is located at The Abraham Lincoln Middle School on Grofftown Road, approximately one mile from the center of the City of Lancaster. The entire county is designated as either meeting or not meeting EPA air quality standards as determined by readings from this monitor.

It is clear from the table that the 1997–99 period represents Lancaster's worst performance for ozone pollution. The American Lung Association's more recent report, *State of the Air: 2002*, focuses on the three-year period from 1998 to 2000 and uses a different evaluation criterion to rank counties and metropolitan areas (i.e., a weighted average of code orange [weight = 1], code red [weight = 1.5], and code purple [weight = 2] days over the three years). Lancaster's 45 code orange and 5 code red days from 1998 to 2000 generated a weighted average score of 17.5, placing Lancaster County in a tie for the fourth 'dirtiest' air in Pennsylvania and (tied for) 65th out of the 595 counties across the United States with complete monitoring data for ozone pollution (i.e., in the 88th percentile). The "good news" is that the Lancaster MSA has dropped out of the "top 25" metropolitan areas across the U.S. in the latest *State of the Air* report, having been ranked at 20th in the previous report and 22nd in the first report of this series (*State of the Air: 2000*).

The American Lung Association has also compiled some estimates on the number of persons at risk in Lancaster County on code orange days, when children, the elderly, and persons with chronic lung disease are advised to limit outdoor activity (also at risk are those engaged in strenuous outdoor activity, like athletes and laborers). The table below reports

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<th>Lancaster County Air Quality Data: Ozone Pollution</th>
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<td><strong>1-Hour Reading</strong></td>
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<td>Number of Exceedance days</td>
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**Notes:**
1-hour attainment standard status: Y = attainment of standard—no more than 1 exceedance day (highest daily 1-hour reading ≥ 120 ppb) in current year and in previous two years.

N = nonattainment of standard—more than 1 exceedance day in current year and/or in previous two years.

**8-hour attainment standard status: N = nonattainment of standard—average of fourth highest 8-hour readings from current and previous two years is 85 ppb or greater.

Code orange day: highest daily 8-hour reading 85 to 104 ppb; air quality is unhealthy for sensitive groups.

Code red day: highest daily 8-hour reading 105 to 124 ppb; air quality is unhealthy.

8-hour readings are not available for years prior to 1995.

Source: Compiled from information provided by EPA Office of Air Quality Planning and Standards.
[http://www.epa.gov/aqspubl1/annual_summary.html; http://www.epa.gov/air/oagps/greenbk/o3co.html]
those numbers, which are based on Census Bureau population estimates for 1999 and national studies of lung disease prevalence. Based on these estimates, it seems fair to surmise that roughly 40 percent of Lancaster County's population falls into one of the "sensitive" groups that should limit outdoor activity on code orange days. The Susquehanna Valley Ozone Action Partnership issues alerts when weather forecasts indicate the likelihood of code orange conditions or worse.

The HP 2010 objective (8-1 a) to reduce the proportion of persons exposed to air that does not meet the EPA's health-based standards for ozone does not directly translate to Lancaster County because for us it's an "all or nothing" proposition: the entire county (and its population) is either in a status of attainment or nonattainment of the EPA standard. But, given our current baseline status of nonattainment, we can adapt the HP 2010 goal as follows: reduce the average annual number of unsafe air days (code orange or above) and eventually reach attainment status so that no one among Lancaster County's population must be wary of limiting outdoor activity to avoid health risks, except in very rare instances.

Disparities exist in the environmental exposures certain populations face and in the health status of these populations. For example, in New York City, African American, Hispanic, and low-income populations have been found to have hospitalization and death rates from asthma three to five times higher than those for all New York City residents. African American children have been found to be three times more likely than white children to be hospitalized for asthma and asthma-related conditions and four to six times more likely to die from asthma.

Within the United States, significant strides toward a reduction in harmful air emissions can be achieved by individuals choosing not to drive their cars. People need to use public transit, walk, or bicycle more often. Laws can help improve street and highway design to facilitate pedestrians and bicyclists, and employers can embrace telecommuting, but the choice remains with the individual. Encouraging individuals to walk or bike also may play a role in reducing the problems of obesity and overweight individuals, which have risen to alarming levels in the U.S. population.

Urban sprawl has become an increasingly important concern in the United States and Lancaster County for several reasons: increased outdoor air pollution, reduced quality of life due to the loss of free time and the stress of increased commuting time, and less green space in major metropolitan areas. Between 1983 and 1995, the average annual vehicle miles traveled increased 80 percent. These conditions lead to negative health conditions, such as asthma and injuries from road rage due to traffic-related stress. In addition, sprawl diminishes the amount of land available for prime recreational and agricultural uses and can bring two land uses together that do not coexist well. For example, a residential development in an area that was previously agricultural may expose residents to environmental hazards, such as pesticides, which may pose a threat to their health.

Improving the availability of environmental health data also will help meet these objectives. The Internet has increased access dramatically to environmental information. Databases such as TOXNET (at http://toxnet.nlm.nih.gov/), Internet Grateful Med (at http://igm.nlm.nih.gov), and TRI (the Toxics Release Inventory www.epa.gov/ceisweb1/ceishome/ceisdata/xplor-tri/explorer.htm) may provide useful information about environmental hazards or other environmental problems in communities to health care providers, policymakers, and the public. Moreover, better dissemination of global environmental health information may reduce the occurrence of disease or exposure to harmful environmental agents for U.S. citizens traveling abroad.

To be successful, programs to improve environmental health must be based on scientific evidence. The complex relationship between human health and the acute and long-term effects of environmental exposures must be studied so prevention measures can be developed.
Surveillance systems to track exposures to toxic substances such as commonly used pesticides and heavy metals must be developed and maintained. To the extent possible, these systems should use bio-monitoring data, which provide measurements of toxic substances in the human body. A mechanism is needed for tracking the export of pesticides restricted or not registered for use in the United States.

Over 100 million Americans live in areas that failed at least one National Ambient Air Quality Standard. Transportation vehicles produce 25–75% of key chemicals that pollute the air, causing smog and health problems. All new cars must meet federal emissions standards. But as vehicles get older, the amount of pollution they produce increases. Vehicles with better fuel economy may produce less pollution over time than vehicles with lower fuel economy.

**Businesses and Government**
- Encourage car-pooling.
- Set up bike stands and make showers available for those interested in biking to work.
- Work with public transportation systems to accommodate your work force where possible.
- Encourage community design that supports village concepts that reduce the need to use cars.
- Design car parks at access points to major transportation routes to encourage car-pooling.
- Partner with the Susquehanna Valley Ozone Action Partnership to educate and encourage good behaviors among your employees and in your own operations.
- Landscape your properties in ways that increase shade and discourage mowing.
- Be aware of ozone alert days and encourage your employees to take precautions both on the job and at home.

**Individuals**
- Walk or ride a bike instead of using your car when possible.
- Try a bus.
- When choosing a new home, consider one located within walking distance to amenities such as shops, schools, parks, and your job.
- Reduce your number of car trips, especially during summer months.
- Plant trees.
- Consider plantings around your home that reduce the use of lawn mowers and power equipment.
- Use a rake instead of a gas leaf-blower.
- Consider turning in your old gas-powered mower for an electric one.
- Purchase vehicles that burn less fuel.
- Maintain your vehicle to reduce exhaust.
- Check appliances, and trade in those that were built prior to the new standards for reducing ozone.
- Write to policy-makers to advocate for maintaining clean air standards and more fuel-efficient and cleaner vehicle standards.
- Contact the American Lung Association for the Ozone Action Partnership’s list of “50 Ways to Help Prevent Air Pollution on Ozone Action Days” and “What You Can Do About Air Pollution.”
What is the local correlation between exceedance days and emergency room admissions?

Is there a local correlation between sprawl and local air pollution?

What are the asthma statistics for Lancaster County and how are they affected by (indoor and outdoor) air quality?

How is our air quality being affected by other areas and how might we impact changes?

How do we promote transportation plans and community design that truly encourage public transportation systems and safe pedestrian and bike paths?

Water quality has a significant impact through a wide range of waterborne diseases, many of which affect the gastrointestinal tract (e.g., giardiasis, cryptosporidiosis, and Campylobacter enteritis). Note that one of the earliest triumphs of public health that led to significant reductions in deaths from illnesses such as cholera and typhoid was a result of making the water supply safe. Drinking water can come from either groundwater sources (via wells) or surface water sources (such as rivers, lakes, and streams). Drinking water, including bottled water, may reasonably be expected to contain at least small amounts of some contaminants. As long as they occur below EPA's standards, they don't pose a significant threat to health, although people with severely compromised immune systems and children may have special needs. EPA sets standards for approximately 90 contaminants in drinking water. EPA's standards, along with each contaminant's likely source and health effects, are available at www.epa.gov/safewater/mcl.html.

Water suppliers must deliver to their customers annual drinking water quality reports (or consumer confidence reports). These reports will tell consumers what contaminants have been detected in their drinking water, how these detection levels compare to drinking water standards, and where their water comes from. The reports must be provided annually before July 1, and, in most cases, are mailed directly to customers’ homes. To find the source of your drinking water, check your annual water quality report or call your water supplier.

There are 1,364.85 miles of streams in Lancaster County of which 38% were impaired, meaning that they are polluted. Most pollution is “non-point source” or agricultural in nature. If our streams are being polluted, it is natural to assume that the nearby on-site wells may also be in danger of pollution.

A number of Lancaster communities experienced drinking water restrictions in the last decade which resulted in a flurry of activity to build new water systems and refurbish older water systems. Some of that building activity was simply the result of population growth, but some of it was spurred as well by the contamination of existing supplies (i.e., a public well). Wellhead protection plans (see appendix) are springing up around the county in response to high nitrate levels. However, we have yet to gauge the extent or even existence of pollution due to pesticides and herbicides which are widely used in lawned suburbs and heavily agricultural areas. Additionally, at least at first glance, we seem to have a slightly elevated incidence of waterborne illnesses according to Department of Health statistics. That will require greater research for verification.

The PA Department of Environmental Protection has an ongoing program to assess the quality of the state's surface waters. But the quality of on-site well water is left to municipalities to assess and regulate. Most municipalities allow private on-lot wells, but none have testing requirements.
Nationally, most water systems use a groundwater source (80%), but most people (66%) are served by a water system that uses surface water. This is because large metropolitan areas tend to rely on surface water, whereas small and rural areas tend to rely on groundwater. In addition, 10–20% of people nationally have their own private well for drinking water. This is in contrast to Lancaster.

In Lancaster County 31% of water delivered by community systems is from wells and 40% of homes have their own on-lot wells for drinking water as well as on-lot sewer systems.

In 1993 there were:
- 150,956 households in Lancaster County.
- 91,264 served by community water suppliers.
- 59,692 served by on-lot wells, cisterns, etc.

Only 32 of the 60 municipalities of the county require compliance with the Lancaster County Subdivision and Land Development Ordinance that requires yield and quality testing before NEW construction.

None of the county's 60 municipalities require testing of on-lot wells. Drinking water protection is a community-wide effort. It begins with:
- Protecting the source of your water.
- Education, funding, and conservation.
- Establishing source water protection programs such as well-head protection planning.
- Adopting watershed efforts.
- Stream bank restoration projects.
- Enacting animal waste management legislation (the enforcement and efficacy should be audited).

Installation of a home water treatment system may be a feasible option for people with contaminated drinking water. However, such systems are usually considered a temporary solution due to periodic maintenance requirements, performance monitoring difficulties, and varying effectiveness with changes in the intensity and type of contamination. The only permanent solutions to water contamination problems are discontinuation of the source(s) of the contamination or finding a new drinking water source. Different types of systems are available involving different treatment technologies. The list of treatment processes includes activated carbon filtration, ion exchanging, reverse osmosis, distillation, chemical oxidation, and UV radiation. No one system removes all possible contaminants, and the various treatment technologies differ widely in their effectiveness in removing different classes of contaminants. For example, while activated carbon filters are efficient in removing organic compounds, pesticides, and lead, distillation effectively removes metals and microorganisms. Therefore, an important first step for the homeowner, before any system is purchased, is to have the drinking water analyzed. The county health department or a private laboratory can provide this analysis and public health officials can interpret these results to help the homeowner determine which treatment process is most appropriate. No federal, state, or local regulations govern the manufacturing or use of home water treatment units. Many different brands are available in the marketplace. To ensure some level of quality and effectiveness, certification of treatment units is carried out by independent testing laboratories such as NSF International (formerly the National Sanitation Foundation). Their insignia will be evident on the packaging, or individuals can contact the NSF to find out if a particular product has been certified for the use intended. Also, the Water Quality Association (WQA), a trade association of manufacturers and distributors, offers voluntary validation standards and advertising guidelines to their members. Thus, the WQA seal of approval provides another indication of product quality.
Local Assets

U.S. Environmental Protection Agency
Office of Air Quality Planning and Standards (OAQPS)
Air Quality Index—Guide to Air Quality and Your Health
http://www.epa.gov/airnow/aqibroch/

EPA–AIR–Teacher and Student Resource Site
http://www.epa.gov/students/air.html

EPA–AIR and Radiation
http://www.epa.gov/air/data/index.html

Fuel Economy
http://www.fueleconomy.gov/
Is that new car you're planning to buy a gas guzzler? This U.S. Department of Energy site lets car shoppers find out which vehicles have the best—and worst—gas mileage. The site also includes estimated annual fuel costs, links to vehicle crash test results, and tips for improving your car's gas mileage.

American Lung Association
Ozone Air Pollution and Your Kids: What Parents Should Know
http://www.lungusa.org/air/envozoneparents.html

American Lung Association
Indoor and outdoor air pollution site
http://www.lungusa.org/air/

American Lung Association
Susquehanna Valley Ozone Action Partnership

DEP Bureau of Watershed Conservation
(717) 787-5259

Lancaster County Conservancy
(717) 392-7891
EPA—Windows To My Environment
An interactive site that allows you to view your environment based on zip code input
http://www.epa.gov/enviro/wme/

Farm*A*Syst/Home*A*Syst
Provides information to help farmers and rural residents assess pollution risks and
develop management plans to meet their unique needs.
http://www.wisc.edu/farmasyst/

EPA's page for private well owners:
http://www.epa.gov/safewater/pwells1.html

EPA Adopt a Watershed
http://www.epa.gov/adopt/

DEP Site
Watershed Weekly
http://www.greenworks.tv/watershed_weekly/index.html

- How do we encourage municipalities to review the status of on-site wells and sewer systems?
- How does the analysis of our water quality impact our community dialogue around sprawl and urban growth boundaries?
- How would we, as a larger community, react to the identification of widespread well water contamination? Would it remain for the individual municipalities to resolve or be regionally addressed?
- How do we design and carry out research on the health effects of our current water delivery systems?
- What role does the medical community play in the discussion around clean water?
- How do drought conditions affect water quality?
Access to Quality Health Services

1-7 Core competencies in health provider training
1-12 Single toll-free number for poison control centers

Cancer

3-1 Overall cancer deaths
3-2 Lung cancer deaths
3-8 Melanoma deaths
3-9 Sun exposure and skin cancer
3-10 Provider counseling about cancer prevention
3-14 Statewide cancer registries

Chronic Kidney Disease

4-1 End-stage renal disease

Disability and Secondary Conditions

6-12 Environmental barriers affecting participation in activities

Educational and Community-Based Programs

7-2 School health education
7-10 Community health promotion programs

Food Safety

10-1 Food-borne infections
10-2 Outbreaks of food-borne infections
10-5 Consumer food safety practices

Health Communication

11-1 Households with Internet access
11-2 Health literacy
11-4 Quality of Internet health information sources

Heart Disease and Stroke

12-1 Coronary heart disease (CHD) deaths

Immunization and Infectious Diseases

14-31 Active surveillance for vaccine safety

Injury and Violence Prevention

15-7 Nonfatal poisonings
15-8 Deaths from poisoning
15-10 Emergency department surveillance systems
15-11 Hospital discharge surveillance systems
15-12 Emergency department visits
15-13 Deaths from unintentional injuries
15-14 Nonfatal unintentional injuries

Maternal, Infant, and Child Health

16-10 Low birth weight and very low birth weight
16-11 Preterm births
16-14 Developmental disabilities
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Occupational Safety and Health

20-1 Work-related injury deaths
20-2 Work-related injuries
20-7 Elevated blood lead levels from work exposure
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22-14 Community walking
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23-1 Public health employee access to the Internet
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23-4 Data for all population groups
23-5 Data for Leading Health Indicators, Health Status Indicators, and Priority Data Needs at state, tribal, and local levels
23-6 National tracking of Healthy People 2010 objectives
23-7 Timely release of data on objectives
23-8 Competencies for public health workers
23-9 Training in essential public health services
23-10 Continuing education and training by public health agencies
23-11 Performance standards for essential public health services
23-12 Health improvement plans
23-13 Access to public health laboratory services
23-14 Access to epidemiology services
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24-5 School or work days lost
24-6 Patient education
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27-9 Exposure to tobacco smoke at home among children
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27-11 Smoke-free and tobacco-free schools
27-12 Work site smoking policies
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28-17 Noise-induced hearing loss in children
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Heart Disease and Stroke

Prevention, detection, and treatment of risk factors leading to cardiovascular disease and stroke

Reduce disparities
### Heart Disease and Stroke

**Goal:** Improve cardiovascular health and quality of life through the prevention, detection, and treatment of risk factors; early identification of heart attacks and strokes; and prevention of recurrent cardiovascular events.

#### HP 2010 Measures/Local Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
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<tbody>
<tr>
<td>12-1</td>
<td>Reduce coronary heart disease deaths.</td>
</tr>
<tr>
<td></td>
<td>Target-setting method: 20 percent improvement</td>
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<td></td>
<td>Data source: National Vital Statistics System (NVSS), CDC, NCHS</td>
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<tr>
<td>12-2</td>
<td>Increase the proportion of adults aged 20 years and older who are aware of the early warning symptoms and signs of a heart attack and the importance of accessing rapid emergency care by calling 911. (developmental)</td>
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<td>Potential Data Source: National Health Interview Survey (NHIS), CDC, NCHS</td>
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<td>12-7</td>
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<td>12-8</td>
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<td>Potential data source: National Health Interview Survey (NHIS), CDC, NCHS</td>
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<td>12-9</td>
<td>Reduce the proportion of adults with high blood pressure.</td>
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<tr>
<td></td>
<td>Target setting method: Better than best</td>
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<tr>
<td></td>
<td>Data Source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS</td>
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<td>12-10</td>
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<td>Data source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS</td>
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<td>12-14</td>
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<tr>
<td>12-15</td>
<td>Increase the proportion of adults who have had their blood cholesterol checked within the preceding 5 years.</td>
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<td></td>
<td>Target-setting method: Better than best</td>
</tr>
<tr>
<td></td>
<td>Data source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS, BRFSS</td>
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</tbody>
</table>
A silent killer at work in all of us is currently taking over 2,600 Americans each day, an average of one death every 33 seconds (American Heart Association, 2002, 2002 Heart and Stroke Update). Cardiovascular disease in its various forms claims almost as many deaths each year as the next seven leading causes of death combined. Clearly, this is a serious threat to our well-being as a nation. The true tragedy is that, even among those with a genetic predisposition, this is a highly preventable and highly treatable health problem. The toll on our population is a direct result of lack of awareness and a denial of personal consequences to making unhealthy lifestyle choices related to food and dieting. We live in a culture where we travel at the speed of light, with increasing stress and overwork, and are encouraged in our fast food consumption, eating on the run, and enjoying the “value” of supersizing one’s meals. We take no time for exercise and pay little attention to our bodies until symptoms notify us of well-established heart disease. Media attention to overweight and obesity issues appeals to the vanity of physical appearance and, now, the clothing industry has responded to the needs of the expanding American girth by creating and selling designs that hide the bulk while fudging size numbers.

According to the American Heart Association’s 2002 Statistical Update, one in five deaths from cardiovascular disease is attributable to smoking and, even worse, between 37,000–40,000 nonsmokers die of cardiovascular disease each year as a result of secondhand smoke. Though public awareness has improved in this area, and adult smoking is going down, teenagers, despite all the evidence of its risks, have begun to smoke in increasing numbers.

Since 1900, cardiovascular disease (CVD) has been the number one killer in the United States every year except for 1918. (American Heart Association, 2002 Heart and Stroke Statistical Update.) Risk factors and types of CVD include high blood cholesterol, high blood pressure, coronary heart disease including myocardial infarction and angina pectoris, stroke, congenital cardiovascular defects, and congestive heart failure. Coronary heart disease (CHD) is the number one killer of both men and women in the United States. Each year, more than 500,000 Americans die of heart attacks caused by CHD. (National Heart, Lung, and Blood Institute, Facts about Coronary Heart Disease).

Cardiovascular disease is the leading cause of death for women. A need exists for greater awareness among women in this area and media campaigns similar to those encouraging an awareness of breast cancer and the need for mammography. The early signs and symptoms of heart attack for women are different than those for men. Women often do not seek treatment for early symptoms. Females have poorer outcomes after a heart attack than do males and, at older ages, are twice as likely to die within a few weeks.

Risk Factors

High Blood Cholesterol

The higher one’s blood cholesterol level, the greater is the risk for heart disease, heart attack, and stroke. Cholesterol is a waxy, fatlike substance in the body that, in excess amounts, builds up on the walls of the arteries to cause a condition called atherosclerosis, or hardening of the arteries. The arteries narrow, and thus the heart is deprived of the oxygen it needs to function. If the blood supply becomes completely cut off, a heart attack occurs.

There are two types of cholesterol: HDL (high-density lipoprotein), which is good and keeps cholesterol from building up on the walls of arteries, and LDL (low-density lipoprotein), which is bad because it is the main source of cholesterol buildup and blockage in the
arteries. High blood cholesterol, above 200 mg/dL, is caused by consuming saturated fat and cholesterol in the diet, by being overweight, by lack of physical activity, by heredity, and by age and gender. People with blood cholesterol above 240 mg/dL are at very high risk for cardiovascular disease. In the years 1988–1994, an average of 21 percent of all adults aged 20 and older fell into this very high risk category. (Healthy People 2010, Heart Disease and Stroke). This constitutes 1 in 5 Americans.

High Blood Pressure

Blood pressure or hypertension is the force of the blood pushing against the walls of the arteries. It is given in two numbers that measure systolic pressure (while the heart is contracting) and diastolic pressure (while the heart is at rest). Desirable pressure is defined as less than 130/85 mmHg. High blood pressure (HBP or hypertension) is defined as systolic pressure of 140mm Hg or higher and diastolic pressure of 90 mm Hg or higher, or taking anti-hypertensive medicine. According to the Pennsylvania Department of Health, the percent of Pennsylvania adults who have had their blood pressure checked in the past two years has declined since the 1991 figures. Control of high blood pressure depends on the public realizing that it is a symptomless condition until it has already done damage to the heart.

- According to the Framingham Heart Study, hypertension is associated with a two- to three-fold risk for the development of congestive heart failure. High blood pressure preceded the development of congestive heart failure in 91 percent of the cases.

- One in four American adults have HBP.

- From 1989 to 1999 the age-adjusted death rate from HBP increased 21 percent, but the actual number of deaths rose 46 percent. (American Heart Association, 2002 Heart and Stroke Statistical Update.)

- Of the one in four American adults with HBP, 31.6 percent are unaware of their condition.

- 27.4 percent of those with known high blood pressure are on medication and have it controlled; 26.2 percent are on medication but do not have their HBP controlled; and 14.8 percent aren’t on medication. (American Heart Association, 2002 Heart and Stroke Statistical Update.)

Coronary Heart Disease (CHD)

Coronary heart disease is a condition in which the flow of blood to the heart muscle is reduced. When coronary arteries become clogged or narrowed, not enough oxygen carrying blood reaches the heart and it may respond with pain called angina. When the blood supply is cut off completely, the result is myocardial infarction, or heart attack.

Risk factors include HBP, cigarette smoking, high blood cholesterol, overweight, physical inactivity, and diabetes. The symptoms of CHD include shortness of breath, heaviness, tightness, pain, burning, pressure or squeezing, usually behind the breastbone but sometimes in arms, neck, or jaws and there is a wide range of severity. Some people have no symptoms
at all; some have intermittent mild symptoms; some find their lives severely restricted by these symptoms. Tests for this condition may include: an electrocardiogram (ECG or EKG); a stress test; nuclear scanning; and coronary angiography.

While many people can control CHD through lifestyle changes and medication, frequent and disabling angina may signal the need for surgery. Surgery and medication are not cures for CHD. They relieve symptoms and buy time. Lifestyle changes can relieve the body of its effects.

**Stroke**

Stroke is a cardiovascular disease process that affects the blood vessels supplying blood to the brain. It occurs when a vessel bringing oxygen and nutrients to the brain bursts or is clogged by a blood clot or some other particle. Nerve cells in the brain, deprived of oxygen, can't function and die within minutes. The effect is devastating because dead brain cells are not replaced and the part of the body they control is permanently affected.

Stroke accounted for 1 out of every 14.3 deaths in the United States and, when considered separately from other cardiovascular disease, ranks as the third leading cause of death. (American Heart Association, 2002, *Stroke*, para. 1). According to the Framingham Heart Study, each year about 600,000 people suffer from new or recurrent stroke; about 500,000 of these are first attacks and 100,000 are recurrent attacks. Over four million stroke survivors are alive today, coping with the damage done by their strokes.

The most important risk factor for stroke is high blood pressure. “Like CHD death rates, stroke death rates have declined over the past 30 years. The decline accelerated in the 1970's for whites and African Americans. The rate of decline however, has slowed in recent years. The overall decline has occurred mainly because of improvements in the detection and treatment of high blood pressure (hypertension).” (American Heart Association, 2002, *Stroke*)

Age, heredity, and race are factors in stroke risk.

- The chance of having a stroke more than doubles for each decade of life after age 65.
- Those with a family history have higher risk, as do African Americans, largely because they have a greater incidence of high blood pressure.
- Cigarette smoking greatly increases risk of stroke, especially smoking along with the use of oral contraceptives. (American Stroke Association, n.d., *Risk Factors of Stroke*, para. 6).
- Stroke deaths occur more often during extremely hot or cold weather.
- Cocaine use and excessive alcohol intake can cause heart failure and lead to stroke.

There are four main types of stroke, two caused by blood clots and/or other particles and two by hemorrhage (internal bleeding). Blood clots plug the artery in cerebral thrombosis and cerebral embolism, and these events account for 70 to 80 percent of all strokes. (American Stroke Association, n.d., *Impact of Stroke*), The other two, cerebral and subarachnoid hemorrhages, are caused by ruptured blood vessels and have a much higher fatality rate.

The effects of a stroke depend primarily on the location of the obstruction and the extent of brain tissue affected. Because one side of the brain controls the opposite side of the body, a stroke affecting the right brain will result in neurological complications for the left side of the body. Prior to a stroke, about 10 percent of people may experience a transient ischemic attack or “mini-stroke” or TIA. A person who has had TIAs is 9.5 times more likely to have a stroke.

The warning signs of stroke include:

- Sudden numbness of the face, arm, leg, especially on one side of the body
- Sudden confusion and trouble speaking or understanding
- Trouble seeing in one or both eyes
Trouble walking, dizziness, loss of balance or coordination

Sudden severe headache with no known cause

Treatment for ischemic stroke includes anticoagulants to dissolve clots, carotid endarterectomy, and angioplasty with stents. The purpose is to restore blood flow to the brain. Treatment for hemorrhagic stroke includes surgical interventions to repair or remove abnormal blood vessels that contain aneurysms.

According to the Pennsylvania Department of Health's Bureau of Health Statistics, heart disease was the leading cause of death in Lancaster County. It is followed closely by all forms of cancer. Stroke is the third leading cause of death. The effects of high cholesterol rates, overweight, lack of exercise, smoking, and poorly controlled blood pressure take years to finally result in a heart attack or stroke. As Lancaster County residents age, the insidious effect of these risk factors becomes more and more evident. Up to the age of 24, heart disease is the fifth leading cause of death in the county, but by age 45 it becomes the second leading cause, and by age 65 it is the leading cause by a significant margin. Clearly, many Lancaster Countians, unaware or ignoring the danger, may be quietly and efficiently setting the scene for premature death through poor lifestyle choices.

Disparity rates in Lancaster County reflect the national trends outlined below. From 1994 to 1996, age-adjusted mortality for whites from coronary heart disease was 207.8 per 100,000. For African Americans overall, the mortality rate was significantly higher at 306.

- Males, regardless of race, died at higher rates than females, 266.9 per 100,000 as opposed to 165.3 for women.
- African American males were the most profoundly affected with a death rate of 317.7.
- African American females have a death rate of 283.0, higher than both white males (267.4) and white females (164.6). (NHLBI, 1994–96, chart 1).
- In Lancaster County, African American males suffer the highest age-adjusted mortality rate at 153.9 while white males die from heart attack at the rate of 98.5.
- Congestive heart failure afflicts whites much more than African Americans, with a death rate of 25.3 in contrast to 7.9. In this case, white women fare better than white men, but African American women fare worse than African American men.

### 12-1 Reduce Coronary Heart Disease Deaths

<table>
<thead>
<tr>
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<td>166</td>
<td>208.3</td>
<td>209.3</td>
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12-1 Reduce CHD Deaths, 
Age-Adjusted* Lancaster Death Rates, by Race and Gender

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<tbody>
<tr>
<td></td>
<td></td>
<td>Males</td>
<td>Females</td>
<td>Total</td>
<td>Males</td>
<td>Females</td>
<td>Total</td>
<td>Males</td>
<td>Females</td>
<td>Total</td>
<td>Males</td>
<td>Females</td>
</tr>
<tr>
<td>1979–1983</td>
<td>331.2</td>
<td>443.3</td>
<td>251.6</td>
<td>331.4</td>
<td>602.9</td>
<td>254.6</td>
<td>397.1</td>
<td>1984–1988</td>
<td>277.8</td>
<td>352.1</td>
<td>224.5</td>
<td>277.7</td>
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<td>1989–1993</td>
<td>228.5</td>
<td>294.8</td>
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<td>171.2</td>
<td>185.0</td>
<td>180.5</td>
<td>1994–1998</td>
<td>198.4</td>
<td>257.6</td>
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*to 2000 Standard Population  
U=Statistically Unreliable  
CHD=ICD 9 codes, 402, 410–414, 429.2

CHD Death Rates for Pennsylvania, Age-Adjusted* by Race and Gender

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<td>Total</td>
<td>Males</td>
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<td>207.1</td>
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<td>224.2</td>
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<td>291.8</td>
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*to 2000 Standard Population

CHD Death Rates for the United States, Age-Adjusted* by Race and Gender

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<td></td>
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<td>Total</td>
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<td>Females</td>
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</table>

*to 2000 Standard Population

12-7 Reduce Stroke Deaths

<table>
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</thead>
<tbody>
<tr>
<td>48</td>
<td>59.6</td>
<td>56.7</td>
<td>53.4</td>
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</tbody>
</table>

Stroke kills more African American men at 82.6 per 100,000, a much higher rate than both white genders. Interestingly, African American women in Lancaster have the lowest stroke mortality rate at 28.2.

12-7 Reduce Stroke Deaths, 
Age-Adjusted* Lancaster Death Rates by Race and Gender

<table>
<thead>
<tr>
<th>Years</th>
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<tbody>
<tr>
<td></td>
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<td>1979–1983</td>
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<td>58.3</td>
<td>60.6</td>
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U=Statistically Unreliable
Although we do better than national and state rates, we have yet to meet the HP 2010 goals. At this time, we do not have NHANES data for Lancaster to compare to the US on the other HP indicators. Additional data that is relevant to lifestyle choices and risk factors will be collecting through the local BRFSS being conducted in Lancaster County. The questions will include information on diet, exercise, awareness, access to care, screening, and compliance with doctor's recommendations with regard to these health issues.

In the case of heart attack and stroke, swift and immediate treatment is the key to survival. Long delays in seeking medical attention for symptoms are associated with factors such as age (older), gender (female), race or ethnicity, low socioeconomic status, and prior medical condition. Coexisting conditions such as high blood cholesterol, high blood pressure, and congestive heart failure affect disparity in death rates.

According to the American Heart Association's 2002 Heart and Stroke Statistical Update, age-adjusted death rates for cardiovascular disease, including stroke, was 42 percent higher in African American males than white males, and 65 percent higher in African American females than white females, and nearly twice as high in males as females. (Healthy People 2010, Heart Disease and Stroke, p. 4).

**Relevant Facts**

- The age-adjusted prevalence of cardiovascular disease in adults is:
  - 30 percent for white males
  - 23.8 percent for white females
  - 40.5 percent for African American males
  - 39.6 percent for African American females
  - 28.8 percent for Mexican American males
  - 26.6 percent for Mexican American females
  (NHANES III (1988–94) CDC, NHS)

- The prevalence of high blood pressure in African Americans in the U.S. is among the highest in the world. Compared with whites, they develop HBP earlier in life and their average blood pressure is much higher, increasing their rate of fatal stroke 1.8 times, and of heart disease death 1.5 times.

- A higher percentage of men than women have high blood pressure until the age of 55.

- When adjusted for age, stroke deaths are almost 80 percent higher in African Americans than in whites and about 17 percent higher in men than women.

- The age-adjusted stroke incidence rates (per 1,000 person-years) are:
  - 1.78 for white men
  - 4.44 for African American men
  - 1.24 for white women
  - 3.10 for African American women
  (NHLBI's ARIC study, Stroke 1999)

- Among children and adolescents ages 4–19, females have significantly higher mean total cholesterol and low-density lipoprotein (LDL) cholesterol than males.
Non-Hispanic black children and adolescents have significantly higher mean total cholesterol, LDL, and HDL levels when compared to non-Hispanic white and Mexican American children and adolescents (NHANES III, 1988-94, CDC, NCHS). Culturally and linguistically appropriate counseling by health care providers is critical to reducing the disparity evident from these statistics. Accessibility to preventive health monitoring and education to ensure early detection and intervention must be investigated and corrected if this disparity is to be eliminated or reduced.

The risk for heart attack and death among persons with established coronary heart disease (CHD) or other atherosclerotic (hardening of the arteries) disease is five to seven times higher than it is for the general public. (Healthy People 2010, National Cholesterol Education Program, “Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults”). Risk factor control in the 12 million adults in this country with CHD could lower the overall rate of heart attacks and CHD deaths by 20 percent. Many people with CHD are not receiving the aggressive risk factor management that they need to comply. While many know their cholesterol levels and blood pressure and understand their relationship to heart disease, compliance with recommended interventions seems to provide a challenge for most people.

Clinical trials have proven that lowering low-density lipoprotein (LDL) cholesterol levels and lowering blood pressure dramatically reduces total deaths from heart disease, stroke, heart attacks, and coronary heart disease.

People need to be willing and able to carry out dietary and exercise recommendations.

Health care providers and health care systems must provide encouragement and monitoring of therapeutic interventions by supporting lifestyle changes and long-term patient cooperation with pharmacological regimens.

Advanced technology, such as magnetic resonance imaging and ultrasound, allows researchers to screen noninvasively and painlessly for developing atherosclerosis.

Early management strategies in the area of public outreach and community health interventions are needed to help people lower their cholesterol and manage their blood pressure.

Delivering outreach messages in ways that people from all cultures can understand and incorporate into their unique cultural lifestyles is critical to reducing disparities.

Smoking cessation programs that are culturally competent are important parts of health care in the United States.

Early identification and treatment in both heart attack and stroke is critical to both survival and limiting damage. Early treatment of heart attack reduces heart-muscle damage, improves heart muscle function, and lowers the heart attack death rate. (Healthy People 2010, Heart Disease and Stroke, Rapid Identification and treatment of patients with acute myocardial infarction, 1994 Annals of Emergency Medicine, 23:311–329)

Recognition of collapse or symptoms by bystanders is a key factor because the sooner CPR and defibrillation is administered, the greater the chance of survival.

The American Heart Association stresses the importance of calling 911 when symptoms arise, rather than calling family or friends, your physician, or waiting for them to pass. Calling 911 at the first sign of symptoms will grant you early access to emergency care services and, improve your chance of survival.

Patients who receive clot-dissolving agents in the first and second hours after the onset of a heart attack experience significant reductions in disability and death (Healthy People 2010, 1996, Lancet 348:771-775).
Other effective acute interventions include balloon angioplasty, coronary stenting, and coronary artery bypass surgery.

Reestablishing blood flow in the affected coronary artery as quickly as possible is always the primary objective. As with heart attacks, deaths from stroke can be reduced or delayed by using the most effective therapies in the most timely way. Damage that results in permanent disability can be minimized if a person is treated with clot-dissolving therapy within three hours of a stroke (Healthy People 2010, 1995, *New England Journal of Medicine* 333(24):1581-1587).

Local Assets

- American Heart Association
  (717) 393-0725
  Operation Stroke, through the local American Heart Association
  http://www.americanheart.org/
- Community Hospital of Lancaster
  Cardiology (717) 239-4219
  Cardiac Rehabilitation (717) 396-0150
- Ephrata Wellness Program
  (717) 859-3991
  ECHWellness@yahoo.com
- HealthSouth
  (717) 691-3718
- Lancaster General Health Campus
  Cardiac Rehabilitation
  (717) 290-3126
- Lancaster General
  Heart Center (717) 290-4921
  Pulmonary Services (717) 290-5930
  Stroke Center (717) 290-3170
- The Lancaster Heart Foundation
  (717) 290-6680
- Lancaster Regional Medical Center
  Cardiac Rehabilitation (717) 291-8593
  Cardiology Services (717) 291-8268
  Heart Hospital (717) 291-8208
- St. Joseph Health Ministries
  Life Enhancement Center
  (717) 239-1195
- American Heart Association Basic Life Support Courses
  Offered at the following locations:
  Ephrata Community Hospital—Wellness Center
  (717) 859-3991
  Masonic Homes
  717-367-1121 ext. 33816
Additional Resources

American Heart Association
2002 Heart and Stroke Statistical Update, from:
http://www.americanheart.org/presenter.jhtml?identifier=1200000

American Stroke Association
About Stroke, from: http://www.nhlbi.nih.gov/resources/deca/descriptions/asympt.htm

Centers of Disease Control, 2002, Cardiovascular Health: Preventing Heart Disease and Stroke, from: http://www.cdc.gov/nccdphp/cvd/cvdaag.htm

Healthy People 2010, Cardiovascular Health Partners
http://www.heartandstrokepartners.org

The National Heart, Lung and Blood Institute Health Information Center
(301) 592-8573
http://www.nhlbi.nih.gov
and Publication Resources for Women, Hispanics, and African Americans, from:
http://www.nhlbi.nih.gov/health/pubs/pub_gen.htm#women

National Stroke Association
1-800-STROKES
http://www.stroke.org

National Institute of Neurological Disorders and Stroke (NINDS)
Brain Resources and Information Network (BRAIN)
NINDS/NIH
1-800-496-5751
http://www.ninds.nih.gov

PA Department of Health, 1996 Behavioral Health Risks of Pennsylvania Adults
http://webserver.health.state.pa.us/health/site/default.asp

U.S. Department of Health and Human Services Healthfinder
http://www.healthfinder.gov

Information on Lowering Cholesterol and Information on Lowering High Blood Pressure
National Institutes of Health
What We Can Do

Businesses and Institutions

- Encourage and facilitate workplace programs such as Weight Watchers to help employees with weight and obesity issues.
- Support national initiatives such as the American Heart Association’s Heart Walk by encouraging workplace teams.
- Support and encourage lunchtime walkers and other opportunities for employees to participate in regular physical activities.
- Invite education programs into the workplace that teach early warning sign recognition of heart attack and stroke in others and themselves.
- Sponsor and provide yearly opportunities for cholesterol checks and blood pressure monitoring through employee health programs.
- Churches and nonprofit health organizations target minority populations especially vulnerable to coronary heart disease and stroke risk in health fairs and information fairs located within easily accessible community areas and in culturally and linguistically appropriate formats.
- Hospitals, doctors’ offices, and church and parish nurses commit to an ongoing campaign designed to support people in controlling risk factors like weight, smoking, and exercise on a regular basis.
- Support programs that educate the public in clinically proven diet choices like the Therapeutic Lifestyle Change (TLC) cholesterol-lowering diet and the DASH, Dietary Approach to Stop Hypertension, diet.
- Provide rewards and incentives for employees successful at smoking cessation, weight loss, and regular exercise programs.
- Community education in the form of public speaking engagements.
- Stroke screenings
- Provide educational programs to primary and secondary schools on heart attack and stroke.

Individuals

- Know your hereditary and genetic risk for coronary heart disease and stroke.
- Know your cholesterol numbers, including HDL and LDL, and what they mean. Have these numbers checked yearly.
- Know your blood pressure numbers and what is optimal for you. Have your blood pressure checked regularly.
- Lose weight if you are overweight or obese.
- Peri- and post-menopausal women should insist on risk factor evaluations from their doctors for heart disease and stroke.
- Consult the American Heart and Stroke Association for guidelines for the right kind of diet for your goals.
- Engage in regular physical activity, at least 30 minutes per day on most, if not all, days.
- Take your medication faithfully if you are receiving drug treatment for high blood pressure or for lowering your cholesterol.
If you are a parent, make certain your children follow a healthful diet and get regular exercise. Model these positive behaviors for them. Do not allow your children to become overweight.

Indulge in fast food only rarely and make wise choices. Reduce sodium consumption.

Increase your consumption of fruit, vegetables, and high-fiber carbohydrates, using meat as a garnish.

Don’t smoke. If you do, join a smoking cessation program and enlist the aid of your family doctor.

Participate in AHA’s community Operation Stroke initiative.

How can we better educate people to recognize stroke symptoms?

In what ways can communities encourage habits and behaviors to prevent heart disease and stroke?

How do we get schools to do a better of job of providing heart healthy meals, physical education, and health training to set up a lifetime of making heart-wise choices?

How can local organizations, institutions, and schools work together to move forward their initiatives regarding heart disease and stroke.

Are we effectively targeting women in education and prevention initiatives? How can we improve our work with this audience?

How can we more competently reach and educate minority populations regarding heart disease and stroke?

Access to Quality Health Services

1-3 Counseling about health behaviors
1-7 Core competencies in health provider training
1-10 Delay or difficulty in getting emergency care
1-11 Rapid pre-hospital emergency care

Chronic Kidney Disease

4-2 Cardiovascular disease deaths in persons with chronic kidney failure

Educational and Community-Based Programs

7-2 School health education
7-5 Work site health promotion programs
7-8 Satisfaction with patient education
7-10 Community health promotion programs
7-11 Culturally appropriate and linguistically competent community health promotion programs
7-12 Older adult participation in community health promotion activities

Health Communication

11-1 Households with Internet access
11-2 Health literacy
11-4 Quality of Internet health information sources
11-6 Satisfaction with health care providers’ communication skills
Nutrition and Overweight

19-1 Healthy weight in adults
19-2 Obesity in adults
19-3 Overweight or obesity in children and adolescents
19-5 Fruit intake
19-6 Vegetable intake
19-8 Saturated fat intake
19-9 Total fat intake
19-11 Calcium intake
19-16 Worksite promotion of nutrition education and weight management

Physical Activity and Fitness

22-1 No leisure-time physical activity
22-2 Moderate physical activity
22-3 Vigorous physical activity
22-6 Moderate physical activity in adolescents
22-7 Vigorous physical activity in adolescents
22-11 Television viewing
22-13 Worksite physical activity and fitness
22-14 Community walking
22-15 Community bicycling

Public Health Infrastructure

23-1 Public health employee access to Internet
23-3 Use of geocoding in health data systems
23-10 Continuing education and training by public health agencies
23-16 Data on public health expenditures

Tobacco Use

27-1 Adult tobacco use
27-2 Adolescent tobacco use
27-3 Initiation of tobacco use
27-4 Age at first use of tobacco
27-5 Smoking cessation by adults
27-10 Exposure to environmental tobacco smoke
27-16 Tobacco advertising and promotion targeting adolescents and young adults
27-17 Adolescent disapproval of smoking
Immunization

Prevention of infectious disease through immunization


<table>
<thead>
<tr>
<th>HP 2010 Measures and Local Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>14-24</strong> Increase the proportion of young children and adolescents who receive all vaccines that have been recommended for universal administration for at least 5 years.</td>
</tr>
</tbody>
</table>

Target and baseline:
- Children aged 19 to 35 months who receive the recommended vaccines (4DTaP, 3 polio, 1 MMR, 3 Hib, 3 hep B)
- Adolescents aged 13 to 15 years who receive the recommended vaccines (Developmental)

Target-setting method: Better than the best

Data source: National Immunization Survey (NIS), CDC, NCHS and NIP; National Health Interview Survey (NHIS), CDC, NCHS

| **14-25** Increase the proportion of providers who have measured the vaccination coverage levels among children in their practice population within the past 2 years. |

Target and baseline:
- Public health providers and private providers

Target-setting method: 36 percent improvement for public health providers; 1,400 percent improvement for private providers

Data source: Immunization Program Annual Reports, CDC, NIP

| **14-29** Increase the proportion of adults who are vaccinated annually against influenza and never vaccinated against pneumococcal disease. |

Target and baseline:
- Noninstitutionalized adults aged 65 years and older:
  - Influenza vaccine
  - Pneumococcal vaccine
- Noninstitutionalized, high-risk adults aged 18 to 64 years:
  - Influenza vaccine
  - Pneumococcal vaccine
- Institutionalized adults (persons in long-term or nursing homes†)
  - Influenza vaccine
  - Pneumococcal vaccine

†National Nursing Home Survey estimates include a significant number of residents who have an unknown vaccination status.

Target-setting method: Better than the best

Data sources: National Health Interview Survey (NHIS), CDC, NCHS—noninstitutionalized populations; National Nursing Home Survey (NNHS), CDC, NCHS—institutionalized populations
Vaccines are among the greatest public health achievements of the 20th century. Immunizations can prevent disability and death from infectious diseases for individuals and can help control the spread of infections within communities. When vaccination levels in a community are high, those who are not vaccinated are often indirectly protected because they live among vaccinated persons who are less likely to expose them to disease.

Vaccines are biological material that works with the person’s immune system to produce a prevention response in the same way as one that is produced when a person is naturally infected. Vaccines can prevent the effects of infectious diseases. Vaccines have helped to eliminate the illness and disability of polio, measles, and rubella. That doesn’t mean the diseases have disappeared. They have retreated, but will re-emerge if the vaccination coverage drops. The evidence of this was in the measles outbreak of 1989 to 1991, resulting in more than 55,000 cases, 11,000 hospitalizations, 120 deaths, and $100 million in direct medical care costs. Vaccination coverage levels of 90 percent are, in general, sufficient to prevent circulation of viruses and bacteria-causing, vaccine-preventable diseases.

Infectious diseases still remain major causes of illness, disability, and death. Considered as a group, three infectious diseases—pneumonia, influenza, and HIV infection—constituted the fifth leading cause of death in the United States in 1997. Between 1980 and 1992, the number of deaths from infectious diseases rose 58 percent in the United States. Even when human immunodeficiency virus (HIV)-associated diagnoses are removed, deaths from infectious diseases still increased 22 percent during this period.

New infectious diseases are being detected, but some diseases that public health officials believed were under control have been coming back. This is due to resistant strains evolving rapidly for a variety of reasons, including infected people who may have less than adequate access to the regular and ongoing health care that is needed to treat some infectious diseases such as tuberculosis.

Infectious diseases must be considered in a global context. Increases in international travel, importation of foods, inappropriate use of antibiotics on humans and animals, and environmental changes multiply the potential for worldwide epidemics of all types of infectious diseases. Actions taken to improve health in one country affect the health of people worldwide (source: HP 2010).

Since 1989, vaccination requirements have been expanded for schools and day care settings. As of the 1998–99 school year, all states required vaccination against diphtheria, measles, and polio. Similarly, all states and the District of Columbia now require vaccination for children in day care.

Childhood immunization rates measure other aspects of health status in a community: access to pediatric primary care and public health immunization programs. Smallpox has been eradicated. Vaccinations have reduced reported cases of the most common childhood illnesses (measles, mumps, rubella, varicella, diphtheria, tetanus, pertussis, polio, hepatitis B, and invasive Hib disease) to record-low levels. Pertussis among children will be reduced by increasing vaccination coverage, but the disease will continue to occur because the organism circulates among older age groups and the vaccine is not 100 percent effective. Hepatitis B virus (HBV) infection will be reduced greatly as the age groups covered by universal infant and adolescent vaccination efforts enter young adulthood, a period when the risk of HBV infection increases.
Three childhood vaccines—diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP); measles, mumps, and rubella vaccine (MMR); and *Haemophilus influenzae* type b (Hib) vaccine—result in substantial direct medical savings for each dollar spent to vaccinate children against these diseases. Consideration of indirect savings—prevention of work loss by parents to care for ill children and prevention of death and lost earnings from disability—shows that vaccines routinely recommended for children are highly cost saving. Savings range from $24 for every dollar spent on DTaP to $2 for the more recently approved Hib vaccine (source: HP 2010).

All children born in the United States (11,000 per day) should be receiving 12 to 16 doses of vaccine by age 2 years to be protected against 10 vaccine-preventable childhood diseases. This recommendation will change in the years ahead as new vaccines are developed, including combinations of current vaccines that may even reduce the number of necessary shots. To decrease hepatitis A transmission, universal vaccination was recommended in 1999 for children who lived in states where the rate of new cases was greater than two times the national average.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Increase in Coverage Levels of Universally Recommended Vaccines</th>
<th>1998</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-24a</td>
<td>Children aged 19 to 35 months who receive the recommended vaccines (4DTaP, 3 polio, 1 MMR, 3 Hib, 3 hep B)</td>
<td>73</td>
<td>80</td>
</tr>
<tr>
<td>14-24b</td>
<td>Adolescents aged 13 to 15 years who receive the recommended vaccines</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Measuring vaccination coverage is difficult, as no mandated and universal reporting system has been established in Pennsylvania for children or adults. But some evidence about the achievement of the HP 2010 objective (14-24a)—that children aged 19 to 35 months should have received 4 doses of DTP vaccine, 3 doses of polio vaccine, 1 dose of MMR vaccine, 3 doses of Hib vaccine, and 3 doses of HepB vaccine (the so called 4:3:1:3:3 series)—is available from the National Immunization Survey (NIS), conducted by the National Immunization Program (NIP) of the Centers for Disease Control (CDC). This national survey, covering approximately 30,000 randomly selected children in the 19 to 35 months of age cohort, provides estimates of 4:3:1:3:3 series coverage for the state of Pennsylvania, for Philadelphia, and for the rest of the state (but unfortunately not for any smaller geographical areas within the state).

It would seem appropriate to use the “rest of the state” estimates as reasonably good estimates for Lancaster County. As panel C of Table I-1 suggests, the “Rest of P” has made good progress in improving its 4:3:1:3:3 series coverage during the latter half of the 1990s. The latest figures available, covering the period from July 2000 through June 2001, indicate that the “Rest of P” has achieved coverage of about 83% (83.3 ± 4.8, meaning that we can be “95 percent confident” that the true percent of children vaccinated falls somewhere in the range from 78.5% to 88.1%). This “Rest of PA” rate compares favorably both to the national rate of 74% (74.2 ± 0.9) and to the Philadelphia rate of 71% (71.4 ± 5.4).

For the more limited vaccination series 4:3:1 and 4:3:1:3 (see panels A and B), both Pennsylvania and the nation as a whole show somewhat higher coverage rates, and Pennsylvania, particularly the “Rest of PA,” again demonstrates superior coverage rates to those of the nation as a whole. It also appears to be the case that the growth in Pennsylvania’s coverage rates has been somewhat more rapid than for the U.S. as a whole.
We do have some early childhood vaccination coverage data specific to Lancaster County, as measured by the Pennsylvania Department of Health’s Clinic Assessment Software Application (CASA) results, which compile the vaccination records of two-year-old children (24–35 months) served by public vaccination provider sites (i.e., County or Municipal Health Departments, State Health Centers, and/or Community Health Projects). The table at right presents these data from 1998 through 2002 for all Pennsylvania reporting units (PA total), Lancaster County, and the five Pennsylvania counties that abut Lancaster County.

The most extensive (4:3:1:3:3) vaccination series, which is the focus of the HP 2010 objective, is not reported in the CASA data until 2002. There are two more important distinctions between these data and those compiled in the National Immunization Survey (NIS): (1) the “completed by 24 months” cutoff date of the CASA data is somewhat more restrictive than the NIS cutoff (up to 35 months, depending on the child’s age at the time of the survey); and (2) the “public provider only” nature of the CASA data constitutes a more restricted sampling of children in the target population. Nevertheless, the CASA 4:3:1 series coverage rates in the “PA total” column— which do not include any Philadelphia data—are quite compatible with the NIS rates for the “Rest of PA” in panel A of the table I-1 (viz: compare 1999 CASA rates of 83% and 85% to 1999 NIS rate of 87% [87.3 ± 4.2]; compare 2000 CASA rate of 86% to 1999 NIS rate of 82% [82.0 ± 5.1]).

In general, the Lancaster coverage rates do not compare favorably with the state rate or with those of our neighboring counties. With the exception of the 2001 results, Lancaster’s coverage rates are always below the state rates by “double digits” and always lower than those of four out of our five neighboring counties (the Dauphin County results, however, are decidedly inferior to Lancaster’s).

We must be cautious, however, about generalizing these patterns to county populations as a whole. The Lancaster data is compiled from the records of the Lancaster State Health Center, whose clientele may not be wholly representative of the larger county population. Similarly, the Lancaster State Health Center clientele may not be similar to those of reporting units in other counties, so the generally lower coverage rates for Lancaster may reflect demographic differences rather than different coverage rates within otherwise similar populations. One potential explanation we can rule out, however, is that the Lancaster coverage data is influenced by cultural practices endemic to the Amish. The Lancaster State Health Center has only a small number of Amish clients, so results based on its aggregate records are not likely to reflect any such influence. Another
possibility that could provide some explanation with further research is that the Lancaster State Health Center may serve a disproportionately high number of “immigrants” and/or otherwise “transitory” families.

Returning to the NIS data, we can also find some information regarding differences in coverage rates by race and ethnicity (see the table at right). In the most recently published 4:3:1:3:3 coverage results (for July 2000–June 2001), white, non-Hispanic children had the highest coverage rate across the nation as a whole: 76.4. Asian children exhibited no significant difference, at 76.0, but the same cannot be said of Hispanic and black, non-Hispanic children, whose coverage rates were, respectively, 71.3 and 69.8. Within Pennsylvania, smaller sample sizes generated a more limited set of statistically meaningful results. In Philadelphia, white, non-Hispanic children showed a 78.1 coverage rate, as against one of only 66.2 for black, non-Hispanic children; in the “Rest of PA” the white, non-Hispanic coverage rate was slightly greater, at 83.9, than the total (i.e., all-group) coverage rate of 83.3 (see the table). Unfortunately, no coverage rates specific to Hispanic children living in Pennsylvania are available from the NIS survey data.

As might be expected, children living in poor households are less likely to have completed the 4:3:1:3:3 series; furthermore, there appears to be very little difference in coverage rates across racial/ethnic groups for children who live in poor households (compare across row 1.a.1 of the table). For the entire country, poverty status appears to exert a more powerful (negative) effect than central city residence, whereas the opposite might appear to be true for Pennsylvania (see Panel B). However, this result may be driven by an over-sampling within Pennsylvania of Philadelphia County, which is an Immunization Action Plan Area. If children in Philadelphia are more likely to be poor than children in other Pennsylvania cities, then an over-sampling of Philadelphia will cause a larger difference associated with residency status in Pennsylvania than would otherwise be the case.

The “good news” is that even poor and/or city resident children in Pennsylvania show a higher vaccination series completion rate than the total U.S. rate and, furthermore, the “non-poor” U.S. (compare bold values in Panel B), although not to a statistical certainty. Similarly, the vaccination rate among white, non-Hispanic children in Pennsylvania is decided higher—and this time to a “statistical certainty”—than it is for the same demographic group in the nation as a whole. While we do not have sufficient evidence to speak with certainty about other racial and/or ethnic groups, it seems reasonable to surmise that, within a given racial/ethnic category, Pennsylvania children are more likely to have completed the 4:3:1:3:3 vaccination series than children in the rest of the nation. It is troubling, however, to note that Philadelphia children, particularly those within the black population, do not measure up well against the overall national rate (i.e., total U.S. coverage rate = 74.2±0.9>

#### Panel A. Race and Ethnicity

<table>
<thead>
<tr>
<th></th>
<th>White, non-Hispanic</th>
<th>Black, Hispanic&lt;sup&gt;b&lt;/sup&gt; non-Hispanic</th>
<th>Asian</th>
<th>Amer. Indian or Pac. Islr.</th>
<th>Amer. Indian or Alaska Nat.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.a United States</td>
<td>76.4±1.0</td>
<td>69.8±2.6</td>
<td>71.3±2.1</td>
<td>76.0±4.8</td>
<td>71.3±8.7</td>
</tr>
<tr>
<td>1.a.1 Poor&lt;sup&gt;b&lt;/sup&gt;</td>
<td>69.3±3.6</td>
<td>69.3±4.0</td>
<td>68.3±3.7</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>2.a Pennsylvania</td>
<td>83.5±4.7</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>2.a.1 Philadelphia</td>
<td>78.1±9.0</td>
<td>66.2±8.1</td>
<td>na</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>2.a.2 Rest of PA</td>
<td>83.9±5.0</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>na</td>
</tr>
</tbody>
</table>

#### Panel B. Poverty Status and Central City Residence

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Poor&lt;sup&gt;b&lt;/sup&gt;</th>
<th>non-Poor&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Central City&lt;sup&gt;c&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.b United States</td>
<td>74.2±0.9</td>
<td>68.7±2.2</td>
<td>76.1±1.0</td>
<td>72.6±1.4</td>
</tr>
<tr>
<td>2.b Pennsylvania</td>
<td>81.5±4.2</td>
<td>79.7±9.6</td>
<td>82.5±5.0</td>
<td>775±6.9</td>
</tr>
<tr>
<td>2.b.1 Philadelphia</td>
<td>71.4±5.4</td>
<td>na</td>
<td>80.5±6.5</td>
<td>71.4±5.4</td>
</tr>
<tr>
<td>2.b.2 Rest of PA</td>
<td>83.3±4.8</td>
<td>na</td>
<td>82.7±5.5</td>
<td>na</td>
</tr>
</tbody>
</table>

**Notes:**

<sup>a</sup>Children of Hispanic ethnicity may be of any race; estimated percentages of Hispanic children 19–35 months of age: U.S., 22.1±0.8; Pennsylvania, 70±2.3; Philadelphia, 13.1±3.7; “Rest of PA”, na; estimated percentages of white, non-Hispanic children 19–35 months of age: U.S., 572±0.8; Pennsylvania, 76.4±4.4; Philadelphia, 30.9±5.4; “Rest of PA”, 82.3±5.1; estimated percentages of black, non-Hispanic children 19–35 months of age: U.S., 15.4±0.8; Pennsylvania, 14.7±3.5; Philadelphia, 50±6.0; “Rest of PA”, na.

<sup>b</sup>(non-)Poor=children living in households with income levels (at or above) below the poverty threshold; estimated percentages of children 19–35 months of age living in poverty: U.S., 20.6±0.8; Pennsylvania, 13.8±3.7; Philadelphia, 28.4±5.4; Rest of PA, na.

<sup>c</sup>Central City=children living in a central city of a metropolitan statistical area; estimated percentages of children 19–35 months of age living in an MSA central city: U.S., 36.6±0.9; Pennsylvania, 34.0±4.5; Philadelphia, 100.0 (Philadelphia is a central city); Rest of PA, 22.3±5.3 na=not available, generally due to small sample size.

**Source:** compiled from data available at the National Immunization Program Web site: http://www.cdc.gov/nip/coverage/#NIS

Philadelphia rate = 71.4±5.4 > Philadelphia black rate = 66.2±8.1). Indeed, the coverage rate for all black children in Philadelphia is below the observed rates for poor children within each of the (white, black, and/or Hispanic) racial/ethnic categories.

As the U.S. population ages, more adults will be at risk for infectious diseases to be a major cause of illness and death. Persons with high-risk conditions such as heart disease, diabetes, and chronic respiratory disease remain at increased risk for these diseases, as do persons living in institutional settings. They are more likely to experience serious complications brought on by weakened immune systems.

Immunizations against influenza and pneumococcal disease are important. Adult immunization rates are not as high as children’s rates, yet the health effects may be just as great. Pneumococcal disease and influenza account for more than 30,000 deaths annually, most of which occur in elderly persons. Many adults don’t know which immunizations are needed, don’t understand vaccinations, and are not adequately informed by their health care providers. Current levels of coverage among adults vary widely among age, risk, and racial and ethnic groups. High-risk adults aged 18 to 64 years may not have insurance coverage for influenza and pneumococcal vaccines. Influenza and pneumococcal vaccines are covered by Medicare; thus vaccinating greater numbers of adults aged 65 years and older is feasible.

Vaccination rates among persons aged 65 years and older continued to increase over the past decade. Influenza vaccine coverage rates were up from 33 percent in 1989 to 64 percent in 1998, and pneumococcal vaccine coverage rates were up from 15 percent to 46 percent.
Despite these increases, coverage rates for certain racial and ethnic groups remain substantially below the general population.

Any new universally recommended vaccine for adults should be at a 60 percent coverage level within five years of recommendation. Recommended immunizations for adults aged 65 years and older include a yearly immunization against influenza (the “flu shot”) and a one-time immunization against pneumococcal disease. In 1996, a vaccine against hepatitis A virus (HAV) was licensed that has the potential to reduce the health burden of this disease. The vaccine is now recommended primarily for high-risk groups.

**National Target and Baseline:**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Increase in Adults Vaccinated 1998*</th>
<th>2010 Target (unless noted)</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-29a</td>
<td>Noninstitutionalized adults aged 65 years and older</td>
<td>64</td>
</tr>
<tr>
<td>14-29b</td>
<td>Influenza vaccine</td>
<td>46</td>
</tr>
<tr>
<td>14-29c</td>
<td>Noninstitutionalized high-risk adults aged 18 to 64 years</td>
<td>26</td>
</tr>
<tr>
<td>14-29d</td>
<td>Influenza vaccine</td>
<td>13</td>
</tr>
<tr>
<td>14-29e</td>
<td>Institutionalized adults (persons in long-term or nursing homes)†</td>
<td>59 (1997)</td>
</tr>
<tr>
<td>14-29f</td>
<td>Pneumococcal vaccine</td>
<td>25 (1997)</td>
</tr>
</tbody>
</table>

*Age adjusted to the year 2000 standard population.
†National Nursing Home Survey estimates include a significant number of residents who have an unknown vaccination status.

See Tracking Healthy People 2010 for further discussion of the data issues.

**Local Data**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Increase in Adults Vaccinated 1999</th>
<th>1997</th>
<th>1996</th>
<th>Local</th>
</tr>
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<tbody>
<tr>
<td>14-29a</td>
<td>Influenza vaccine</td>
<td>64±4</td>
<td>67±4</td>
<td>62±4</td>
</tr>
<tr>
<td>14-29b</td>
<td>Pneumococcal vaccine</td>
<td>54±4</td>
<td>48±4</td>
<td>43±4</td>
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<tr>
<td>14-29c</td>
<td>Noninstitutionalized high-risk adults aged 18 to 64 years</td>
<td>23±2</td>
<td>19±2</td>
<td>17±2</td>
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<tr>
<td>14-29d</td>
<td>Pneumococcal vaccine</td>
<td>9±1</td>
<td>9±1</td>
<td>9±1</td>
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</tbody>
</table>

Significant achievements were made among racial and ethnic groups in that most of the 1996 goals for the Childhood Immunization Initiative were met for individual vaccines. Vaccination rates for preschool children in racial and ethnic groups with lower vaccination rates, however, have been increasing at a more rapid rate, significantly narrowing the gap. Neighborhood Health Centers, Head Start and early school programs have increased the number of vaccinated children. But very young children are still at risk, particularly children living in poverty in both urban areas or isolated rural communities.

The updated Preventing Emerging Infectious Diseases: A Strategy for the 21st Century focuses on certain emerging infectious disease issues and on particular groups of people at risk. In addition to very young children, many adults are at increased risk for VPDs.
Vaccination against pneumonia and influenza among persons aged 65 years and older has increased slightly for African Americans and Hispanics. The coverage in these groups, however, remains substantially below the general population. For example, influenza vaccination rates for whites were 66 percent in 1997, while for African Americans and Hispanics rates were only 45 percent and 53 percent, respectively. In September 1997, the U.S. Department of Health and Human Services approved a plan to improve adult vaccination rates and reduce disparities among racial and ethnic groups. The elimination of disparities, however, may require further interventions in particular geographic, cultural, and racial and ethnic populations (source: HP 2010).

Financing for childhood vaccinations has improved significantly as a result of two initiatives—Vaccines for Children and the States’ Children’s Health Insurance Programs (CHIP)—that cover children on Medicaid, uninsured children, and American Indian and Alaska Native children. Under-insured children who receive vaccinations at federally qualified health centers also are covered. Because they promote free vaccines for children, these programs eliminate vaccine cost as a barrier to childhood vaccination. Also, the Public Health Service Act, Section 317 immunization grant program and state funds provide free vaccines for children not covered by other programs.

Locally, Southeast Health Center provides vaccines for its patients. Lancaster General’s Child Protect Program provides free vaccines. Welsh Mountain Clinic has provided a vaccine outreach program that has gone into local Plain churches to provide immunizations in rural Lancaster County. These have been well attended. This program, however, is in need of staffing as the health care professional shortage has affected their pool of nursing volunteers. Local hospital clinics do not get reimbursed for their vaccination program for the uninsured and one hospital noted that the cost ran as much as $9000 a month in vaccines alone. They have continued to provide outreach programs with the Department of Health, particularly for those adults in high risk categories including those suffering from asthma, CCPD and diabetes during cold and flu season. Most nursing homes also provide vaccination programs to their patients.

Requiring immunizations for school enrollment in public schools in PA has helped increase immunization rates for children in school. But there are many exemptions for private schools and those home-schooled. Compliance by private schools is not mandatory. Licensed child care facilities also require compliance. But most children are not in licensed child care. Changes in required immunizations for all school-age children should be considered. That still leaves very young children unmonitored except through well baby visits. Greater outreach in non-traditional settings may be the best options for increasing coverage.

Adults without insurance are not likely to visit primary care physicians for annual physicals. Nor would a provider readily offer immunization updates to such a patient. Additionally, many adults do not know enough about the importance of immunizations to take advantage of those that exist. Again, non-traditional opportunities must be developed to reach this population and increase awareness of the importance to quality of life and longevity issues. Continued partnerships with the Office of the Aging, home health care organizations, and visiting nurses is essential. But we must increase outreach to churches and service organizations as well.

According to HP 2010 and CDC, the major strategies to protect people from infectious diseases are the following:

- Improving the quality and quantity of vaccination delivery services.
- Minimizing financial burdens for needy persons.
- Increasing community participation, education, and partnership.
- Improving monitoring of disease and vaccination coverage.
- Developing new or improved vaccines and improving vaccine use.
Many communities have used a variety of strategies to increase coverage rates among children and adults. Some of these proven strategies are:

- Over 90 million emergency department visits are made in the United States annually. Emergency department vaccination is likely to increase vaccination rates among select populations that are difficult to vaccinate through office-based programs.
- Churches and community centers hold pot luck suppers that include free vaccination programs.
- Emergency rooms share vaccination information with primary care physicians.
- Private schools also require immunizations as entry requirements for school and report regularly to the department of health.
- PTOs encourage immunizations in extended families.
- Populations can be reached through linkages with other programs, including Women, Infants, and Children (WIC) services or Healthy Beginnings Plus programs.
- State and local registries have enrolled children and record their vaccinations to help parents and providers identify immunization needs of individual children, assessing coverage in individual practices, and generating communitywide estimates.
- All health care providers should assess routinely the vaccination status of their patients. Likewise, health plans should develop mechanisms for assessing the vaccination status of their participants, as vaccinations decrease health care costs.
- Nursing home facilities and hospitals should ensure that policies exist to promote vaccination.
- Guidelines and tools for implementing interventions (such as standing orders for vaccinations) are available through Put Prevention Into Practice, a national campaign to improve delivery of clinical preventive services.

HP 2010 recommends population-based immunization registries that will be a cornerstone of the nation's immunization system by 2010. Responsibility for registry development rests with state and local communities, with assistance from federal agencies and private partners. Registries facilitate the timely vaccination of children by ensuring that the child's complete vaccination history is available to the health care provider. Registries are valuable considering the mobile nature of today's population and that many persons do not see the same provider consistently. Registries also can be used to monitor the vaccination status of populations that are low income, uninsured, and at greater risk for incomplete vaccination.

A fully operational population-based registry includes capabilities to:

- Protect confidential information.
- Enroll all children at the state or community level automatically at birth.
- Give providers access to complete vaccination history.
- Recommend needed vaccinations.
- Notify children who are due and overdue for vaccinations.
- Assess practice and geographic-level coverage.
- Produce authorized immunization records.

Registries may provide other important functions such as assisting in the evaluation of vaccine safety. Registries may serve other purposes as well, including VPD surveillance, vaccine efficacy monitoring, and vaccine inventory management (source: HP 2010).
Community Hospital of Lancaster—(717) 397-3711
Ephrata Community Hospital—(717) 733-0311
Hepatitis C Clinic—(717) 290-3069
Lancaster County Office of the Aging—(717) 299-7979
Lancaster General’s Child Protect Program — (717) 290-5511
Lancaster Regional Medical Center Clinic—(717) 291-8388
PA Dept of Health (local office)—(717) 299-7597
Southeast Health Clinic—(717) 299-6371
State Health Hotline—(800) 692-7254
United Way LINC—(717) 291-LINC (5462)
Welsh Mountain Medical and Dental Clinic—(717) 354-4711

National Immunization Program/CDC
800-232-2522 (English); 800-232-0233 (Spanish);
888-CDC-FAXX (fax-back);
http://www.cdc.gov/nip/

PA Dept of Health, Division of Immunizations
(717) 787-5681

Businesses and Institutions
- Work with insurers to improve health care coverage for vaccinations.
- Work with health care providers to distribute information on vaccinations to employees.
- Provide opportunities to get vaccinations conveniently during organized events at the workplace.
- Provide information on recommendations for vaccination to retirees.
- Ask providers to make screening for vaccinations a part of their annual check up of your employees.
- Make vaccinations a part of workplace safety education programs.

Individuals
- Vaccinate your children in a timely manner and keep good records.
- Take your elderly parents for free vaccinations when you see them advertised.
- Call your local Office of the Aging about available programs.
- Have your college-bound student vaccinated before they leave home.
- Check for your vaccination updates at your annual check-up—most immunizations are not once for a lifetime.
I How do we encourage insurance companies to increase the scope of immunization coverage.
I How do we increase accessibility to the most vulnerable populations (non-insured) within the economic constraints posed by lack of third-party payment.
I How do we deal with the new threats of bio-terrorism and the building of a quick response infrastructure to deal with possible immunization challenges.
I How do we deal with the issue of confidentiality while trying to track babies and their mothers in a registry to ensure timely immunization for all children under three.

Diseases Preventable Through Universal Vaccination

14-1 Vaccine-preventable diseases
14-2 Hepatitis B in infants and young children
14-3 Hepatitis B in adults and high-risk groups
14-4 Bacterial meningitis in young children
14-5 Invasive pneumococcal infections

Diseases Preventable Through Targeted Vaccination

14-6 Hepatitis A
14-7 Meningococcal disease
14-8 Lyme disease

Infectious Diseases and Emerging Antimicrobial Resistance

14-9 Hepatitis C
14-10 Identification of persons with chronic hepatitis C
14-11 Tuberculosis
14-12 Curative therapy for tuberculosis
14-13 Treatment for high-risk persons with latent tuberculosis infection
14-14 Timely laboratory confirmation of tuberculosis cases
14-15 Prevention services for international travelers
14-16 Invasive early onset group B streptococcal disease
14-17 Peptic ulcer hospitalizations
14-18 Antibiotics prescribed for ear infections
14-19 Antibiotics prescribed for common cold
14-20 Hospital-acquired infections
14-21 Antimicrobial use in intensive care units

Vaccination Coverage and Strategies

14-22 Universally recommended vaccination of children aged 19 to 35 months
14-23 Vaccination coverage for children in day care, kindergarten, and first grade
14-24 Fully immunized young children and adolescents
14-25 Providers who measure childhood vaccination coverage levels
14-26 Children participating in population-based immunization registries
14-27 Vaccination coverage among adolescents
14-28 Hepatitis B vaccination among high-risk groups
14-29 Influenza and pneumococcal vaccination of high-risk adults

Vaccine Safety

14-30 Adverse events from vaccinations
14-31 Active surveillance for vaccine safety
Access to Quality Health Services

1-1  Persons with health insurance
1-2  Health insurance coverage for clinical preventive services
1-3  Counseling about health behaviors
1-4  Source of ongoing care
1-5  Usual primary care provider
1-6  Difficulties or delays in obtaining needed health care
1-7  Core competencies in health provider training
1-8  Racial and ethnic representation in health professions
1-9  Hospitalization for ambulatory-care-sensitive conditions
1-14 Special needs of children
1-15 Long-term care services

Educational and Community-Based Programs

7-2  School health education
7-4  School nurse-to-student ratio
7-5  Work site health promotion programs
7-6  Participation in employer-sponsored health promotion activities
7-7  Patient and family education
7-8  Satisfaction with patient education
7-9  Health care organization sponsorship of community health promotion activities
7-10 Community health promotion programs
7-11 Culturally appropriate and linguistically competent community health promotion programs
7-12 Older adult participation in community health promotion activities

Environmental Health

8-5  Safe drinking water
8-6  Water-borne disease outbreaks
8-29 Global burden of disease
8-30 Water quality in the U.S.-Mexico border region

Food Safety

10-1  Food-borne infections
10-2  Outbreaks of food-borne infections
10-3  Antimicrobial resistance of Salmonella species

Health Communication

11-1  Households with Internet access
11-2  Health literacy
11-3  Research and evaluation of communication programs
11-4  Quality of Internet health information sources
11-5  Centers for excellence
11-6  Satisfaction with health care providers' communication skills

HIV

13-9  HIV/AIDS, STD, and TB education in state prisons
13-11 HIV testing in TB patients
13-12 Screening for STDs and immunization for hepatitis B

Maternal, Infant, and Child Health

16-22 Medical homes for children with special health care needs
Addendum I: A Plan for Creating a Healthy Lancaster Community

Public Health Infrastructure
  23-1 Public health employee access to the Internet
  23-2 Public access to information and surveillance data
  23-3 Use of geo-coding in health data systems
  23-4 Data for all population groups
  23-5 Data for Leading Health Indicators, Health Status Indicators, and Priority Data Needs at State, Tribal, and local levels
  23-6 National tracking of Healthy People 2010 objectives
  23-7 Timely release of data on objectives
  23-8 Competencies for public health workers
  23-9 Training in essential public health services
  23-10 Continuing education and training by public health agencies
  23-11 Performance standards for essential public health services
  23-12 Health improvement plans
  23-14 Access to epidemiology services
  23-15 Model statutes related to essential public health services
  23-17 Population-based prevention research

Sexually Transmitted Diseases
  25-13 Hepatitis B vaccine services in STD clinics
Injury and Violence

Reduce injuries, disabilities, and deaths due to unintentional injuries and violence
## HP 2010 Measures and Local Measures

### 15-15 Reduce deaths caused by motor vehicle crashes.

- **Target and baseline:**
  - Deaths per 100,000 population
  - Deaths per 100 million vehicle miles traveled
- **Target-setting method:** Better than the best for 15-15a; 50 percent improvement for 15-15b. (Better than the best will be used when data are available.)
- **Data sources:** National Vital Statistics System (NVSS), CDC, NCHS; Fatality Analysis Reporting System (FARS), DOT, NHTSA

### 15-27 Reduce deaths from falls.

- **Target:** 3.0 deaths per 100,000 population
- **Baseline:** 4.7 deaths per 100,000 population were caused by falls in 1998 (age adjusted to the year 2000 standard population)
- **Target-setting method:** Better than the best
- **Data source:** National Vital Statistics System (NVSS), CDC, NCHS

### 15-32 Reduce homicides.

- **Target:** 3.0 homicides per 100,000 population
- **Baseline:** 6.5 homicides per 100,000 population occurred in 1998 (age adjusted to the year 2000 standard population)
- **Target-setting method:** Better than the best
- **Data sources:** National Vital Statistics System (NVSS), CDC, NCHS; FBI Uniform Crime Reports, U.S. Department of Justice

### 15-33 Reduce maltreatment and maltreatment fatalities of children.

#### 15-33a Reduce maltreatment of children.

- **Target:** 10.3 per 1,000 children under age 18 years.
- **Baseline:** 12.9 child victims of maltreatment per 1,000 children under age 18 years were reported in 1998.
- **Target-setting method:** 20 percent improvement. (Better than the best will be used when data are available.)
- **Data source:** National Child Abuse and Neglect Data System (NCANDS), Administration on Children, Youth and Families, Administration for Children and Families (ACF), Children's Bureau
- **Data for population groups currently are not analyzed.**

#### 15-33b Reduce child maltreatment fatalities.

- **Target:** 1.4 per 100,000 children under age 18 years
- **Baseline:** 1.6 child maltreatment fatalities per 100,000 children under age 18 years occurred in 1998
- **Target-setting method:** 12 percent improvement. (Better than the best will be used when data are available.)
- **Data source:** National Child Abuse and Neglect Data System (NCANDS), Administration on Children, Youth, and Families, Administration for Children and Families (ACF), Children's Bureau

### 15-34 Reduce the rate of physical assault by current or former intimate partners.

- **Target:** 3.3 physical assaults per 1,000 persons aged 12 years and older
- **Baseline:** 4.4 physical assaults per 1,000 persons aged 12 years and older by current or former intimate partners occurred in 1998.
- **Target-setting method:** Better than the best
- **Data source:** National Crime Victimization Survey (NCVS), U.S. Department of Justice, Bureau of Justice Statistics
Preventable death due to unintentional injuries is a significant cause of death. It does not include intentional deaths caused by violence. Most persons sustain a significant injury at some time during their lives. (Baker, S.P.; O’Neill, B.; Ginsburg, M.J.; et al. *The Injury Fact Book*. 2nd ed. New York, NY: Oxford University Press, 1992.) Many systems are impacted by and are needed to impact firearm safety, falls, poisoning, fire safety, traffic, and workplace safety. Most injuries are not accidents but are predictable and preventable. Actions taken to reduce deaths from unintentional injuries are also likely to reduce morbidity due to injury. Many areas could be studied, including choking, poisoning, fire, drowning, and suffocation. Motor vehicle crashes are the most common cause of serious injury. We will focus on motor vehicle crashes and also consider death by falls, of particular significance to our aging population. The impact of these injuries on the quality of life is enormous. For example, half of all elderly adults hospitalized for hip fracture cannot return home or live independently after the fracture. The total direct cost of all fall injuries for adults aged 65 years and older in 1994 was $20.2 billion. (Englander, F.; Hodson, T.J.; and Teregrossa, R.A. “Economic dimensions of slip and fall injuries.” *Journal of Forensic Science* 41(5): 746–773, 1996.)

In 1998, there were 15.6 deaths from motor vehicle crashes per 100,000 persons.

To say that we are a society plagued by violence is a statement that would get little resistance in these times. The violence is more often from within our own homes or between acquaintances than perpetrated by strangers. Awareness of the health, social, and economic effects of violence on our families, children, and the community at large has been increasing. Yet the levels of violence in a community are not easily measured and certainly not by a single factor. Communities should choose measures that reflect the intensity of the effects of violence over a lifetime. Rates for homicide, family or partner violence, maltreatment of our children, and delinquent youth violence capture important elements of the emotional, psychological, and social environments of different population groups.

Measuring the incidence of violence against children gives us insight into our ability and will as a caring and just society to protect our most vulnerable members. It also gives us
a glimpse of what the future may hold for families if we do not intervene into the lives of our most injured youth. Youth may be carrying the violence found in their homes into other areas of life, such as school. These violent behaviors of youth are a reflection of the community's atmosphere of violence.

Physical violence is the leading cause of death and injury among youths and young adults and correlates to a community's sense of its quality of life. Potential data sources for this indicator might be community statistics provided by local law enforcement agencies, social welfare organizations, and national data disseminated by the U.S. Department of Justice. It is difficult to compare data from different counties or systems. Issues that impede the public health response to progress in this area include lack of comparable data sources, lack of standardized definitions and definitional issues, lack of resources to establish adequately consistent tracking systems, and lack of resources to fund promising prevention programs.

Unintentional Injury

In 1997, 146,400 persons in the United States died from injuries due to a variety of causes such as motor vehicle crashes, firearms, poisonings, suffocations, falls, fires, and drownings. One death out of every 17 in the United States results from injury. In 1997, injuries accounted for 20 percent more years of potential life lost (YPLL) than cancer did (1,990 per 100,000 compared to 1,500 per 100,000). (Baker, S.P.; O’Neill, B.; Ginsburg, M.J.; et al. The Injury Fact Book. 2nd ed. New York, NY: Oxford University Press, 1992.) For ages one through 44 years, deaths from injuries far surpass those from cancer—the overall leading natural cause of death at these ages—by about three to one.

- Unintentional injury deaths include approximately 42,000 resulting from motor vehicle crashes per year. Motor vehicle crashes account for approximately half the deaths from unintentional injuries.

### Health Profile, 1999: Leading Causes of Death per 1,000 by Age Group (1997)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>State</th>
<th>Lancaster</th>
<th>Chester</th>
<th>York</th>
<th>Berks</th>
<th>Dauphin</th>
<th>Lebanon</th>
<th>Lehigh</th>
<th>Northampton</th>
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<tbody>
<tr>
<td>Under 5</td>
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In 1997, of approximately 50,000 intentional injury deaths, almost 31,000 were classified as suicide and nearly 20,000 as homicide.

Of the unintentional deaths caused by injury, 63 percent are classified as unintentional and 34 percent as intentional injuries. Additional millions of persons are incapacitated by unintentional injuries, with many suffering lifelong disabilities. In 1995, 29 million persons visited emergency departments as a result of unintentional injuries. (Schappert, S.M. “Ambulatory care visits to physician offices, hospital outpatient departments and emergency departments: U.S., 1995.” Vital and Health Statistics 13(29):1–38, 1997.)

Some Demographics

- More persons aged 1 to 34 years die as a result of unintentional injuries than any other cause of death.
- Injuries cause more than two out of five deaths (43 percent) of children aged one through 4 years and result in four times the number of deaths due to birth defects, the second leading cause of death for this age group.
- For ages 15 to 24 years, injury deaths exceed deaths from all other causes combined from ages 5 through 44 years.
- For ages 15 to 24 years, injuries are the cause of nearly four out of five deaths. After age 44 years, injuries account for fewer deaths than other health problems, such as heart disease, cancer, and stroke. But the death rate from injuries is actually higher among older persons than among younger persons.
- The motor vehicle death rate per 100,000 persons is especially high among persons aged 16 to 24 years and persons aged 75 years and older.
- In 1998, persons aged 70 years and older made up 9 percent of the population but accounted for 14 percent of all traffic fatalities and 18 percent of all pedestrian fatalities.

The common cause of death among motorcyclists is catastrophic head injury. Death rates from head injuries are twice as high among cyclists in states lacking helmet laws or having laws that apply only to young riders, compared with states where laws apply to all riders. The physical and emotional toll associated with head and spinal cord injuries can be significant for the survivors and their families. In addition, persons with existing disabilities from head and spinal cord injuries are at high risk for further secondary disabilities.

Falls account for 87 percent of all fractures among adults aged 65 years and older and are the second leading cause of both spinal cord injury and brain injury for this age group. (Kraus, K.F.; Black, M.A.; Hessol, N.; et al. “The incidence of acute brain injury and serious impairment in a defined population.” American Journal of Epidemiology 119:186–201, 1984.) Falls also cause the majority of deaths and severe injuries from head trauma among children under age 14 years. Falls account for 90 percent of the most severe playground-related injuries treated in hospital emergency departments (mostly head injuries and fractures) and one-third of reported fatalities.
Human suffering and loss of life is incalculable, and the financial cost is staggering. The costs of direct medical care and rehabilitation as well as lost income and productivity are included in the costs associated with injuries.

- By the late 1990s, injury costs were estimated at more than $441 billion annually, an increase of 42 percent over the 1980s. (National Safety Council. Accident Facts. 1995 ed. Itaska, IL: the Council, 1995.)
- Every bicycle helmet saves $395 in direct medical costs and other costs. (National Safe Kids Campaign. Childhood Injury Factsheet. Itaska, IL: the Campaign, 1997.)
- Every smoke detector saves $35 in direct medical costs and an additional $865 in other costs.

On an average day in America:

- 53 persons die from homicide.
- At least 8,000 persons survive interpersonal assaults.
- 84 persons complete suicide.
- 3,000 persons attempt suicide.
- 17 youth homicide victims die per day in the United States.

Low income, discrimination, lack of education, and lack of employment opportunities are risk factors for violent and abusive behavior. Violence can be random. This is what most fear: being attacked or struck down while going about our business in life. But the fact is that most violence is perpetrated by family members or acquaintances. Elderly persons, females, and children continue to be targets of both physical and sexual assaults.

Homicide was the cause of death for 19,491 persons in United States (7.2 per 100,000 population) in 1997. (NCHS. Mortality Data Tapes. Hyattsville, MD: NCHS.) Homicide is the second leading cause of death for young persons aged 15 to 24 years and the leading cause of death for African Americans in this age group. (Singh, G.K.; Kochanek, K.D.; and MacDorman, M.F. “Advance report of final mortality statistics, 1994.” Monthly Vital Statistics Report 45(3S), 1996.) In 1997, 32,436 individuals died from firearm injuries; of this number, 42 percent were victims of homicide. The increase in the total homicide rate from 1979 through 1993 resulted solely from increases in firearm-related homicides. (Fingerhut, L.A.; Ingram, D.D; and Feldman, J.J. “Firearm and non firearm homicide among persons 15 to 19 years of age: Differences by level of urbanization. United States 1979–89.” Journal of the American Medical Association 267(22):3048–3053, 1992.)

Males are most often the victims and the perpetrators of homicides. The homicide rate among males aged 15 to 24 years in the United States is 10 times higher than in Canada, 15 times higher than in Australia, and 28 times higher than in France or Germany. (World Health Organization (WHO). World Health Statistics Annual, 1994. Geneva, Switzerland: WHO, 1995.) African Americans are more than five times as likely as whites to be murdered. There has been a decline in the homicide of intimates, including spouses, partners, boyfriends, and girlfriends over the past decade, but this problem remains significant.

Homicide rates are dropping among all groups, but the decreases are not as dramatic among youth, who already exhibit the highest rates. Youth are involved as both perpetrators and victims of violence. In 1997, homicide was the third leading cause of death for children aged 5 to 14 years, an increasing trend in childhood violent deaths. In 1996, more than 80 percent of infant homicides were considered to be fatal child abuse.

In 1997, nearly 19,000 children aged 19 years and under were victims of injury—33 percent from violence. (NCHS. Vital Statistics Mortality Data, Underlying Cause of Death, 1962–97. Hyattsville, MD: HHS, 1999.) The United States has higher rates of lethal childhood violence than every other industrialized country. (CDC. “Rates of homicide, suicide, and firearm-related death among children— 26 industrialized countries, 1950–1993.” Morbidity
In examination of these trends in childhood injury-related cause of death, information has typically come from one of several sources (vital statistics, protective service records, and the FBI Uniform Crime Report), each with specific limitations.

### 15-15 Reduce deaths caused by motor vehicle crashes.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Reduction in Deaths Caused by Motor Vehicle Crashes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>15-15a. Deaths per 100,000 population</td>
</tr>
<tr>
<td>1998 Baseline</td>
<td>15.6*</td>
</tr>
<tr>
<td>2010 Target</td>
<td>9.2</td>
</tr>
</tbody>
</table>

*Age adjusted to the year 2000 standard population

Target setting method: Better than the best for 15-15a; 50 percent improvement for 15-15b. (Better than the best will be used when data are available.)

Data sources: National Vital Statistics System (NVSS), CDC, NCHS; Fatality Analysis Reporting System (FARS), DOT, NHTSA


Fewer persons aged 70 years and older are licensed to drive compared to younger persons, and they drive fewer miles per licensed driver. Persons in this older age group, however, have higher rates of fatal crashes per mile driven, per 100,000 persons, and per licensed driver, than any other group except young drivers (aged 16 to 24 years). Compared with the fatality rate for drivers aged 25 through 69 years, the rate for drivers in the oldest group is nine times higher. (NHTSA. *Traffic Safety Facts 1998: Older Populations*. Washington, DC: NHTSA, 1998.) Older persons also are more susceptible than younger persons to medical complications following motor vehicle crash injuries. Thus, they are more likely to die from their injuries.

Pedestrians account for about 13 percent of motor vehicle deaths. The problem of pedestrian deaths and injuries is worse among young children and older adults. Children are more likely to be injured, while older adults are more likely to die in pedestrian crashes. On average, a pedestrian is killed in a motor vehicle crash every 101 minutes, and one is injured every 8 minutes. (NHTSA. *Traffic Safety Facts 1998: Older Populations*.)

### Data

<table>
<thead>
<tr>
<th>Total Population, 1998 (unless noted)</th>
<th>Motor Vehicle Crash Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15-15a Rate per 100,000</td>
</tr>
<tr>
<td></td>
<td>15.6</td>
</tr>
<tr>
<td>Race and ethnicity</td>
<td></td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>30.4</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>9.3</td>
</tr>
<tr>
<td>Black or African American</td>
<td>16.8</td>
</tr>
<tr>
<td>White</td>
<td>15.6</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>14.7</td>
</tr>
<tr>
<td>Cuban</td>
<td>10.9</td>
</tr>
<tr>
<td>Mexican</td>
<td>16.5</td>
</tr>
<tr>
<td>Puerto Rican</td>
<td>10.8</td>
</tr>
<tr>
<td>Not Hispanic or Latino</td>
<td>15.6</td>
</tr>
<tr>
<td>Black or African American</td>
<td>173</td>
</tr>
<tr>
<td>White</td>
<td>15.5</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>10.1</td>
</tr>
<tr>
<td>Male</td>
<td>21.6</td>
</tr>
<tr>
<td>Education level (aged 25 to 64 years)</td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>25.8</td>
</tr>
<tr>
<td>High school graduate</td>
<td>20.2</td>
</tr>
<tr>
<td>At least some college</td>
<td>8.9</td>
</tr>
<tr>
<td>Select populations</td>
<td></td>
</tr>
<tr>
<td>Children aged 14 years and under (not age adjusted)</td>
<td>4.4</td>
</tr>
<tr>
<td>Persons aged 15 to 24 years (not age adjusted)</td>
<td>26.4</td>
</tr>
<tr>
<td>Persons aged 70 years and older (not age adjusted)</td>
<td>25.5</td>
</tr>
<tr>
<td>Motorcyclists</td>
<td>NA</td>
</tr>
</tbody>
</table>

DNA=Data have not been analyzed. DNC=Data are not collected. DSU=Data are statistically unreliable. NA=not applicable. Note: Data for 15-15a. are age adjusted to the year 2000 standard population.
Facts 1998: Pedestrians. Washington, DC: NHTSA, 1998.) In 1998, 69,000 pedestrians were injured and 5,220 were killed in traffic crashes in the United States.

**15-27 Reduce deaths from falls.**

| Target: 3.0 deaths per 100,000 population |
| Baseline: 4.7 deaths per 100,000 population were caused by falls in 1998 (age adjusted to the year 2000 standard population). |
| Target-setting method: Better than the best |
| Data source: National Vital Statistics System (NVSS), CDC, NCHS |

<table>
<thead>
<tr>
<th>Total Population, 1998</th>
<th>Deaths from Falls Rate Per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>4.7</td>
</tr>
<tr>
<td>Race and ethnicity</td>
<td></td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>4.4</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>3.4</td>
</tr>
<tr>
<td>Black or African American</td>
<td>3.1</td>
</tr>
<tr>
<td>White</td>
<td>4.9</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>3.7</td>
</tr>
<tr>
<td>Not Hispanic or Latino</td>
<td>4.7</td>
</tr>
<tr>
<td>Black or African American</td>
<td>3.2</td>
</tr>
<tr>
<td>White</td>
<td>4.9</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>3.5</td>
</tr>
<tr>
<td>Male</td>
<td>6.4</td>
</tr>
<tr>
<td>Education level</td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>29</td>
</tr>
<tr>
<td>High school graduate</td>
<td>24</td>
</tr>
<tr>
<td>At least some college</td>
<td>12</td>
</tr>
<tr>
<td>Select populations</td>
<td></td>
</tr>
<tr>
<td>Persons aged 65 to 84 years (not age adjusted)</td>
<td>172</td>
</tr>
<tr>
<td>Persons aged 85 years and older (not age adjusted)</td>
<td>1079</td>
</tr>
</tbody>
</table>

Among the elderly, falls are the most common cause of injuries and hospital admissions for trauma. For persons aged 65 years and older, 60 percent of fatal falls occur in the home, 30 percent occur in public places, and 10 percent occur in health care institutions. (Hingson, R., and Howland, J. “Alcohol and non-traffic intentional injuries.” *Addiction* 88(7):877–883, 1993.) The most serious fall-related injury is hip fracture. Approximately 212,000 hip fractures occur each year in the United States among adults aged 65 years and older; 75 to 80 percent of all hip fractures are sustained by females. (Cummings, S.R.; Rubin, S.M.; and Black, D. “The future of hip fractures in the United States. Numbers, costs, and potential effects of postmenopausal estrogen.” *Clinical Orthopedics* 252:163–166, 1990.)

Since most fractures are the result of falls, understanding the reasons falls occur is essential to designing effective prevention and intervention strategies. For all ages combined, alcohol use has been implicated in 35 to 63 percent of deaths from falls. Factors that contribute to falls include difficulties with walking and balance, neurological and musculoskeletal disabilities, psychoactive medications, dementia, and visual impairment. (Tinetti, M.E., and Speechley, M. “Prevention of falls among the elderly.” *New England Journal of Medicine* 320(16):1055–1059, 1989.) Other hazards such as slippery surfaces, uneven floors, poor lighting on stairs, loose rugs, unstable furniture, and objects on floors also may play a role. Often the elderly are unable to keep up with the maintenance of their home and this increases their risk of accident. Although we will not go into detail here about workplace safety issues, suffice it to say that clean work sites are safer work sites. Falls in the workplace is another area that should be studied; it is also an area of concern in the farming and construction industries.
15-32 Reduce homicides.
Target: 3.0 homicides per 100,000 population
Baseline: 6.5 homicides per 100,000 population occurred in 1998 (age adjusted to the year 2000 standard population).
Target-setting method: Better than the best
Data sources: National Vital Statistics System (NVSS), CDC, NCHS; FBI Uniform Crime Reports, U.S. Department of Justice

In both 1997 and 1998 there were 12 homicides each year. Between 1979 and 1998 the number of homicides in Lancaster County ranged from 4 in 1984 to 16 in 1993.

15-32 Reduce Homicides

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>6.5</td>
<td>5.4</td>
<td>2.7</td>
<td>3.0</td>
</tr>
</tbody>
</table>

Rates are per 100,000 and are age adjusted to 2000 standard population

15-33 Reduce maltreatment and maltreatment fatalities of children.

15-33a Reduce maltreatment of children.
Target: 10.3 per 1,000 children under age 18 years
Baseline: 12.9 child victims of maltreatment per 1,000 children under age 18 years were reported in 1998.
Target-setting method: 20 percent improvement (Better than the best will be used when data are available.)
Data source: National Child Abuse and Neglect Data System (NCANDS), Administration on Children, Youth and Families, Administration for Children and Families (ACF), Children's Bureau

Currently, data for population groups is not analyzed.

15-33b Reduce child maltreatment fatalities.
Target: 1.4 per 100,000 children under age 18 years
Baseline: 1.6 child maltreatment fatalities per 100,000 children under age 18 years occurred in 1998.
Target-setting method: 12 percent improvement (Better than the best will be used when data are available.)
Data source: National Child Abuse and Neglect Data System (NCANDS), Administration on Children, Youth, and Families, Administration for Children and Families (ACF), Children's Bureau

Currently, data for population groups is not analyzed.
The 1997 Child Maltreatment report from individual states to the National Child Abuse and Neglect Data System found:

- In 1996 there were 1 million child victims of mistreatment in the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam. In 1997 there were approximately 984,000 victims.
- The national rate of child victims was 13.9 per 1,000 children in the general population in 1997, which is slightly higher than the rate of 13.4 victims per 1,000 children in 1990.
- Based on data from 39 states, 75.4 percent of the perpetrators were the victim’s parents, 10.2 percent were relatives, and 1.9 percent were individuals in other care-taking relationships. (HHS, Administration on Children, Youth, and Families. Child Maltreatment 1997: Reports from the States to the National Child Abuse and Neglect Data System. Washington, DC: U.S. Government Printing Office (GPO), 1999.)
- In 1997, there were an estimated 1,196 fatalities due to child maltreatment in the 50 states and the District of Columbia.
- Types of maltreatment were as follows: 55.9 percent neglect, 24.6 percent physical abuse, 12.5 percent sexual abuse, and 6.1 percent emotional abuse.
- 58.8 percent of the substantiated or indicated reports of maltreatment were reported by professional sources: legal, medical, social service, or education professionals.

The issue for us locally is how to measure the number of maltreated children. We asked local experts about using the numbers of substantiated cases that all PA County Children and Youth Agencies report to the state. This is the indicator used by Kids Count (Anne E. Casey Foundation publication, with statistics for each state). It is linked to their “State of the Child” report.

The following are the comparative numbers for PA, Lancaster, and our peer counties.

### Children Abused or Neglected—Substantiated Cases

<table>
<thead>
<tr>
<th></th>
<th>State</th>
<th>All County Mean</th>
<th>Lancaster</th>
<th>Chester (G)</th>
<th>York (G)</th>
<th>Berks (P)</th>
<th>Dauphin (G)</th>
<th>Lebanon (G)</th>
<th>Lehigh (P)</th>
<th>Northampton (P)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995–1997 Rate per 100 children under 18</td>
<td>2.2</td>
<td>2.2</td>
<td>1.4</td>
<td>1.0</td>
<td>2.1</td>
<td>2.3</td>
<td>2.1</td>
<td>2.0</td>
<td>2.0</td>
<td>1.8</td>
</tr>
</tbody>
</table>

### Children in Out-of-Home Placements

<table>
<thead>
<tr>
<th></th>
<th>State</th>
<th>All County Mean</th>
<th>Lancaster</th>
<th>Chester (G)</th>
<th>York (G)</th>
<th>Berks (P)</th>
<th>Dauphin (G)</th>
<th>Lebanon (G)</th>
<th>Lehigh (P)</th>
<th>Northampton (P)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995–1997 Rate per 1,000 children under 18</td>
<td>7.4</td>
<td>4.6</td>
<td>4.1</td>
<td>2.0</td>
<td>4.7</td>
<td>6.7</td>
<td>6.2</td>
<td>5.5</td>
<td>6.5</td>
<td>6.8</td>
</tr>
</tbody>
</table>

### Delinquent Children Placed Out-of-Home by Juvenile Court

<table>
<thead>
<tr>
<th></th>
<th>State</th>
<th>All County Mean</th>
<th>Lancaster</th>
<th>Chester (G)</th>
<th>York (G)</th>
<th>Berks (P)</th>
<th>Dauphin (G)</th>
<th>Lebanon (G)</th>
<th>Lehigh (P)</th>
<th>Northampton (P)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995–1997 Rate per 1,000 children 10–17</td>
<td>3.2</td>
<td>2.0</td>
<td>2.8</td>
<td>1.1</td>
<td>2.1</td>
<td>4.0</td>
<td>6.1</td>
<td>2.2</td>
<td>4.1</td>
<td>1.5</td>
</tr>
</tbody>
</table>

- Higher than Lancaster County
- Lower than Lancaster County
- Equivalent to Lancaster County
Indicators are more meaningful when combined with an analysis of the communities reporting the substantiation findings. States have different laws, different definitions of abuse, and different mandated action levels. Counties within the state of PA vary significantly as well. A low substantiated rate may mean a county has a low abuse rate. It can also mean that the county is under-performing in identifying and processing reports. Children being placed out of the home certainly reflect a terrible family situation. But low rates of such placements may also reflect a lack of foster or institutional placements, which would hamper or, at the very least, affect the decision to remove a child. Some differences may be because:

- Community awareness may be higher or lower and, therefore, people may be more or less likely to report suspected abuse or neglect.
- Norms may be different, and what some communities may view as vigilance, others may view as interfering with a parent's right to discipline their child as they see fit.
- The judicial philosophy of particular judges may make it more or less difficult for agencies to prove their cases of neglect and abuse or to free abused children for adoption.
- Standards for bringing a case to court may be different from county to county based on caseload, ability to prosecute successfully, and the ability to place a child after a substantiation finding.
- Definitions vary from county to county.
- The inability to hire and maintain an experienced staff makes it difficult to build cases to substantiate abuse or free a child for adoption, or even to aggressively manage family restorative efforts. Throughout 1999–00, the Lancaster Children & Youth Agency has struggled with ongoing staff turnover. During this time period, 17 caseworkers, four clerical, two case aides, and two casework supervisors resigned from the Agency. The Agency was able to hire 16 new caseworkers, two fiscal technicians, and one case aide. Several times during this period, the Agency exhausted the available civil service lists for caseworkers. The Agency not only competes with the Office of Aging and Office of Mental Health Mental Retardation, but surrounding county children and youth agencies as well. The Agency has started the process of trying to hire staff in various classifications through an emergency hiring process (from the 2001–03 Lancaster County Children and Youth Annual Plan).

Better indicators would be those that follow a child or family over time and indicate that both the family and child have survived and even benefited from contact with the child welfare system. Many abused and neglected children end up in the juvenile justice system, drug and alcohol or mental health systems, as homeless, teen parents, and/or in the system as parents who abuse, neglect, or in some way are unable to protect their children from abusers. It is a well-documented cycle of family violence and abuse. No tracking system exists at this time in Lancaster County. Confidentiality laws are major barriers in developing such a system. Software that can track cases across delivery systems and caseworker time to manage such a system and data inputting is a challenge.

Additionally, poverty rates, numbers of single mothers with children, and the prevalence of children living in homes with alcohol or substance abusers are important to consider.

- One in five Lancastrians live in poverty. Those most likely to live in poverty are also the most vulnerable to family abuse and violence.
- According to the 1990 Census, 30,517 Lancaster County children are living in poverty.
- For female-headed households with children under five, the likelihood of living in poverty rose to 51.7%.
- The median family income for Lancaster County residents is $37,800. However, for families living in Lancaster City median income is only $27,002.
Some families are forced to reside in emergency shelters or other transitional housing facilities as they work to stabilize their lives. According to recently published statistics, 58% of the homeless in Lancaster County are women and children.

- 50% of homeless women and children are fleeing domestic violence situations.
- As of March 2000, 1,118 families were receiving TANF (Temporary Assistance to Needy Families) through the Lancaster County Assistance Office. In addition, 29,819 persons were eligible for medical assistance and 4,986 received food stamps.

Additionally, it is important that we begin to understand and to evaluate the standard of care that our children receive while in county custody (dependents of the court). We must study the number of children that are freed for adoption and the length of time they spend in the system before they are freed. This data is gathered and should be analyzed. The sooner a child finds a stable and loving home, the better chance they have of becoming happy and functioning adults. We should measure the opportunities available for children to be adopted into homes that may love and care for them in order to repair the damage of their short and troubled family history.

The following graph is the percentage of children who were victims of substantiated or indicated child abuse and/or neglect that had another substantiated or indicated report within a six-month period. “Class” is an average of all the Pennsylvania Class 3 counties. Class 3 counties include Berks, Chester, Dauphin, Erie, Lackawanna, Lancaster, Lehigh, Luzerne, Northampton, Westmoreland, and York.

In PA, county Children and Youth Agencies are mandated to provide programs and services that help achieve movement toward three statewide child welfare goals. Programs, services, and strategies to improve service delivery are directly related to the major issues described under each of the three goals.

**Prevent child abuse, neglect, and exploitation.**

The significant issues impacting this goal include the number of families presenting with drug and/or alcohol abuse issues, poverty, limited accessibility of mental health treatment for adults and children, adolescent/family issues, and parenting. Other agency issues include providing adequate and mandated legal representation, staff turnover, and Pennsylvania Automated Child Welfare Information System (PACWIS) implementation.

<table>
<thead>
<tr>
<th>Child Abuse Rate per 1000 Children</th>
<th>Actual</th>
<th>Estimated</th>
<th>Projected</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>1.1</td>
<td>1.3</td>
<td>1.1</td>
</tr>
<tr>
<td>2000</td>
<td>1.1</td>
<td>1.1</td>
<td>1.1</td>
</tr>
</tbody>
</table>

According to the 1997 U.S. Census estimate, Lancaster County's population of 0–17 year olds was 121,514. The rate per thousand children who were victims of child abuse in Lancaster County in 1999 is 1.3. This number increased only slightly from the 1998 figure of 1.1. Lancaster County has remained at or below the statewide average since 1996. The statewide average for 1999 is 1.6.
The number of referrals necessitating Child Protective Services (CPS) and General Protective Investigations (GPS) has remained approximately the same for the past two years. Neglect investigations (GPS) are mostly referrals concerning lack of supervision, allegations of parental drug and alcohol use, and poor living conditions.

Drug and alcohol addiction is a major problem in the lives of many of the families and children served by our agencies. Agency staff estimates that over 75% of the families active with the agency are using drugs and/or alcohol. During May 1999 through May 2000, agency clients completed 265 drug screens. This tool is extremely valuable to caseworkers providing services to families where there may be a suspicion of drug use by the parent or caretaker.

A need exists in the community for improved mental health services for adults and children. Changes in Medical Assistance coverage for mental health services have restricted the access for this service. In many cases, the issues presented by children and adults may not meet the criteria established by the county MH/MR system. Nevertheless, families and children could benefit from mental health services that would be accessible and affordable.

Ensure that all abused, neglected, or otherwise dependent children are protected from further abuse and neglect in their own or some other permanent home.

The significant issues which impact this goal include providing culturally sensitive, community collaborative services to families in their own homes and to children in some other permanent home. Services need to be timely, competent, and professional. Casework services include but are not limited to: announced and unannounced home visits; school visits; court appearances; placement of children via Court Order in foster care; transportation of clients to doctor appointments; mental health counseling; grocery shopping; employment; court hearings; attending multidisciplinary team meetings; referring clients for community services and office visits.

Because of staff shortages in the Child Protective Services unit, many in-home protective social workers assist intake workers to help investigate child abuse cases. In addition, approximately 50% of caseworkers’ job duties involve documentation of case activity and other state and federally mandated paperwork.

There is a need to reduce caseload size, increase reunification services, and locate more foster/adopt placement resources. The need to see children on a regular basis is important, but the ever-increasing demands of documentation for federal and state programs causes a strain on the social work practice of in-home units. This strain causes many qualified social workers to exit child welfare and enter more financially rewarding and less stressful employment.
According to the 1999 Child Abuse Report, there were 13 substantiated re-abuses in Lancaster County, or 7.6%. The percentage remains below the statewide average of 13%.

Number of Children Served in Their Own Homes

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>9</td>
<td>13</td>
<td>7</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Percentage</td>
<td>6.2%</td>
<td>7.6%</td>
<td>3.7%</td>
<td>4%</td>
<td>4%</td>
</tr>
</tbody>
</table>

As of March 31, 2000, the agency was active with a total of 2,859 children. As of March 31, 1999, the agency was active with 2,580 children, an additional 1,157 children when compared to FY 1996–97, or an increase of 81%. Through the use of purchased and direct services, the Agency projects that more than 80% of all children served will receive services in their own home.

Number and Percent of Children in Placement Who Have a Goal of Adoption

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>86</td>
<td>113</td>
<td>135</td>
<td>140</td>
<td>145</td>
</tr>
<tr>
<td>Percentage</td>
<td>18.81%</td>
<td>19.89%</td>
<td>22.65%</td>
<td>22.76%</td>
<td>23.56%</td>
</tr>
</tbody>
</table>

The number of children with a goal of adoption has increased significantly over the past four years. The trend is expected to continue. In cases of aggravated circumstance, the Agency has successfully petitioned the court to set a goal of adoption at the time of a child's placement. There are currently 135 children with a goal of adoption or 22.65% of the total number of children in placement.

Number and Percent of Children With the Goal of Adoption Who Have Been Freed for Adoption and Who Are Awaiting Adoptive Placement

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>40</td>
<td>29</td>
<td>19</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Percentage*</td>
<td>8.75%</td>
<td>5.10%</td>
<td>3.19%</td>
<td>4.07%</td>
<td>4.07%</td>
</tr>
</tbody>
</table>

Currently, the number of children who have been freed for adoption and are awaiting adoptive placement is 19. This represents six percent of the total population in placement with a goal of adoption.

Number and Percent of Adoptions Finalized

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>21</td>
<td>2</td>
<td>45</td>
<td>55</td>
<td>55</td>
</tr>
<tr>
<td>Percentage*</td>
<td>525%</td>
<td>4.05%</td>
<td>751%</td>
<td>8.94%</td>
<td>8.94%</td>
</tr>
</tbody>
</table>

*Average of four available quarters for 97–98, 98–99, and 99–00 of children in placement, chart b, column 2.
During 1999–00, thirty-two children who were adopted were receiving adoption assistance. The Agency anticipates continued growth in the number of children who are eligible for and who receive adoption assistance. There are currently 167 children receiving adoption subsidies. Subsidies normally correlate with our approved foster family rates, which are allotted by the age of the child. The average subsidy can now be as high as $734 per month. The average subsidy, however, is $558.

### Provide for the well-being of children during substitute care.

The major issues impacting this goal include the recruitment of more quality foster homes, more timely access to court, the exploration of increased relative care, the development of more adoptive homes, the reduction of foster care caseloads, and the movement to managed care. Another significant issue is the timely provision of quality mental health services for children.

### Children reentering care within 12 months of reunification with parents or caretakers

(This number could include children placed in an emergency shelter for one night only. The inclusion of this information could artificially inflate the statistics. Nevertheless, the Agency remains significantly below the statewide average.)

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Number of Children</th>
<th>Percentage of Children</th>
<th>Statewide Average Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct 97–Mar 98</td>
<td>12</td>
<td>8.6%</td>
<td>14.9%</td>
</tr>
<tr>
<td>Apr 98–Sep 98</td>
<td>7</td>
<td>4.2%</td>
<td>17.5%</td>
</tr>
<tr>
<td>Oct 98–Mar 99</td>
<td>5</td>
<td>3.2%</td>
<td>18.7%</td>
</tr>
<tr>
<td>Apr 99–Sep 99</td>
<td>12</td>
<td>9.4%</td>
<td>17.8%</td>
</tr>
</tbody>
</table>

As of July 2000, the Agency had 194 foster homes. In 1999–00, the Agency approved and opened 38 new homes and closed 17 homes. In addition, it is anticipated that ten additional homes will be approved following the June/July orientation currently under way. The composite of Agency foster homes as of July 2000 is:

- Hispanic: 25
- African American: 18
- Biracial: 1
- Caucasian: 150
- Total foster homes: 194

Mental health issues presented by foster children can be very challenging to foster parents and other temporary caregivers. The Agency makes great efforts to assure that foster parents receive training so that they are equipped to assist these children and maintain them in their foster home. Caseworkers also work closely with foster parents to address concerns and to refer and coordinate community services the child may receive while in foster care. Combined, these efforts target reducing placement disruption.
15-34 Reduce the rate of physical assault by current or former intimate partners.

Target: 3.3 physical assaults per 1,000 persons aged 12 years and older
Baseline: 4.4 physical assaults per 1,000 persons aged 12 years and older by current or former intimate partners occurred in 1998.
Target-setting method: Better than the best
Data source: National Crime Victimization Survey (NCVS), U.S. Department of Justice, Bureau of Justice Statistics

Local and state data is not readily available. Local groups have attempted to gauge the number of individuals, including children, living with family violence by looking at Protection From Abuse orders (PFA) and violations of PFAs. But these inquiries have their own set of challenges that are methodological, systemic, and analytical.

Both females and males experience family and intimate violence and sexual assault. Perpetrators can be the same or opposite sex. Male victimization of females is more common in intimate partner violence and sexual assault. Violence against women is primarily partner violence. Although most assault victims survive, they suffer physically and emotionally. About one in three females who were injured during a rape or physical assault required medical care. (Tjaden, P., and Thoennes, N. Prevalence, Incidence, and Consequences of Violence Against Women: Findings From the National Violence Against Women Survey. Pub. No. NCJ 172837. Washington, DC: National Institute of Justice and CDC, 1998.)

In 1994, more than 500,000 females were seen in hospital ERs for violence-related injuries, and 37 percent of those females were there for injuries inflicted by spouses, ex-spouses, or nonmarital partners. (Bureau of Justice Statistics (BJS). Violence-Related Injuries Treated in Hospital Emergency Departments. Washington, DC: U.S. Department of Justice (DOJ), 1997.)

- In 1995, almost 5,000 females in the United States were murdered. In those cases for which the Federal Bureau of Investigation had data on the relationship between the offender and the victim.
  ✔ 85 percent were killed by someone they knew.
  ✔ Nearly half of the females who knew the perpetrators were murdered by a husband, ex-husband, or boyfriend. (Federal Bureau of Investigation. Crime in the United States: 1996. Washington, DC: GPO, 1997.)


Males who are physically violent toward their partners are more likely to be sexually violent toward them and are more likely to use violence toward children. (Tjalling, G.T., and Sugarman, D.B. “An analysis of risk markers in husband to wife violence: The current state of knowledge.” Violence and Victims 1:101–124, 1986.) Perpetrators of this violence are usually adults who, as children or adolescents, witnessed family violence or who were the targets of violence from their parents or guardians. (CDC. “Youth Risk Behavior Surveillance—United States, 1999.” Morbidity and Mortality Weekly Report 49(SS5), June 9, 2000.)
15-35 Reduce the annual rate of rape or attempted rape.

**Target:** 0.7 rapes or attempted rapes per 1,000 persons

**Baseline:** 0.8 rapes or attempted rapes per 1,000 persons aged 12 years and older occurred in 1998.

**Target-setting method:** Better than the best

**Data source:** National Crime Victimization Survey (NCVS), U.S. Department of Justice, Bureau of Justice Statistics

In PA there were 1,506 people charged with forcible rape, 1,391 arrested, 1,180 total dispositions, 245 guilty of offense charged, 250 guilty of lesser offense, 430 acquitted or dismissed, 255 referred to juvenile court, 3,017 reported offenses.

A national survey conducted from November 1995 to May 1996 estimates that:

- Approximately 1.5 million females and 834,700 males are raped and/or physically assaulted by an intimate partner annually in the United States.
- Seventy-six percent of the females who were raped and/or physically assaulted since age 18 years were assaulted by a current or former husband, cohabiting partner, or date, compared with 18 percent of the males.
- 32 percent of the females and 16 percent of the males who were raped since age 18 years were injured during their most recent rape.
- 39 percent of the females and 25 percent of the males who were physically assaulted since age 18 years were injured during their most recent assault.

The National Women's Study, in conjunction with estimates based on the U.S. Census, suggests that 12.1 million females in the United States have been victims of forcible rape sometime in their lives. According to this study, 0.7 percent or approximately 683,000 of adult females experienced a forcible rape in the past year. (Kilpatrick, D.G.; Edmunds, C.N.; and Seymour, A.L. "Rape in America: A Report to the Nation." Arlington, VA: National Victim Center, 1992, p. 2.)

The issue of teen date rape and violence requires national attention and prevention efforts that focus on adolescent violence within the larger context of family violence. Battering in teen relationships is very different from IPV that occurs between adults. Teen dating violence is a concern that may stem from childhood abuse or other experiences with violence. Little is known about the factors that increase or decrease the likelihood that males will behave violently toward females, the factors that endanger or protect females from violence, and the physical and emotional consequences of such violence for females and their children.
15-37 **Reduce physical assaults.**

Target: 13.6 physical assaults per 1,000 persons aged 12 years old or older
Baseline: 31.1 physical assaults per 1,000 persons aged 12 years old or older occurred in 1998.
Target-setting method: Better than the best
Data source: National Crime Victimization Survey (NCVS), U.S. Department of Justice, Bureau of Justice Statistics

The PA UCR report has assaults divided into two categories: aggravated and other. This makes it difficult to compare local and state data to national data, and is the reason this table is fractured between Physical Assaults, Aggravated Assaults, and Other Assaults. PA and Lancaster data are significantly below the national baseline as well as the HP 2010 goal, which would lead one to suspect that the categories may not be completely comparable.

- Assaults were significantly higher among males.
- While the total assaults for blacks and whites and Hispanics and non-Hispanics were similar, aggravated assault was higher for blacks than whites (11.9 versus 7.0 per 1,000), and simple assault was higher for non-Hispanics than Hispanics (23.9 versus 19.5 per 1,000).
- Assaults were higher for those with lower household incomes; rates of assault victimization decreased from 54.2 per 1,000 persons in households with annual incomes of less than $7,500 to less than 30 per 1,000 persons in households with annual incomes greater than $35,000. (DOJ. *Statistics. Criminal Victimization 1998: Changes 1997–98 With Trends, 1993–98.* Pub. No. NCJ-176353. Washington, DC: DOJ, 1999.)

In 1998, physical assault victimization among adolescents took place twice as often as in the general population of persons aged 12 years and older. Nationwide, 4 percent of students had been treated by a doctor or nurse for injuries sustained in a physical fight one or more times during the 12 months preceding the survey. Overall, male students were significantly more likely than female students to have been in a physical fight. This gender difference was identified for white and Hispanic students and for each grade.

- In 1999, 36 percent of students in grades 9 through 12 had been in a physical fight one or more times during the 12 months preceding the survey.
- Overall, Hispanic students (40 percent) were significantly more likely than white students (33 percent) to have been in a physical fight.
- Female and male students in grade 9 were significantly more likely than female and male students in grade 11 to have been in a physical fight.
- Black female students were more likely than white female students to report this behavior, and male students in grade 9 were much more likely than male students in grade 12 to report this behavior.

### 1998 Pennsylvania UCR Juveniles and Violence

<table>
<thead>
<tr>
<th>Persons Aged 12 Years and Older, 1998</th>
<th>Physical Assaults Rate per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td><strong>31.1</strong></td>
</tr>
<tr>
<td><strong>Race and ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td><strong>99.4</strong></td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td><strong>13.7</strong></td>
</tr>
<tr>
<td>Native Hawaiian and other Pacific Isander</td>
<td><strong>DNC</strong></td>
</tr>
<tr>
<td>Black or African American</td>
<td><strong>33.8</strong></td>
</tr>
<tr>
<td>White</td>
<td><strong>31.0</strong></td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td><strong>25.9</strong></td>
</tr>
<tr>
<td>Not Hispanic or Latino</td>
<td><strong>31.4</strong></td>
</tr>
<tr>
<td>Black or African American</td>
<td><strong>DNA</strong></td>
</tr>
<tr>
<td>White</td>
<td><strong>DNA</strong></td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td><strong>25.1</strong></td>
</tr>
<tr>
<td>Male</td>
<td><strong>DSU</strong></td>
</tr>
<tr>
<td><strong>Select populations</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Age groups</strong></td>
<td></td>
</tr>
<tr>
<td>Adolescents aged 12 to 15 years</td>
<td><strong>70.5</strong></td>
</tr>
<tr>
<td>Adolescents aged 16 to 19 years</td>
<td><strong>76.8</strong></td>
</tr>
<tr>
<td>Young adults aged 20 to 24 years</td>
<td><strong>56.0</strong></td>
</tr>
</tbody>
</table>

DNA=Data have not been analyzed. DNC=Data are not collected. DSU=Data are statistically unreliable.
Nationwide, 6.9 percent of students carried a weapon (a gun, a knife, or a club) onto school property one or more times during the 30 days preceding the survey. Overall, male students were significantly more likely than female students to have carried a weapon onto school property. This significant gender difference was identified for white and Hispanic students and each grade.

Lancaster County has a juvenile population between the ages of 10–7 years of 51,584, the sixth highest in the state of Pennsylvania, as indicated by the 1997 estimates furnished by the Pennsylvania State Data Center. During 1999, they experienced a 6.1% decrease in referrals (1,744) as compared to 1,858 in 1998. However, even with significant decreases in referrals for crimes and decreases in possession of weapons on or off school property by 30.2% and 39.5%, respectively, and a decrease of 9.8% in the total crimes referred, there is reason to worry.

The trends and current status indicate that, while numbers of referrals, total crimes, and possession of weapons charges have decreased, major crimes involving violence and drug charges have increased. In 1999, Lancaster County JPP experienced increases of 8.1% in violent crimes, 9.2% in drug offenses, and a 22% increase in the number of juveniles violating their probation/parole either by committing new misdemeanors/felonies and/or technical violations.

Locally, special programs and services have been developed over the past few years (i.e., School-Based, Community Intensive Treatment for Youth Services (CITY), and Pathways Sex Offender Services). Youth at Promise (YAP) is an initiative wherein balanced attention is given to each juvenile and victim of juvenile crime regarding accountability, community protection, and competency development as to available resources within the community to assist juveniles. It helps them to develop necessary skills for responsible behavior in the community. Nevertheless, the challenges have become more difficult in application of the Balanced and Restorative Justice (BARJ) principles.

Violent crimes and drug offenses increased in 1999 as compared to 1998, while possession of weapons, in and out of school, and total crimes decreased significantly. Additionally, the total number of referrals decreased by 6.1% with 1,744 juveniles referred as compared to 1,858 in 1998. Juveniles who commit violent crimes, serious felonies, or meet other detention eligibility criteria are considered for detention pending their hearing in Juvenile Court.

Other information that is being collected about the lives of these youth seem to present a trend whereby overall violence and drug involvement by juveniles is directly connected to other associated problems. These problems include an increase in dysfunctional families, out of control youth, disconnected/detached youth from society in general, and an ever-increasing number of youth with mental health needs.
A growing number of delinquent youth choose not to take advantage of the services offered. Issues and situations such as failure to attend, continual use of drugs/alcohol, out-of-control behavior, lack of parental involvement/support, and unwillingness on the part of the juvenile to change behaviors continue to occur. Without full cooperation and positive connection by the juveniles and families in the treatment process, we will continue to struggle in our efforts to reduce out-of-home placements while maintaining protection of the community from known juvenile offenders.

Even with the aforementioned programs in place to serve juvenile offenders, JPP experienced a 22% increase in the number of juveniles re-offending in 1999 as compared to 1998. During 1998 we experienced a decrease of 15.5%. In the preceding years, we experienced increases of 8.1% in 1997 and 21.7% in 1996.

The number and percentage of juvenile offenders re-adjudicated while under juvenile court supervision are as follows:

<table>
<thead>
<tr>
<th>1997</th>
<th>1998</th>
<th>1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>247</td>
<td>61%</td>
<td>205</td>
</tr>
</tbody>
</table>

### Disparities

- Higher death rates from unintentional injury occur among African Americans.
- Adults aged 65 years and older are at increased risk of death from fire because they are more vulnerable to smoke inhalation and burns and are less likely to recover. Sense impairment (such as blindness or hearing loss) may prevent older adults from noticing a fire, and mobility impairment may prevent them from escaping its consequences. Older adults also are less likely to have learned fire safety behavior and prevention information because they grew up at a time when minimal fire safety was taught in schools, and most current educational programs target children.
- Homicide victimization is especially high among African American and Hispanic youth.
- In 1995, African American males and females aged 15 to 24 years had homicide rates (74.4 per 100,000) that were more than twice the rate of their Hispanic counterparts (34.1 per 100,000) and nearly 14 times the rate of their white non-Hispanic counterparts (5.4 per 100,000). (Anderson, R.N.; Kockanck, K.D.; and Murphey, S.L. “Report of final mortality statistics, 1995.” *Monthly Vital Statistics Report* 45(Suppl. 2):11, 1997.)
- Trends in suicide among blacks aged 10 to 19 years in the United States during 1980–95 indicate that suicidal behavior among all youth has increased; however, rates for black youth have shown a greater increase. (CDC. “Suicide Among Black Youths—United States, 1980–1995.” *Morbidity and Mortality Monthly Report* 47(10):193, 1998.) Although black youth historically have lower suicide rates than whites, during 1980–95, the suicide rate for black youth aged 10 to 19 years increased from 2.1 to 4.5 per 100,000 population. As of 1995, suicide was the third leading cause of death among blacks aged 15 to 19 years.

- Many school-aged children suffer disabling and fatal injuries each year. Quality health education curricula should include injury prevention information for children at appropriate grade levels.
- Community-based prevention models can work. For instance, Metro Pizza in Lititz and the volunteer fire corps teamed up to send firefighters to check random homes for smoke detectors with pizza delivery. If they passed inspection, the pizza was free. If detectors failed, firemen installed a new one for free.
- Safety belts and child restraints, when worn correctly, are the most effective way to reduce the risk of death and serious injury in a motor vehicle crash. As of December 1998, the national safety belt use rate was 69 percent. As of December 1997, 49 states had safety belt laws. Eleven states had primary enforcement laws, and the remaining 38 States had secondary enforcement laws. (Advocates for Highway and Auto Safety (AHAS). *Safety Belt Fact Sheet*. Washington, DC: AHAS, 1998). In 1998, the average observed belt use rate by states with secondary enforcement laws was 62 percent, compared to 79 percent in states with primary enforcement laws. Among children aged 1 to 14 years, crash injuries are the leading cause of death. Because all states have child restraint laws, more children now ride restrained. However, loopholes in the laws exempt many children from coverage under either safety belt or child restraint use laws. Another problem is the persistence of incorrect use of child restraints and safety belts. (NHTSA. *Traffic Safety Facts 1997: Children*. Washington, DC: NHTSA, 1997.)
- Wearing a motorcycle helmet reduces the chances of dying in a motorcycle crash by 29 percent and reduces the chances of brain injury by 67 percent. Riders without helmets are 40 percent more likely to suffer a fatal head injury than helmeted riders.
- Teenagers accounted for 10 percent of the U.S. population in 1997 and 15 percent of the motor vehicle deaths. (NHTSA. *Traffic Safety Facts 1998: Young Drivers*. Washington, DC: NHTSA, 1998.) Graduated licensing laws allow a young driver to gain driving experience at incremental levels. Graduated licensing is a system for phasing in on-road driving that allows beginners to obtain their initial experience under lower-risk conditions. The National Committee on Uniform Traffic Laws and Ordinances (NCUTLO) has developed a model law that calls for a minimum of 6 months in the learner stage and a minimum of 6 months in the intermediate license stage with night driving restrictions.
- The public health approach to violence prevention must be multidisciplinary. We must encourage experts from scientific disciplines, community organizations, churches and citizens to work together to find solutions to violence.
- Strategies for reducing violence should begin early in life, before violent beliefs and behavioral patterns can be adopted. Family violence and abuse in the very young has devastating effects on a child’s cognitive development. Many day cares are beginning anti-violence and anti-family violence curriculums.
Successful communities reorganized themselves after they evaluated the effectiveness of existing anti-violence programs in their schools, institutions, and churches. They focused on what worked and turned the page on what did not.

Respite care and respite opportunities for families in crisis, mediation services and training, shelters for runaway teens, drug and alcohol prevention, and intervention programs are all in short supply but very effective. Once a family or individual breaks the silence that perpetuates violence and neglect, a compassionate community must respond swiftly. Systems must be efficient and well-staffed so that the response is professional and encourages recovery. These services are labor intensive and require vigilance.

Many culturally and linguistically competent intervention strategies for violence prevention exist, such as parent training, mentoring, home visitation, and education. (NCIPC. Best Practices for Preventing Violence by Children and Adolescents: A Source Book. Atlanta, GA: NCIPC, November 1999 (in press.) Evaluation of ongoing programs is a major part of identifying effective approaches for violence prevention.

 Violence prevention programs for youth need to focus on strategies that reduce involvement in physical fighting and discourage weapon carrying on school property. Strategies to reduce weapon carrying on school property, physical fighting, and resulting injuries among youth should begin early in life and must be tailored to youth of widely varying social, economic, cultural, and ethnic backgrounds. (NCIPC. Best Practices for Preventing Violence by Children and Adolescents: A Source Book. Atlanta, GA: NCIPC, November 1999 in press.)

 Physicians and other health professionals are in a position to provide effective primary prevention messages to youth and their families. Primary care physicians can be instrumental in screening for family violence issues that range from spousal abuse to elder abuse.

 In response to the increasing trend of violence against children and the lack of a comprehensive data source on violent childhood deaths, the Child Fatality Review Team (CFRT) process was developed in 1978 in California. The goal of the CFRTs is the prevention of childhood fatalities. Their responsibility is to review “suspicious” or “preventable” childhood fatalities. Minimal or core standards for CFRTs must include representatives from criminal justice, health, and social services. After integrating information from multiple sources, review teams determine if the cause and manner of death was recorded accurately and suggest prevention initiatives for all relevant agencies. Simply reviewing fatalities is not helpful unless recommendations for prevention are included and periodic follow-ups are completed to ensure that recommendations are being acted on. Focusing on children aged 14 years and under will include most “unexplained” childhood deaths and is considered a more reasonable goal to achieve.

 ED workers treating adolescents with fight-related injuries can practice secondary interventions, as they do with victims of child abuse, sexual assault, or attempted suicide.

 Emergency department (ED) patient records and hospital discharge systems are an important source of public health surveillance and an integral part of the vision of electronically linked health information systems that can serve multiple purposes. Communities also need to begin collecting data from pre-emergency room sources (EMTs). Because of the volume and case mix of patients they treat, EDs are well positioned to provide data on cause and severity of injuries. Access to such data can help with the development of population-based public health.
Local Assets

County-Wide Communications (9-1-1)
(717) 664-1100
1-800-297-LCWC (5292)

Domestic Relations
(717) 299-8141

Drug & Alcohol Commission
(717) 299-8023

Emergency Management Agency
(717) 664-1200
Toll Free 1-800-808-5236

Lancaster County Children & Youth Agency
(717) 299-7925

Lancaster County Juvenile Probation and Parole
(717) 299-8161

Lancaster General Hospital
Wound Management
(717) 290-3216
Emergency and Trauma Information
(717) 290-4925

Lancaster Regional Medical Center
Wound Care Services
(717) 291-6720

The Lancaster Shelter for Abused Women
(717) 299-7249

Mental Health/Mental Retardation
(717) 299-8021

Office of Aging
(protective services)
(717) 299-7979
1-800-490-8505

PA Dept of Health
local office
(717) 299-7597

St. Joseph Health Ministries
(717) 397-7625

Sexual Assault Hotline
(717) 392-7273

Sheriff
(717) 299-8200

State Health Hotline
(800) 692-7254
Additional Resources

Youth Intervention Center
(717) 299-7821

Adoptions from the Heart
http://www.adoptionsfromtheheart.org/

Children's Aid Society
http://www.caspa.org/

COBYS Family Services
http://www.co.lancaster.pa.us/LINC/950yibwm.htm

Bethany Christian Services
http://www.bethany.org/

Children's Home of Pittsburgh
http://www.adopt-infant.org/

Juvenile Justice Center of Philadelphia
http://www.adoptionsfromtheheart.org/

Lutheran Services Northeast
http://www.lsn.org/

PA Adoption Exchange
http://www.dpw.state.pa.us/adoptpakids/

Welcome House Social Services of the Pearl S. Buck Foundation
http://www.pearl-s-buck.org/

Adoption Forum, Inc.
PO Box 12502
Philadelphia, PA 19151
Tel: 215-238-1116

National Youth Violence Prevention Resource Center
http://www.SAFETYOUTH.org

National Center for Injury Prevention and Control (NCIPC)
http://www.cdc.gov/ncipc

U.S. Consumer Product Safety Commission (CPSC)
http://www.cpsc.gov

National Highway Traffic Safety
http://www.nhsta.dot.gov

National Domestic Violence Hotline
1-800-799-SAFE (800-799-7233)
TDD 1-800-787-3224

National Health Resource Center on Domestic Violence
1-800-537-2238

Violence Against Women Office
http://www.ojp.usdoj.gov/vawo/welcome.html

National Criminal Justice Reference Service
http://www.ncjrs.org

National Clearinghouse on Child Abuse and Neglect Information
http://www.calib.com/nccanch

National Clearinghouse for Alcohol and Drug Information (NCADI)
http://www.health.org
Businesses and Institutions

- Provide mental health services for your employees and their families.
- Provide ongoing education related to workplace safety and be mindful of literacy and language issues when preparing materials.
- Sponsor car seat checks where parents can stop and have someone make sure their children's car safety seats are properly installed.
- Provide strict safety standards to your employees regarding drinking and driving, and also the use of cell phones while driving.
- Encourage mentoring of youth by your employees in order to encourage school success.
- Communities should send clear messages about their intolerance of the physical and sexual mistreatment of children by anyone, including parents. Communities that succeed in protecting children are clear about what constitutes abuse. Courts must reinforce the community's standards of conduct and prove that they are being upheld.
- Policy-makers at every level must readjust their spending priorities to combat the cycle of family violence if they truly believe in family values. This cycle that produces generations of dysfunctional families and young violent offenders, threatens the future safety and health of our entire community.
- Voice your opinion about setting public spending priorities. Our children represent the future workforce with which businesses will deal. We will be a more productive society if every child has the opportunity to grow into a healthy and balanced adult.

Schools

- Be vigilant in looking for signs of abuse or neglect among your students.
- Educate students on safety issues (i.e., helmet use; buckling up; stop, drop, and roll, etc.)
- Ensure that students play safely on playground equipment. Potentially dangerous equipment should be brought to the attention of school officials.
- Implement a curriculum that combats bullying and fighting.
- Work to ensure students are safe going to school. Violence often occurs on the way to and from school and can result in absenteeism and poor academic performance.
- Refer students to proper mental health services and be diligent about following up to be sure they are receiving the treatment they need.
- Provide workshops on date rape and dating violence for parents and students. Watch for signs of dating violence among your students. Take student comments and conversations seriously.
- Children must be taught about respecting themselves and others. They must know what is appropriate—not just sexually, but in conflict resolution, anger, relationships, and stress management. Adults must model respectful behavior in their relationships. Everyone is a teacher when conveying family, personal, and community values.

Individuals

- Use proper safety equipment when riding bikes, motorcycles, scooters, etc. Insure that your children use proper safety equipment at all times.
- Take you family, including elderly parents, to safety fairs.
- Regularly check that your smoke detectors are in working order.
- Reduce alcohol consumption.
- Never drink and drive or allow your friends to drink and drive.
I Enroll your teenage son or daughter in their high school’s “Behind the Wheel” drivers’ education program. Do not let them drive with friends who they tell you drive recklessly.

I Be aware of family situations in your neighborhood. If you feel that children are being neglected or abused, contact Children and Youth.

I Whenever you are in a moving vehicle be sure that everyone uses their seatbelts, and make sure you have properly installed child safety seats that are appropriate for your child’s size.

I If you have firearms or other weapons in your home, lock them up and keep them away from the hands of children.

I Turn off violent shows and don’t purchase violent video games. Question the appropriateness of violence in children’s programming and games. Talk to your children about the violence they watch. (Studies are being done on the exposure of young children and youth to violence on television and in video games.)

I Understand the role that anger and violence has played in shaping you and your own beliefs.

I Be conscious of the messages your children get from the world around them: movies, TV, music, newspapers, your home, their friends. Talk to them about what they believe is right and wrong and why they believe what they do.

I Know what your children do with their free time and with whom they are hanging out. Get to know the parents of your child’s friends.

I Teach your sons and daughters that, in a sexual context, “no” means “no.”

I Make sure that older adults have living arrangements that will not unnecessarily put them in danger of falling or otherwise injuring themselves. Check in with them often.

I Talk to your sons and daughters from an early age about violence and sex. Be vigilant!

I If you are in a relationship in which you do not feel safe, seek help.

I If we, the community, want to send the message that we care about every child, then we must be willing to financially support children who need to find caring and safe homes. Tell your legislators and local officials.

I How can we as a community make mental health services available and accessible?

I How do we grow the political will to deal with the issue of full staffing in the agencies that provide support to our most troubled families and children?

I What can we do to encourage proper safety habits within our citizenry?

I How do we encourage more mentors for youth everywhere?

I How can we ensure that juvenile offenders are receiving proper treatment for mental health, substance abuse, and cognitive developmental issues?

I How does the entire community address the fact that we are growing increasingly violent youth? How do we deal with the conditions that produce this result in a scientifically sound but community- and family-based way?

I How can our community provide better support to those who are victims of child abuse, domestic violence, or elder abuse? How do we increase the options for safe living situations?

I How do we raise our sons and daughter in ways that will build self-respect and respect for members of the opposite sex?
Injury and Violence Prevention

Goal: Reduce injuries, disabilities, and deaths due to unintentional injuries and violence.

Injury Prevention

15-1 Nonfatal head injuries
15-2 Nonfatal spinal cord injuries
15-3 Firearm-related deaths
15-4 Proper firearm storage in homes
15-5 Nonfatal firearm-related injuries
15-6 Child fatality review
15-7 Nonfatal poisonings
15-8 Deaths from poisoning
15-9 Deaths from suffocation
15-10 Emergency department surveillance systems
15-11 Hospital discharge surveillance systems
15-12 Emergency department visits

Unintentional Injury Prevention

15-13 Deaths from unintentional injuries
15-14 Nonfatal unintentional injuries
15-15 Deaths from motor vehicle crashes
15-16 Pedestrian deaths
15-17 Nonfatal motor vehicle injuries
15-18 Nonfatal pedestrian injuries
15-19 Safety belts
15-20 Child restraints
15-21 Motorcycle helmet use
15-22 Graduated driver's licensing
15-23 Bicycle helmet use
15-24 Bicycle helmet laws
15-25 Residential fire deaths
15-26 Functioning smoke alarms in residences
15-27 Deaths from falls
15-28 Hip fractures
15-29 Drownings
15-30 Dog bite injuries
15-31 Injury protection in school sports

Violence and Abuse Prevention

15-32 Homicides
15-33 Maltreatment and maltreatment fatalities of children
15-34 Physical assault by intimate partners
15-35 Rape or attempted rape
15-36 Sexual assault other than rape
15-37 Physical assaults
15-38 Physical fighting among adolescents
15-39 Weapon carrying by adolescents on school property
Related Objectives from Other Focus Areas

Access to Quality Health Services
- 1-3 Counseling about health behaviors
- 1-11 Rapid prehospital emergency care
- 1-12 Single toll-free number for poison control centers

Educational and Community-Based Programs
- 7-3 Health-risk behavior information for college and university students

Environmental Health
- 8-13 Pesticide exposures
- 8-24 Exposure to pesticides
- 8-25 Exposure to heavy metals and other toxic chemicals

Mental Health and Mental Disorders
- 18-1 Suicide
- 18-2 Adolescent suicide attempts

Occupational Safety and Health
- 20-1 Work-related injury deaths
- 20-2 Work-related injuries
- 20-5 Work-related homicides
- 20-6 Work-related assaults

Substance Abuse
- 26-1 Motor vehicle crash deaths and injuries
- 26-5 Alcohol-related hospital emergency department visits
- 26-6 Adolescents riding with a driver who has been drinking
- 26-7 Alcohol- and drug-related violence
- 26-24 Administrative license revocation laws
- 26-25 Blood alcohol concentration (BAC) levels for motor vehicle drivers
Mental Health

Improve mental health and ensure access to appropriate, quality mental health services
### Mental Health

**Goal:** Better than the best

#### HP 2010 Measures and Local Measures

<table>
<thead>
<tr>
<th>HP 2010 Measures and Local Measures</th>
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<tbody>
<tr>
<td><strong>18-1</strong> Reduce the suicide rate.</td>
<td></td>
</tr>
<tr>
<td>Target: 5.0 suicides per 100,000 population</td>
<td></td>
</tr>
<tr>
<td>Baseline: 11.3 suicides per 100,000 population occurred in 1998 (age adjusted to the year 2000 standard population).</td>
<td></td>
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<tr>
<td>Target-setting method: Better than the best</td>
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<tr>
<td>Data source: National Vital Statistics System (NVSS), CDC, NCHS</td>
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<tr>
<td><strong>18-3</strong> Reduce the proportion of homeless adults who have serious mental illness (SMI).</td>
<td></td>
</tr>
<tr>
<td>Target: 19 percent.</td>
<td></td>
</tr>
<tr>
<td>Baseline: 25 percent of homeless adults aged 18 years and older had SMI in 1996.</td>
<td></td>
</tr>
<tr>
<td>Target-setting method: 24 percent improvement. (Better than the best will be used when data are available.)</td>
<td></td>
</tr>
<tr>
<td>Data source: Projects for Assistance in Transition from Homelessness (PATH) Annual Application, SAMHSA, CMHS</td>
<td></td>
</tr>
<tr>
<td>Data for population groups currently are not collected.</td>
<td></td>
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<tr>
<td><strong>18-6</strong> (Developmental) Increase the number of persons seen in primary health care who receive mental health screening and assessment.</td>
<td></td>
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<tr>
<td>Potential data source: Primary Care Data System/Federally Qualified Health Centers, HRSA</td>
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<tr>
<td><strong>18-7</strong> (Developmental) Increase the proportion of children with mental health problems who receive treatment.</td>
<td></td>
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<tr>
<td>Potential data source: National Household Survey on Drug Abuse (NHSDA), SAMHSA, OAS</td>
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<tr>
<td><strong>18-9</strong> Increase the proportion of adults with mental disorders who receive treatment.</td>
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<tr>
<td>Target and baseline:</td>
<td></td>
</tr>
<tr>
<td>a. Adults aged 18 to 54 years with serious mental illness</td>
<td></td>
</tr>
<tr>
<td>b. Adults aged 18 years and older with recognized depression</td>
<td></td>
</tr>
<tr>
<td>c. Adults aged 18 years and older with schizophrenia</td>
<td></td>
</tr>
<tr>
<td>d. Adults aged 18 years and older with generalized anxiety disorder</td>
<td></td>
</tr>
<tr>
<td>Target-setting method: 17 percent improvement for 18-9a. (Better than the best will be used when data are available.) Better than the best for 18-9b, 18-9c, and 18-9d.</td>
<td></td>
</tr>
<tr>
<td>Data sources: Epidemiologic Catchment Area (ECA) Program, NIH, NIMH; National Household Survey on Drug Abuse (NHSDA), SAMHSA, OAS; National Comorbidity Survey, SAMHSA, CMHS; NIH, NIMH</td>
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</table>
Like physical health, mental health is not just the absence of disease. It includes a sense of well-being and extends to a person’s ability to meet routine demands of ordinary daily life. Healthy People 2010 defines it as “a state of successful mental functioning, resulting in productive activities, fulfilling relationships, and the ability to adapt to change and cope with adversity. Mental health is indispensable to personal well-being, family and interpersonal relationships, and one’s contribution to society.” An example of the breadth of mental health topics is stress. Stress, and living with constant stress, is a major risk factor for mental and physical illness. It complicates our ability to perform well at work and at home, to enjoy relationships, and to appreciate life. Stress management is being seen as a major issue by businesses and health professionals. The total estimated direct and indirect cost of mental illness in the United States in 1996 was $150 billion. In established market economies such as the United States, mental illness is on a par with heart disease and cancer as a cause of disability. (Murray, C.J.L., and Lopez, A.D. *The Global Burden of Disease*. Cambridge, MA: Harvard University Press, 1996.)

Ninety percent of those who complete suicide have a diagnosed mental illness. Mental illness is the term that refers collectively to all diagnosable mental disorders. Helping persons with mental illnesses to access appropriate scientifically based care and treatments is essential. Some of the most commonly diagnosed problems are mood disorders (depression, bipolar disorder, anxiety), psychotic disorders, and schizophrenia. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof). They are associated with distress and/or impaired functioning and spawn a host of human problems that may include disability, pain, or death.

Mental disorders vary in severity and in their impact on people’s lives. Mental disorders—such as schizophrenia, major depression and bipolar illness (manic depression), and obsessive-compulsive disorder and panic disorder—can be enormously disabling.
Affective disorders, which encompass major depression and bipolar illness, constitute a second category of severe mental illness. Bipolar illness affects around one percent of adults, with comparable rates of occurrence in men and women. A high rate of suicide is associated with such mood disorders.

Depression is associated with other medical conditions, such as heart disease, cancer, and diabetes as well as anxiety and eating disorders. Depression also has been associated with alcohol and illicit drug abuse. At some time or another, almost all adults will experience an unexpected or tragic loss or a serious setback. Almost everyone suffers times of profound sadness, grief, or distress. Major depressive disorder is different both quantitatively and qualitatively from normal sadness or grief, which is usually less all-consuming and generally of a more limited amount of time. Some of the symptoms of severe depression, such as the inability to experience pleasure, severe hopelessness, and loss of one's ability to feel a mood uplift in response to something positive, only rarely accompany normal sadness.

Major depression is the leading cause of disability and is the cause of more than two-thirds of suicides each year. A person with a depressive disorder often is unable to fulfill the daily responsibilities of being a spouse, partner, or parent. Yet the misunderstanding of mental illness and the associated stigma prevents many persons with depression from seeking professional help. Although only a minority seek professional help to relieve a mood disorder, depressed people are significantly more likely than others to visit a physician for some other reason. Available medications and psychological treatments, alone or in combination, can help 80 percent of those with depression.

In the workplace, depression is a leading cause of absenteeism and diminished productivity. Depression also has been associated with alcohol and illicit drug abuse. An estimated 8 million persons aged 15 to 54 years had coexisting mental and substance abuse disorders within the past year.

Schizophrenia will affect more than 2 million people in the United States in one year. It is characterized by profound disruption in cognition and emotion, affecting the most fundamental human attributes: language, thought, perception, effect, and sense of self. Persons suffering from schizophrenia assign unusual significance or meaning to normal events or hold fixed false beliefs. The disorder tends to follow a long-term course, although the severity of symptoms may be fluid depending on the availability and response to treatment. With modern treatments, increasing numbers of persons with schizophrenia can and do view recovery as an achievable goal.

Anxiety disorders encompass several discrete conditions, including panic disorder, obsessive-compulsive disorder, posttraumatic stress disorder, and phobia. More common than other mental disorders, anxiety disorders affect as many as 19 million people in the United States annually. Twenty-four percent of the population will experience an anxiety disorder, many with overlapping substance abuse disorders.

Co-occurring mental and addictive disorders are more common than previously recognized. In general, 19 percent of the adult U.S. population has a mental disorder alone (in one year); three percent have both mental and addictive disorders; and six percent have addictive disorders alone. About 28 to 30 percent of the population has either a mental or addictive disorder.

In the United States approximately 40 million people aged 18 to 64 years, or 22 percent of the population, had a diagnosis of mental disorder alone (19 percent) or of a co-occurring mental and addictive disorder in the past year. (Regier; Narrow; Rae. National Institute of Mental Health unpublished analysis, 1999.) Adults and older adults have the highest rates of depression. An estimated 25 percent of older people (8.6 million) experience specific mental disorders, such as depression, anxiety, substance abuse, or dementia, that are not part of normal aging.
Modern treatments for mental disorders are highly effective, with a variety of treatment options available for most disorders; there is no “one size fits all” treatment. Similarly, there exists today a diverse array of treatment settings. A person may have the option of selecting a setting based on health care coverage, the clinical needs associated with a particular type or stage of illness, and personal preference.

### 18-9 Increase the proportion of adults with mental disorders who receive treatment.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Increase in Adults With Mental Disorders Receiving Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-9a</td>
<td>Adults aged 18 to 54 years with serious mental illness</td>
</tr>
<tr>
<td>18-9b</td>
<td>Adults aged 18 years and older with recognized depression</td>
</tr>
<tr>
<td>18-9c</td>
<td>Adults aged 18 years and older with schizophrenia</td>
</tr>
<tr>
<td>18-9d</td>
<td>Adults aged 18 years and older with generalized anxiety disorder</td>
</tr>
</tbody>
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</thead>
<tbody>
<tr>
<td>DNA</td>
<td>DSU</td>
<td>DSU</td>
<td>DSU</td>
<td>DNC</td>
</tr>
<tr>
<td>Asian or Pacific Islander DNA</td>
<td>DSU</td>
<td>DSU</td>
<td>DSU</td>
<td>DNC</td>
</tr>
<tr>
<td>Native Hawaiian and other Pacific Islander DNA</td>
<td>DNC</td>
<td>DSU</td>
<td>DNC</td>
<td>DNC</td>
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<tr>
<td>Black or African American DNA</td>
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<td>DNC</td>
<td>DNC</td>
<td>DNA</td>
</tr>
<tr>
<td>White DNA</td>
<td>24</td>
<td>DNC</td>
<td>DNC</td>
<td>DNC</td>
</tr>
<tr>
<td>Hispanic or Latino DNA</td>
<td>20</td>
<td>42</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>Not Hispanic or Latino DNA</td>
<td>DNC</td>
<td>DNC</td>
<td>DNC</td>
<td>DNC</td>
</tr>
<tr>
<td>Black or African American DNA</td>
<td>DNA</td>
<td>DNA</td>
<td>DNA</td>
<td>DNA</td>
</tr>
<tr>
<td>White DNA</td>
<td>DNA</td>
<td>DNA</td>
<td>DNA</td>
<td>DNA</td>
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</tbody>
</table>

Despite the effectiveness of treatment, two issues prevent people from seeking and obtaining that help. The first issue is personal choice in treatment. Insurance policies do not adequately reimburse for long-term or even short-term care. There is a national shortage of mental health providers, but especially providers for children. Additionally, there is a lack of providers who are culturally competent. Many facilities do not accept dually-diagnosed mental illness patients.
Only 25 percent of persons with a mental disorder obtain help for their illness in the health care system. In comparison, 60 to 80 percent of persons with heart disease seek and receive care. More critically, 40 percent of all people who have a severe mental illness do not seek treatment from either general medical or specialty mental health providers. Indeed, the majority of persons with mental disorders do not receive mental health services. Of those aged 18 years and older getting help, about 15 percent receive help from mental health specialists. The second issue is the stigma attached to mental illness. Our society reacts with compassion to physical issues such as heart disease, cancer, and diabetes, but is wary and uncertain about mental issues. There is a tendency to either attach blame, or, in the case of depression, to believe that the sufferer simply is not rising to life’s challenges.

The direct costs of diagnosing and treating mental disorders totaled approximately $69 billion in 1996. Lost productivity and disability insurance payments due to illness or premature death accounted for an additional $74.9 billion. People with mental illnesses are overrepresented in jail populations; many do not receive treatment. (Frese, Psychiatric Clinics of North America 21:233–249. 1998.) Of the $69 billion spent for diagnosing and treating mental disorders, nearly 70 percent was for the services of mental health specialty providers, with most of the remainder for general medical services providers. The majority—53 percent—of mental health treatment was paid for by public sector sources, including states and local governments as well as Medicaid and Medicare and other Federal programs; 47 percent of expenditures were from private sources. Of expenditures from private sources, almost 60 percent were from private insurance. The remainder came from out-of-pocket payments, including insurance copayments, with a small amount from sources such as foundations.

Mental health issues affect children whether they are themselves the sufferers or live in a home with someone who is mentally ill. Because they are children, their symptoms (defiance, sadness, inability to pay attention, sleep problems, eating disorders, angry outbursts) are often seen simply as bad behavior. The same symptoms in adults would be a signal for treatment. Mental and behavioral disorders and serious emotional disturbances (SEDs) in children and adolescents can lead to school failure, alcohol or illicit drug use, violence, or suicide. (Brandenberg, N.; Friedman, R.; and Silver, S. “The epidemiology of childhood psychiatric disorders: Prevalence findings from recent studies.” Journal of the American Academy of Child and Adolescent Psychiatry 29:76–83, 1990.)

Of young people aged 9 to 17 years who have a mental disorder, 27 percent receive treatment in the health sector. (Howard and Lyons, *Archives of General Psychiatry* 53:696–703, 1996). However, an additional 20 percent of children and adolescents with mental disorders use mental health services only in their schools.

Differences between men and women are evident in the number of cases of particular mental disorders.

- Women who are poor, on welfare, less educated, unemployed, and from certain racial or ethnic populations are more likely to experience depression.
- 12 percent of older persons hospitalized for problems such as hip fracture or heart disease are diagnosed with depression.
- Rates of depression for older persons in nursing homes range from 15 to 25 percent. (Healthy People 2010).
- Alzheimer's disease strikes 8 to 15 percent of people over age 65 years, with the number of cases in the population doubling every 5 years of age after age 60 years. By age 85 years, the rate grows to 25 percent (Ritchie and Kildea, *Lancet* 346:931–934, 1995).
- Alzheimer's disease is thought to be responsible for 60 to 70 percent of all cases of dementia and is one of the leading causes of nursing home placements. Alzheimer's disease affects equal numbers of women and men, although women's longer average life spans mean that more women than men have Alzheimer's disease at any point in time (CDC, Priorities for Women's Health. 1993).
- Women attempt suicide more often than men, but men's risk of completed suicide is on average four and one half times higher than women's (CDC, Scientific Data, Surveillance, and Injury Statistics, 1999). This suicide gender gap begins in adolescence and grows through middle and later life (NCHS, CDC, *Vital Statistics of the United States*, 1991).
- Schizophrenia occurs more often in young men than in women and usually has its onset in the late teen and early adult years.
- Eating disorders, affecting up to 2 percent of the population, arise predominantly—but not exclusively—in adolescent and young adult women (90 percent of all cases); the median age of onset is 17 years. Eating disorders often persist into adulthood and have among the highest death rates of any mental disorder.
- Although fewer old persons attempt suicide than do young persons, the rate of completed suicide is highest among elderly men. Elderly white men have a suicide rate six times the national average.
- Studies of the number of cases of mental health problems among racial and ethnic populations, while increasing in number, remain limited and often inconclusive. Discussion of the rates of existing cases must consider differences in how persons of different cultures and racial and ethnic groups perceive mental illness.
- Depression and anxiety are seen more frequently among people with disabilities than those without disabilities.
Local Experts

Local experts say that Healthy People 2010 goals and those that the Department of Health have set forth are somewhat helpful. The problem is that there is no way to accurately count those suffering from mental illness locally. The stigma attached to mental illness makes this so, as well as the laws of Pennsylvania regarding confidentiality. Furthermore, these laws are important to many who fear prejudice in the workplace and social settings, where knowledge of their illness may have serious repercussions. “A striking finding of the landmark Global Burden of Disease study is that the impact of mental illness on overall health and productivity in the United States and throughout the world often is profoundly under-recognized. In established market economies such as the United States, mental illness is on a par with heart disease and cancer as a cause of disability” (HP 2010).

Accurate accounting of the incidence of illness locally may enable our community to calculate its impact on productivity, which may, in turn, help to build our political and societal will to deal with mental illness more effectively. It is important for us to begin measuring the occurrence of this illness so that we can adequately recruit and train enough professionals to deal with the challenges our families, businesses, and communities face.

Many ideas have surfaced about how we could begin such a local measuring process. But all of these require coordinating a collaborative local effort. And then it must be recognized that the data may not be comparable to other areas. Additionally, the analysis and significance of the data would rest with those gathered to study the issue within this community. Some suggested ideas are:

- Count the number of prescriptions written/consumed including, over-the-counter pain and stress relief medications, anti-depressants, anti-psychotics, anti-anxiety. Source: pharmacists, drug companies; admittedly may be tough to get.
- Count the number of calls for mental health help, specifically measuring peak times. Source: CIS, hospital intake, triage, contact.
- Count the number of petty disturbance calls which are often mental health related. Source: police records.
- Count the number of people who define themselves as feeling connected/balanced or who admit to being stressed or depressed. Source: BRFSS.
- Measure stigma/public perceptions: 1) receiving mental health assessments, 2) being diagnosed, 3) length of treatment, 4) leaving treatment prematurely. Source: Locally commissioned random survey.
- Track persons by diagnoses—the percentage of the general population with character pathology. Axis I are by far the primary consumers of mental health services. The following breakdown of four types was suggested: Axis I psychotic, Axis I non-psychotic, Axis I and/or Axis II, and Axis I and Axis III. Source: Physicians and hospitals would have such information available but, again, the collection (which would not include specific client data) would be time-consuming to gather.
- Keep records on number and types of mental health commitments. Source: CIS, hospital and provider records.
- Measure the impact of state and mental hospital closings. After 6–12 months, track where the deinstitutionalized persons live. How many in shelters, prisons, homeless, etc.?
- Measure the number of primary care practitioners who attended training on mental health issues, psychotropic meds, system-wide mental health referrals. Track the number of bicultural/bilingual mental health professionals.

Again, all of these issues need some attention and could lead to improving our interventions and strategies for dealing with mental health issues. But the community's will and capacity to deal with the research of all of these queries requires examination as well. There are some established measures that we can begin to look at in the meantime.
18-1 Reduce the suicide rate.

National target: 5.0 suicides per 100,000 population
National baseline: 11.3 suicides per 100,000 population occurred in 1998 (age adjusted to the year 2000 standard population)
Target-setting method: Better than the best
Data source: National Vital Statistics System (NVSS), CDC, NCHS

<table>
<thead>
<tr>
<th>Total Population, 1998</th>
<th>Suicides Rate per 100,000</th>
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<tbody>
<tr>
<td>TOTAL</td>
<td>11.3</td>
</tr>
<tr>
<td>Race and ethnicity</td>
<td></td>
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<tr>
<td>American Indian or Alaska Native</td>
<td>12.6</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>6.6</td>
</tr>
<tr>
<td>Asian</td>
<td>DNC</td>
</tr>
<tr>
<td>Native Hawaiian and other Pacific Islander</td>
<td>DNC</td>
</tr>
<tr>
<td>Black or African American</td>
<td>5.8</td>
</tr>
<tr>
<td>White</td>
<td>12.2</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>6.3</td>
</tr>
<tr>
<td>Not Hispanic or Latino</td>
<td>11.8</td>
</tr>
<tr>
<td>Black or African American</td>
<td>6.0</td>
</tr>
<tr>
<td>White</td>
<td>12.8</td>
</tr>
</tbody>
</table>

Gender
- Female: 4.3
- Male: 19.2

Education level (aged 25 to 64 years)
- Less than high school: 179
- High school graduate: 19.2
- At least some college: 10.0

Although 90% of people who kill themselves have a mental or substance abuse disorder, or a combination of disorders, most persons with a mental or substance abuse disorder do not kill themselves. Suicide, however, is the most often used measure of mental illness because it can be counted more accurately. But suicide is a very small part of the mental health picture. The real struggle for those with mental health issues is living and functioning with mental illness and mental disorders.

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<tbody>
<tr>
<td>5.0</td>
<td>11.3</td>
<td>11.1</td>
<td>10.6</td>
</tr>
</tbody>
</table>

Suicide was the ninth leading cause of death in the United States in 1996 and the third leading killer of young persons between age 15 and 24 years (NCHS, CDC, Health, United States, 1996). Suicide is a complex behavior that can be prevented in many cases by early recognition and treatment of mental disorders (NIMH Suicide Research Consortium, Suicide Facts, 1997). As the population gets older, experts predict that by 2015, suicide and complications due to mental illness will be the third leading cause of death in America.

18-3 Reduce the proportion of homeless adults who have serious mental illness (SMI) (developmental).

National target: 19 percent
Baseline: 25 percent of homeless adults aged 18 years and older had SMI in 1996.
Target-setting method: 24 percent improvement. (Better than the best will be used when data are available.)
Data source: Projects for Assistance in Transition from Homelessness (PATH) Annual Application, SAMHSA, CMHS. Data for population groups currently are not collected nationally.
Local target: Better than the Best
Local baseline: Developmental
Data sources: Annual Homeless Survey
Approximately one-quarter of homeless persons in the United States have a serious mental illness (SMI) (Tessler and Dennis, DHHS Pub. No. 94-303014, 1989). Many of these individuals are the victims of the deinstitutionalization that took place in the last decade. It occurred without sufficient national and state funding for community-based mental health, support, and housing services as had been promised to advocated and local providers. These are those lost to our society through federal and state budget cutting sessions and who, because of their illnesses, are unable to lift their own voices for redress and services. New approaches developed over the past 10 years provide ways to lower the number of persons who are homeless and who also have Severe Mental Illness (SMI). Using persistent patient outreach and engagement strategies, service providers are helping homeless persons with SMI connect with mainstream treatment systems (Lam and Rosenheck, Medical Care 37:894–907, 1999), but these are costly and too few.

Treatment alone, however, is not enough. Once permanent housing is located, appropriate mental health and social supports can help persons with mental illness maintain that housing. Much of this support occurs in the form of case management, particularly if it is responsive both to emerging mental health issues and to the skills a person needs to function and thrive in the community. Counter to popular thought, many people who receive treatment and services for mental illness can and do work and are productive members of our communities. Recreational opportunities are equally important.

18-6 (Developmental) Increase the number of persons seen in primary health care who receive mental health screening and assessment.

Potential data source: Primary Care Data System/Federally Qualified Health Centers, HRSA

Family, clergy, family physicians, friends, teachers and school counselors need to be able to access information so that they can appropriately help the person confiding in them. Because of the stigma associated with mental illness, too few people actually receive appropriate treatment. It is important that those with whom they speak are able to direct them to appropriate help. It is also important that such help be available and accessible.

The primary care medical system (family doctors, internists, pediatricians, and nurse practitioners in office-based practice, clinics, acute medical and surgical hospitals, and nursing homes) has long been identified as the initial point of contact for many adults with mental disorders. For some, it may be the only source of mental health services. Therefore, attention to mental state in primary care can promote early detection and intervention for mental health problems. Close to six percent of the adult U.S. population use the general medical sector for mental health care, with an average of about four mental health visits per year—far lower than the average of 14 visits per year found in the specialty medical sector. (Regier, D.A.; Narrow, W.; Rae, D.S.; et al. “The de facto U.S. mental and addictive disorders service system. Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services.” Archives of General Psychiatry 50:85–94, 1993.)

Two prominent forces of change are federal and state efforts to improve access to health care, including mental health care and the rapid growth and impact of managed care. In 1998, the Mental Health Parity Act (P.L. 104–204) was implemented to help increase access to care. (The term “parity” or “mental health parity” refers generally to insurance coverage for mental health services that include the same benefits and restrictions as coverage for other health services.) Although the Federal Mental Health Parity Act is quite limited in reducing insurance coverage discrepancies between physical and mental disorders, 53 percent of the U.S. population is now covered by state mental health parity laws.

Because of issues of confidentiality and the inability to access private files, we do not know who is or isn’t getting service. Except through testimonies at local public agency planning hearings or during events that rally advocates, a data-driven picture cannot be drawn.
It is hard to answer the questions concerning the number of adults and children who are in need of mental health services and are not receiving them. Possible sources: Adults—clergy survey, ICAN, family doctors, shelters, emergency rooms. Children—daycare centers, CAP, public and private schools, CYA, Boys and Girls Club.

**18-7** (Developmental) Increase the proportion of children with mental health problems who receive treatment.

- **Potential data source:** National Household Survey on Drug Abuse (NHSDA), AMHSA, OAS
- **Local target:** Better than the best
- **Local baseline:** Developmental
- **Data sources:** School-based Student Assistance Programs (SAP), Special Education Programs

For many children aged 18 years and under, lifelong mental disorders may start in very early childhood or adolescence. They range in severity and level of debilitation. These disorders may affect their ability to learn and to pursue or maintain strong social and family connections or absorb lessons that are essential to getting along in life and with others.

We must promote effective collaboration across critical areas of support: families, social services, health, mental health, juvenile justice, and schools in order to provide effective services for children, particularly for those with serious emotional disturbance. The goals for these children, particularly for children with serious emotional disturbance and their families, are greater school retention, decreased contact with the juvenile justice system, increased stability of living arrangements, and improved educational, emotional, and behavioral development. (Greenburg, Domitrovich, and Burnbarger, *Preventing Mental Disorders in School Children...,* HHS, PHS, SAMHSA, CMHS, 1999.)


Especially at risk for alcohol use problems are boys diagnosed with so-called externalizing disorders such as conduct problems, oppositional-defiant disorder, and attention deficit/hyperactivity disorder (ADHD) (Winkle, *Journal of Studies in Alchohol*, 1988). From public health promotion and disease prevention perspectives, it is noteworthy that children and adolescents with mental illnesses often do not become substance abusers until after the mental illness becomes apparent (Christie, Burke and Regier, et al, *American Journal of Psychiatry* 145:971–975, 1988). This time lag creates a window of opportunity when prevention of substance abuse in these children may be possible.

For many other children, normal development is disrupted by biological, environmental, and psycho-social factors which impair their mental health, interfere with education and social interactions, and keep them from realizing their full potential as adults. Children can be victimized by family violence or family addiction issues. Many undiagnosed and diagnosed young people end up in the juvenile justice system. Unfortunately, this is often the point of entry into a lifetime of systems, programs, and incarceration, some of which may have been avoided with early diagnosis.

Other ideas for local tracking include:

- Track the number of children in treatment; the number who transition into adult services, CYA, and juvenile justice and criminal systems; the number who complete treatment as children; how many in residential placement; rate of recidivism; level of parental involvement; the number in therapeutic foster care; integration of treatment and consequences between justice and mental health systems.

- The number of children successfully completing treatment (SAP, PCP, Private Providers, IP, OP, schools, therapists, Salud Hispana, BC/GC, Nuestra Clinica).

- The number of children successfully completing school each year.
LOCAL INDICATOR: (Developmental) Increase the number of juveniles in the juvenile justice system being screened for mental health, drug and alcohol abuse, and learning disabilities to 100%.

Local target: 100% of juveniles involved with Lancaster Juvenile Probation and Parole who are screened for mental health, drug and alcohol addiction, or abuse and learning disabilities
Local baseline: Developmental
Data sources: Lancaster County JPP
Potential data source: Inventory of Mental Health Services in Juvenile Justice Facilities, SAMHSA

It is estimated that over 100,000 youth are placed in juvenile justice facilities annually (Otto, Responding to the Mental Health Needs of Youth in the Juvenile Justice System, National Coalition for the Mentally Ill in the Criminal Justice System, 1992). Although exact numbers of youths with mental disorders among those entering this system are not available, the proportion is considerably higher than in the general population. Not surprisingly, problems of suicide, self-injurious behavior, and other disorders are significant among youths in the juvenile justice system (Cocozza, Corrections Today, December 1997). Screening activities, including parent or caregiver interviews, should be conducted by qualified mental health personnel. This approach can help ensure that all youths entering the juvenile justice system who also have a treatable mental health problem are identified and receive appropriate treatment.

18-10 Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders.

Potential data sources: National Health Interview Survey (NHIS), CDC, NCHS; National Household Survey on Drug Abuse (NHSDA), SAMHSA, OAS; Replication of National Comorbidity Survey, NIH, NIMH
Local target: Developmental
Data sources: D&A Commission and MH/MR, PA DOH and PA DP

The lifetime rates of co-occurrence of mental disorders and addictive disorders are strikingly high. About 28 to 30 percent of the population has either a mental or addictive disorder (Kessler, R.C.; Nelson, C.B.; McGonagle, K.A.; et al. “The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization.” American Journal of Orthopsychiatry 66:21–23, 1996). Nearly one in three adults who have a mental disorder in their lifetime also experience a co-occurring substance abuse (alcohol or other drugs) disorder, which complicates treatment. Individuals who suffer from mental illness and addiction are more likely to experience a chronic course and to use services than are those with either type of disorder alone. Clinicians, program developers, and policymakers need to be aware of these high rates of co-existing conditions. How public health service systems can best address issues of treating the full range of persons with co-occurring mental and substance-related disorders remains a challenge. Treatment protocols continue to be refined as research findings and promising practices are disseminated to programs and practitioners.

Access to Care Indicators

Businesses everywhere are concerned with productivity, employability, and workplace skills of the work force, all of which are affected by mental illness. In addition to the stigma of mental illness, those who finally choose to get help or who are asked to do so by their employers must still find providers and work through the insurance system to get coverage. Employers can help by providing Employee Assistance Programs and training their Human Resource departments in how to make referrals in a sensitive, effective, and efficient manner.
Increase the % of employers who provide health insurance that includes mental health services in their benefits.

Increase percentage of employers who provide health insurance who have some kind of Employee Assistance Program or contracted service for such. Increase percentage of employers who mandate drug screening and have an AEP in place.

Target: Better than the best
Local baseline: Developmental
Data sources: Chamber of Commerce Survey

Stigma creates barriers to providing and receiving competent and effective mental health treatment and can lead to inappropriate treatment, unemployment, and homelessness. The reduction of stigma associated with mental disorders will, in turn, encourage more individuals to seek needed mental health care. Evidence that mental disorders are legitimate and highly responsive to appropriate treatment promises to be a potent antidote to stigma.

Social and behavioral research is beginning to explore the concept of resilience to identify strengths that may promote health and healing. It is generally assumed that resilience involves the interaction of biological, psychological, and environmental processes. We know that children who lack this quality tend to have problems later in life. With increased understanding of how to identify and promote resilience, it will be possible to design effective programs that draw on such internal capacity.

The public health sector increasingly is concerned with the impact of stress, its prevention and treatment, and the need for better coping skills. Coping skills, acquired throughout the lifespan, affect the ability to manage stressful events. Additional research can help identify ways to prevent or alleviate stress through environmental or individual strategies.

Progress in fundamental science and emphasizing clinical applications of that knowledge can strengthen opportunities for change in the clinical and service system.
Intensive Case Management  
(717) 293-5104

Intensive Day Treatment  
(for children)  
(717) 295-9630

Lancaster Behavioral Health Network  
(717) 560-3782

Lancaster General Health Campus  
Behavioral Medicine and Neuropsychology  
(717) 290-3172

Lancaster General Hospital  
Mental Health & Substance Abuse Services  
(717) 290-5887

Lancaster Guidance Center  
(717) 560-2971

Lancaster-Lebanon I.U. 13  
(717) 655-2366

Lancaster Regional Medical Center  
(717) 291-8030

LUTHERCARE  
(717) 626-1171

Mental Health Association  
(717) 397-7461

Mental Health/Mental Retardation  
Case Management (717) 393-0421  
Children & Adolescent Service System Program (717) 399-7416

Nuestra Clinica  
(717) 293-4150

PA Mental Health Consumers  
(717) 564-4930

Philhaven  
(717) 299-4829

Samaritan Counseling Center  
(717) 299-7979

United Way LINC  
(717) 291-LINC
Center for Mental Health Services, SAMHSA
http://www.mentalhealth.org/cmhs/index.htm

Knowledge Exchange Network, SAMHSA
http://www.mentalhealth.org/

National Institute of Mental Health Information Line, NIH
800-421-4211
http://www.nimh.nih.gov/publicat/depressionmenu.cfm

- How do we get increased funding for mental health services, that is flexible and even “family” oriented?
- Do we have the ability to look outside the box for new, creative, effective services which integrate across treatment systems and counties?
- How do we integrate mental health and D&A services given the current funding dilemmas?
- What do we in Lancaster mean by integration of services in the mental health area?
- Can we create true community behavioral health centers with reduced fragmentation and improved coordination of services for dually-diagnosed persons and their families?
- How can we recruit mental health professionals for Lancaster County including child specialists and bi-cultural practitioners?
- Can we improve access to mental health screenings and consequent treatment of children involved in “at risk” situations, like parents in drug and alcohol treatment, residential placement, or prison?
- What do we mean by prevention efforts when we are talking about mental health issues?

### Mental Health Status Improvement

18-1 Suicide
18-2 Adolescent suicide attempts
18-3 Serious mental illness (SMI) among homeless adults
18-4 Employment of persons with SMI
18-5 Eating disorder relapses

### Treatment Expansion

18-6 Primary care screening and assessment
18-7 Treatment for children with mental health problems
18-8 Juvenile justice facility screening
18-9 Treatment for adults with mental disorders
18-10 Treatment for co-occurring disorders
18-11 Adult jail diversion programs

### State Activities

18-12 State tracking of consumer satisfaction
18-13 State plans addressing cultural competence
18-14 State plans addressing elderly persons
Nutrition and Overweight

Reduce child and adult obesity
### HP 2010 Measures and Local Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>19-2 Reduce the proportion of adults who are obese.</strong></td>
<td>Target-setting method: Better than the best</td>
</tr>
<tr>
<td><strong>Data source:</strong> National Health and Nutrition Examination Survey (NHANES), CDC, NCHS</td>
<td>Baseline: 23 percent of adults aged 20 years and older were identified as obese (defined as a BMI of 30 or more) in 1988-1994 (age adjusted to the year 2000 standard population).</td>
</tr>
<tr>
<td><strong>Target:</strong> 15 percent</td>
<td></td>
</tr>
<tr>
<td><strong>Baseline:</strong> 11 percent of adults aged 20 years and older were identified as obese (defined as a BMI of 30 or more) in 1988-1994 (age adjusted to the year 2000 standard population).</td>
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</tr>
</tbody>
</table>

| **19-3 Reduce the proportion of children and adolescents who are overweight or obese.**             |                                                                                             |
| **Target-setting method:** Better than the best                                                    |                                                                                             |
| **Data source:** National Health and Nutrition Examination Survey (NHANES), CDC, NCHS               |                                                                                             |
| **Target:** 5 percent                                                                               |                                                                                             |
| **Baseline:** 11 percent of children and adolescents aged 6-19 years were overweight or obese 1988-1994. |                                                                                             |
Although the push to be thin seems greater than ever, the American lifestyle increasingly promotes an overweight and unhealthy population. One in three Americans is considered overweight, making us the most overweight major nation in the industrialized world. Higher body weights are associated with higher death rates. Leading national health organizations, such as the NIH and the CDC, define overweight as a body mass index of 25 or more. Body mass index (BMI) is your weight (in kilograms) divided by the square of height (in meters), or weight (in pounds) divided by the square of height (in inches) times 704.5. Because it is readily calculated, BMI is the measurement of choice as an indicator of healthy weight, overweight, and obesity. Even more disturbing are the health risks associated with the rising number of obese people (defined as having BMIs of 30 or greater). Obese individuals suffer from more chronic health problems than do daily smokers and heavy drinkers. In fact, weight may soon overtake smoking as the number one cause of preventable disease and death (Pierce, Neal. “How to Combat Our Obesity Epidemic?” Neal Pierce Column, Washington Post Writer’s Group, Jan 27, 2002).

Being overweight or obese typically reflects a diet higher in fat and lower in more healthful foods such as whole grains, fruits, and vegetables. Even though research documenting the precise relationships between dietary habits and disease incidence and outcomes is in its infancy, we know that nutritional, or dietary, factors contribute substantially to the burden of preventable illnesses and premature deaths in the United States (Frazao, E. “The high costs of poor eating patterns in the United States.” In: Frazao, E., ed. America’s Eating Habits: Changes and Consequences. Washington, DC: U.S. Department of Agriculture (USDA), Economic Research Service (ERS), AIB–750, 1999). Dietary factors are associated with 4 of the 10 leading causes of death: coronary heart disease (CHD), some types of cancer, stroke, and type 2 diabetes (National Center for Health Statistics (NCHS). Report of Final Mortality Statistics, 1995. Monthly Vital Statistics Report 45(11):Suppl. 2, June 12, 1997). Obesity is directly associated with both the prevalence and the consequences of diabetes. Approximately 300,000 deaths from diabetes, hypertension, breast and colon cancer are directly linked to obesity (Pierce, Neal. “How to Combat Our Obesity Epidemic?” Neal Pierce Column, Washington Post Writers Group, Jan 27, 2002). Dietary factors also are associated with osteoporosis, which affects more than 25 million persons in the United States and is the major underlying cause of bone fractures in postmenopausal women and elderly persons (NIH Consensus Statement: Optimal Calcium Intake. 12(4), 1994).

Conversely, those falling below a BMI of 18.5 are also at risk for certain health issues, such as menstrual irregularity, infertility, and osteoporosis. The epidemic of overweight and obesity in the United States, often overshadows the issue of under-nutrition. We may think under-nutrition in the U.S. is only the result of eating disorders, such as anorexia and bulimia. But hunger and lack of food does affect segments of the population, particularly those who are poor and socially isolated, such as elderly and homeless persons. People living in settings where access to food may be strictly limited, such as nursing homes or correctional facilities, could also be at risk for under-nutrition.

Behavioral Risk Factor Surveillance Survey and the Youth Risk Behavior Survey may serve as potential sources of data concerning body mass index and exercise.

There are many nutritional deficiencies that we could measure, all of which have health implications that impact us more intensely at different times of our lives. Some of them are: fat intake (increased heart disease and cancer risk), sodium intake (increased blood pressure and risk for pregnant women), calcium deficiency (children and teens, pregnant women, and post menopausal/osteoporosis), iron deficiency (children and pregnant women, anemia). Risk is highest for these negative health outcomes among the poor. However, Americans’ eating habits are such that everyone must be vigilant. It is the guidelines to sound nutrition and good eating on which we will concentrate.
The 2000 Dietary Guidelines for Americans recommends that, to stay healthy, persons aged two years and older should follow these ABCs for good health: Aim for fitness, Build a healthy base, and Choose sensibly.

- **Aim for fitness**, aim for a healthy weight, and be physically active each day.

- **Build a healthy base**, let the Pyramid guide food choices; choose a variety of grains daily, especially whole grains; choose a variety of fruits and vegetables daily; and keep food safe to eat.

- **Choose sensibly**, choose a diet that is low in saturated fat and cholesterol and moderate in total fat; choose beverages and foods to moderate intake of sugars; choose and prepare foods with less salt; and, if consuming alcoholic beverages, do so in moderation.


The Dietary Guidelines for Americans also emphasizes the need for adequate consumption of iron-rich and calcium-rich foods. Some progress has been made since the 1970s in reducing the prevalence of iron deficiency among low-income children, (Yip, R. “The changing characteristics of childhood iron nutritional status in the United States.” In: Filer, Jr., L.J., ed. Dietary Iron: Birth to Two Years. New York, NY: Raven Press, Ltd., 1989, 37–61), but much more is needed to improve the health of children of all ages and of women who are pregnant or are of childbearing age. Since the start of this decade, consumption of calcium-rich foods, such as milk products, has generally decreased and is especially low among teenaged girls and young women (NCHS. Healthy People 2000 Review, 1998–99. DHHS Pub. No. (PHS) 99-1256. Hyattsville, MD: Public Health Service (PHS), 1997). In recent years there has been a concerted effort to increase the folic acid intake of females of childbearing age through fortification and other means to reduce the risk of neural tube defects (HHS. “Recommendations for the use of folic acid to reduce the number of cases of spina bifida and other neural tube defects.” Morbidity and Mortality Weekly Report 41:1–7, 1992).

Away-from-home food tends to have a higher saturated fat content, and persons tend to consume more calories when eating away from home than at home (Lin, B.H.; Guthrie, J.; and Frazao, E. Nutrient contribution of food away from home. In: Frazao, E., ed. America’s “Eating Habits: Changes and Consequences.” Washington, DC: USDA, ERS, AIB-750, 1999). The proportion of all meals and snacks from away-from-home sources increased by more than two-thirds between 1977–78 and 1995, from 16 percent of all meals and snacks in 1977–78 to 27 percent of all meals and snacks in 1995. In 1995, the average total fat and saturated fat content of away-from-home foods (a percentage of calories) was 38 percent and 13 percent, respectively, compared with 32 percent and 11 percent for at-home foods.


- A similar increase in overweight and obesity also has been observed in children above age 6 years in both genders and in all population groups (Troiano, R.P., and Flegal, K.M. “Overweight Children and Adolescents: Description, Epidemiology, and Demographics.” Pediatrics 101:497–504, 1998).

Americans are gaining weight with age, and often do not become overweight until adulthood. But losing our girlish or boyish figure is not simply a cosmetic issue. There are serious consequences associated with the growing epidemic of overweight Americans. As we get older, our bodies tend to burn fewer calories due to a slowing of the metabolism. We also lose muscle mass, which requires increased physical activity and exercise to a moderate fitness level. Because excess weight is usually the result of a diet high in fat and calories and deficient in healthy foods like fruits and vegetables, we are more at risk for diseases affected by diet. Carrying excess weight can also cause undue stress on internal organs, such as the heart, and in a vicious cycle can keep us from being physically active. This is bad news for the 61 percent of American adults considered overweight or obese (Doheny, Kathleen. “Baby Boomers Need Help Beating the Bulge.” *Health Scout*. Aug 4, 2002. http://healthscout.com/template.asp?page=newsdetail&ap=1&id=507835 [Oct. 10, 2002]). Adults over 40 years old are particularly susceptible to being overweight or obese. According to the National Center for Health Statistics, weight problems peak between the ages of 45 and 64. (Doheny, Kathleen. “Baby Boomers Need Help Beating the Bulge.” *Health Scout*. Aug 4, 2002. http://healthscout.com/template.asp?page=newsdetail&ap=1&id=507835 [Oct. 10, 2002]).

Although younger adults have fewer weight problems, a longitudinal study indicates that those who are even mildly overweight at 20 or 21 are more likely to become obese by 36. In fact, the researchers were able to develop a statistical model to predict obesity using BMI, gender, and ethnicity (Melville, Nancy. “Obesity Sets in Between 20 and 35 for Many.” *Health Scout*. Aug 18, 2002. http://healthscout.com/template.asp?page=newsdetail&ap=43&id=507563 [October 10, 2002]). While this does not suggest we have a weight destiny that cannot be altered, it does suggest that unhealthy lifestyle patterns may leave early clues before completely manifesting themselves later in life. Early intervention of those at risk for obesity should be a top priority of both the individual and their health care provider.


## 19-2 Reduce the proportion of adults who are obese.

**Target-setting method:** Better than the best  
**Data source:** National Health and Nutrition Examination Survey (NHANES), CDC, NCHS  
**Target:** 15 percent  
**Baseline:** 23 percent of adults aged 20 years and older were identified as obese (defined as a BMI of 30 or more) in 1988–1994 (age adjusted to the year 2000 standard population).
Simple and health-oriented definitions of overweight and obesity should be based on the amount of excess body fat at which health risks to individuals begin to increase. No such definitions currently exist. Most current clinical studies assessing the health effects of overweight rely on BMI. While the relation of BMI to body fat differs by age and gender, it provides valid comparisons across racial and ethnic groups (Gallagher, D.; Visser, M.; Sepulveda, D.; et al. “How useful is body mass index for comparison of body fatness across age, sex, and ethnic groups?” American Journal of Epidemiology 143(3):228–239, 1996). However, BMI does not provide information concerning body fat distribution, which has been identified as an independent predictor of health risk (NIH. “Clinical guideline on the identification, 

<table>
<thead>
<tr>
<th>Adults Aged 20 Years and older, 1988–94 (unless noted)</th>
<th>Obese Both Genders</th>
<th>Females</th>
<th>Males</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>23</td>
<td>25</td>
<td>20</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Race and ethnicity</th>
<th>DSU</th>
<th>DSU</th>
<th>DSU</th>
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</thead>
<tbody>
<tr>
<td>American Indian or Alaska Native</td>
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<tr>
<td>Asian or Pacific Islander</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Native Hawaiian and other Pacific Islander</td>
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<tr>
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<td>White</td>
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<td>24</td>
<td>21</td>
</tr>
<tr>
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<td>DSU</td>
<td>DSU</td>
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</tr>
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</tr>
<tr>
<td>Black or African American</td>
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<td>38</td>
<td>21</td>
</tr>
<tr>
<td>White</td>
<td>22</td>
<td>23</td>
<td>20</td>
</tr>
</tbody>
</table>

| Age 20 to 39 years                                      | 18  | 21  | 15  |
| 40 to 59 years                                          | 28  | 30  | 25  |
| 60 years and older                                      | 24  | 26  | 21  |

<table>
<thead>
<tr>
<th>Family income level†</th>
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<tr>
<td>Higher income (&gt;130 percent of poverty threshold)</td>
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<thead>
<tr>
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<td>Persons with disabilities</td>
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<td>21</td>
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<td>33</td>
<td>27</td>
</tr>
<tr>
<td>Persons without arthritis</td>
<td>21</td>
<td>23</td>
<td>19</td>
</tr>
<tr>
<td>Persons with diabetes</td>
<td>41</td>
<td>DNA</td>
<td>DNA</td>
</tr>
<tr>
<td>Persons without diabetes</td>
<td>22</td>
<td>DNA</td>
<td>DNA</td>
</tr>
<tr>
<td>Persons with high blood pressure</td>
<td>38</td>
<td>47</td>
<td>33</td>
</tr>
<tr>
<td>Persons without high blood pressure</td>
<td>18</td>
<td>20</td>
<td>16</td>
</tr>
</tbody>
</table>

DNA=Data have not been analyzed. DNC=Data are not collected.
DSU=Data are statistically unreliable. Note: Age adjusted to the year 2000 standard population.
*Data for females and males are displayed to further characterize the issue. †A household income below 130 percent of poverty threshold is used by the Food Stamp Program.
evaluation and treatment of overweight and obesity in adults—The evidence report.”


The epidemic of overweight and obesity is not limited to adults. Although the percentage of overweight and obese children and adolescents is lower than the percentage of adults, the situation is no less dangerous. The condition of our youth will profoundly affect the health of our nation as they grow older. A healthy diet is important throughout life, but especially important for children and adolescents. As we tend to carry the same eating patterns throughout life, parents should establish good habits for their children early. Unfortunately, if parents follow a poor diet themselves, they make it nearly impossible for their children to eat well. Even children who eat poorly but are not overweight, are at risk for being overweight as an adult and also developing diseases associated with a high-fat, high-caloric diet.

Because childhood and adolescence is a time of growth, it is important that strategies incorporate physical activity and a properly balanced diet. A recent study done by the University of Minnesota, suggests children of middle-school age need repeated reminders, classroom intervention, and access to healthy food in order to change eating habits (Health Scout. “Shaping Up Kids’ Eating Habits.” Aug 7, 2002. http://healthscout.com/template.asp?page=newsdetail&ap=43&id=508319 [Oct. 10, 2002]). School, following closely behind family, remains an important influence on children’s eating habits.

Because puberty occurs at different ages, and has different effects on girls and boys, measures of body fat and weight are much more difficult to interpret for children and adolescents. Teenaged boys lose some fat accumulated before puberty during adolescence, but fat deposition continues in girls. Thus, without measures of sexual maturity, measures of body fat and body weight are difficult to interpret in children and adolescents. Therefore, the goal is to reduce overweight and obese children by 5 percent. Healthy People 2010 uses gender- and age-specific 95th percentile of BMI from CDC Prevention Growth Charts for overweight and obese designations.

19-3 Reduce the proportion of children and adolescents who are overweight or obese.

Target-setting method: Better than the best
Data source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS
Target: 5 percent
Baseline: 11 percent of children and adolescents aged 6-19 years were overweight or obese from 1988 to 1994.

Obese children also may experience psychological stress. Research is needed to better define the prevalence and health consequences of overweight and obesity in children and adolescents, as well as the implications of such findings for these persons as they become adults.

Improving the quality of students’ diet at school is important because, for many children, meals and snacks eaten at school make a major contribution to their total daily intake of food and nutrients. National food consumption data collected in 1994 and 1995 show that school foods had the highest saturated fat density of all food outlets (Lin, B.H.; Guthrie, J.; and Frazao, E. “Nutrient Contribution of Food Away From Home.” In: Frazao, E., ed. America’s Eating Habits: Changes and Consequences. Washington, DC: USDA, ERS, AIB-750, 1999).
School foods also had higher than recommended levels of sodium—as did other away-from-home foods and at-home foods. Nonetheless, these analyses also showed positive aspects of foods obtained from school. School foods had the highest calcium density of all sources and the highest dietary fiber density of all away-from-home sources.

**Disparities**

Biology, environment, and culture can all influence weight. Consequently, disparities in body mass indexes exist between different gender, age, ethnic, racial, and income groups. Overweight and obesity are observed in all population groups, but obesity is particularly common among Hispanic, African American, Native American, and Pacific Islander women.

Despite concerns about the increase in overweight and certain excesses in U.S. diets, segments of the population also suffer from under-nutrition, including persons who are socially isolated and poor. Over the years, the recognition of the consequences of food insecurity (limited access to safe, nutritious food) has led to the development of national measures and surveys as to accessibility to fresh food, hunger, and the ability to assess disparities. Data also are insufficient to target the fastest-growing segment of the population, old and very old persons who live independently.

A concerted public effort will be needed to prevent further increases of overweight and obesity. Health care providers, health plans, and managed care organizations need to be alert to the development of overweight and obesity in their clients and should provide information concerning the health risks. These groups need to provide guidance to help consumers address this health problem. Work site programs can reach employees with information, activities, and services that encourage healthy dietary and physical activity behaviors (PHS. “Worksites Nutrition: A Guide to Planning, Implementation, and Evaluation.” 2nd ed. Washington, DC: American Dietetic Association (ADA) and Office of Disease Prevention and Health Promotion, PHS, HHS, 1993). Health care professionals, as well as those training to be primary care physicians need more training related to diet, nutrition and exercise. Preventive counseling related to diet and nutrition, must be reimbursable for consumers and physicians. Overweight persons will need long-term lifestyle changes in dietary and physical activity patterns that they can easily incorporate into their lives if they are to lose weight and keep it off.
Employer-sponsored programs can be offered on site or in partnership with community organizations.

A recent study of worksite health promotion programs found that specific interventions at the work site resulted in employees choosing to reduce the amount of fat calories they consumed and eating more fruits, vegetables, and dietary fiber. (Sorensen, G.; Stoddard, A.; Hunt, M.K.; et al. “The effects of a health promotion-health protection intervention on behavior change: The WellWorks Study.” American Journal of Public Health 88(11):1685–1690, 1998.)


Primary care providers can screen for age-specific and diagnosis-related nutrition risk factors as a part of routine patient contact.

Dietary assessment, counseling, and follow-up by physicians and qualified nutrition professionals are effective in reducing patient dietary fat intake and serum cholesterol and have been found to be cost-effective for patients with type 2 diabetes.

Nutrition services also are a critical component of improved health outcomes for many other diseases and conditions, including obesity, gastrointestinal and hepatic disease, renal disease, cancer, HIV/AIDS, pressure ulcers, burns and trauma, eating disorders, and prenatal care.

Health care providers and CBOs should develop specific campaigns targeting female, African-American and Hispanic populations.


### Proportion of Overweight Children and Adolescents*
(by age for selected years, United States, 1963–94)

<table>
<thead>
<tr>
<th>Percent</th>
<th>Aged 6 to 11 years</th>
<th>Aged 12 to 17 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHES II (1963–65)</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>NHES III (1969–70)</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>NHANES I (1971–74)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NHANES II (1976–80)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NHANES III (1988–94)</td>
<td>12</td>
<td>12</td>
</tr>
</tbody>
</table>

*Overweight is defined as at or above the gender–and age-specific 95th percentile of body mass index (BMI) based on preliminary analysis of data from the revised CDC Growth Charts for the United States.

Local Assets

- American Cancer Society
  (717) 397-3744 Patient Services
- American Heart Association
  (717) 393-0725
- Area Agency on Aging
  (717) 299-7979
- Ephrata Wellness Center
  (717) 464-5476
- Lancaster Regional Medical Center
  Diabetes Educator
  (717) 291-8194
- Lancaster General Hospital
  Education and Wellness Center (717) 290-3138
  Nutrition Services and Weight Management (717) 290-5923
- Parish Resource Center
  (717) 299-1113
- Samaritan Counseling Center
  (717) 560-9969
- South Central Regional Activity Network
  (717) 290-3202
- United Way LINC
  (717) 291-LINC

Other Resources

- State Health Department
  (717) 299-7597
- President’s Council on Physical Fitness and Sports
  (202) 690-9000
  http://www.fitness.gov

What You Can Do

- Examples of possible worksite health promotion programs include weight management classes, physical activity programs, lunchtime seminars, self-help programs, cooking demonstrations and classes, healthy food service and vending machine selections, point-of-purchase nutrition information, and flexible health benefits that include nutrition-related services.
- Study the health care costs reduction, including employer costs for insurance programs, disability benefits, and medical expenses that can be attributed to worksite health promotion success.
- Have employees get involved in developing a comprehensive health promotion program in the workplace.
- In addition, employers could reimburse health promotion activities and provide company time for employees to participate in the programs.
- Make some worksite programs available to the family members of employees and company retirees as well as current employees.
- Programs should be offered in a culturally and linguistically competent manner and any educational materials provided should be culturally and linguistically appropriate.
- Develop, along with public education efforts, public programs in a variety of settings (recreation centers, work sites, health care settings, and schools) that address the importance of healthy eating.
- Develop a campaign that links poor levels of physical activity and bad diet to poor health and quality of life standards.
- Give employees healthy, affordable choices in food vending machines.
- Offer healthy cooking classes to support healthy eating campaigns.
- Programs addressing the body image for young women should provide instruction and experiences that increase their confidence and develop acceptance based on health and fitness.
- As purchasers of group health and life insurance plans, employers can design employee benefit packages that include coverage for nutritional counseling and fitness classes.
- Employers can offer reduced insurance premiums and rebates for employees and their families who participate regularly in work site fitness programs or who can document increased fitness.
- School boards can examine food vending contracts to maximize nutritional choices for students and staff.

Individual
- Keep a food diary and assess your eating habits against the ABCs for good health: Aim for fitness, Build a healthy base, and Choose sensibly.
- Don’t wait until the last minute to think about eating. Plan your meals and your family’s meals with the ABC’s in mind.
- Have you children help plan meals with you and help shop for the foods they have chosen.
- Buy fresh produce whenever possible, and eat it while it is fresh.
- Plant a vegetable garden.
- Become a role model for your own family—choose treats wisely.
- Lobby school boards and legislatures to develop a well-designed health education curriculum that includes developing the knowledge, attitudes, behavioral skills, and confidence needed to adopt and maintain a physically sound body and active lifestyle.
- Work with PTOs to develop an educational campaign linking nutrition to cognitive development and academic achievement.
- Send healthy treats to school for your kids, especially on special occasions.
- Contact your doctor before starting any diet program that requires a move away from the recommended food groups.
Remaining Questions

- What is the role of insurance companies in promoting sound nutrition and a healthy lifestyle?
- How do we encourage medical schools to teach more about nutrition and prevention strategies?
- How do we lobby the government for better food labeling?
- How is local farmland important to our community’s food security? What role do the farmer’s markets play in maintaining Lancaster’s food security?
- How do we reclaim the institution of the evening family meal?
- Is there a way to make fast foods healthier?
- How do we get more restaurants to offer healthier options on their menus?
- Can we stop schools from having our children sell candy and get them to switch to fruit baskets?
- Is there a more effective way to collect data that we can compare with other regions, the state, and the country?

HP 2010 Objectives

Weight Status and Growth
- Healthy weight in adults
- Obesity in adults
- Overweight or obesity in children and adolescents
- Growth retardation in children

Food and Nutrient Consumption
- Fruit intake
- Vegetable intake
- Grain product intake
- Saturated fat intake
- Total fat intake
- Sodium intake
- Calcium intake

Iron Deficiency and Anemia
- Iron deficiency in young children and in females of childbearing age
- Anemia in low-income pregnant females
- Iron deficiency in pregnant females

Schools, Work Sites, and Nutrition Counseling
- Meals and snacks at school
- Work site promotion of nutrition education and weight management
- Nutrition counseling for medical conditions

Food Security
- Food security

Access to Quality Health Services
- Counseling about health behaviors

Arthritis, Osteoporosis, and Chronic Back Conditions
- Cases of osteoporosis
Cancer
   3-1 Overall cancer deaths
   3-3 Breast cancer deaths
   3-5 Colorectal cancer deaths
   3-10 Provider counseling about cancer prevention

Chronic Kidney Disease
   4-3 Counseling for chronic kidney failure care

Diabetes
   5-1 Diabetes education
   5-2 New cases of diabetes
   5-6 Diabetes-related deaths

Educational and Community-Based Programs
   7-2 School health education
   7-5 Work site health promotion programs
   7-6 Participation in employer-sponsored health promotion activities
   7-10 Community health promotion programs
   7-11 Culturally appropriate and linguistically competent community health promotion programs

Food Safety
   10-4 Food allergy deaths
   10-5 Consumer food safety practices

Health Communication
   11-4 Quality of Internet health information sources

Heart Disease and Stroke
   12-1 Coronary heart disease (CHD) deaths
   12-7 Stroke deaths
   12-9 High blood pressure
   12-11 Action to help control blood pressure
   12-13 Mean total blood cholesterol levels
   12-14 High blood cholesterol levels

Maternal, Infant, and Child Health
   16-10 Low birth weight and very low birth weight
   16-12 Weight gain during pregnancy
   16-15 Spina bifida and other neural tube defects
   16-16 Optimum folic acid levels
   16-17 Prenatal substance exposure
   16-18 Fetal alcohol syndrome
   16-19 Breastfeeding

Mental Health and Mental Disorders
   18-5 Eating disorder relapses

Physical Activity and Fitness
   22-1 No leisure-time physical activity
   22-2 Moderate physical activity
   22-3 Vigorous physical activity
   22-6 Moderate physical activity in adolescents
   22-7 Vigorous physical activity in adolescents
   22-9 Daily physical education in schools
   22-13 Work site physical activity and fitness

Substance Abuse
   26-12 Average annual alcohol consumption
Physical Activity

Promote regular physical activity
### HP 2010 Measures and Local Measures

<table>
<thead>
<tr>
<th>22-2</th>
<th>Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes per day.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Target-setting method:</strong> Better than the best</td>
</tr>
<tr>
<td></td>
<td><strong>Target:</strong> 30 percent</td>
</tr>
<tr>
<td></td>
<td><strong>Baseline:</strong> 15 percent of adults aged 18 years and older engaged in moderate physical activity for at least 30 minutes five or more days per week in 1997 (age adjusted to the year 2000 standard population).</td>
</tr>
<tr>
<td></td>
<td><strong>Data source:</strong> National Health Interview Survey (NHIS), CDC, NCHS, BRFSS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>22-7</th>
<th>Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardio respiratory fitness three or more days per week for 20 or more minutes per occasion.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Target-setting method:</strong> Better than the best</td>
</tr>
<tr>
<td></td>
<td><strong>Target:</strong> 85 percent</td>
</tr>
<tr>
<td></td>
<td><strong>Baseline:</strong> 65 percent of students in grades 9 through 12 engaged in vigorous physical activity three or more days per week for 20 or more minutes per occasion in 1999.</td>
</tr>
<tr>
<td></td>
<td><strong>Data source:</strong> Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPH, BRFSSPP</td>
</tr>
</tbody>
</table>
Regular and sustained physical activity, whether vigorous or moderate, has documented beneficial effects on cardiovascular functioning, the prevention of osteoporosis, the effects of osteoarthritis, diabetes management, and on mental health conditions such as depression and stress management. Physical activity is also an important element of weight control (being overweight is an additional risk factor for many diseases and conditions). Regular physical activity is associated with lower death rates for adults of any age, even when only moderate levels of physical activity are performed.

This indicator addresses physical activity across the age spectrum. Children who acquire the habit of engaging in regular physical activity tend to maintain the habit throughout their lives. At the same time, a regular program of physical activity has some of its most beneficial effects on conditions faced by older persons. Specific recommendations on the best levels of activity have changed over-time but the idea is to move away from a sedentary life and become more physically active on a regular basis. The Youth Risk Behavior Survey and the Behavioral Risk Factor Surveillance Survey might both be useful in measuring the status of this indicator.

The 1990s brought an historic new perspective to exercise, fitness, and physical activity by shifting the focus from intensive vigorous exercise to a broader range of health-enhancing physical activities. Research has demonstrated that virtually all individuals will benefit from regular physical activity.

A Surgeon General’s report on physical activity and health concluded that moderate physical activity can reduce substantially the risk of developing or dying from heart disease, diabetes, colon cancer, and high blood pressure. Physical activity also may protect against lower back pain and some forms of cancer (e.g., breast cancer), but the evidence is not yet conclusive. Regular exercise has been linked to better mental health, and older citizens who engage in regular physical activity are more mentally alert and independent and report a higher quality of life. On average, physically active people outlive those who are inactive. (U.S. Department of Health and Human Services. Physical Activity and Health: A Report of the Surgeon General. Atlanta, GA: Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion, 1996.)

Physical activity plays a significant role in preventing coronary heart disease (CHD), which is the leading cause of death and disability in the United States. Although vigorous physical activity is recommended for improved cardiorespiratory fitness, moderate physical activity also can have significant health benefits, including a decreased risk of CHD. For people who are inactive, even small increases in physical activity are associated with measurable health benefits.

An important but not widely known fact is that the risk posed by physical inactivity is almost as high as cigarette smoking, high blood pressure, and high blood cholesterol. But inactivity is much more prevalent than any of those factors. Physically inactive people are almost twice as likely to develop CHD as persons who engage in regular physical activity. (Kaplan, G.A.; Strawbridge, W.J.; Cohen, R.D.; et al. “Natural history of leisure-time physical activity and its correlates: Associations with mortality from all causes and cardiovascular disease over 28 years.” American Journal of Epidemiology 144(8): 793–797,1996.)

Regular physical activity is especially important for people who have joint or bone problems and has been shown to improve muscle function, cardiovascular function, and physical performance. However, people with arthritis (20 percent of the adult population) are less active than those without arthritis. People with osteoporosis, a chronic condition affecting more than 25 million people in the United States, may respond positively to regular physical activity, particularly weight-bearing activities, such as walking, and especially when combined with appropriate drug therapy and calcium intake. Increased bone mineral density has been positively associated with aerobic fitness, body composition, and muscular strength.
A Plan for Creating a Healthy Lancaster Community—2010

Addendum I: A Plan for Creating a Healthy Lancaster Community

Few people are physically active on a regular basis despite its documented benefits. Only about 23 percent of adults in the United States report regular, vigorous physical activity that involves large muscle groups in dynamic movement for 20 minutes or longer three or more days per week. Only 15 percent of adults report physical activity for five or more days per week for 30 minutes or longer, and another 40 percent do not participate in any regular physical activity.

**22-2 Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes per day.**

<table>
<thead>
<tr>
<th>Adults Aged 18 Years and Older, 1997</th>
<th>20 Minutes of Activity 3 or More Days per Week*</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>15</td>
</tr>
<tr>
<td>Race and ethnicity</td>
<td></td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>13</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>15</td>
</tr>
<tr>
<td>Asian</td>
<td>15</td>
</tr>
<tr>
<td>Native Hawaiian and other Pacific Islander</td>
<td>11</td>
</tr>
<tr>
<td>Black or African American</td>
<td>10</td>
</tr>
<tr>
<td>White</td>
<td>15</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>11</td>
</tr>
<tr>
<td>Not Hispanic or Latino</td>
<td>15</td>
</tr>
<tr>
<td>Black or African American</td>
<td>10</td>
</tr>
<tr>
<td>White</td>
<td>15</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>13</td>
</tr>
<tr>
<td>Male</td>
<td>16</td>
</tr>
<tr>
<td>Education level (aged 25 years and older)</td>
<td></td>
</tr>
<tr>
<td>Less than 9th grade</td>
<td>7</td>
</tr>
<tr>
<td>Grades 9 through 11</td>
<td>11</td>
</tr>
<tr>
<td>High school graduate</td>
<td>14</td>
</tr>
<tr>
<td>Some college or AA degree</td>
<td>17</td>
</tr>
<tr>
<td>College graduate or above</td>
<td>17</td>
</tr>
<tr>
<td>Geographic location</td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>15</td>
</tr>
<tr>
<td>Rural</td>
<td>15</td>
</tr>
<tr>
<td>Disability status</td>
<td></td>
</tr>
<tr>
<td>Persons with disabilities</td>
<td>12</td>
</tr>
<tr>
<td>Persons without disabilities</td>
<td>16</td>
</tr>
<tr>
<td>Select populations</td>
<td></td>
</tr>
<tr>
<td>Age groups 18 to 24 years</td>
<td>17</td>
</tr>
<tr>
<td>25 to 44 years</td>
<td>15</td>
</tr>
<tr>
<td>45 to 64 years</td>
<td>14</td>
</tr>
<tr>
<td>65 to 74 years</td>
<td>16</td>
</tr>
<tr>
<td>75 years and older</td>
<td>12</td>
</tr>
<tr>
<td>Persons with arthritis symptoms</td>
<td>15</td>
</tr>
<tr>
<td>Persons without arthritis symptoms</td>
<td>15</td>
</tr>
</tbody>
</table>

DNA=Data have not been analyzed. DNC=Data are not collected. DSU=Data are statistically unreliable. Note: Age adjusted to the year 2000 standard population. *Data for 20 minutes of activity 3 or more days per week are displayed to further characterize the issue.

Engaging in moderate physical activity for at least 30 minutes per day will help ensure that sufficient calories are used to provide health benefits. A minimum level of intensity (e.g., a brisk walk for 30 minutes per day) would, for most persons, result in an energy expenditure of about 600 to 1,100 calories per week. If calorie intake remains constant, this expenditure translates into a weight loss of roughly one-sixth to one-third pound per week. Increases in daily activity to ensure a weekly expenditure of 1,000 calories would have significant individual and public health benefit for CHD prevention and deaths from all causes, especially for persons who are sedentary. Furthermore, this level of activity is feasible for most people even though the relative intensity of any activity will vary by age. Starting out slowly and gradually increasing the frequency and duration of physical activity is the key to successful behavior change (HP 2010).
Light to moderate activity is defined as 30 minutes per session five or more times per week. Vigorous activity is defined as that which promotes the development and maintenance of cardiorespiratory fitness 20 or more minutes per session three or more times per week (e.g., aerobics).

Locally, in 2002, we will complete a BRFSS survey that will collect this local data. For now, we can look at the Lancaster Community Indicator Project's August 2000 Quality of Life Survey for physical activity data. Unfortunately it is not collected in the same way, making it difficult to compare to the state's data. In this survey, respondents were asked to choose the statement which best described their habits regarding physical exercise from the following statements:

- I currently follow a regular exercise routine which includes vigorous physical activity at least three times per week for 20 minutes or more each session.
- I currently follow a regular exercise routine which includes light physical activity at least three times per week for 20 minutes or more each session.
- I exercise sometimes, but I don't follow a regular routine.
- I don't exercise.

Additionally, the Pennsylvania BRFSS collected data about what types of physical activity people took part in. You will find a table showing the percentage of adults who reported taking part in these different types of physical activities in 1996, 1998, and 2000. These will also be collected on the upcoming BRFSS of Lancaster County along with workplace activity.

Nationally, over 75 percent of all trips less than one mile were made by automobile in 1995. In addition, the number of walking trips as a percentage of all trips taken (of any distance) has declined over the years. Walking trips made by adults dropped from 9.3 percent in 1977 to 7.2 percent in 1990 and again to 5.4 percent in 1995. Walking has declined even more sharply for children. Bicycling is another form of transportation that may be used by both children and adults for distances that may not be feasible, practical, or efficient to cover by walking.
But the environment must provide safe opportunities for physical activities such as walking and bicycling. Sedentary activities such as watching television, playing video games, and using personal computers have contributed to increases in the number of people who are overweight. (Anderson, R.E.; Crespo, C.J.; Bartlett, S.J.; et al. “Relationship of physical activity and television watching with body weight and level of fatness among children: Results from the Third National Health and Nutrition Examination Survey.” Journal of the American Medical Association 279:938–942, 1998.)

Disparities in levels of physical activity exist among population groups.

- Women generally are less active than men at all ages.
- People with lower incomes and less education are typically not as physically active as those with higher incomes and education. African Americans and Hispanics are generally less physically active than whites. Adults in northeastern and southern states tend to be less active than adults in north-central and western states.
- People with disabilities are less physically active than people without disabilities.
- By age 75, one in three men and one in two women engage in no regular physical activity.
- Participation in all types of physical activity declines strikingly as age or grade in school increases.

Regular physical activity is important throughout life. Good habits are best started early. Parents, educators, and health care providers are role models and should be involved in encouraging physical activity and fitness in children and adolescents, and in providing opportunities for them. One study found that one-quarter of U.S. children spend four hours or more watching television daily (Anderson, R.E.; Crespo, C.J.; Bartlett, S.J.; et al. “Relationship of physical activity and television watching with body weight and level of fatness among children: Results from the Third National Health and Nutrition Examination Survey.” Journal of the American Medical Association 279:938–942, 1998). A lifestyle that includes regular activity and activity that is adopted early in life may continue into adulthood. Studies found that among children aged 3 to 4 years, those who were less active tended to remain less active after age 3 years than most of their peers (Pate, R.R.; Baranowski, T.; Dowda, M.; et al. “Tracking of physical activity in young children.” Medicine and Science in Sports and Exercise 28(1):92–96, 1996).

Many children are less physically active than recommended, and physical activity declines during adolescence. In 1999, 65 percent of adolescents engaged in the recommended amount of physical activity. Data demonstrate that major decreases in vigorous physical activity occur during grades 9 through 12.

**22-7 Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardiorespiratory fitness three or more days per week for 20 or more minutes per occasion.**

Target: 85 percent.
Baseline: 65 percent of students in grades 9 through 12 engaged in vigorous physical activity three or more days per week for 20 or more minutes per occasion in 1999.

Target-setting method: Better than the best
Data source: Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP
This decrease in physical activity is more profound for girls than for boys, whether the measure is engaging in vigorous physical activity in general or in team sports. Adolescents' interest and participation in physical activity differ by gender. Compared to boys, girls are less likely to participate in team sports but more likely to participate in aerobics or dance. Often girls and boys perceive different benefits from physical activity, with boys viewing such activity as competition and girls as weight management (President's Council on Physical Fitness and Sports. Physical Activity & Sport in the Lives of Girls. Washington, DC: The President's Council on Physical Fitness and Sports, 1997).

Currently, the state of Pennsylvania is in the process of accepting new Academic Standards for Health, Safety, and Physical Education proposed by the PA Department of Education. These standards are for all grade levels. The proposed standards will help students to:

- Identify physical activities and participate in them.
- Understand a variety of effects and benefits of regular participation in such activities.
- Understand and monitor their body's response to activity, and what factors may affect their body's responses.
- Identify and understand what may influence their preference for certain types of activities throughout their lives.
- Understand how physical activities improve motor skills, and how the degree of improvement and personal differences affect selection in physical activities.
- Understand team or group dynamics and how group interaction can have positive or negative effects on one's choices to participate.

Additionally, as the students move into higher grades, the importance of lifelong physical activity is stressed, and the student is allowed to choose their own activity plan geared towards reaching personal fitness and activity goals while promoting lifelong participation.

There is no requirement for how often students must engage in such activities, or for how long. This is left to the discretion of the schools or districts. While objective 22-7 stresses the importance of vigorous activity for 20 or more minutes three times per week, students may not be participating that often. As we age, HP 2010 urges us to take part in physical activity five times or more per week. If we are not setting the example when they are young, when will we? Or should the difference in weekly activity be encouraged by the parents in order to better promote lifelong fitness? With the growing number of overweight and obese children, adolescents, and adults, it is clear that both parental and school influences are needed.

Findings suggest that the quantity and, in particular, the quality of school physical education programs have a significant positive effect on the health-related fitness of children and adolescents by increasing their participation in moderate to vigorous activities. Studies have shown that spending 50 percent of physical education class time on physical activity is an ambitious but feasible target. (Sallis, J.F.; McKenzie, T.L.; Alcaraz, J.E.; et al. "The effects of a 2-year physical education program (SPARK) on physical activity and fitness in elementary school students." American Journal of Public Health 87(8):1328-1334, 1997.)
Best Researched Practices

- Good quality school physical education ensures a minimum amount of physical activity and provides a forum to teach physical activity strategies and activities that can be continued into adulthood. Being active for at least half of physical education class time on at least half of the school days would provide a substantial portion of the physical activity time recommended for adolescents. (Sallis, J.F., and Patrick, K. “Physical activity guidelines for adolescents: Consensus statement.” Pediatric Exercise Science 6:302–314, 1994.)

- Health education and other courses can teach that physical activity is an important component of a healthy life. Instruction on physical activity also can be integrated into the lesson plans of other school subjects, such as mathematics, biology, and language arts. Programs that have included classroom instruction in physical activity have been effective in enhancing students’ physical activity-related knowledge.

- Daily adaptive physical education programs should be available for children with special needs.

- School physical education requirements are recommended for students in preschool and postsecondary programs (CDC. “Guidelines for school and community programs to promote lifelong physical activity among young people.” Morbidity and Mortality Weekly Report 46(RR-6):1–36, 1997).

- The President’s Council on Physical Fitness and Sports concluded that because boys are more likely than girls to have higher self-esteem and greater physical strength, programs addressing the needs of girls should provide instruction and experiences that increase their confidence and their opportunities to participate in activities, as well as social environments that support involvement in a range of physical activities.

- Public education efforts need to address the specific barriers that inhibit the adoption and maintenance of physical activity by different population groups. Older adults, for example, need information about safe walking routes. Persons with foot problems need to learn about proper foot care and footwear in order to reach appropriate activity levels. People with CHD and other chronic conditions must understand the importance of regular physical activity to maintain physical function.

- Encouraging any type or amount of physical activity in leisure time can provide important health benefits compared to a sedentary lifestyle. Activities that promote strength and flexibility are important because they may protect against disability, enhance functional independence, and encourage regular physical activity participation. These benefits are particularly important for older people—a good quality of life means being functionally independent and being able to perform the activities of daily living.

- The message that a sedentary lifestyle plays a role in both overweight and weight loss needs to be addressed more effectively, as does the role primary care providers can play in counseling individuals to increase their daily activities.

- Data to evaluate access and availability of community fitness facilities is not available.
Local Assets

American Cancer Society
Patient Services (717) 397-3744

American Heart Association
(717) 393-0725

Area Agency on Aging
(717) 299-7979

Ephrata Area Recreation Center
(717) 738-1167

Ephrata Wellness Center
(717) 464-5476

Hempfield Recreation Commission
(717) 898-3102

Lampeter-Strasburg Recreation Commission
(717) 687-9916

Lancaster General Hospital
Nutrition and Weight Management Services (717) 290-5923
Education and Wellness Center (717) 290-3138
"Over 50 & Fit" (717) 290-3140

Lancaster Recreation Commission
(717) 392-2115

Lancaster Regional Medical Center
Diabetes Educator
(717) 291-8194

Lititz Community Center
(717) 626-5096

Manheim Central Recreation Commission
(717) 664-7506

Manheim Township Parks and Recreation Dept.
(717) 397-4769

Office of Aging
(717) 299-7979

Parish Resource Center
(717) 299-1113

Samaritan Counseling Center
(717) 560-9969

Solanco Area Senior Center
(717) 786-4770

United Way LINC
(717) 291-LINC

YMCA
(717) 397-7474

YWCA
(717) 393-1735
What You Can Do

- Develop, along with public education efforts, public programs in a variety of settings (recreation centers, work sites, health care settings, and schools) need to be developed, evaluated, and shared as potential models. The availability of group activities in the community is important for many.

- Primary care providers must increase their counseling of patients about the need to participate in physical activity.

- Ensure that facilities are accessible to people with disabilities.

- Increasing work site fitness programs.

- Campaign must be expanded on the message that even some activity is better than none.

- Take the time to develop a process (public and private) of evaluating programs’ access and quality. The availability of group activities for disabled in the community is important, as are transportation barriers.

- Health care providers and CBOs should develop specific campaigns targeting women, African-American and Hispanic populations (no leisure-time physical activity is higher among women than men, higher among African Americans and Hispanics than whites).

- Programs addressing the needs of girls should provide instruction and experiences that increase their confidence and their opportunities to participate in activities, as well as social environments that support involvement in a range of physical activities.

- A campaign to increase physical activity in the work force should be developed that is community-wide in scope and emphasizes community fitness and health. Track and field (individual sports) should be encouraged as well as team sports (basketball, softball, and volleyball leagues).

- Quantity and quality of school physical education programs must be evaluated with 50 percent of physical education class time on physical activity.

- Provide materials and education to primary care providers so that they can more easily talk about the need to participate in physical activity with their patients as an important way to change their behavior and improve their health status.

- Continue increasing work site fitness programs.

- As purchasers of group health and life insurance plans, employers can design employee benefit packages that include coverage for fitness club membership fees and community-based fitness classes.

- Employers can offer reduced insurance premiums and rebates for employees who participate regularly in work site fitness programs or who can document participation in regular physical activity.

- School boards can make school facilities more available for physical activity programs for the community and particularly for students.
Individual
- Begin to journal your physical activity and take it seriously as a health risk assessment.
- Recognize that starting out slowly with an activity that is enjoyable and gradually increasing the frequency and duration of the activity is central to the adoption and maintenance of physical activity behavior.
- Join a community effort to support community planning that supports pedestrian and bicycle safety.
- Lobby school boards and legislatures to develop a well-designed health education curriculum that can help students develop the knowledge, attitudes, behavioral skills, and confidence needed to adopt and maintain physically active lifestyles.
- Work with the PTOs to develop an educational campaign highlighting the need for parents and educators to become role models.
- Join a campaign to reinvigorate the Presidential Fitness Awards for students and that promotes of physical activity and fitness in children and adolescents.
- Get off the couch today and start some kind of physical activity.
- Volunteer to coach or referee for a sports team.
- Work with schools and community coalitions and community-based physical activity programs to take maximum advantage of school facilities for the benefit of children and adolescents and the community as a whole.

How can we make physical activity a priority for our policy-makers, employers, and schools?
- How can we change the medical community's focus from a disease model to a preventative model?
- What is the role of insurance companies in promoting physical activities and a healthy lifestyle?
- Is there an effective way to persuade developers to plan for active communities by providing safe roads, trails, and open spaces in their plans? Or must this responsibility fall upon policy-makers to legislate?
- How do we overcome the safety concerns of individuals when it is posed as a barrier to physical activity?
- What are effective strategies to educate people of all ages about finding physical activities to participate in throughout their lives and to help them understand the benefits of such physical activity?
- Once they understand the benefits and importance of physical activity, how can we better motivate people to begin?
- How can we overcome the media images that promise quick fixes in place of real physical activity and positive lifestyle changes?
- What are some ways to get the whole family involved in physical activity to improve the health of adults while showing children the importance of exercise through example?
- What are some other effective ways for parents to teach our children the importance of lifelong fitness without always using a sports team model?
- Is there a more effective way to collect data that we can compare with other regions, the state, and the country?
Physical Activity in Adults
22-1 No leisure-time physical activity
22-2 Moderate physical activity
22-3 Vigorous physical activity

Muscular Strength/Endurance and Flexibility
22-4 Muscular strength and endurance
22-5 Flexibility

Physical Activity in Children and Adolescents
22-6 Moderate physical activity in adolescents
22-7 Vigorous physical activity in adolescents
22-8 Physical education requirement in schools
22-9 Daily physical education in schools
22-10 Physical activity in physical education class
22-11 Television viewing

Access
22-12 School physical activity facilities
22-13 Work site physical activity and fitness
22-14 Community walking
22-15 Community bicycling

Access to Quality Health Services
1-2 Health insurance coverage for clinical preventive services
1-3 Counseling about health behaviors

Arthritis, Osteoporosis, and Chronic Back Conditions
2-2 Activity limitations due to arthritis
2-3 Personal care limitations
2-8 Arthritis education
2-9 Cases of osteoporosis
2-11 Activity limitations due to chronic back conditions

Cancer
3-5 Colorectal cancer deaths
3-7 Prostate cancer deaths
3-9 Sun exposure and skin cancer
3-10 Provider counseling about cancer prevention

Chronic Kidney Disease
4-8 Medical therapy for persons with diabetes and proteinuria

Diabetes
5-1 Diabetes education
5-2 New cases of diabetes
5-3 Overall cases of diagnosed diabetes
5-4 Diagnosis of diabetes
5-5 Diabetes deaths
5-6 Diabetes-related deaths
5-7 Cardiovascular disease deaths in persons with diabetes

Disability and Secondary Conditions
6-2 Feelings and depression among children with disabilities
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<th>Nutrition and Overweight</th>
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<td>8-2 Alternative modes of transportation</td>
<td>19-2 Obesity in adults</td>
</tr>
<tr>
<td>8-9 Beach closings</td>
<td>19-3 Overweight or obesity in children and adolescents</td>
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<td>8-20 School policies to protect against environmental hazards</td>
<td>19-16 Work site promotion of nutrition education and weight management</td>
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<td>20-1 Work-related injury deaths</td>
</tr>
</tbody>
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<td>23-2 Public access to information and surveillance data</td>
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<td>11-4 Quality of Internet health information sources</td>
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</tr>
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<td></td>
</tr>
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</tr>
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</tr>
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<thead>
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<th>Maternal, Infant, and Child Health</th>
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</tr>
</thead>
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<td>26-9 Substance-free youth</td>
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</tr>
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</tr>
</thead>
<tbody>
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<td>17-2 Linked, automated information systems</td>
<td>27-1 Adult tobacco use</td>
</tr>
<tr>
<td>17-3 Provider review of medications taken by patients</td>
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</tr>
<tr>
<td>17-5 Receipt of oral counseling about medications from prescribers and dispensers</td>
<td>27-3 Initiation of tobacco use</td>
</tr>
<tr>
<td></td>
<td>27-4 Age at first tobacco use</td>
</tr>
</tbody>
</table>

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<tr>
<th>Mental Health and Mental Disorders</th>
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<td>18-5 Eating disorder relapses</td>
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<td>18-7 Treatment for children with mental health problems</td>
<td></td>
</tr>
<tr>
<td>18-9 Treatment for adults with mental disorders</td>
<td></td>
</tr>
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Responsible Sexual Behavior

Promote sexually responsible behavior
Teen Pregnancy

Goal: Better than the best

Sexually Transmitted Diseases and HIV/AIDS

Goal: Better than the best

HP 2010 Measures

<table>
<thead>
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<th>Measure</th>
<th>Description</th>
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<tbody>
<tr>
<td>9-7</td>
<td>Reduce pregnancies among adolescent females.</td>
</tr>
</tbody>
</table>

Target-setting methods: Better than the best
Data sources: Abortion Provider Survey, The Alan Guttmacher Institute; National Vital Statistics System (NVSS), CDC, NCHS; National Survey of Family Growth (NSFG), CDC, NCHS; Abortion Surveillance Data, CDC, NCCDPHP; Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.

Local Measures

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Target-setting method: Better than the best
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HP 2010 Measures

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<td>13-1</td>
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</tr>
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<td>13-5</td>
<td>Reduce the number of cases of HIV infection among adolescents and adults (developmental).</td>
</tr>
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<td>13-14</td>
<td>Reduce deaths from HIV infection.</td>
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Target-setting methods: Better than the best
Data sources: HIV/AIDS Surveillance System, CDC NCHSTP; National Survey of Family Growth (NSFG), CDC, NCHS; National Vital Statistics System, CDC, NCHS; National Survey of Family Growth, (NSFG), CDC, NCHS; Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.

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In the United States, sex and sexuality pervade almost every aspect of our culture. We seem to be fascinated by sexual matters and, while we see sexuality as a normal part of human functioning, paradoxically we are secretive and extremely private about our sexual behaviors. Talking openly and comfortably about sex is extremely difficult. Yet, we accept the marketing of almost any product in the most overtly sexual manner. In a 1995 study, The ABC's of STDs, it stated that one-fourth of women and one-fifth of men had no knowledge of their partner's sexual history. This is an extremely dangerous practice given current rates of STDs and HIV Infection.

The Institute of Medicine stated in its 1997 study “The Hidden Epidemic: Confronting Sexually Transmitted Diseases,” “The secrecy surrounding sexuality impedes sexuality education programs for adolescents, open discussion between parents and their children and between sex partners, balanced messages from mass media, education and counseling activities of health professionals, and community activism regarding STDs.”

This statement is also true of our ability to deal with pregnancy and family planning. We will address adolescent sexual behavior specifically because they are at higher risk for STDs (including HIV infection) and unintended pregnancy. They experience a disproportionate share of STDs and unintended pregnancies when they engage in sex. Additionally, the younger that a person becomes sexually active the more likely one is to have multiple partners and the less one is likely to have protected sex. The consequences of an unintended pregnancy are compounded for a teen mother.
We will target the AIDS epidemic, as it is the most devastating of sexually transmitted diseases to individuals, families, and communities. Adolescents are also among the fastest-growing population infected with AIDS. Other STDs are highly prevalent within the affected population. Furthermore, risk behaviors, such as drug and alcohol abuse, compound and enhance the problems.

The national goal is to achieve 70% planned and wanted pregnancies. Currently 50% of all pregnancies in the U.S. are unintentional. The consequences of unintended pregnancies impact everyone regardless of age and marital status. Risks and costs are social and economic in the form of reduced educational attainment and employment opportunity, greater welfare dependency, and even potential child abuse and neglect. Furthermore, medical risks increase due to lost opportunity to prepare for an optimal pregnancy, increased risk of child and maternal illness, and the likelihood of abortion.

With an unintended pregnancy, a mother is less likely to seek prenatal care in the first trimester and may not seek care at all. She is less likely to breastfeed and more likely to use tobacco, drugs, or alcohol during her pregnancy. Such a child is at greater risk of having a lower birth weight, dying in the first year, being abused, and not receiving sufficient resources for healthy development. (Brown, S.S., and Eisenberg, L., eds. The Best Intention: Unintended Pregnancy and the Well-Being of Children and Families. Washington, DC: National Academy Press, 1995).

Induced abortion is another consequence of unintended pregnancy. Although the number of abortions has been declining over the past 15 years, reducing unintended pregnancies will continue to drive that number down. Each year, publicly subsidized family planning services prevent an estimated 1.3 million unintended pregnancies (Family Planning Perspectives 29(1):6–14, 1997).

Reducing unintended pregnancies is possible. Unintended pregnancy rates in the United States have been declining. The rates remain highest among teenagers, women aged 40 years or older, and poor and African American women. More than 4 in 10 pregnancies to white and Hispanic females are unintended; 7 in 10 pregnancies to African American females are unintended. Unintended pregnancies during contraceptive use are highest among Hispanics and African Americans. And this highly correlates to poverty due to the difficulty of poor women in obtaining and using the more effective contraceptives and gaining access to adequate family planning services.

Approximately 1 million teenage girls each year in the United States have unintended pregnancies. The cost to U.S. taxpayers for adolescent pregnancy is estimated at between $7 billion and $15 billion a year (Healthy People 2010).

It is important to note who is having babies in Lancaster County so that we can put this issue in perspective. We have very high birth rates. The majority of babies are not born to teens. Nor are they born to single mothers. The majority of babies born in Lancaster County are being born to wed mothers. We have lower teen birth rates than our peer counties, the state, and the nation. Pregnancy and birth rates for Lancaster County are higher than...
those for the state as a whole and for most of the surrounding counties. Clearly, we do have many more women having babies overall in Lancaster County, and fewer of them are born to females younger than 18 than in other places.

The overall rate of induced abortion for the county is approximately 9%, with much higher rates in the teen populations. The induced abortion rate is considerably lower than the state (19%) and each peer county. This low rate may reflect the lower rates of pregnancy in Lancaster County’s teen residents, but it is believed that our culture and values deter abortion. No abortion services are available in Lancaster County. There may also exist a perceived unavailability of fiscal resources. Despite the low level of induced abortion, at least 10% of the county’s pregnancies are deemed unwanted, which again is lower than nationwide (50%). Improved contraceptive or sexual abstinence programs may reduce this number even further as well as spur treatment for sexually transmitted diseases.

Nonetheless, the issues surrounding teen pregnancy and child mothers are so serious that Lancaster must continue to target teen pregnancy and teen birth rates as a priority. Additionally, this issue is one that affects the poor and ethnic/racial minority populations with even greater impact. Teen pregnancy encompasses issues that go beyond a debate on the appropriateness or morality of teens engaging in risky sexual activity. Few believe that such activity is a smart choice. The real dilemma for us as a community comes when we try to deal with the realities of life for the ill-equipped mother and her child or children.

We know that the community is unable socially and financially to support the majority of young parents attempting to deal with the challenges of teen parenting when they are themselves almost children. We know this because statistics show that teen mothers are still more highly at risk for domestic violence, substance abuse, poverty related to underemployment, homelessness, and poor health care coverage. Only one-third of teen mothers receive a high school diploma. Her children are more likely to be born with birth defects or at low birth weight. Children are less likely to be immunized or, like their mother, to complete high school. Her children are at a higher risk of being abused or neglected, and of being victims of violence and crime. They are also more likely to become substance abusers, to get in trouble with the law, and finally to become teen parents themselves.

The teenage pregnancy rate in the United States is much higher than in many other developed countries—twice as high as in England and Wales, France, and Canada and nine times as high as in the Netherlands or Japan. (The Alan Guttmacher Institute. Sex and America’s Teenagers. New York, NY: the Institute, 1994.) According to the US Department of Health and Human Services, about 80 percent of the children born to unmarried teenagers who dropped out of high school are poor. In contrast, just 8 percent of children born to married high school graduates aged 20 or older are poor.

Finally, all of these issues point to the wear and tear on social and medical systems attempting to deal with a single family with multiple issues. But, most importantly, they are measures of the human suffering and wasted potential of youth in our communities.
9-7 Reduce pregnancies among adolescent females.

Target: 43 pregnancies per 1,000.
Target-setting method: Better than the best

The rates given are the number of pregnancies among females aged 15 to 17 years old divided by the number of adolescent females aged 15 to 17 years. They are presented as pregnancies per 1000 population.

<table>
<thead>
<tr>
<th>15 to 17 years old</th>
<th>National</th>
<th>State</th>
<th>Lancaster</th>
<th>Neighbors</th>
<th>Peers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>68</td>
<td>34.9</td>
<td>26.9</td>
<td>30.6</td>
<td>33.9</td>
</tr>
<tr>
<td>1999</td>
<td>30.0</td>
<td>24.1</td>
<td>278</td>
<td>31.4</td>
<td></td>
</tr>
</tbody>
</table>

Teen pregnancy rates are lower than the national, state and most reference county rates and the HP 2010 objective target. We did not have local ethnic and racial numbers available for pregnancy.

However, we know that most adolescent childbearing occurs outside marriage, a trend that has increased markedly during the past two decades. In 1997, 78 percent of births to adolescent females (under age 20 years) were out of wedlock, compared to 44 percent two decades earlier (1977). (Ventura, S.J.; Martin, J.A.; Curtin, S.C.; et al. “Births: Final data for 1997.” National Vital Statistics Reports 47(18), 1999.) The following data is not for pregnancies but for births, and it includes 18 and 19 year olds. It does show a significant local issue of disparity that mirrors national trends. Of all births to Hispanic and African American women of Lancaster County, almost one-third were to unmarried women under 20 years of age.

This birth rate information indicates that within the black and Hispanic communities, there is a significant pregnancy issue in women under 20. We can assume that the pregnancy rates would be higher than the birth rate for this same group. And if we applied the HP 2010 target (43 pregnancies per 1000), we can conclude that these two groups need prevention services, education, counseling, and support.

9-8 Increase the proportion of adolescents who have never engaged in sexual intercourse.

Target-setting method: Better than the best
Data sources: Females—National Survey of Family Growth (NSFG), CDC, NCHS; Males—National Survey of Adolescent Males (NSAM), Urban Institute

This data is unavailable locally.

- In 1999, 85 percent of adolescents abstained from sexual intercourse or used condoms if they were sexually active.
- This 85 percent includes 50 percent of students in grades 9–12 who were not ever sexually active, 14 percent who were not sexually active in the past three months, and 21 percent who were sexually active but used a condom at the last intercourse.
- Data on males aged 15–19 years will be collected in 2003.

Sources: Centers for Disease Control and Prevention.

The two major health consequences to unprotected sex are STDs including HIV infection and pregnancy. Abstinence is the MOST effective way to avoid both. Condoms cannot prevent all STDs but they should always be used in conjunction with hormonal birth control methods if teens choose to have sex. Hormonal birth control methods cannot prevent STDs or HIV infection. This is as important with the first intercourse as with the last.

<table>
<thead>
<tr>
<th>Never Engaged in Sexual Intercourse</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adolescents Aged 15 to 17</strong></td>
</tr>
<tr>
<td><strong>Females 9-9a</strong></td>
</tr>
<tr>
<td>Total</td>
</tr>
<tr>
<td>Selected Race and Ethnicity</td>
</tr>
<tr>
<td>Black or African American</td>
</tr>
<tr>
<td>White</td>
</tr>
<tr>
<td>Hispanic</td>
</tr>
<tr>
<td>Not Hispanic or Latino</td>
</tr>
<tr>
<td>Black or African American</td>
</tr>
<tr>
<td>White</td>
</tr>
</tbody>
</table>

9-11.1 Increase the proportion of young adults who have received formal instruction before turning age 18 years on reproductive health issues, including all of the following topics: birth control methods, safer sex to prevent HIV, prevention of sexually transmitted diseases, and abstinence.

Target: 90 percent.
Baseline: 64 percent of females aged 18 to 24 years reported having received formal instruction on all of these reproductive health issues before turning age 18 years in 1995. (Data on males will be available in the future.)
Target-setting method: Better than the best

Local experts agreed with the concept, but the age target was viewed as naïve. Young people receive misinformation and exposure to the sexual messages of the media throughout their lives. Many students are experimenting by age 12, and data shows that almost 20% of young people engage in intercourse before age 15.

Adolescents need to receive reproductive health education long before they begin having sex. Ideally this should be age appropriate and should involve parents, educators, the media, and our churches. But simple biology is not enough. Adolescents need strong reinforcement from parents, schools, media, community, church, and other sources in order to make conscious, informed, and responsible decisions. They need coaching to resist media, cultural, and peer pressure, and this information must be culturally and linguistically appropriate to the students. They need to learn about and experience healthy relationships and accept that caring and affection can be demonstrated in many ways.

Community and involved parents help to emphasize the bigger picture and consequences of their choices. Society must be more open to talking about sexuality with our children. They are exposed to frequent sexual messages in the media. Therefore, good education, understanding, and communication with parents are critical to balancing the picture that is being painted by the world around them.

<table>
<thead>
<tr>
<th>Adolescents Aged 15 to 19 Years, 1995</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No Intercourse Before Age 15 Years</strong></td>
</tr>
<tr>
<td><strong>9-8a Females</strong></td>
</tr>
<tr>
<td>Percent</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
</tr>
<tr>
<td><strong>Race and ethnicity</strong></td>
</tr>
<tr>
<td>Black or African American</td>
</tr>
<tr>
<td>White</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
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<tr>
<td>Not Hispanic or Latino</td>
</tr>
<tr>
<td>Black of African American</td>
</tr>
<tr>
<td>White</td>
</tr>
</tbody>
</table>

Data sources: Females—National Survey of Family Growth (NSFG), CDC, NCHS; Males—National Survey of Adolescent Males (NSAM), Urban Institute
The 10% improvement stated in the Healthy People 2010 goal may be unrealistic. Teens locally are neither abstaining nor using condoms. A very vocal and politically active segment of our local community does not support teaching these young people about the use of condoms and other safety issues about the choice to be sexually active. They have affected the ability of our local school districts or local organizations to disseminate this information to teens. This puts education squarely in the parents' hands. Research tells us that teaching abstinence as well as the use of condoms must be permitted and practiced. This should be done in concert with working toward enriching and deepening positive experiences in the lives of the community’s young through social programs, recreation, and career-building opportunities.

The difficulty with some teens is that having babies as an unmarried teen is acceptable. Their parents were teens when they were born and they see it as the norm. Teen women born into poverty or economically challenged homes often receive no medical care or special attention of any kind until they become pregnant. After pregnancy, medical care is offered and the girls become less invisible to their families. Their personal worth seems enhanced to them. They may have teen friends who already have children. Many young women are engaged in relationships with older men. Families may see the older men as more stable, often a false assumption. Many young women do not see themselves with any other kind of future and have few assets in their lives to shepherd them in a different direction. They are sometimes failing in school or are not supported by their families to pursue an education.

For teens, giving birth to a second child while still a teen further increases risks to her and her children. Preventing second and third births is critical during teen years. Research has shown that such births are associated with physical and mental health problems for the mother and the child (Klerman, L. “A Paper for Program on Preventing Second Births to Teenage Mothers: Demonstration Findings,” sponsored by the American Enterprise Institute for Public Policy Research, March 6, 1998).
✓ Abstinence: Abstinence and personal responsibility must be primary messages of prevention programs.

✓ Clear Strategies for the Future: Young people must be given clear connections and pathways to college or jobs that give them hope and a reason to stay in school and avoid pregnancy.

✓ Community Involvement: Public and private sector partners throughout communities, including parents, schools, business, media, health and human services providers, and religious organizations, must work together to develop comprehensive strategies.

✓ Sustained Commitment: Real success requires a sustained commitment to the young person over a long period of time.

- Remove obstacles, for county teens, to contraceptive treatment centers.
- Authorize the local school districts to provide contraceptive education in areas where it has previously been disallowed by public mandate.
- Churches must more adequately address sexuality and pregnancy before marriage.
- Churches need to go to teens, or draw in teens, to influence their spiritual development.
- Financial coverage for contraceptives must be found.
- The Assets program or Mentoring programs must grow.
- More community health centers/clinics with an ob/gyn available need to be located in high-risk areas.
- Laws should be changed to encourage single moms to marry, (i.e., remove financial penalty—loss of Medical Assistance).
- Provide more parenting programs for teens to break the cycle and prevent a second birth.
- Prosecute statutory rape.
- Provide more culturally competent services and prevention programs.
- Increase awareness of services among teens, as they are the most common referral source among friends—information cards and posters in restrooms.
- Increase pregnancy prevention programs utilizing teen parents as speakers.
- Provide services within walking distance or located on bus routes.
- Provide timely service and reduced waiting time for teens looking for services.
- Introduce Peter Benson, Ph.D.—Search Institute based programs: 40 developmental assets with outcome-based data. Having these assets within your community decreases the rates of teen pregnancy.
- Introduce Washington State Model: Provides free birth control for teen moms for one or two years to reduce repeat pregnancies.
Sexually transmitted diseases (STDs), including infection with the human immuno-deficiency virus (HIV) that causes AIDS, can result from unprotected sexual behaviors. They are common, costly, and preventable. Sexually transmitted diseases refer to the more than 25 infectious organisms transmitted primarily through sexual activity. Abstinence is the only method for complete protection. Condoms, if used correctly and consistently, can help prevent both unintended pregnancy and STDs.


Women generally suffer more serious STD complications than men, including pelvic inflammatory disease, ectopic pregnancy, infertility, chronic pelvic pain, and cervical cancer from the human papilloma virus. (Cates, W. “Epidemiology and control of sexually transmitted diseases in adolescents.” In: Schydlower, M., and Shafer, M., eds. AIDS and Other Sexually Transmitted Diseases. Philadelphia, PA: Hanly & Belfus, Inc., 1990, 409–427.) African Americans and Hispanics have higher rates of STDs than whites. The total cost of the most common STDs and their complications is conservatively estimated at $17 billion annually.

Despite the burdens, costs, complications, and preventable nature of STDs, they remain a significant public health problem, largely unrecognized by the public, policy-makers, and public health and health care professionals in the United States. STDs cause many harmful, often irreversible, and costly clinical complications, such as reproductive health problems, fetal and perinatal health problems, and cancer. In addition, studies of the worldwide human immunodeficiency virus (HIV) pandemic link other STDs to a causal chain of events in the sexual transmission of HIV infection.

There are biological and social factors that sustain STD and HIV/AIDS transmission in the United States. Any effective strategy must address them.

Biological factors. STDs are behavior-linked diseases that result from unprotected sex. Several biological factors contribute to their rapid spread.

- **Asymptomatic nature of STDs.** The majority of STDs either do not produce any symptoms or signs, or they produce symptoms that are so mild that they aren’t attended to. Often, a long interval—sometimes years—occurs between acquiring an STD and recognizing a health problem. For example, as many as 85 percent of women and up to 50 percent of men with chlamydia have no symptoms. A person infected with HIV may be asymptomatic and may give the disease to another person. That person may, in turn, be infected for years but be unaware until symptoms manifest themselves and transmit it to yet others. As a result, people frequently do not see a connection between the original point of contact and the resulting health problem and symptoms (Stamm, W., and Homes, K. Sexually Transmitted Diseases. 2nd ed. New York, NY: McGraw-Hill, Inc, 1990, 181–193).

- **Gender and age.** STDs are more difficult to diagnose in women due to the physiology and anatomy of the female reproductive tract. This combination of increased susceptibility and “silent” infection frequently can result in women being unaware of an STD, which results in delayed diagnosis and treatment. Women are at higher risk than men for most STDs, and young women are more susceptible to certain STDs than are older women. The higher risk is partly because the cervix of adolescent females is covered with cells that are especially susceptible to STDs, such as chlamydia. For a variety of behavioral, social, and biological reasons, STDs also disproportionately affect adolescents and young adults (Alan Guttmacher Institute. Sex and America’s Teenagers. New York, NY: the Institute, 1994).
Social and behavioral factors. The spread of STDs is directly affected by social and behavioral factors. Preventive measures sometimes fly in the face of social norms regarding sex and sexuality.

- **Poverty and marginalization.** STDs disproportionately affect persons who are in groups where high-risk sexual behavior is common and where access to care or even seeking out health professionals is compromised. Examples include sex workers (people who exchange sex for money, drugs, or goods), teens, runaways, persons in detention, and migrant workers. Without publicly supported STD services, many people lack access to STD care and consequently compromise everyone's health. Studies show that comprehensive screening of incarcerated populations can be done successfully and safely within the criminal justice system. Most STDs respond to treatment.

- **Access to health care.** Access to high-quality health care is essential for early detection, treatment, and behavior-change counseling, but groups with the highest rates of STDs often have limited access to health services. This limitation relates to:
  - ✔ Lacking access to publicly supported STD clinics (present in only 50 percent of U.S. public health jurisdictions).
  - ✔ Having no health care coverage.
  - ✔ Having coverage that imposes a copayment or deductible.
  - ✔ Having coverage that excludes the basic preventive health services that help avert STDs or their complications.

- **Sexual coercion.** Sexual violence against women contributes both directly and indirectly to STD transmission. Additionally, many young women do not enter sexual relationships as willing partners. Sexual coercion is a major problem for significant numbers of young women in the United States. Directly, women experiencing sexual violence are less able to protect themselves from STDs or pregnancy. Indirectly, research demonstrates that women with a history of forced sexual intercourse are more likely to have voluntary intercourse at earlier ages—a known risk factor for STDs—than women who are not sexually abused. In 1995, 16 percent of females whose first sexual intercourse took place when they were aged 15 years or under reported that it was not voluntary (Abma, J.; Driscoll, A; and Moore, W.; Family Planning Perspectives 30(1):12–18, 1998). This aspect of adolescent sexual behavior demands increased national and local attention, both for social justice and for health reasons.

- **Sexual secrecy.** Secrecy is perhaps the most important social factor contributing to the spread of STDs in the United States. This factor most significantly separates the United States from those industrialized countries with low rates of STDs.
Media The entertainment industry, particularly television, bombards us with sexual themes. But very little informed, high-quality STD prevention advice or discussion exists regarding contraception, sexuality, or the risks of early, unprotected sexual behavior. Popular television programs depict as many as 25 instances of sexual behaviors for every one instance of protected behavior or discussion about STDs or pregnancy prevention. Media companies can play an important part in reshaping sexual behaviors and norms in the United States in the next decade.

In 1995, STDs were the most common reportable diseases in the United States (CDC). They accounted for 87% of the top 10 infections most frequently reported to the CDC from State health departments. Each year an estimated 15 million new STD infections occur in the U.S., and nearly 4 million are teenagers. The direct and indirect costs of the major STDs (chlamydia, gonorrhea, AIDS, syphilis, and hepatitis B) are conservatively estimated at $17 billion annually. STD rates exceed those in all other countries of the industrialized world.

In 1997, females aged 15 to 19 years had the highest reported rates of both chlamydia and gonorrhea among women; males aged 20 to 24 years had the highest reported rates of both chlamydia and gonorrhea among men. (CDC, Division of STD Prevention. Sexually Transmitted Disease Surveillance, 1997. U.S. Department of Health and Human Services (HHS), Public Health Service (PHS). Atlanta, GA: CDC, September 1998.) Encouraging data is emerging from a new and expanding chlamydia prevention program, suggesting that chlamydia screening is reducing disease burden and preventing complications.

Chlamydial infections and gonorrhea that ascend past the cervix into the upper reproductive tract result in pelvic inflammatory disease (PID), among the most serious threats to female reproductive capability. More than 1 million women have an episode of PID annually. (Washington, A.E., and Katz, P. “Cost and payment source for pelvic inflammatory disease.” Trends and projections, 1983 through 2000. Journal of the American Medical Association 266:2565–2569, 1991.) PID often results in scarring and either complete or partial blockage of the fallopian tubes. As a result, as many as one-quarter of women with acute PID experience serious long-term sequelae, most often an ectopic pregnancy or tubal factor infertility. In 1992, approximately 9 percent of all pregnancy-related deaths were caused by ectopic pregnancy.

Because so many people are already infected, and millions more are infected annually, viral STDs present special challenges for prevention and control. One of the most serious health problems associated with STDs is sexually acquired HIV infection that is helped along by the presence of an inflammatory or ulcerative STD in one or both sex partners.

- A nationally representative study showed that genital herpes infection is very common in the United States (Fleming, D.T.; McQuillin, R.E.; et al. {Herpes Simplex Virus Type 2 in the United States, 1976 to 1994." New England Journal of Medicine 337:1105–1111, 1997).
Nationwide, 45 million persons aged 12 years and older, or one out of five of the total adolescent and adult population, are infected with herpes simplex virus type 2.

As many as 20 million persons in the United States already are infected with strains of the human papillomavirus, and an estimated 5.5 million new infections occur annually.

Description

In 1981, a new infectious disease, AIDS, or acquired immunodeficiency syndrome, was identified in the United States. (Centers for Disease Control. “Kaposi’s sarcoma and pneumocystis pneumonia among homosexual men—New York City and California.” Morbidity and Mortality Weekly Report 30(25):305–308, 1981.) Several years later, the causative agent of AIDS—human immunodeficiency virus (HIV)—was discovered. Individuals may carry and transmit the HIV virus and not be symptomatic (AIDS). This discovery coincided with the growing recognition of AIDS in the United States as part of a global infectious disease pandemic.

HIV/AIDS has been reported in almost every racial and ethnic population, every age group, and every socioeconomic group in every state and most large cities in the United States. In fact, there is growing concern over the increase in HIV/AIDS in the senior population due to unprotected sex. The AIDS epidemic is composed of diverse multiple sub epidemics that vary by region and community. By the end of 1998, more than 680,000 cases of AIDS had been reported, and nearly 410,800 people had died from HIV disease or AIDS (CDC).

The lifetime costs of health care associated with HIV, in light of recent advances in diagnostics and therapeutics, have grown from $55,000 to $155,000 or more per person (Sweeney, P.A.; Fleming, P.L.; Karon, J.M.; et al. “A Minimum estimate of the number of living HIV-infected persons confidentially tested in the United States” (Abstract 1-16). Presented at the Interscience Conference on Antimicrobial Agents and Chemotherapy in Toronto, Canada, September 1997). These costs mean that HIV prevention efforts may be even more cost-effective, and even cost-saving, to society. Prevention efforts include availability of culturally and linguistically appropriate HIV counseling and testing, partner counseling, and referral systems for individuals at high risk for HIV infection; and needle and syringe exchange programs; and information, education, treatment, and counseling for injection drug users.

The true extent of the epidemic remains difficult to assess for several reasons, including the following:

- Because of the long period of time from initial HIV infection to AIDS and because Highly Active Antiretroviral Therapy (HAART) has slowed the progression to AIDS, new cases of AIDS no longer provide accurate information about the current HIV epidemic in the United States.

- Lack of awareness by individuals of their HIV status as well as delays in accessing counseling, testing, and care services may result in no care for the HIV-infected persons until late in the course of their infection.

- Estimates of the number of people infected with HIV in the United States range from 800,000 to 900,000. AIDS is mandated to be a reportable disease. But because of the stigma associated with this illness, required reporting of HIV status has not been
universally accepted or mandated at either federal or state levels. Recently introduced therapies for HIV/AIDS have reduced illness, disability, and death due to HIV/AIDS; however, access to culturally and linguistically appropriate testing and care may limit progress in this area.

13-1 Reduce AIDS among adolescents and adults.

Target: 1.0 new case per 100,000 persons
Baseline: 19.5 cases of AIDS per 100,000 persons aged 13 years and older in 1998.
Data are estimated and adjusted for delays in reporting.
Target-setting method: Better than the best
Data source: HIV/AIDS Surveillance System, CDC, NCHSTP

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Source: PA Dept of Health Web site

The national baseline from 1998 is 19.5, which we are well below, although we are still considerably higher than the goal of 1.0 new cases per 100,000 people.

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<th>National Persons Aged 13 Years and Older, 1998</th>
<th>New AIDS Cases</th>
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<td>Rate per 100,000</td>
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<td>Total</td>
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<td>Hispanic or Latino</td>
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<td>Black or African American</td>
<td>82.9</td>
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<td>White</td>
<td>8.5</td>
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</table>

Data source: HIV/AIDS Surveillance System, CDC, NCHSTP.

13-14 Reduce deaths from HIV infection.

Target: 0.7 deaths per 100,000 persons
Baseline: 4.9 deaths from HIV infection per 100,000 persons in 1998 (age adjusted to the year 2000 population)
Target-setting method: Better than the best
Data source: National Vital Statistics System, CDC, NCHS
Local experts and those who work in the field do not believe that AIDS deaths are a good indicator for the following reasons.

- On death certificate, families commonly do not write the cause of death as being HIV related for fear of stigma or revealing the loved one's status for insurance claims.

- Individuals who are HIV positive may die from other causes, such as injury, car accidents, or other illnesses that may not be attributable to HIV disease, and, therefore, these deaths would not be reflected in the HRSA statistics.

- It was also noted that AIDS mortality is not an accurate indicator for a community, as it does not reflect the incidence of HIV infection.

According to PA Department of Health Data in 1999, there were seven HIV deaths among Lancaster residents aged 25–44. Of those seven, three were white, four were black, and one was of Hispanic origin. Over a five-year period (1995–1999) there were 64 HIV deaths among those 25–44 in Lancaster, 48 whites and 16 blacks; 23 were of Hispanic origin. The numbers during that time period dramatically declined. For example in 1995, there were 10 Hispanic HIV deaths in this age group, 9 in 1996, 1 in 1997, 2 in 1998, and 1 in 1999.
In the United States, HIV/AIDS remains a significant cause of illness, disability, and death, despite declines in 1996 and 1997. The incidence of HIV/AIDS varies not only by region and community but also may vary by population, risk behavior, and geography. Elimination of disparities in the rate of infection among certain racial and ethnic groups, particularly African American and Hispanic populations, remains a challenge.

The proportion of different population groups affected by HIV/AIDS has changed over time. By 1998, 83 percent of the cumulative AIDS cases had occurred in males, 16 percent in females, and 1 percent in children. Response to the epidemic reflects these changes:

Comparing the 1980s to the 1990s, the proportion of AIDS cases in white men who have sex with men declined, whereas the proportion in females and males in other racial and ethnic populations increased, particularly among African Americans and Hispanics. AIDS cases also appeared to be increasing among injection drug users and their sexual partners.

Increases among women have occurred over time. By the mid-1980s, the majority of AIDS cases had been reported among males, with only 7 percent reported among females in 1983. (CDC. “Current trends update: Acquired immunodeficiency syndrome (AIDS)—United States.” Morbidity and Mortality Weekly Report 32(52):688–691, 1984.) Reported AIDS cases in females have increased steadily since then and have accounted for nearly 23 percent of the cases reported in 1998. Young heterosexual women, especially minority women, are increasingly acquiring HIV infection and developing AIDS. In 1998, 41 percent of reported AIDS cases in persons aged 13 to 24 years occurred in young women, and more than four of every five AIDS cases reported in women occurred in certain racial and ethnic groups (mostly African American or Hispanic).

In 1996, for the first time, African Americans accounted for a larger proportion of AIDS cases than whites and this trend has continued.

In the United States, African Americans and Hispanics have been affected disproportionately by HIV and AIDS, compared to other racial and ethnic groups.

Although 55 percent of the reported AIDS cases occurred among African Americans and Hispanics, these two population groups represent an estimated 13 percent and 12 percent, respectively, of the total U.S. population. (Centers for Disease Control and Prevention (CDC). HIV/AIDS Surveillance Report 10(2), 1998.)


The AIDS case rate among African Americans in calendar year 1998 was 66.4 per 100,000 persons, or eight times the rate for whites (8.2 per 100,000), and over twice the rate for Hispanics (28.1 per 100,000). (Centers for Disease Control and Prevention (CDC). HIV/AIDS Surveillance Report 10(2), 1998.)

Among women with AIDS, African Americans and Hispanics have been especially affected, accounting for nearly 77 percent of cumulative cases reported among women by 1998. Of the 109,311 AIDS cases in women reported through December 1998, 61,874 cases occurred in African American women and 21,937 occurred in Hispanic women.

This disproportionate impact of HIV/AIDS on African Americans and Hispanics highlights the importance of sustained and culturally effective prevention efforts for these racial and ethnic populations. As important as being mindful of the multiracial and multicultural nature of society are other social and economic factors—such as poverty, underemployment, and poor access to the health care system.
The community needs:

- More integration between HIV and STD services, especially in agencies which provide HIV outreach education and among adolescents.
- More funding to be directed towards HIV/AIDS outreach education and testing.
- More bilingual persons fluent in both Spanish and English to deal with all STDs and HIV/AIDS.
- More attention to transmission issues directly related to drug and alcohol abuse.
- More detailed and accurate statistical gathering procedures: Although, it may be beneficial to look at AIDS mortality, the common concern is addressing the issues of those individuals living with the virus. A more appropriate assessment of those individuals may be achieved through a variety of methods, which include:
  - Requesting data from HIV/AIDS providers that serve Lancaster County. Agencies are required by their funding sources to keep accurate data on client's served, and this data would portray a better picture on not only reported AIDS cases, but also numbers on persons living with HIV. One of the recognized limitations of this form of data retrieval would be that clients may utilize more than one agency; however, it would still be useful in getting a “ball park figure.” Another limitation of this would be counting the population of infected individuals who do not access services.
  - Requesting current HIV/AIDS data from the PA Department of Health’s Division of Vital Statistics. If and when HIV will become a reportable disease, it was agreed that this would provide more accurate information regarding incidence.
  - Current testing and counseling data and surveying private providers. This data would be helpful in determining the effectiveness of prevention and outreach efforts on targeted and at-risk populations. This data could be attained through the Division of HIV/AIDS but presents some limitations as well, as it would be data collected only from publicly funded sites. It would not include tests given through private physicians and would represent only about one third of all tests done.
  - Accurate demographic data. Aside from actual numbers of HIV infection, in order to have a better understanding of the impact of the disease, all demographic data needs to be presented, i.e., age, race, mode of transmission, income, insurance status, family make up, and gender.

- An entire population of individuals in the community is HIV positive and chooses NOT to access care or services. This may be attributed to several reasons, such as: 1) Individuals feel they may be able to “handle the issues on their own,” 2) “Perceived” lack of resources based on economic status, and 3) Individuals may not seek treatment or services out of fear and stigma associated with the disease. Mick Kaufman, of Dr. Kirchner’s Comprehensive Care clinic, further illustrated the issue of access to care with the clients they serve. He stated that in looking at the demographics of their patients, they tend to have more Latino patients who are HIV positive, but more African American patients who are clinically diagnosed with AIDS. Several additional reasons for the disparity were suggested: 1) As a result of stigma, individuals wait longer before seeing a physician, thus allowing a more rapid progression of the disease, and 2) individuals may not know their HIV status until they exhibit symptoms of advanced HIV disease.
- Black and Hispanic patients infected with the HIV virus are less likely than whites to participate in clinical studies of new treatments or to receive experimental drugs, according to the first study that has used nationally representative data to examine such disparities. They have fewer options and are less likely to get access to these
experimental medicines, which can be an important component of care. (Allen L. Gifford of the Veterans Affairs San Diego Healthcare System, principal author of the study, published in the May 2, 2002, New England Journal of Medicine.)

✔ The researchers found that, in addition to being black or Hispanic, other factors also reduced patients' likelihood of participating in a clinical trial. They included having less than a high school education, belonging to a health maintenance organization, and living eight or more miles from a major research hospital.

✔ Among patients who were enrolled in a clinical trial at the start of the study, blacks were more likely than whites to drop out. In follow-up interviews, 25 percent of blacks reported that they were still enrolled, compared with 53 percent of whites.

✔ Although 24 percent of patients in the study reported that they had taken an experimental drug, an additional 8 percent said they had tried and failed to obtain such drugs. Patients who were white, who were highly educated, or who received their health care close to a research center were more likely than others to receive experimental drugs.

✔ Among patients who sought such medicines, whites received them more often than blacks (77 percent vs. 69 percent), and people with fee-for-service insurance were given the drugs more often than HMO members or uninsured patients.

✔ The same issues and ambiguities exist in regard to Hepatitis. Local providers do not see Hepatitis B as having a significant impact on their clients. An issue of greater concern was hepatitis C. As hepatitis C and HIV are commonly transmitted through the same means, co-infection of the two diseases presents an increasing problem, especially with clients who are HIV positive and those who are taking medication. HAART medication has a high level of toxicity, and if a client has a liver disease such as hepatitis C it exacerbates the liver complications a patient may have. Several providers emphasized this point by stating that they have lost many clients to liver cancer and other problems associated with co-infection of HIV and hepatitis C. Currently hepatitis C is reported only as hepatitis non-A or hepatitis non-B to the State Department of Health, and the Department of Health counts only acute cases and not chronic cases. So again, the community is confronted with the same problems in determining the incidence of disease. Co-infection of HIV and hepatitis poses a real threat to the clients local providers serve and something needs to be done to help those clients.

Overall behavioral and biomedical strategies for the prevention of unwanted pregnancy, and the prevention of HIV and STD infection overlap.

Behavioral interventions can:

- Help persons abstain from sexual intercourse, delay initiation of intercourse, reduce the number of sex partners, and increase the use of effective physical barriers such as condoms, or emerging chemical barriers, such as microbicides.

- Enhance prevention strategies for populations that are particularly high risk, such as injection drug users, homeless persons, runaway youth, mentally ill persons, and incarcerated persons. Some of these populations are also difficult to reach.

- Help parents become better at imparting information. Currently, a small percentage of adolescents receive prevention information from parents (American Social Health Association. “Teenagers know more than adults about STDs, but knowledge between both groups is low.” STD News 3:1, 5, 1996).
Schools are the main source of STD information for most teenagers, indicating that school-based interventions can play a significant role in informing young people about STD exposure and transmission issues and in motivating them to modify their behaviors. Both school-based health information and school-based health service programs are potentially beneficial to young persons.

Mass media campaigns have been effective in bringing about significant changes in awareness, attitude, knowledge, and behaviors for other health problems, such as smoking.

Biomedical interventions can affect aspects of transmission and duration factors:

- Vaccines minimize the probability of infection, disease, or both, after exposure (transmission). While vaccines for some STDs are in various stages of development, the only effective and widely available STD vaccine is for hepatitis B. Setting the discovery of a safe and effective HIV vaccine as a reachable goal, as a result of ongoing HIV vaccine testing. The development and testing of candidate microbicides may be important in enhancing prevention efforts until a vaccine is available.

- Correct and consistent condom use decreases STDs.

- Screening and treatment for curable STDs can be cost-effective, or even cost-saving, in altering the period during which infected persons can infect others. For STDs that frequently are asymptomatic, screening and treatment benefit those who are likely to suffer severe complications (especially women) if infections are not detected and treated early. Selective screening for chlamydia in the Pacific Northwest reduced the burden of disease in the screened population by 60 percent in 5 years. (Britton, T.; DeLisle, S.; and Fine, D. “STDs and family planning clinics: A regional program for chlamydia control that works.” American Journal of Gynecological Health 6:80–87, 1992.) STD screening of specific high-risk populations in nontraditional settings appears to be a promising control strategy that expands access to underserved groups. The success of screening programs will depend on the availability of funds, the willingness of communities and institutions to support them, and the availability of well-trained health care providers and of well-equipped and accessible laboratories.

- Identifying and treating partners of persons with curable STDs to break the chain of transmission in a sexual network always have been integral to organized control programs. New approaches for getting more partners treated are being assessed both in traditional and nontraditional STD treatment settings. With partner treatment, the initially infected person benefits from a reduced risk of reinfection from an untreated partner, and the partner avoids acute infection and its potential complications. Future sex partners are protected by treating partners; thus, this treatment strategy also benefits the community.

- Increasing the number of people who learn their HIV status in order to detect HIV infection when the potential for transmission is greatest and the need for prevention, care, and treatment, including HAART, is greatest.

- Improving access to HAART, thereby reducing deaths and HIV-associated illness and, possibly, infection of others.

Promoting responsible adolescent sexual behavior targets three protective behaviors that reduce the risk of STDs (including HIV infection) and unintended pregnancy. They are: completely abstaining from sexual intercourse during adolescence (primary abstinence), reverting to abstinence for long periods of time after having had intercourse in the past (secondary abstinence), and at least using condoms (a single method that offers protection against both pregnancy and some STDs) consistently and correctly if regular intercourse is
occurring. Abstaining from sexual intercourse offers maximum protection to adolescents who are generally poorly prepared to deal with the physical and psychological consequences of HIV infection, other STDs, and pregnancy.

**Related Data**

- Overall, 50 percent of high school youth practice abstinence.
- Abstinence in high school varied by race and ethnicity. The rate was 55 percent among white youth and 29 percent among African American youth.
- Abstaining from sexual intercourse decreased as young people progressed through high school, from 61 percent of 9th graders to 35 percent among 12th graders.
- At least 39 percent of 9th graders had had intercourse during or before this school year. Among them, 12 percent had not had intercourse in the past three months, 17 percent were currently sexually active and used a condom at last intercourse, and the remaining 10 percent were sexually active and had not used a condom at last intercourse.

This data supports the need for counseling, education, interventions, and service for many young people even before the start of high school.

<table>
<thead>
<tr>
<th>25-11 Increase the proportion of adolescents who abstain from sexual intercourse or use condoms if currently sexually active.</th>
</tr>
</thead>
</table>
| **Target:** 95 percent  
**Baseline:** 85 percent of adolescents in grades 9 through 12 abstained from sexual intercourse or used condoms in 1999 (50 percent had never had intercourse; 14 percent had intercourse but not in the past 3 months; and 21 percent currently were sexually active and used a condom at last intercourse).  
**Target-setting method:** 12 percent improvement  
**Data source:** Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP |

In 1999, 85 percent of high school youth demonstrated at least one of the responsible behaviors. Increasing and maintaining the proportion of youth who exhibit the above protective behaviors reduces the risks of HIV infection, other STDs, and unintended pregnancies for adolescents because the proportion of youth who are currently sexually active and do not use condoms will be reduced.

Young people who have had sexual intercourse in the past but are not currently sexually active need special attention and services. Even if pregnancy were avoided in the past, the same may not be true for STDs. Previously sexually active adolescents need to be educated about this possibility, and medical evaluation and counseling are strongly suggested both to identify treatable conditions and to reinforce abstinence messages. In addition to reinforcing abstinence messages, responsible and influential adults should help young males and females gain easy access to high-quality, confidential, comprehensive reproductive health care in their communities that can help them reduce HIV infection, STD, and pregnancy risk.
Research clearly demonstrates that—despite fears to the contrary—young persons who participate in comprehensive HIV and STD prevention programs that include approaches to ensure access to condoms are no more likely to initiate or increase sexual activity than other young persons (Warren, C.; Santelli, J.; Everett, S; et al. “Sexual Behavior among U.S. high school students, 1990–1995.” *Family Planning Perspectives* 30(4):170–172, 1998).

### Students in Grades 9 through 12, 1999

<table>
<thead>
<tr>
<th>Students in Grades 9 through 12, 1999</th>
<th>25-11 Abstained from Sexual Intercourse or Used Condom [Column a= (Column b + Column c + Column d)]</th>
<th>NOT Currently Sexually Active</th>
<th>Currently Sexually Active</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Never Had Intercourse* [Column b]</td>
<td>No Intercourse in Past three Months [Column c]</td>
<td>Used Condom at Last Intercourse [Column d]</td>
</tr>
<tr>
<td>Percent</td>
<td>85</td>
<td>50</td>
<td>14</td>
</tr>
<tr>
<td><strong>Race and ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13-6a Black or African American</td>
<td>83</td>
<td>30</td>
<td>17</td>
</tr>
<tr>
<td>13-6b White</td>
<td>86</td>
<td>55</td>
<td>13</td>
</tr>
<tr>
<td>13-6c Hispanic or Latino</td>
<td>84</td>
<td>46</td>
<td>18</td>
</tr>
<tr>
<td>13-6d Not Hispanic or Latino</td>
<td>85</td>
<td>51</td>
<td>13</td>
</tr>
<tr>
<td>13-6e Black or African American</td>
<td>84</td>
<td>29</td>
<td>18</td>
</tr>
<tr>
<td>13-6f White</td>
<td>85</td>
<td>55</td>
<td>12</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13-6g Female</td>
<td>81</td>
<td>52</td>
<td>11</td>
</tr>
<tr>
<td>13-6h Male</td>
<td>87</td>
<td>48</td>
<td>16</td>
</tr>
<tr>
<td><strong>Grade</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13-6i 9th</td>
<td>90</td>
<td>61</td>
<td>12</td>
</tr>
<tr>
<td>13-6j 10th</td>
<td>87</td>
<td>53</td>
<td>14</td>
</tr>
<tr>
<td>13-6k 11th</td>
<td>84</td>
<td>47</td>
<td>15</td>
</tr>
<tr>
<td>13-6l 12th</td>
<td>73</td>
<td>35</td>
<td>14</td>
</tr>
<tr>
<td><strong>Number of sex partners (past 3 months)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13-6m None</td>
<td>100</td>
<td>79</td>
<td>21</td>
</tr>
<tr>
<td>13-6n 1</td>
<td>57</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>13-6o 2 to 3</td>
<td>62</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>13-6p 4 or more</td>
<td>60</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

DNA=Data have not been analyzed. DNC=Data are not collected. DSU=Data are statistically unreliable. NA=Not applicable.*

---

**Condoms**

**13-6 Increase the proportion of sexually active persons who use condoms.**

<table>
<thead>
<tr>
<th>Objective Increase in Sexually Active Persons Using Condoms</th>
<th>Baseline 1995</th>
<th>Target 2010 Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>13-6a Females aged 18 to 44 years</td>
<td>23</td>
<td>50 Developmental</td>
</tr>
<tr>
<td>13-6b Males aged 18 to 49 years</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Condom use is important to every sexually active individual who has not been in a monogamous relationship or is unsure of the medical and sexual history of their sexual partner. Age does not protect you from STD or AIDS. Recent trends indicate that STD’s and HIV infection is increasing among those over 50 and in senior retirement communities. This population is less likely to think of themselves as vulnerable and, of course, unlikely
to use condoms for contraceptive reasons. Many individuals, recently single but who had been in long-term relationships, are too willing to assume that those of their own generation have been the same. Naivety and lack of recognition of sexuality in healthy seniors must be overcome (e.g., questions are not asked of and data regarding sexual partners and condom use is not collected in the BRFSS survey of those over 50). Educational and counseling opportunities must be developed.

When used consistently and correctly, latex condoms are highly effective in preventing HIV transmission and some STDs. Increased use of latex condoms is essential for slowing the spread of HIV infection. Carefully designed studies among heterosexual couples in which one partner is HIV positive and the other is not demonstrate that latex condoms provide a high level of protection against HIV (CDC. "HIV counseling and testing in publicly funded sites" 1996 Annual Report. Atlanta, GA: US Department of Health and Human Services, CDC, 1998).

- Access: The lack of readily accessible condoms may also be a significant barrier to consistent use. Persons in some populations, old and young but especially sexually active young persons, may experience problems in obtaining access to condoms because of several factors, including cost, convenience, and embarrassment. To eliminate this barrier, many local communities actively support programs that make condoms available to populations most vulnerable to HIV infection, including sexually active young persons.

- In addition to access, the correct and consistent use of condoms is an issue for many young females, some of whom are having intercourse with older males. Young females often are limited by intimidation or threats of mistrust by their partners if they suggest condom use. Knowledge of effective negotiating skills is another critical element of increased condom use.

<table>
<thead>
<tr>
<th>Unmarried Females 18 to 44 years, 1995</th>
<th>13-6a Reported Condom Use by Partners* Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>23</td>
</tr>
<tr>
<td>Race and ethnicity</td>
<td></td>
</tr>
<tr>
<td>Black or African American</td>
<td>22</td>
</tr>
<tr>
<td>White</td>
<td>23</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>17</td>
</tr>
<tr>
<td>Aged 18 to 19 years</td>
<td>16</td>
</tr>
<tr>
<td>Aged 20 to 24 years</td>
<td>18</td>
</tr>
<tr>
<td>Aged 25 to 29 years</td>
<td>19</td>
</tr>
<tr>
<td>Aged 30 to 34 years</td>
<td>22</td>
</tr>
<tr>
<td>Aged 35 to 44 years</td>
<td>9</td>
</tr>
<tr>
<td>Black or African American</td>
<td>22</td>
</tr>
<tr>
<td>Aged 18 to 19 years</td>
<td>31</td>
</tr>
<tr>
<td>Aged 20 to 24 years</td>
<td>35</td>
</tr>
<tr>
<td>Aged 25 to 29 years</td>
<td>23</td>
</tr>
<tr>
<td>Aged 30 to 34 years</td>
<td>17</td>
</tr>
<tr>
<td>Aged 35 to 44 years</td>
<td>12</td>
</tr>
<tr>
<td>White</td>
<td>24</td>
</tr>
<tr>
<td>Aged 18 to 19 years</td>
<td>39</td>
</tr>
<tr>
<td>Aged 20 to 24 years</td>
<td>29</td>
</tr>
<tr>
<td>Aged 25 to 29 years</td>
<td>24</td>
</tr>
<tr>
<td>Aged 30 to 34 years</td>
<td>14</td>
</tr>
<tr>
<td>Aged 35 to 44 years</td>
<td>18</td>
</tr>
<tr>
<td>Family income level</td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>16</td>
</tr>
<tr>
<td>Near poor</td>
<td>21</td>
</tr>
<tr>
<td>Middle/high income</td>
<td>27</td>
</tr>
<tr>
<td>Education level</td>
<td></td>
</tr>
<tr>
<td>(aged 25 to 44 years)</td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>7</td>
</tr>
<tr>
<td>High school</td>
<td>15</td>
</tr>
<tr>
<td>At least some college</td>
<td>25</td>
</tr>
<tr>
<td>Geographic location</td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>24</td>
</tr>
<tr>
<td>Rural</td>
<td>18</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>DNC</td>
</tr>
</tbody>
</table>

Data source: National Survey of Family Growth (NSFG), CDC, NCHS

DNA=Data have not been analyzed. DNC=Data are not collected. DSU=Data are statistically unreliable. *Data for both genders and for males currently are not collected.
### Family Planning, Sexuality and Pregnancy:

<table>
<thead>
<tr>
<th>Organization</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Women's Concern</td>
<td>(717) 394-1561</td>
</tr>
<tr>
<td>Brephos Pregnancy Center</td>
<td>(717) 442-8694</td>
</tr>
<tr>
<td>COBYS Family Services</td>
<td>(717) 392-0504</td>
</tr>
<tr>
<td>Community Hospital of Lancaster</td>
<td>(717) 392-2154</td>
</tr>
<tr>
<td>Center City Family Health</td>
<td></td>
</tr>
<tr>
<td>Council on Drug and Alcohol Abuse—Baby Think It Over</td>
<td>(717) 299-2831</td>
</tr>
<tr>
<td>Crisis Pregnancy Hotline</td>
<td>(800) 238-4269 (24 hours)</td>
</tr>
<tr>
<td>Department of Health “Healthy Baby Line”</td>
<td>1-800-986-BABY (2229)</td>
</tr>
<tr>
<td>Destination Graduation (YWCA)</td>
<td>(717) 393-1735</td>
</tr>
<tr>
<td>Ephrata Pregnancy Center</td>
<td>(717) 733-9440</td>
</tr>
<tr>
<td>Ephrata Community OB/GYN Services:</td>
<td></td>
</tr>
<tr>
<td>New Holland (717) 354-9593</td>
<td></td>
</tr>
<tr>
<td>Cocalico (717) 335-0066</td>
<td></td>
</tr>
<tr>
<td>Akron (717) 859-7820</td>
<td></td>
</tr>
<tr>
<td>Family Services—Parenting Program</td>
<td>(717) 397-5241</td>
</tr>
<tr>
<td>Girl Power (YWCA)</td>
<td>(717) 393-1735</td>
</tr>
<tr>
<td>Girl Scouts—Penn Laurel Council</td>
<td>(717) 397-8115 or (717) 396-9997</td>
</tr>
<tr>
<td>Healthy Beginnings Plus Prenatal Care Program</td>
<td>(717) 290-4305</td>
</tr>
<tr>
<td>Lancaster County Coalition for the Prevention of Teen Pregnancy</td>
<td>(717) 290-3203</td>
</tr>
<tr>
<td>Lancaster County State Health Center</td>
<td>(717) 299-7597</td>
</tr>
<tr>
<td>Lancaster General Family Health Center</td>
<td>(717) 290-4950</td>
</tr>
<tr>
<td>Lancaster General Women &amp; Babies Hospital</td>
<td>(717) 290-3700</td>
</tr>
<tr>
<td>Lancaster Regional Family Health Center</td>
<td>(717) 291-8388</td>
</tr>
</tbody>
</table>
Lititz Pregnancy Center Hotline  
(717) 627-4357

March of Dimes—Storks Nest  
(717) 397-6131

McCaskey High School—Pregnancy Program  
(717) 291-6211

Mom’s House  
(717) 396-9130

PA Dept of Health, Information Line  
(877) 724-3258

Planned Parenthood of the Susquehanna Valley  
(717) 299-2891

Southeast Lancaster Health Services  
(717) 299-6371

Urban League of Lancaster County Inc.—Program for Pregnant and Parenting Teens (School Completion)  
(717) 394-1966

Welsh Mountain Medical and Dental Center  
(717) 354-4711

HIV/AIDS and STDs:

Arch Street Center, (717) 392-8536

Nuestra Clinica of SACA, (717) 295-7994

The Gathering Place, (717) 295-4630

Project Hope of the Urban League, (717) 394-1966

AIDS Community Alliance, 1-800-867-1550

Comprehensive Care Clinic of LGH, (717) 290-4943

Betty Finney House, (717) 396-8689

Dr. Woodward of Center City Family Health, (717) 392-2154

The American Red Cross, (717) 299-5561

The Hope House, (717) 293-9089

Planned Parenthood, (717) 299-2891

South East Lancaster Health Services, (717) 299-6371

United Way LINK, (717) 291-LINC

The Lancaster County State Health Center provides free anonymous and confidential HIV Testing, Counseling and Partner Notification services. The scheduled clinic hours are Tuesday from 12:30 p.m. to 3:30 p.m. by appointment. The State Health Center also assists HIV positive individuals in providing CD 4 and Viral Load tests for the uninsured as well as serving as a liaison by connecting clients with needed case management and medical services.
Family Planning & Teen Pregnancy Prevention
This site provides links to sites focusing on family planning and teen pregnancy prevention issues. http://www.socio.com/links/family_l.htm

U.S. Department of Health and Human Services
This site provides information on our national strategy and provides descriptions and contact information for programs that have succeeded in reaching targets incorporating the key principles within their approach. http://aspe.os.dhhs.gov/hsp/teenp/intro.htm

CDC National AIDS Hotline
800 342-AIDS (800-342-2437); http://www.cdc.gov/hiv/hivinfo/nah.htm

CDC National Sexually Transmitted Diseases (STD) Hotline
800-227-8922 http://www.cdc.gov/nchstp/dstd/dstdp.html

CDC National Prevention Information Network
800-458-5231 http://www.cdcnpin.org

Office of Population Affairs
301-654-6190 http://opa.osophs.dhhs.gov

AIDS Factline
1-800-662-6080
For information about HIV and available services, including viral load testing

Special (HIV/AIDS) Pharmaceutical Benefits Program
1-800-922-9384 for information about obtaining pharmaceutical treatments for HIV disease. For further information call (717)783-0479.

Promising Practices Network on Children, Families, and Communities
Programs that used the Indicator “Increase the percentage of youth who abstain from sexual activity or do not engage in risky sexual behavior” can be found at the following Web site: http://www.promisingpractices.net/benchmark.asp?Benchmark=50

The Proven Programs are:
- Seattle Social Development Project
- Self Center (School-Linked Reproductive Health Services)

Promising Programs are:
- Be Proud! Be Responsible!
- Get Real About AIDS
- Postponing Sexual Involvement/Human Sexuality Educational Series
- Quantum Opportunity Program
- Reducing the Risk
- Teen Outreach Program
- Teen T

You don’t have to be a parent to affect the lives of young people in ways that encourage them to think about their futures positively. It is important that adults are knowledgeable and able to give young people information that is correct or can refer them to credible sources of good information. Most importantly, though, is communicating that you believe in them and their ability to learn how to make good choices.

- Talk to your children early about making smart choices.
- Talk to your children about their sexuality and the pressures they face.
Build at least one sustained, caring relationship with a child or adolescent.

Model responsible behavior for young people.

Volunteer to work in a youth program as a coach, group leader, or tutor.

Stay involved in your kids lives and help them think about their future positively.

Help your children succeed in school—show them their education is important to you.

Talk to your kids about alcohol and drug use. There is a direct relationship between drug and alcohol use and unwanted pregnancies.

Schools and Community-Based Organizations

- Increase the proportion of middle, junior high, and senior highs that provide school health education to prevent teen pregnancy, including abstinence and the use of condoms.
- Increase the proportion of middleschools, junior highs, and senior highs that provide information about making good choices and the responsibilities of parenting, such as “Baby Think It Over.”
- Increase the proportion of middle, junior high, and senior high students who are successful in school and see themselves going on to viable employment or post-secondary training or education.
- Provide educational opportunities for pregnant teens that include healthy baby and parenting curriculum and that aims at preventing a second pregnancy.

Businesses can:

- Provide open houses to young people so that they can visit your workplaces and talk about career opportunities.
- Sponsor public service announcements about responsible sexual behavior and teen pregnancy when approached by community groups.
- Carefully consider sponsoring events and media presentations that promote positive messages about sexuality and education.
- Help increase the proportion of middle, junior, and high school students engaged in after-school activities, volunteer opportunities or employment (all institutions and businesses).
- Provide mentoring programs for teen mothers such as big brothers/big sisters.
- Consider family-friendly policies that support parents spending time with their children.

Individuals can:

- Learn about sexual issues, health risks, and contraception.
- Teach their children about making decisions at an early age.
- Use information, not just fear, to warn their children about the dangers of risky behavior.
- Be clear about the medical consequences of risky behavior.
- Use condoms, if they are sexually active.
- Talk to their medical practitioner openly about their sexual practices so that the practitioners can help them better understand personal health concerns and risks.
Be conscious of the use of sex in marketing and its affect on their attitudes towards sex.

Talk to their children about how they develop their attitudes towards sex— if you don’t someone will.

Get screened, if they have engaged in risky behavior.

They believe that if they or their partner are over fifty that they are protected from STD’s or HIV. You are not.

Why do some communities succeed in keeping their young women in school and focused on the future— what are they doing right?

How do we get young men to think more carefully about their responsibilities as potential fathers?

At what age should we begin talking to children about relationships and expectations within different kinds of relationships?

Are the politics of “Choice” and “Pro-Life” impairing or enhancing our community's ability to deal with this issue from a medical prevention model?

Since one-half of all teen pregnancies are terminated through abortions, can common ground be found around the issues of prevention and family planning?

Has reliance solely on the Abstinence curriculum hurt or helped this problem in Lancaster County?

Bacterial STD Illness and Disability

25-1 Chlamydia
25-2 Gonorrhea
25-3 Primary and secondary syphilis

Viral STD Illness and Disability

25-4 Genital herpes
25-5 Human papillomavirus infection (STD complications affecting females)
25-6 Pelvic inflammatory disease (PID)
25-7 Fertility problems
25-8 Heterosexually transmitted HIV infection in women (STD complications)

Affecting the Fetus and Newborn

25-9 Congenital syphilis
25-10 Neonatal STDs (personal behaviors)
25-11 Responsible adolescent sexual behavior
25-12 Responsible sexual behavior messages on television

Community Protection Infrastructure

25-13 Hepatitis B vaccine services in STD clinics
25-14 Screening in youth detention facilities and jails
25-15 Contracts to treat nonplan partners of STD patients

Personal Health Services

25-16 Annual screening for genital chlamydia
25-17 Screening of pregnant women
25-18 Compliance with recognized STD treatment standards
25-19 Provider referral services for sex partners
Access to Quality Health Services

1-3 Counseling about health behaviors
1-7 Core competencies in health provider training

Cancer

3-4 Cervical cancer deaths
3-11 Pap tests

Educational and Community-Based Programs

7-2 School health education

Family Planning

9-8 Abstinence before age 15 years
9-9 Abstinence among adolescents aged 15 to 17 years
9-10 Pregnancy prevention and sexually transmitted disease (STD) protection
9-11 Pregnancy prevention education
9-12 Problems in becoming pregnant and maintaining a pregnancy

HIV

13-5 New HIV cases
13-6 Condom use
13-9 HIV/AIDS, STD, and TB education in state prisons
13-12 Screening for STDs and immunization for hepatitis B

Immunization and Infectious Diseases

14-3 Hepatitis B in adults and high-risk groups
14-28 Hepatitis B vaccination among high-risk groups

Injury and Violence Prevention

15-35 Rape or attempted rape
15-36 Sexual assault other than rape

Maternal, Infant, and Child Health

16-1 Fetal and infant deaths
16-6 Prenatal care
16-10 Low birth weight and very low birth weight
16-11 Pre-term births
Substance Abuse

Reduce substance abuse to protect the health, safety, and quality of life for all, especially children
Drug and Alcohol Abuse

Goal: Better than the best

**HP 2010 Measures and Local Measures**

<table>
<thead>
<tr>
<th>HP 26-10</th>
<th>Reduce past-month use of illicit substances.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>26-10a</strong> Increase the proportion of adolescents not using alcohol or any illicit drugs during the past 30 days.</td>
<td></td>
</tr>
<tr>
<td>Baseline: 79 percent of adolescents aged 12 to 17 years reported no alcohol or illicit drug use in the past 30 days in 1998.</td>
<td></td>
</tr>
<tr>
<td>Target-setting method: Better than the best</td>
<td></td>
</tr>
<tr>
<td>Data source: National Household Survey on Drug Abuse (NHSDA), SAMHSA</td>
<td></td>
</tr>
<tr>
<td>- Percentage of middle and high school aged youth who have admitted using alcohol within the past 30 days</td>
<td></td>
</tr>
<tr>
<td>- Percentage of middle and high school aged youth who have admitted use of an illegal drug or other controlled substance within the past 30 days</td>
<td></td>
</tr>
<tr>
<td>Target-setting method: Better than the best</td>
<td></td>
</tr>
<tr>
<td>Data source: Pennsylvania Youth Survey (PA Commission of Crime and Delinquency)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HP 26-10c</th>
<th>Reduce the proportion of adults using any illicit drug during the past 30 days.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline: 5.8 percent of adults aged 18 years and older used any illicit drug during the past 30 days in 1998.</td>
<td></td>
</tr>
<tr>
<td>Target-setting method: Better than the best (consistent with Office of National Drug Control Policy)</td>
<td></td>
</tr>
<tr>
<td>Data source: National Household Survey on Drug Abuse (NHSDA), SAMHSA</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HP 26-11c</th>
<th>Reduce the proportion of adults aged 18 and older who engaged in binge drinking during the past month.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>HP 26-11d</th>
<th>Reduce the proportion of adolescents aged 12 to 17 who engaged in binge drinking during the past month.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline: Differs with populations</td>
<td></td>
</tr>
<tr>
<td>Target-setting method: Better than the best</td>
<td></td>
</tr>
</tbody>
</table>
Substance abuse and related problems are among the most pervasive and unmanageable of all health and social concerns. There has been a long-term drop in overall use, but many people in the United States still use illicit drugs. Substance abuse correlates with other serious health and social problems. Illicit drug abuse and related acquired immunodeficiency syndrome (AIDS) deaths account for at least another 12,000 deaths. In 1995, the economic cost of alcohol and drug abuse was $276 billion. (Harwood, H.; Fountain, D.; and Livermore, G. The Economic Costs of Alcohol and Drug Abuse in the United States, 1992. NIH Pub. No. 98-4327. Rockville, MD: National Institutes of Health (NIH), 1998.) Use of alcohol and illicit drugs increases the risk of heart disease, stroke, hypertension, hepatitis, HIV infection and AIDS, cirrhosis of the liver, and the incidence of rape, STD’s, teen pregnancy, and homelessness. About 100,000 deaths in the United States are related to alcohol consumption each year. Alcohol abuse alone is associated with motor vehicle crashes, homicides, suicides, and drowning—leading causes of death among youth. Long-term heavy drinking can lead to heart disease, cancer, alcohol-related liver disease, and pancreatitis (McGinnis, J.M., and Foege, W.H. “Actual causes of death in the United States.” Journal of the American Medical Association 270:2207–2212, 1993). Alcohol use during pregnancy is known to cause fetal alcohol syndrome, a leading cause of preventable mental retardation.

A significant proportion of the population consumes alcohol. Although alcohol problems are diverse and vary along many dimensions, they can be described in part by their duration (acute, intermittent, chronic) and severity (mild, moderate, substantial, severe). (Institute of Medicine. Broadening the Base of Treatment for Alcohol Problems. Washington, DC: National Academy Press, 1990.) Light-to-moderate drinking (one to two drinks a day) can have beneficial effects on the heart, particularly among those at greatest risk for heart attacks, such as men over age 45 years and women after menopause (Zakhari, S. “Alcohol and the cardiovascular system: Molecular mechanisms for beneficial and harmful action.” Alcohol Health & Research World 21(1):21–29, 1997).


Binge drinking is a national problem. but it is particularly an issue among males and young adults. The National Household Survey on Drug Abuse defines binge drinking as drinking five or more drinks on the same occasion on at least one day in the past 30 days. The Monitoring the Future Study defines binge drinking as drinking five or more drinks on the same occasion during the past two weeks. Although rates of binge drinking don’t vary much with educational levels, people with some college were more likely than those with less than a high school education to binge drink. In all age groups, more males than females engaged in binge drinking; among adults, the ratio was two or three to one. Binge drinking among women of childbearing age (defined as 18 to 44 years) is a problem because of the risk for prenatal alcohol exposures.

Alcohol dependence is defined as a maladaptive pattern of alcohol use that leads to clinically significant impairment or distress, as manifested by three or more of the following occurring at any time in the same 12-month period:

- tolerance;
- withdrawal;
- often taking alcohol in larger amounts or over a longer period than was intended;
- persistent desire or unsuccessful efforts to cut down or control alcohol use;
- spending a great deal of time in activities necessary to obtain alcohol or recover from its effects;
- giving up or reducing important social, occupational, or recreational activities because of alcohol use;
- continued alcohol use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.

**Adult Use**

- Forty-four percent of adults aged 18 years and older (more than 82 million persons) report having consumed 12 or more alcoholic drinks in the past year. (Dawson, D.A.; Grant, B.F.; Chou, S.P.; et al. “Subgroup variation in U.S. drinking patterns: Results of the 1992 National Longitudinal Alcohol Epidemiologic Study.” *Journal of Substance Abuse* 7:331–344, 1995).

- Among these current drinkers, 46 percent report having been intoxicated at least once in the past year—nearly 4 percent report having been intoxicated weekly.

- More than 55 percent of current drinkers report having consumed five or more drinks on a single day at least once in the past year—more than 12 percent did so at least once a week.

- Nearly 20 percent of current drinkers report having consumed an average of more than two drinks per day.

- Nearly 10 percent of current drinkers (about 8 million persons) meet diagnostic criteria for alcohol dependence. An additional 7 percent (more than 5.6 million persons) meet diagnostic criteria for alcohol abuse. (National Institute on Alcohol Abuse and Alcoholism (NIAAA). Unpublished analysis of 1992 data.)

- Nearly 15 percent of persons aged 12 years or older reported binge drinking in the past 30 days, with young adults aged 18 to 25 years more likely (27 percent) than all other age groups to have engaged in binge drinking.

**Adolescent Use**

The adolescent years appear to be the most critical in establishing lifelong patterns of drug and alcohol use. Alcohol use and alcohol-related problems are also common among adolescents. (O’Malley, P.M.; Johnston, L.D.; and Bachman, J.F. “Alcohol use among adolescents.” *Alcohol Health & Research World* 22(2):85–93, 1998.) This may be related to the lack of societal stigma associated with alcohol use. In fact, our culture often portrays alcohol as the prescription for stress management and social anxiety. The perception that alcohol use is socially acceptable correlates with the fact that more than 80 percent of youth in the United States consume alcohol before their 21st birthday, whereas the lack of social acceptance of other drugs correlates with comparatively lower rates of use. Studies indicate that school-based programs focused on altering perceived peer-group norms about alcohol use and developing skills in resisting peer pressures to drink reduce alcohol use among participating students. (Shope, J.T.; Copeland, L.A.; Maharg, R.; et al. “Assessment of adolescent refusal skills in an alcohol misuse prevention study.” *Health Education Quarterly* 20(3):373-390, 1993.)
Similarly, widespread societal expectations that young persons will engage in binge drinking may encourage this highly dangerous form of alcohol consumption. (O'Malley, P.M.; Johnston, L.D.; and Bachman, J.F. “Alcohol use among adolescents.” Alcohol Health & Research World 22(2):85–93, 1998.) The age at which a person starts drinking strongly predicts the development of alcohol abuse and dependency over a lifetime. Persons with a family history of alcoholism have a higher prevalence of lifetime dependence than those without such a history. (Grant, B.F. “The impact of a family history of alcoholism on the relationship between age at onset of alcohol use and DSM-IV alcohol dependence.” Alcohol Health & Research World 22(2):144–148, 1998.) The messages about harm and risk that they receive are often influenced by family dynamics and denial. Risk and harm messages targeted to youth must therefore take this into account.

- About 40 percent of those who start drinking at age 14 years or under develop alcohol dependence at some point in their lives.
- Of those who start drinking at age 21 years or older, about 10 percent develop alcohol dependence at some point in their lives. (Grant, B.F., and Dawson, D.A. “Age at onset of alcohol use and its association with DSM-IV alcohol abuse and dependence: Results from the National Longitudinal Alcohol Epidemiologic Survey.” Journal of Substance Abuse 9:103–110, 1997.)
- More than 11 million children and adolescents under age 18 years have at least one parent who is addicted to alcohol or drugs. (Eigen, L., and Rowden, D.A. “A methodology and current estimate of the number of children of alcoholics in the U.S.” Children of Alcoholics, Selected Readings. Rockville, MD: National Association of Children of Alcoholics, 1995.)

An analysis of the epidemiologic evidence reveals that 72 conditions requiring hospitalization are wholly or partially attributable to substance abuse (Merrill, J.; Fox, K.; and Chang, H. The Cost of Substance Abuse to America’s Health Care System: Report 1. Medicaid Costs. New York, NY: Center on Addiction and Substance Abuse, 1993). For each man, woman, and child in the United States, the annual per person costs associated with the care for patients with substance abuse problems are $1,000. It costs more than $1,000 for every man, woman, and child in the United States to cover the expense of health care, motor vehicle crashes, crime, lost productivity, and other adverse outcomes of alcohol and drug abuse. For the total population, rates of drug-related deaths and drug-abuse-related emergency department (ED) visits have increased.

Drug dependence is a chronic, relapsing disorder. Illicit drug use has been near the present rate of 6 percent since 1980. Men continue to have higher rates of illicit drug use than women have, and rates of illicit drug use in urban areas are higher than in rural areas. Chronic drug use is defined as the use of any heroin or cocaine for more than 10 days in the past month. Drug dependence is defined as a pattern of drug use leading to clinically significant impairment or distress, as manifested by three or more of the following occurring at any time in the same 12-month period:

- tolerance;
- withdrawal;
- use in larger amounts or over a longer period of time than intended;
- persistent desire or unsuccessful efforts to cut down, and spending a great deal of time in activities necessary to obtain drug(s);
- giving up or reducing important social, occupational, or recreational activities;
- continued use despite knowledge of having a persistent or recurrent physical or psychological problem.

Illicit Drug Use
Addicted persons frequently engage in self-destructive and criminal behavior. Illegal use of drugs, such as heroin, marijuana, cocaine, and methamphetamine, is associated with serious risks including injury, illness, disability, and death as well as crime victimization, rape, domestic violence, and lost workplace productivity. Drug users and those with whom they have sexual contact run high risks of contracting STDs and human immunodeficiency virus (HIV), hepatitis, and tuberculosis. (Garfien, R.S.; Vlahov, D.; Galai, N.; et al. “Viral infections in short-term injection drug users: The prevalence of the hepatitis C, hepatitis B, human immunodeficiency, and human T-lymphotropic virus.” American Journal of Public Health 86:655–661, 1996.)

The use of cocaine, nitrates, and other substances can produce cardiac irregularities and heart failure, convulsions, and seizures. Cocaine use temporarily narrows blood vessels in the brain, contributing to the risk of strokes (bleeding within the brain) and cognitive and memory deficits. (Kaufman, M.J.; Levin, J.M.; Ross, M.H.; et al. “Cocaine-induced cerebral vasoconstriction detected in humans with magnetic resonance angiography”. Journal of the American Medical Association 279:376–380, 1998.) Long-term consequences, such as chronic depression, sexual dysfunction, and psychosis, may result from drug use. Chronic use of hallucinogens and huffing can result in permanent brain damage and symptoms and behaviors that mirror severe mental illness.

Researchers have identified lasting brain and nervous system damage from drugs, including changes in nerve cell structure associated with alcohol and drug dependence. Other research has focused on the long-term effects of alcohol and drug abuse on the immune system as well as the effects of prenatal alcohol and drug exposure on the behavior and development of children.

- In 1998, there were 13.6 million current users of any illicit drug in the total household population aged 12 years and older, representing 6.2 percent of the total population (U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA). 1998 National Household Survey on Drug Abuse. Rockville, MD: SAMHSA, 2000).
- Among persons aged 12 years and older, 35.8 percent have used an illegal drug in their lifetime. Of these, more than 90 percent used marijuana or hashish, and approximately 30 percent tried cocaine.
- Of the estimated 4.4 million chronic drug users in the United States in 1995, 3.6 million were chronic cocaine users (primarily crack cocaine), and 810,000 were chronic heroin users. (Office of National Drug Control Policy (ONDCP). What America’s Users Spend on Illegal Drugs, 1995–1998. Washington, DC: U.S. Government Printing Office (GPO), 1997.)
- Marijuana is the most commonly used illicit drug, and 60 percent of users abuse marijuana only.

Adolescent Use

Youth marijuana use has been associated with a number of dangerous behaviors. Adolescents aged 12 to 17 years who smoke marijuana were more than twice as likely to cut class, steal, attack persons, and destroy property than those who did not smoke marijuana. (HHS, SAMHSA. Analyses of Substance Abuse and Treatment Need Issues. Rockville, MD: SAMHSA, 1997.) Drug and alcohol use by youth also is associated with other forms of unhealthy and unproductive behavior, including delinquency and high-risk sexual activity. Some of these persons with a predisposition to substance addiction can be identified by their behavior problems at the time of their entry into elementary school. (Shedler, J., and Block, J.)

- Drug use among adolescents aged 12 to 17 years doubled between 1992 and 1997, from 5.3 percent to 11.4 percent.
- Nearly 1 million youth aged 16 to 18 years (11 percent of the total) have reported driving in the past year at least once within two hours of using an illegal drug (most often marijuana). (HHS. “Driving After Drug or Alcohol Use: Findings from the 1996 National Household Survey on Drug Abuse.” Rockville, MD: SAMHSA, 1998.)
- Average age of first use of harmful substances by adolescents aged 12 to 17 years has increased. In addition, past-month use of alcohol by adolescents aged 12 to 17 years has declined, as has steroid use by high school seniors.
- Past-month use of marijuana and cigarettes among adolescents aged 12 to 17 years has increased since 1994.
- Among high school seniors, both perception of harm and perception of social disapproval of substance abuse have declined.

We do not have local data that is exactly comparable to the national data used by HP 2010. For instance, locally we have percentages of 6th, 8th, and 10th grade students, rather than the percentage use of all adolescents aged 12–17 who abstained from using alcohol or illicit drugs in the past 30 days. Additionally, there is not statewide data to compare to the local and national data.

Pennsylvania Youth Survey
The Pennsylvania Youth Survey, which measured levels of substance use and related risk factors among middle school and high school students, was conducted in Lancaster County during April and May 2000. A total of 6,404 students in 6th through 12th grade, from seven public school districts and three private schools participated. This is not considered a good enough sampling by local experts, who would like to do a survey more in line with the National Youth Survey or National Household Survey on Drug Abuse. However, it is difficult to get school districts to agree to yet another survey, or even one.

The survey was conducted for the Pennsylvania Department of Education by Developmental Research and Programs (DRP), Seattle, Washington. Participation by Pennsylvania schools was voluntary. The Lancaster County Drug and Alcohol Commission offered grants of up to $1,000 per district to assist schools in paying for the cost of the survey. A grant was also given to I.U. 13 to assist non-public schools that wished to participate.

### Data

| Percentage of Students Who Did Not Report Using Substances Over the Past 30 Days |
|-----------------------------------------------|------------------|------------------|------------------|------------------|------------------|
|                                              | Lancaster 6th Grade, 2000 Lancaster | Lancaster 8th Grade | Lancaster 10th Grade | National Baseline, 1998 Aged 12–17 | HP 2010 Goal for Adolescents Aged 12–17 |
| Alcohol                                     | 88%               | 76%               | 61%               | 81%               | 89% (for Alcohol and illicit drugs combined) |
| Any Illicit Drug                            | 96%               | 91%               | 87%               | 90%               |                                           |
| Marijuana                                   | 99%               | 93%               | 80%               | 91.7%             | 99.3%                                        |
The first goal of the 1999 National Drug Control Strategy is to “educate and enable America’s youth to reject illegal drugs as well as alcohol and tobacco.” (ONDCP. *The National Drug Control Strategy: 1999*. Washington, DC: GPO, 1999.) In response to this goal, specific targets for the reduction of drug use among adolescents aged 12 to 17 years have been established under the Youth Substance Abuse Prevention Initiative (YSAPI). These targets, which have a baseline of 1996 and goals for the year 2002 (7 years), are as follows:

**Reverse the upward trend and reduce past-month use of marijuana among adolescents aged 12 to 17 years by 20 percent (1996 baseline: 7.1 percent; target: 5.7 percent in 2002). Reduce past-month use of any illicit drugs among adolescents aged 12 to 17 years by 20 percent (1996 baseline: 9.0 percent; target: 7.2 percent in 2002).**

**Reduce past-month use of alcohol among adolescents aged 12 to 17 years by 10 percent (1996 baseline: 18.8 percent; target: 16.9 percent in 2002).**

**26-10a Increase the proportion of adolescents not using alcohol or any illicit drugs during the past 30 days.**

Target: 89 percent
Baseline: 79 percent of adolescents aged 12 to 17 years reported no alcohol or illicit drug use in the past 30 days in 1998.
Target-setting method: Better than the best
Data source: National Household Survey on Drug Abuse (NHSDA), SAMHSA

<table>
<thead>
<tr>
<th>Adolescents Aged 12 to 17 Years, 1998</th>
<th>26-10a No Alcohol or Illicit Drug Use in Past 30 Days</th>
<th>No Alcohol Use in Past 30 Days</th>
<th>No Illicit Drug Use in Past 30 Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>79</td>
<td>81</td>
<td>90</td>
</tr>
<tr>
<td>Race and ethnicity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>72</td>
<td>76</td>
<td>87</td>
</tr>
<tr>
<td>Asian</td>
<td>87</td>
<td>89</td>
<td>94</td>
</tr>
<tr>
<td>Asian Pacific Islander</td>
<td>DNC</td>
<td>DNC</td>
<td>DNC</td>
</tr>
<tr>
<td>Native Hawaiian and other Pacific Islander</td>
<td>DNC</td>
<td>DNC</td>
<td>DNC</td>
</tr>
<tr>
<td>Black or African American</td>
<td>82</td>
<td>87</td>
<td>90</td>
</tr>
<tr>
<td>White</td>
<td>77</td>
<td>79</td>
<td>90</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>79</td>
<td>81</td>
<td>90</td>
</tr>
<tr>
<td>Not Hispanic or Latino</td>
<td>79</td>
<td>81</td>
<td>90</td>
</tr>
<tr>
<td>Black or African American</td>
<td>82</td>
<td>87</td>
<td>90</td>
</tr>
<tr>
<td>White</td>
<td>77</td>
<td>79</td>
<td>90</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>79</td>
<td>81</td>
<td>91</td>
</tr>
<tr>
<td>Male</td>
<td>78</td>
<td>81</td>
<td>90</td>
</tr>
<tr>
<td>Family income level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>75</td>
<td>79</td>
<td>84</td>
</tr>
<tr>
<td>Near poor</td>
<td>80</td>
<td>84</td>
<td>89</td>
</tr>
<tr>
<td>Middle/high income</td>
<td>79</td>
<td>81</td>
<td>91</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>DNC</td>
<td>DNC</td>
<td>DNC</td>
</tr>
</tbody>
</table>

DNA=Data have not been analyzed. DNC=Data are not collected. DSU=Data are statistically unreliable.
*Data for no alcohol use and no illicit drug use are displayed to further characterize the issue.*
26-10c Reduce the proportion of adults using any illicit drug during the past 30 days.

Target: 2.0 percent
Baseline: 5.8 percent of adults aged 18 years and older used any illicit drug during the past 30 days in 1998.
Target setting method: Better than the best (consistent with Office of National Drug Control Policy)
Data source: National Household Survey on Drug Abuse (NHSDA), SAMHSA

Past-month use of any illicit drug and marijuana was about the same in 1997 as in 1996 and most of the 1990s for adults aged 18 years and older. (HHS, SAMHSA. National Household Survey on Drug Abuse: Population Estimates 1996. Rockville, MD: SAMHSA, 1997.) However, young adults aged 18 to 25 years continued to be the age group with the highest rates of use. In 1998, past-month use of drugs decreased among adolescents aged 12 to 17 years. However, the 1998 rates of past month use of any illicit drug (9.9 percent) and marijuana (8.3 percent) were significantly higher than the 1997 rates of use by this age group (11.4 percent and 9.4 percent, respectively). Furthermore, past-month use of illicit drugs by youths was significantly higher in 1997 than at any time during the four years between 1991 and 1994. Past-month use of alcohol was about the same in 1998 as in 1997.

<table>
<thead>
<tr>
<th>Adults Aged 18 Years and Older, 1998</th>
<th>26-10c Illicit Drug Use in Past 30 Days</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percent</td>
</tr>
<tr>
<td>TOTAL</td>
<td>5.8</td>
</tr>
<tr>
<td>Race and ethnicity</td>
<td></td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>8.4</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>2.5</td>
</tr>
<tr>
<td>Asian</td>
<td>DNC</td>
</tr>
<tr>
<td>Native Hawaiian and other Pacific Islander</td>
<td>DNC</td>
</tr>
<tr>
<td>Black or African American</td>
<td>8.2</td>
</tr>
<tr>
<td>White</td>
<td>5.6</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>5.5</td>
</tr>
<tr>
<td>Not Hispanic or Latino</td>
<td>5.8</td>
</tr>
<tr>
<td>Black or African American</td>
<td>8.0</td>
</tr>
<tr>
<td>White</td>
<td>5.7</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>4.0</td>
</tr>
<tr>
<td>Male</td>
<td>7.8</td>
</tr>
<tr>
<td>Education level</td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>6.6</td>
</tr>
<tr>
<td>High school graduate</td>
<td>6.2</td>
</tr>
<tr>
<td>At least some college</td>
<td>5.3</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>DNC</td>
</tr>
</tbody>
</table>

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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percent</td>
</tr>
<tr>
<td>TOTAL</td>
<td>5.8</td>
</tr>
<tr>
<td>Race and ethnicity</td>
<td></td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>8.4</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>2.5</td>
</tr>
<tr>
<td>Asian</td>
<td>DNC</td>
</tr>
<tr>
<td>Native Hawaiian and other Pacific Islander</td>
<td>DNC</td>
</tr>
<tr>
<td>Black or African American</td>
<td>8.2</td>
</tr>
<tr>
<td>White</td>
<td>5.6</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>5.5</td>
</tr>
<tr>
<td>Not Hispanic or Latino</td>
<td>5.8</td>
</tr>
<tr>
<td>Black or African American</td>
<td>8.0</td>
</tr>
<tr>
<td>White</td>
<td>5.7</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>4.0</td>
</tr>
<tr>
<td>Male</td>
<td>7.8</td>
</tr>
<tr>
<td>Education level</td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>6.6</td>
</tr>
<tr>
<td>High school graduate</td>
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</tr>
<tr>
<td>At least some college</td>
<td>5.3</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>DNC</td>
</tr>
</tbody>
</table>

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Target and baseline:
Objective: Reduction in Adults and Adolescents Engaging in Binge Drinking During Past Month
Baseline: 1998
Target: 2010

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>26-11c Adults aged 18 years and older</td>
<td>16.6</td>
</tr>
<tr>
<td>26-11d Adolescents aged 12 to 17 years</td>
<td>7.7</td>
</tr>
</tbody>
</table>

Target-setting method: Better than the best
Data source: National Household Survey on Drug Abuse (NHSDA), SAMHSA
For this measure, adults reporting binge drinking over the past 30 days, we have national HP 2010 measures and we have state data from the BRFSS. However, at this point we do not have local data. Local data from the Lancaster-wide BRFSS will be available in 2003.

### Disparities

Substance abuse affects all racial, cultural, and economic groups. Alcohol is the most commonly used substance, regardless of race or ethnicity, and there are far more persons who smoke cigarettes than persons who use illicit drugs.

Usage rates for an array of substances reveal that for adolescents aged 12 to 17 years:

- Whites and Hispanics are more likely than African Americans to use alcohol.
- Whites are more likely than African Americans and Hispanics to use tobacco.
- Whites and Hispanics are more likely than African Americans to use illicit drugs.
Older adolescents and adults with co-occurring substance abuse and mental health disorders need explicit and appropriate treatment for their disorders.

The population aged 65 years and older faces risks for alcohol-related problems, although this group consumes comparatively low amounts of alcoholic beverages. (Dufour, M., and Fuller, R.K. “Alcohol in the elderly.” Annual Review of Medicine 46:123–132, 1995.) Adverse alcohol-drug interaction can put older people in the hospital, since many take multiple medications. In addition, many cases of memory deficits and dementia now are understood to result from alcoholism.

Alcohol problems, drug problems, and suicide attempts frequently cause ER visits. ERs are strategically well positioned to ensure appropriate referrals for follow-up care, but underlying behavioral risk factors must be identified and appropriate follow-up services must be available. The effectiveness of ED interventions for these risk factors is determined by how well the affected patients are evaluated and treated in the ED and by the extent of communication and coordination with other settings and organizations in the community. (U.S. Consumer Product Safety Commission (CPSC), Division of Hazard and Injury Data Systems. Hospital-Based Pediatric Emergency Resource Survey. Bethesda, MD: CPSC, 1997.)

Lancaster Community Indicator Project has attempted to gather data on alcohol related ER visits but are changing the methodology for collection of information in 2003. The current data is shown in the chart at right.

<table>
<thead>
<tr>
<th>Substance</th>
<th>White, Not Hispanic</th>
<th>Hispanic</th>
<th>African American, Not Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Ages 17 Years</td>
<td>All Ages 17 Years</td>
<td>All Ages 17 Years</td>
</tr>
<tr>
<td>Alcohol</td>
<td>67.8</td>
<td>35.1</td>
<td>58.5</td>
</tr>
<tr>
<td>Cigarette</td>
<td>30.8</td>
<td>26.9</td>
<td>29.6</td>
</tr>
<tr>
<td>Any illicit drug</td>
<td>10.4</td>
<td>16.9</td>
<td>10.5</td>
</tr>
<tr>
<td>Marijuana</td>
<td>8.4</td>
<td>14.6</td>
<td>8.2</td>
</tr>
<tr>
<td>Cocaine</td>
<td>1.7</td>
<td>1.9</td>
<td>2.3</td>
</tr>
<tr>
<td>Inhalants</td>
<td>1.0</td>
<td>3.4</td>
<td>0.9</td>
</tr>
<tr>
<td>Heroin</td>
<td>0.1</td>
<td>DSU</td>
<td>0.1</td>
</tr>
</tbody>
</table>

DSU=Data are statistically unreliable.

![Alcohol-Related Emergency Room Visits, Lancaster County Hospital, 2000](chart)

Source: Each county hospital provided individual data to be included in the Lancaster Community Indicators Project Quality of Life Measures, 2001. “Measure Up Lancaster.”
Note: Data is for admissions that are specifically alcohol related and does not include any admissions where alcohol may have been a contributing factor (i.e., accidental injuries, automobile accidents, etc.). Also, each individual hospital may have used varying definitions of what constitutes an alcohol-related admission. Data for Community Hospital of Lancaster was not available. LGH–Susquehanna houses a detox unit.
The effective prevention and treatment of substance abuse requires that all abused substances be targeted—from tobacco and alcohol to marijuana and other illicit drugs. Tobacco use prevention and cessation programs are equally important parts of a comprehensive substance abuse prevention program. Community-wide cooperation must increase between government, employers, the faith community, and other organizations in the private and nonprofit sectors to meet the wide range of service needs. Findings suggest that having community partnerships in place for sustained periods of time produces significant results in decreasing alcohol and drug use in males. Literature shows that having “buy-in” from local participants greatly enhances the success of any endeavor. Studies also show that changing norms is extremely effective in reducing substance abuse and related problems. (HHS. The National Structured Evaluation of Alcohol and Other Drug Abuse Prevention. Rockville, MD: HHS, 1994.)

We must directly apply all that we have learned through prevention and treatment research. Communities must develop adaptations of research-proven programs for specific racial and ethnic populations and field test them with process and outcome evaluations. Communities must commit to providing services where they are needed most critically. Gaps in substance abuse treatment capacity must be identified and implemented by every level of government and community. That means that communities must be honest as they assess local programs culturally, linguistically, and for age-appropriate content and service; job training and employment; parenting training; general education; more behavioral research; and programs for women, dually diagnosed patients, and persons with learning disabilities are critical to closing the revolving door of relapse and rehabilitation and/or incarceration.

Particular attention must be given to young persons under age 18 years who have an addicted parent because these youth are at increased risk for substance abuse. Because alcoholism and drug abuse continue to affect lesbians, gay men, and transgendered persons at two to three times the rate of the general population, programs that address the special risks and requirements of these population groups also are needed. (McKirnan, D.J., and Peterson, P.L. “Alcohol and drug use among homosexual men and women: Epidemiology and population characteristics.” Addictive Behaviors 14:545–553, 1989.)

The targets that resulted from the 1999 National Drug Control Strategy to educate and enable America’s youth to reject illegal drugs as well as alcohol and tobacco were used as the basis for identifying Healthy People 2010 objectives. This approach includes focusing on mobilizing and leveraging resources, raising public awareness, and countering pro-use messages in order to:

- Increase the involvement of parents and parent groups at the local level.
- Increase the number of adult volunteers involved in drug prevention at the local level.
- Change attitudes among youth from “everyone’s using drugs” to “everyone has better things to do.”
- Increase the proportion of youth participating in positive skill-building activities.

Adopting an approach to youth substance abuse prevention that has many components may increase the long-term effectiveness of efforts. Studies indicate that making youth and others aware of the health, social, and legal consequences associated with drug abuse has an impact on use. Core strategies for preventing substance abuse among youth include:

- raising awareness of dangers and consequences;
- educating and training parents and others;
- strengthening families;
- providing alternative activities after school hours;
- building skills (education and life) and in doing so, building confidence;
mobilizing and empowering communities;
employing environmental and community-wide approaches to supporting good choices.

Scientific research has identified many opportunities to prevent alcohol-related problems. To address the problem of binge drinking and reduce access to alcohol by underaged persons, several additional policies and strategies may be effective, including:


- Restrictions on the sale of alcoholic beverages at recreational facilities and entertainment events where minors are present.

- Improved enforcement of state laws prohibiting distribution of alcoholic beverages to anyone under age 21 years and more severe penalties to discourage distribution to underaged persons.

- Implementation of server training and standards for responsible hospitality. (Holder, H.D., and Wagenaar, A.C. “Mandated server training and reduced alcohol-involved traffic crashes: A time series analysis of the Oregon experience.” *Accident Analysis and Prevention* 26:89–97, 1994.) States could require periodic server training or use the regulatory authority of alcohol distribution licensing to mandate a minimal level of training for individual servers.

- Institution of a requirement that college students reporting to student health services following a binge drinking incident receive an alcohol screening that would identify the likelihood of a health risk. An alcohol screening would provide student health services with the information needed to assess the student's drinking and refer the student to an appropriate intervention.

- Restrictions on marketing to underaged populations, including limiting advertisements and promotions. Although alcohol advertising has been found to have little or no effect on overall consumption, this strategy may reduce the demand that results in illicit purchase or binge consumption. (Saffer, H. “Alcohol advertising and alcohol consumption: Econometric studies.” In: Martin, S.E., and Mail, P., eds. *The Effects of the Mass Media on the Use and Abuse of Alcohol*. NIAAA Research Monograph No. 28. NIH Publication No. 95–3743. Bethesda, MD: NIH, 1995.)

- Higher prices for alcoholic beverages are associated with reductions in the probability of frequent beer consumption by young persons and in the probability of adults drinking five or more drinks on a single occasion. (Coate, D., and Grossman, M. “Effects of alcoholic beverage prices and legal drinking ages on youth alcohol use.” *Journal of Law and Economics* 31:145–171, 1988.)

Research has confirmed that treatment can help end dependence on addictive drugs and reduce the consequences of addictive drug use on society. While no single approach for substance abuse and addiction treatment exists, comprehensive and carefully tailored treatment works. (HHS. *The National Structured Evaluation of Alcohol and Other Drug Abuse Prevention*. Rockville, MD: HHS, 1994.)

It is estimated that 5.3 million persons are most in need of treatment for the use of illicit drugs (ONDCP. *The National Drug Control Strategy, 1999: A Ten Year Plan*. Washington, DC: GPO, 1999). The treatment gap is the difference between the number of persons who need treatment for the use of illicit drugs and the number of persons who are receiving treatment in a given year. Clinically appropriate and effective treatment for alcohol problems is
limited. The size of the gap is not well defined. Despite the widely acknowledged problem of drug abuse in the United States, accepted estimates of the number of persons who need treatment and the number who receive treatment are not available. National efforts are under way to estimate better the size of the gaps, to develop strategies to expand capacity, and to eliminate barriers to access for those in need. These strategies involve seeking changes in financial barriers created by funding constraints and inadequate health and disability insurance coverage (Buck, J.A., and Umland, B. “Covering mental health and substance abuse services.” Health Affairs 16:120–126, 1997) and improvements in gender-specific and culturally appropriate treatment methods.

Wide variability exists among jurisdictions in total treatment capacity and in how that capacity is distributed among settings and modalities. Increasing the availability of treatment is critical because of the pervasive impact these problems have on all aspects of society. Strategies to be employed here are similar to those needed to improve access to appropriate primary, rehabilitative, and long-term care through addressing the many barriers that exist at multiple levels. Key barriers include:

- Lack of knowledge or skepticism on the part of patient about the effectiveness of treatment.
- Lack of money or insurance coverage to pay for treatment.
- Lack of trained personnel.
- Stigma (the stigma attached to substance abuse increases the unmanageability and severity of the problem. The hiding of substance abuse, for example, can prevent persons from seeking and continuing treatment and from having a productive attitude toward treatment).
- Lack of health and disability insurance coverage.
- Inadequate reimbursement for clinically necessary services through public funding mechanisms such as the Substance Abuse Prevention and Treatment Services Block Grant and Medicaid. (Sing, M.; Hik, S; Smolkin, S.; et al. The Costs and Effects of Parity for Mental Health and Substance Abuse Benefits. Rockville, MD: SAMHSA, 1998.)
- Inappropriate settings and unavailability of care for dually diagnosed patients (research confirms that a substantial number of frequent users of cocaine, heroin, and illicit drugs other than marijuana have co-occurring chronic mental health disorders).
- Lack of real treatment options for the incarcerated (compounding the issue has been the criminalization of addiction as well as the sale of illegal addictive substances. Much attention has been focused on the link between substance abuse and criminality, in part because of the large increase in the number of individuals incarcerated for drug-related offenses, such as possession, trafficking, and crimes of violence. In general, criminal offenders frequently have high occurrences of a substance abuse history, may or may not have previously received treatment, and without treatment have a greater likelihood of committing a criminal offense).
### Local Assets

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and Drug Treatment Referral Intervention/Rapid Detox</td>
<td>(800) 996-3784 and Toll Free (800) 454-8966</td>
</tr>
<tr>
<td>Alcohol Hotline</td>
<td>(800) 252-6465</td>
</tr>
<tr>
<td>Assessment and Referral Center</td>
<td>(800) 555-2911</td>
</tr>
<tr>
<td>Cocaine Hotline</td>
<td>(800) 667-HELP</td>
</tr>
<tr>
<td>The Council on Drug and Alcohol Abuse</td>
<td>(717) 299-2831</td>
</tr>
<tr>
<td>Dept. of Veterans Affairs Medical Centers</td>
<td>(800) 409-8771</td>
</tr>
<tr>
<td>Lancaster County Drug and Alcohol Commission</td>
<td>(717) 299-8023</td>
</tr>
<tr>
<td>National Clearinghouse for A&amp;D Information</td>
<td>(800) 729-6686</td>
</tr>
<tr>
<td>National Helpline</td>
<td>(800) 667-HELP (24 hours)</td>
</tr>
<tr>
<td>PA Dept of Health, Research &amp; Information Clearinghouse</td>
<td>(800) 582-7746</td>
</tr>
<tr>
<td>United Way LINC</td>
<td>(717) 291-LINC</td>
</tr>
<tr>
<td>Salud Hispana</td>
<td>(717) 396-1155</td>
</tr>
</tbody>
</table>

### Inpatient Help

- DARS Supervised Independent Living Program                           | (717) 393-1796                                      |
- The Gate House for Men                                               | (717) 626-9524                                      |
- The Gate House for Women                                             | (717) 285-2300                                      |
- Immediate and Emergency Help Crisis Intervention Service             | (717) 394-2631                                      |
- Hopeline                                                              | (717) 393-HOPE                                      |
- Lancaster Hogar Crea                                                  | (717) 397-8633                                      |
- Manos (DARS)                                                          | (717) 393-0573                                      |
- Nuestra Clinica Residential                                          | 414-1435 or 1-888-344-0630                          |
- Susquehanna Addictions Center                                         | (717) 684-2841 or 1-800-242-2333                    |
- Vantage/Gaudenzia, Inc                                               | (717) 291-1020                                      |
- White Deer Run of Lancaster                                          | (717) 396-0650                                      |

### Outpatient Counseling

- Family Service                                                        | (717) 397-5241                                      |
- HSA Counseling, Inc.                                                 | (717) 394-5334                                      |
- Lancaster Clinical Counseling Associates                              | (717) 299-0131                                      |
- Lancaster Freedom Center                                             | (717) 397-9118                                      |
- Management & Professional Services Corporation                       | (717) 390-0353                                      |

### Additional Resources

- Naaman Center                                                        | (717) 367-9115 or 1-888-243-4316                     |
- http://www.naamancenter.com                                           |
- Nuestra Clinica—SACA D&A Program                                     | (717) 293-4150                                      |
- PA Counseling Services—Lancaster City                                | (717) 397-8081                                      |
- T.W. Ponessa and Assoc. Counseling Services, Inc.                   | (717) 560-9717                                      |
- Susquehanna Addictions Center                                         | (717) 684-2841 or 1-800-242-2333                    |
- Water Street Rescue Mission                                          | (717) 393-7709                                      |
- Women for Sobriety                                                   | (215) 536-8026                                      |

- Nuestra Clinica Residential                                          | 414-1435 or 1-888-344-0630                          |
- Susquehanna Addictions Center                                         | (717) 684-2841 or 1-800-242-2333                    |
- Vantage/Gaudenzia, Inc                                               | (717) 291-1020                                      |
- White Deer Run of Lancaster                                          | (717) 396-0650                                      |
Preventing Drug Use Among Children (PDFY)

The primary goal of PDFY is to increase family involvement that is rewarding and enhances parent-child bonds. The program is offered in a series of sessions, each designed to focus on one of five areas. The program was pilot-tested in ten Seattle public schools and among participating students, 52 percent were minorities, 48 percent were from low-income families, and 39 percent were from single-parent homes. The evaluation studies looked at 209 families in the central Midwest, where the families were predominantly white. It has been used to train more than 120,000 urban, suburban, and rural families in several states. The program begins with increasing parents’ knowledge of the risk factors associated with drug abuse. It then focuses on teaching parents the skills that help mitigate these risk factors, such as how to clearly communicate expectations for behavior, how to reduce family conflict, and how to encourage the expression of positive feelings and love. One of the sessions teaches both parents and children various ways to resist peer and social pressures to engage in inappropriate behavior.

Businesses and Institutions

- Provide Employee Assistance Programs (EAP) to your employees.
- Educate your employees, including supervisors, to recognize signs of substance abuse.
- Implement comprehensive programs to include policy, education, training, testing, and access to treatment for your employees.
- Help employees to understand the effects of drug and alcohol abuse on their employment status, absentee rate, and likelihood of being involved in a workplace accident.
- Provide information to your employees about the long-term effects of drugs and alcohol on their physical health, mental health, and family life.
- Make materials on help and community available in places that are private and non-threatening for employees.

Support Groups

<table>
<thead>
<tr>
<th>Support Group</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Children of Alcoholics, ACOA</td>
<td>(717) 393-7767</td>
</tr>
<tr>
<td>Al-Anon/Alateen</td>
<td>Meets Daily—(717) 393-7767</td>
</tr>
<tr>
<td>Alcoholics Anonymous, AA</td>
<td>Meets Daily—(717) 394-3238</td>
</tr>
<tr>
<td>Cocaine Anonymous</td>
<td>(800) 482-0983</td>
</tr>
<tr>
<td>Narcotics Anonymous, NA</td>
<td>Meets Daily—(717) 393-4546</td>
</tr>
<tr>
<td>Nar-Anon Family Group</td>
<td>Meets twice a week—(717) 738-3074</td>
</tr>
<tr>
<td>Steps to Freedom (Recovery)</td>
<td>Thursday evenings, 7-9 p.m.—(717) 656-4271</td>
</tr>
</tbody>
</table>

Additional Resources

National Clearinghouse for Alcohol and Drug Information, Substance Abuse and Mental Health Services Administration (SAMHSA)
800-729-6686; 800-487-4889 (TDD);
http://www.health.org/

National Institute on Drug Abuse, NIH
http://www.nida.nih.gov/

National Institute on Alcohol Abuse and Alcoholism, NIH
201-443-3860;
http://www.niaaa.nih.gov/

Preparing for the Drug Free Years
http://www.promisingpractices.net/program.asp?programid=91
- Provide health insurance that includes treatment options for employees and family members.
- Guarantee your employees that your HR department is vigilant regarding matters of confidentiality.
- Encourage primary care physicians and facilities to learn how to screen for signs of substance abuse. Provide opportunities for patients to talk about family members about whom they are concerned.

Schools
- Provide information to parents from elementary school years onward about helping children make decisions.
- Provide after-school programs from elementary through high school.
- Implement curriculums in schools that encourage the idea that drugging is not cool.
- Get students involved in developing and disseminating anti-drug campaigns.
- Open school buildings to the community to provide lots of recreational opportunities in the community as an alternative to “getting high.”

Individuals
- If you are abusing drugs or alcohol, seek help—no one can “get clean and sober” without help.
- Be a resource to friends, family members, or coworkers who are dealing with substance abuse issues.
- Provide support to those dealing with recovery.
- If you or your loved one is affected by addiction or addicted, contact a support group (AA, Al-anon, Nar-anon).
- Think about the ramifications of privatizing the PA State Liquor Store system and the increased advertising of alcohol use that privatization will bring. Contact your state legislator with your opinion and ideas.
- Act as a positive role model to young people. Set a good example and speak with them about the risks and consequences of substance abuse.
- Be thoughtful about the messages you give your children about the use of alcohol and drugs and the role they play in your daily life.
- Never drive drunk and never let a friend drive drunk.
- If you suspect that a friend or family member is struggling with substance abuse issues, speak to them about it.
- Ask your children where they are going and who they will be with. Be a parent—not a friend.

- What are effective strategies for reaching our youth and preventing them from abusing alcohol or using illicit drugs now and as they grow older?
- How do we enlist the aid of school districts and parents in allowing Youth surveys that must be conducted to gather community information about personal drug and alcohol use?
- How can we do a better job of treating substance abuse issues when individuals enter the justice system?
- How does a community organize all of the different interest groups to put together a community-wide campaign promoting alternative activities for young people?
- What steps do we need to take to implement a comprehensive state and local program which addresses education, health, law enforcement, corrections, welfare, and treatment?
All Substance Use and Abuse Objectives

Adverse Consequences of Substance Use and Abuse
- 26-1 Motor vehicle crash deaths and injuries
- 26-2 Cirrhosis deaths
- 26-3 Drug-induced deaths
- 26-4 Drug-related hospital emergency department visits
- 26-5 Alcohol-related hospital emergency department visits
- 26-6 Adolescents riding with a driver who has been drinking
- 26-7 Alcohol- and drug-related violence
- 26-8 Lost productivity

Substance Use and Abuse
- 26-9 Substance-free youth
- 26-10 Adolescent and adult use of illicit substances
- 26-11 Binge drinking
- 26-12 Average annual alcohol consumption
- 26-13 Low-risk drinking among adults
- 26-14 Steroid use among adolescents
- 26-15 Inhalant use among adolescents

Risk of Substance Use and Abuse
- 26-16 Peer disapproval of substance abuse
- 26-17 Perception of risk associated with substance abuse

Treatment for Substance Abuse
- 26-18 Treatment gap for illicit drugs
- 26-19 Treatment in correctional institutions
- 26-20 Treatment for injection drug use
- 26-21 Treatment gap for problem alcohol use

State and Local Efforts
- 26-22 Hospital emergency department referrals
- 26-23 Community partnerships and coalitions
- 26-24 Administrative license revocation laws
- 26-25 Blood alcohol concentration (BAC) levels for motor vehicle drivers

Access to Quality Health Services
- 1-1 Persons with health insurance
- 1-2 Health insurance coverage for clinical preventive services
- 1-3 Counseling about health behaviors
- 1-4 Source of ongoing care
- 1-5 Usual primary care provider
- 1-6 Difficulties or delays in obtaining needed health care
- 1-7 Core competencies in health provider training
- 1-8 Racial and ethnic representation in the health professions
- 1-10 Delay or difficulty in getting emergency care
- 1-11 Rapid pre-hospital emergency care
- 1-12 Single toll-free number for poison control centers
- 1-13 Trauma care systems
- 1-11 Special needs of children

Cancer
- 3-10 Provider counseling about cancer prevention
Disability and Secondary Conditions
6-2  Feelings and depression among children with disabilities

Educational and Community-Based Programs
7-1  High school completion
7-2  School health education
7-3  Health-risk behavior information for college and university students
7-4  School nurse-to-student ratio
7-5  Work site health promotion programs
7-6  Participation in employer-sponsored health promotion activities
7-7  Patient and family education
7-8  Satisfaction with patient education
7-9  Health care organization sponsorship of community health promotion activities
7-10  Community health promotion programs
7-11  Culturally appropriate and linguistically competent community health promotion programs
7-12  Older adult participation in community health promotion activities

Family Planning
9-8  Abstinence before age 15 years
9-9  Abstinence among adolescents aged 15 to 17 years
9-10  Pregnancy prevention and sexually transmitted disease (STD) protection
9-11  Pregnancy prevention education
9-12  Problems in becoming pregnant and maintaining a pregnancy

HIV
13-3  AIDS among persons who inject drugs
13-4  AIDS among men who have sex with men and who inject drugs
13-8  HIV counseling and education for persons in substance abuse treatment
13-12  Screening for STDs and immunization for hepatitis B
13-13  Treatment according to guidelines

Immunization and Infectious Diseases
14-28  Hepatitis B vaccination among high-risk groups

Injury and Violence Prevention
15-12  Emergency department visits
15-13  Deaths from unintentional injuries
15-14  Nonfatal unintentional injuries
15-15  Deaths from motor vehicle crashes
15-16  Pedestrian deaths
15-17  Nonfatal motor vehicle injuries
15-18  Nonfatal pedestrian injuries
15-29  Drownings
15-32  Homicides
15-37  Physical assaults

Maternal, Infant, and Child Health
16-17  Prenatal substance exposure
16-18  Fetal alcohol syndrome
Medical Product Safety

17-3 Provider review of medications taken by patients

Mental Health and Mental Disorders

18-6 Primary care screening and assessment
18-10 Treatment for co-occurring disorders
18-13 State plans addressing cultural competence

Public Health Infrastructure

23-2 Public access to information and surveillance data
23-3 Use of geocoding in health data systems
23-4 Data for all population groups
23-5 Data for Leading Health Indicators, Health Status Indicators, and Priority Data Needs at tribal, state, and local levels
23-6 National tracking of Healthy People 2010 objectives
23-7 Timely release of data on objectives
23-8 Competencies for public health workers
23-9 Training in essential public health services
23-10 Continuing education and training by public health agencies
23-11 Performance standards for essential public health services
23-12 Health improvement plans
23-14 Access to epidemiology services
23-15 Model statutes related to essential public health services
23-16 Data on public health expenditures
23-17 Population-based prevention research

Sexually Transmitted Diseases

25-11 Responsible adolescent sexual behavior
25-12 Responsible sexual behavior messages on television
25-13 Hepatitis B vaccine services in STD clinics
25-14 Screening in youth detention facilities and jails

Tobacco Use

27-1 Adult tobacco use
27-2 Adolescent tobacco use
27-3 Initiation of tobacco use
27-4 Age at first tobacco use
27-5 Smoking cessation by adults
27-6 Smoking cessation during pregnancy
27-7 Smoking cessation by adolescents
27-8 Insurance coverage of cessation treatment
27-9 Exposure to tobacco smoke at home among children
27-10 Exposure to environmental tobacco smoke
27-11 Smoke-free and tobacco-free schools
27-12 Work site smoking policies
27-13 Smoke-free indoor air laws
27-14 Enforcement of illegal tobacco sales to minors laws
27-15 Retail license suspension for sales to minors
27-16 Tobacco advertising and promotion targeting adolescents and young adults
27-17 Adolescent disapproval of smoking
27-18 Tobacco control programs
27-19 Preemptive tobacco control laws
27-20 Tobacco product regulation
27-21 Tobacco tax
Tobacco Use

Prevent and reduce tobacco use
### HP 2010 Measures and Local Measures

<table>
<thead>
<tr>
<th>27-2b</th>
<th>Reductions in tobacco use by students in grades 9 through 12.</th>
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<tbody>
<tr>
<td></td>
<td>Target-setting method: Better than the best</td>
</tr>
<tr>
<td></td>
<td>Data source: Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP, PA DOH</td>
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<table>
<thead>
<tr>
<th>27-1a</th>
<th>Reductions in tobacco use by adults aged 18 years and older.</th>
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<tbody>
<tr>
<td></td>
<td>Target-setting method: Better than the best</td>
</tr>
<tr>
<td></td>
<td>Data source: National Health Interview Survey (NHIS), CDC, NCHS, BRFSS</td>
</tr>
</tbody>
</table>

Environmental tobacco smoke (ETS) or secondhand smoke, increases the risk of heart disease and significant lung conditions, especially asthma and bronchitis in children (Glantz, S.A., and Parmely, W.W. “Passive smoking and heart disease: Mechanism and risk.” Journal of the American Medical Association 273:1047–1053, 1995). Asthma and other respiratory conditions often are triggered or worsened by tobacco smoke. ETS is responsible for an estimated 3,000 lung cancer deaths each year among adult nonsmokers. Studies also have found that secondhand smoke exposure causes heart disease among adults. Data reported from a study of the U.S. population, aged 4 years and older, indicated that among tobacco nonusers, 88 percent had detectable levels of serum cotinine, a biological marker for exposure to secondhand smoke. (Pirkle, J.L.; Flegal, K.M.; Bernet, J.T.; et al. “Exposure of the U.S. population to environmental tobacco smoke.” Journal of the American Medical Association 275:1233–1240, 1996.) Both home and workplace environments have contributed to the widespread exposure to secondhand smoke. (CDC. “State-specific prevalence of cigarette smoking among adults, and children's and adolescents' exposure to environmental tobacco smoke—United States.” Morbidity and Mortality Weekly Report 46:1038–1043, 1997.)

Other forms of tobacco are not safe alternatives to smoking cigarettes. Use of spit tobacco causes a number of serious oral health problems, including cancer of the mouth and gum, periodontitis, and tooth loss. Cigar use causes cancer of the larynx, mouth, esophagus, and lung.

- Tobacco use is responsible for more than 430,000 deaths per year among adults in the United States, representing more than 5 million years of potential life lost. (CDC. “Cigarette smoking-attributable mortality and years of potential life lost—United States, 1984.” Morbidity and Mortality Weekly Report 46(20):444–451, 1997.)
- If current tobacco use patterns persist in the United States, an estimated 5 million persons under age 18 years will die prematurely from a smoking-related disease.
- Researchers have identified more than 4,000 chemicals in tobacco smoke; of these, at least 43 cause cancer in humans and animals.
- Each year, because of exposure to secondhand smoke, an estimated 3,000 nonsmokers die of lung cancer, and 150,000 to 300,000 infants and children under age 18 months experience lower respiratory tract infections. (U.S. Environmental Protection Agency (EPA). Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders. EPA Pub. No. EPA/600/6-90/006F. Washington, DC: EPA, 1992.)
Smoking among adults declined steadily from the mid-1960s through the 1980s. However, smoking among adults appears to have leveled off in the 1990s. The rate of smoking among adults in 1997 was 25 percent.

Overwhelming evidence indicates that nicotine found in tobacco is addictive and that addiction occurs in most smokers during adolescence. Youth are put at increased risk of starting to use tobacco products due to socio-demographic, environmental, and personal factors. Socio-demographic risk factors include coming from a low-income family or other substance abuse issues in the home. Environmental risk factors include access to and availability of tobacco products, cigarette advertising and promotion practices, the price of tobacco products, perceptions that tobacco use is normal, peers’ and siblings’ use and approval, and lack of parental involvement. Personal risk factors include low self-image and low self-esteem, the belief that tobacco use provides a benefit, and the lack of ability to refuse offers to use tobacco. (HHS. Preventing Tobacco Use Among Young People: A Report of the Surgeon General. Atlanta, GA: HHS, PHS, CDC, NCCDPHP, OSH, 1994.)

One proposed indicator focuses in particular on school-age students for two reasons. First, school age is when most people first try tobacco products and when addictions to tobacco products are often established. Second, although there has been steady progress in reducing the rates of tobacco use among adults, we have not been as successful when it comes to cutting down on the level of use in youth, particularly for adolescent females and some racial and ethnic minority groups. A wide variety of strategies address not only the prevention of tobacco use among youth but also improvements in the rates at which youthful smokers quit. Furthermore, tobacco use may increase the probability that an adolescent will use other drugs.

Among adults in the United States who have ever smoked daily, 82 percent tried their first cigarette before age 18 years, and 53 percent became daily smokers before age 18 years. Among students who were high school seniors during 1976–86, 44 percent of daily smokers believed that in five years they would not be smoking. Follow up studies, however, indicated that five to six years later, 73 percent of these persons remained daily smokers. Consequently, preventing tobacco use among youth has emerged as a major focus of tobacco control efforts. (HHS. Preventing Tobacco Use Among Young People: A Report of the Surgeon General. Atlanta, GA: HHS, PHS, CDC, NCCDPHP, OSH, 1994.)

Smoking During Pregnancy
Tobacco use during pregnancy is known to contribute to complications, low birth weight, and infant mortality, as well as negatively affecting children’s health and development after birth. Evidence is accumulating that shows maternal tobacco use is associated with mental retardation and birth defects such as oral clefts. Direct medical costs related to smoking during pregnancy are approximately $1.4 billion per year. (CDC. “Medical-care expenditures attributable to cigarette smoking during pregnancy—United States, 1995.” Morbidity and Mortality Weekly Report 46:1048–1050, 1997.)

Fortunately, throughout the 1990’s, the percentage of women who smoked during pregnancy declined every year. There are disparities among which women are more likely to smoke while pregnant based on race or ethnicity, age, and education.

Between 1990 and 1999, American Indian women were the most likely to smoke during pregnancy, and reported the least improvement. Non-Hispanic white women
were second most likely, followed by non-Hispanic Black women. Hispanic women and Asians and Pacific Islanders were the least likely.

- From 1990–1994, women aged 20–24 were most likely to smoke while pregnant. But since 1996, the rate has been highest among teenagers.
- Among teenage mothers, non-Hispanic whites reported the highest incidence of smoking throughout the 1990s.
- Smoking rates were highest among women with only 9–11 years of education, whereas women with four or more years of college were least likely. While only 3.7% of Hispanic women overall reported smoking in 1999, nearly half of Hispanic women completing only 9–11 years of education reported smoking in the same year.

Among teens, throughout the 1990s, the smoking rate decreased significantly, but during the second half of the decade, 22 states, including Pennsylvania, showed significant increases of smoking among pregnant women. While the overall decrease among all women shows that education has worked, the increase in the latter portion of the decade show that we must continue to spread the message. Additionally, women who quit smoking during pregnancy are likely to resume smoking within one year of delivery. For those who wait to quit until seeking prenatal care, it may be too late, as damage to the fetus may already have occurred. (National Vital Statistics Reports, Volume 49, Number 7, *Smoking during pregnancy in the 1990s* T.J. Matthews, M.S.; Division of Vital Statistics, August 28, 2001).

National and state data has been collected via telephone and written surveys. These are the Adult (BRFSS) Behavioral Risk Factor Surveillance Survey (phone) and the Youth BRFSS, which is usually conducted by schools in written form. National data has numbers broken down into sub-sets that are unavailable locally. We could assume that we would break out in the same proportions, but we prefer not to do that. Local data is sometimes available through national and state sources that have used these tools, but not consistently. Schools, for example, are not mandated to perform these surveys and so they are not done consistently through all counties’ districts. The PA Department of Health is starting a new process for collecting data from schools. Local experts do not believe it will yield results that are any better than past measures. And because schools are doing those surveys, they are not inclined to do a locally generated survey even if it might yield data that would be valid and could be compared to national data sets. LHC will be conducting the BRFSS in Lancaster County and the data will be available in 2003.

National Youth Risk Behavior Surveillance Survey revealed that past-month smoking among 9th to 12th graders rose from 28 percent in 1991 to 36 percent in 1997.

### Youth Use

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>27-2b Reduction in tobacco use by students in grades 9 through 12.</td>
<td></td>
<td>16</td>
<td>35</td>
<td>27.2</td>
</tr>
</tbody>
</table>

In Lancaster, we have data from the year 2000 for 6th, 8th, and 10th grade students who reported using cigarettes in the last 30 days. Healthy People collects for 9th–12th, but breaks it down by grade, so we can compare the smoking habits of our 10th grade students to 10th grade students across the nation.
## Reported Using Cigarettes in the Last 30 Days

<table>
<thead>
<tr>
<th>Data Source</th>
<th>6th Grade</th>
<th>8th Grade</th>
<th>10th Grade</th>
<th>12th Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lancaster County, 2000—PA Youth Survey, Pennsylvania Commission of Crime and Delinquency</td>
<td>5%</td>
<td>15%</td>
<td>26%</td>
<td></td>
</tr>
<tr>
<td>United States, 1999—Healthy People 2010 Baseline Data</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Students in Grades 9 Through 12, 1999 (unless noted)

<table>
<thead>
<tr>
<th>Current Cigarette Smoking (smoking cigarettes on 1 or more of the 30 days preceding the survey)</th>
<th>27-2b Both Genders</th>
<th>Females*</th>
<th>Males*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>35</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td>Race and ethnicity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>DSU</td>
<td>DSU</td>
<td>DSU</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>DSU</td>
<td>DSU</td>
<td>DSU</td>
</tr>
<tr>
<td>Asian</td>
<td>DSU</td>
<td>DSU</td>
<td>DSU</td>
</tr>
<tr>
<td>Native Hawaiian and other Pacific Islander</td>
<td>DSU</td>
<td>DSU</td>
<td>DSU</td>
</tr>
<tr>
<td>Black or African American</td>
<td>20</td>
<td>19</td>
<td>22</td>
</tr>
<tr>
<td>White</td>
<td>39</td>
<td>40</td>
<td>38</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>33</td>
<td>32</td>
<td>34</td>
</tr>
<tr>
<td>Not Hispanic or Latino</td>
<td>35</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td>Black or African American</td>
<td>20</td>
<td>18</td>
<td>22</td>
</tr>
<tr>
<td>White</td>
<td>39</td>
<td>39</td>
<td>38</td>
</tr>
<tr>
<td>Parents’ education level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>DNC</td>
<td>DNC</td>
<td>DNC</td>
</tr>
<tr>
<td>Selection populations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9th grade</td>
<td>28</td>
<td>29</td>
<td>26</td>
</tr>
<tr>
<td>10th grade</td>
<td>35</td>
<td>36</td>
<td>34</td>
</tr>
<tr>
<td>11th grade</td>
<td>36</td>
<td>36</td>
<td>36</td>
</tr>
<tr>
<td>12th grade</td>
<td>43</td>
<td>41</td>
<td>46</td>
</tr>
</tbody>
</table>

DNA=Data have not been analyzed. DNC=Data are not collected. DSU=Data are statistically unreliable.
*Data for females and males are displayed to further characterize the issue.

---

**Related Objective**

**27-2a Reduce use of tobacco products in adolescents.**

**Measure:** Reduction in tobacco use by students in grades 9 through 12

<table>
<thead>
<tr>
<th>Students in Grades 9 through 12, 1999 (unless noted)</th>
<th>Current Cigarette Smoking (smoking cigarettes on 1 or more of the 30 days preceding the survey)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>27-2b Both Genders</td>
</tr>
<tr>
<td></td>
<td>Percent</td>
</tr>
<tr>
<td>TOTAL</td>
<td>40</td>
</tr>
</tbody>
</table>

*Data for females and males are displayed to further characterize the issue.*
Adult Use

**Target and baseline:**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Reduction in tobacco use by adults aged 18 years and older</th>
<th>Percent</th>
<th>Baseline*</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>27-1a</td>
<td>Cigarette smoking</td>
<td>24</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>27-1b</td>
<td>Spit tobacco</td>
<td>2.6</td>
<td>0.4</td>
<td></td>
</tr>
<tr>
<td>27-1c</td>
<td>Cigars</td>
<td>2.5</td>
<td>1.2</td>
<td></td>
</tr>
<tr>
<td>27-1d</td>
<td>Other products (developmental)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Age adjusted to the year 2000 standard population

**Target-setting method:** Better than the best

**Data source:** National Health Interview Survey (NHIS), CDC, NCHS

An adult BRFSS survey will be administered in Lancaster County in 2002. This should give us a clearer picture of local tobacco use. Until this survey is completed, we can glean a fair picture by using statewide HP 2010 data and the statewide BRFSS.

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>27-1a</td>
<td>Smoke cigarettes</td>
<td>12</td>
<td>25</td>
<td>25</td>
<td>24</td>
<td>24</td>
<td>25</td>
</tr>
</tbody>
</table>

**PA 2000 BRFSS Data, Tobacco Use**

<table>
<thead>
<tr>
<th>Current Smokers %</th>
<th>Former Smokers %</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Adults</td>
<td>24</td>
</tr>
<tr>
<td>Male</td>
<td>25</td>
</tr>
<tr>
<td>Female</td>
<td>23</td>
</tr>
<tr>
<td>18–29</td>
<td>34</td>
</tr>
<tr>
<td>30–44</td>
<td>29</td>
</tr>
<tr>
<td>45–64</td>
<td>24</td>
</tr>
<tr>
<td>65+</td>
<td>9</td>
</tr>
</tbody>
</table>

**Disparities**

**Men are more likely to smoke than women (26 percent compared to 22 percent).**

**Disparities in tobacco use exist among certain racial and ethnic populations.** American Indians or Alaska Natives (35 percent) are more likely to smoke than other racial and ethnic groups, with considerable variations in percentages by tribe.

**Hispanics (18 percent) and Asians or Pacific Islanders (13 percent) are less likely to smoke than other groups.** Regional and local data, however, reveal much higher smoking levels among specific population groups of Hispanics and Asians or Pacific Islanders. Smoking levels among Vietnamese and Korean Asian Americans are higher than previously reported, according to a 1997 multilingual survey (HHS, Tobacco Use Among U.S. Racial/Ethnic Minority Groups—African Americans, American Indians, and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: A Report of the Surgeon General. Atlanta, GA: HHS, PHS, CDC, NCCDPHP, OSH, 1998).

**Studies have found higher levels of cigarette use among gay men and lesbians than among heterosexuals.** Gay men and lesbians with higher education levels are less likely to use cigarettes as frequently as those with lower levels of education (Skinner, W.F. “The prevalence and demographic predictors of illicit and licit drug use among lesbians and gay men.” *American Journal of Public Health* 84(8):1307–1310, 1994.)
Persons with 9 to 11 years of education (38 percent) have significantly higher levels of smoking than individuals with 8 years or less of education or 12 years or more. Individuals with 16 or more years of education have the lowest smoking rates (11 percent). Individuals who are poor are significantly more likely to smoke than individuals of middle or high income (34 percent compared to 21 percent). (CDC, NCHS. National Health Interview Survey. Unpublished data, 1998.)

Data reveal high levels of tobacco use among college students. In 1995, 29 percent of college students smoked in the previous month (28 percent of females and 30 percent of males). Five percent of college students used spit tobacco in the previous month (0.3 percent of females and 12 percent of males). (CDC. “Youth Risk Behavior Surveillance: National College Health Risk Behavior Survey—United States, 1995.” Morbidity and Mortality Weekly Report 46(SS-6):1–56, 1997.) This is higher than adult smoking rates of all adults.

Among adolescents, smoking rates differ between whites and African Americans. By the late 1980s, smoking rates among white teens were more than triple those of African American teens. In recent years, smoking has started to increase among African American male teens, but African American female teens continue to have lower smoking rates. In 1997, 40 percent of white high school females were smokers, compared to 17 percent of African American high school females. (CDC. “Tobacco use among high school students—United States, 1997.” Morbidity and Mortality Weekly Report 47:229–233, 1998.)

The goals of comprehensive tobacco prevention and reduction efforts include:

- Preventing people from starting to use tobacco.
- Helping people quit using tobacco.
- Reducing exposure to secondhand smoke.
- Identifying and eliminating disparities in tobacco use among population groups.

To address these goals, the following strategies are used to build capacity to implement and support tobacco use prevention and control interventions:

- A focus on change in social norms and environments that support tobacco use.
- Policy and regulatory strategies.
- Community participation.
- Establishment of public and private partnerships.
- Strategic use of media.
- Development of local programs.
- Coordination of statewide and local activities.
- Linkage of school-based activities to community activities.
- Use of data collection and evaluation techniques to monitor program impact.

As education programs for school-aged youth are developed and proven effective in preventing initiation and in cessation, these programs should be included in quality health education curricula at each grade level. Education should aim to prevent initiation among youth, provide knowledge about effective cessation methods, and increase understanding of the health effects of tobacco use.

The importance of these various strategies has been demonstrated in a number of states, such as Arizona, California, Florida, Massachusetts, and Oregon. Community research studies and evidence from California, Florida, Massachusetts, and Oregon have shown that comprehensive programs can be effective in reducing average cigarette consumption per person. Both California and Massachusetts increased cigarette excise taxes and designated a por-
tion of the revenues for comprehensive tobacco control programs. Data from these states indicate that (1) increasing excise taxes on cigarettes is one of the most cost-effective short-term strategies to reduce tobacco consumption among adults and to prevent initiation among youth; and (2) the ability to sustain lower consumption increases when the tax increase is combined with an antismoking campaign. As with almost all consumer products, the demand for cigarettes decreases as price increases. An increase in the excise tax on tobacco products would reduce rates of use of both cigarettes and spit tobacco among adults and youth. Economists agree that a 10 percent increase in the price of cigarettes will reduce overall smoking among adults by approximately 4 percent. Data suggest that the prevention effect on youth would be at least as large, if not larger.

A 1989 report predicted that for every 10 percent increase in the price of cigarettes, there would be a 7.6 to 12 percent decrease in teen smoking participation rates (i.e., whether teens smoke at all). The report concluded that among teens smoking participation responds strongly to price, and that excise taxes and aggressive educational efforts combined were the most effective smoking-cessation strategy. (CDC. “Cigarette smoking before and after an excise tax increase and an antismoking campaign.” Morbidity and Mortality Weekly Report 45:966–970, 1996.) Studies conducted since the release of this report reinforce and support these conclusions. Data also indicate that earmarking funds from an excise tax increase for tobacco prevention and control programs increases both public support for the proposed tax and the public health impact of the price increase.

Recent data from Florida indicates that past-month smoking decreased significantly among public middle school students (19 percent to 15 percent) and high school students (27 percent to 25 percent) from 1998 to 1999 following implementation of a comprehensive program to prevent and reduce tobacco use among youth in that state. (CDC. “Tobacco use among middle and high school students—Florida, 1998 and 1999.” Morbidity and Mortality Weekly Report 48:248–253, 1999.) In the Minnesota Heart Health Program, smoking rates were reduced by approximately 40 percent in the intervention community with a combined school-based curriculum, community-based activities, and mass media intervention (Perry, C.L.; Kelder, S.H.; Murray, D.M.; et al. “Community-wide smoking prevention: Long-term outcomes of the Minnesota Heart Health Program and the Class of 1989 Study.” American Journal of Public Health 82(9):1210–1216, 1992). Furthermore, a preliminary report on the effectiveness of the American Stop Smoking Intervention Study (ASSIST) indicated that in 1993–94, per capita cigarette consumption was 7 percent less in the 17 ASSIST states than in the remaining states (excluding California).

In these and other states, tobacco control programs are supported through funding from the federal government, private foundations, state tobacco taxes, state lawsuit settlements, and other sources. These programs address issues such as reducing exposure to secondhand smoke, restricting minors’ access to tobacco, treating nicotine addiction, limiting the impact of tobacco advertising, increasing the price of tobacco products, and directly regulating the product (e.g., requiring product ingredient reporting). Tobacco control programs and materials should be culturally and linguistically appropriate.

Effective prevention approaches for reducing tobacco use among adolescents include school-based prevention programs as an integral part of community-wide strategies that address the overall social context of tobacco use. School-based tobacco prevention programs identify the social influences that promote tobacco use among youth and teach skills to resist these influences. Such programs have demonstrated consistent and significant reductions or delays in adolescent smoking. The effects dissipate over time if they are not followed by additional educational interventions or linkages to community programs. Studies have shown that the effectiveness of school-based tobacco prevention programs appears to be strengthened by booster sessions or further application of the programs and community-wide programs involving parents, school policies, mass media, youth access, and community organizations. Limiting the appeal of tobacco products to young people involves both restricting tobacco advertising and promotions and countering the ability of pro-tobacco messages to reach large segments of the population quickly and efficiently. Because of their appeal,
mass media can serve as a powerful tool for tobacco control. Television and radio stations, magazines, and other media can deliver information and educational messages directly to targeted audiences, build public support for tobacco control programs and policies, reinforce social norms supporting the nonuse of tobacco, and counteract the pro-use messages and images of tobacco marketing and public relations campaigns.

Local Assets

- **American Cancer Society**  
  Lancaster County Unit  
  (717) 397-3744

- **American Lung Association of Pennsylvania**  
  (717) 397-5203

- **Ephrata Community Hospital**  
  Smokeless: Individual Smoking Cessation Counseling  
  (717) 738-6186

- **Freedom From Smoking**  
  (717) 733-0405

- **Hempfield Counseling Associates**  
  Tobacco Awareness & Cessation  
  (717) 795-9127

- **Lancaster General Hospital**  
  Individual Smoking Cessation Counseling (717) 290-3138  
  Freedom From Smoking (717) 290-3143

- **Lancaster Regional Medical Center**  
  Individual Smoking Cessation Counseling (717) 291-8377  
  Freedom from Smoking (717) 291-8377

- **Nicotine Anonymous Support Group**  
  (717) 898-8571

- **St. Joseph Health Ministries**  
  Lung Cancer Community  
  (717) 239-1196

- **United Way LINC**  
  (717) 291-LINC

Additional Resources

- **Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC**  
  800-CDC-1311;  
  [http://www.cdc.gov/tobacco/](http://www.cdc.gov/tobacco/)

- **Cancer Information Service, NIH**  
  800-4-CANCER;  

- **American Lung Association**  
  [http://www.lungusa.org](http://www.lungusa.org)
Addendum I: A Plan for Creating a Healthy Lancaster Community

Proven Programs
http://www.promisingpractices.net/benchmark.asp?benchmarkid=4

Big Brothers Big Sisters of America
Life Skills Training
Prenatal and Infancy Nurse Home Visitation Program
Project ALERT
Project Northland
Project STAR/Midwestern Prevention Project
Seattle Social Development Project

Promising Programs
Athletes Training and Learning to Avoid Steroids
CASASTART
Creating Lasting Family Connections
Know Your Body
Preparing for the Drug Free Years

Business and Institutions
- Provide working smoking cessation programs through the workplace.
- Provide educational materials for workers to share with their family.
- Do anti-smoking campaigns that address personal and insurance costs as well as quality of life issues.
- Support the excise tax on tobacco products.
- Understand your own business costs related to smoking.
- Develop smoke-free workplace policies.
- Build incentives (fun or economic) into smoking cessation campaigns.
- Contribute to community coalitions looking for media sponsors for PR campaigns.
- Lobby the state legislature for a comprehensive approach to tobacco-use cessation from the health care cost impact perspective—it’s good for business.
- Sponsor “How to Talk to Your Kids” workshops for your employees.
- Get serious about secondhand smoke policies and provide statistics.
- Consider supporting and encouraging restaurants and bars that are or wish to become non-smoking establishments.

Individuals
- Smoke less, or better yet, quit.
- Accept help when quitting—join support groups, get a patch, see your doctor, do what you must to support a healthy lifestyle.
- Don’t smoke around children or non-smokers.
- Patronize no smoking establishments such as bars and restaurants.
- Lobby for state supported comprehensive smoking cessation programs like those in successful states such as MA, MN, FL and CA.
- Exercise more.
- Begin talking to your kids at a very early age about smoking.
- Talk to your kids about advertising and the message they are receiving when they see people smoking in the movies, on TV or in the media.

What You Can Do
Don’t let others smoke in your home if you are maintaining a non-smoking environment for your children.

Lobby against corner stores selling cigarettes out of the packet—per cigarette.

Be prepared with information on all tobacco products.

Do not smoke while you are pregnant.

Express support for friends and family members who are trying to quit.

How can we get the entire community involved locally to better motivate people to quit smoking?

How can we prevent young people from trying tobacco and becoming addicted?

What other types of positive incentives or support can we as institutions and employers offer to those trying to quit?

What tools might we develop to help reach pregnant women, especially teens, who are still smoking?

How can we keep women who quit while pregnant from beginning again after delivery?

Are there new ways we can work together to provide more smoking cessation programs, particularly for young people?

How can we as a community prevent non-smokers from being subjected to environmental tobacco smoke (secondhand smoke)?

**Tobacco Use in Population Groups**

27-1 Adult tobacco use
27-2 Adolescent tobacco use
27-3 Initiation of tobacco use
27-4 Age at first tobacco use

**Cessation and Treatment**

27-5 Smoking cessation by adults
27-6 Smoking cessation during pregnancy
27-7 Smoking cessation by adolescents
27-8 Insurance coverage of cessation treatment

**Exposure to Secondhand Smoke**

27-9 Exposure to tobacco smoke at home among children
27-10 Exposure to environmental tobacco smoke
27-11 Smoke-free and tobacco-free schools
27-12 Work site smoking policies
27-13 Smoke-free indoor air laws

**Social and Environmental Changes**

27-14 Enforcement of illegal tobacco sales to minors laws
27-15 Retail license suspension for sales to minors
27-16 Tobacco advertising and promotion targeting adolescents and young adults
27-17 Adolescent disapproval of smoking
27-18 Tobacco control programs
27-19 Preemptive tobacco control laws
27-20 Tobacco product regulation
27-21 Tobacco tax
Access to Quality Health Services
   1-2 Health insurance coverage for clinical preventive services
   1-3 Counseling about health behaviors

Cancer
   3-1 Overall cancer deaths
   3-2 Lung cancer deaths
   3-4 Cervical cancer deaths
   3-6 Oropharyngeal cancer deaths

Educational and Community-Based Programs
   7-5 Work site health promotion programs
   7-6 Participation in employer-sponsored health promotion activities
   7-10 Community health promotion programs
   7-11 Culturally appropriate and linguistically competent community
      health promotion programs
   7-12 Older adult participation in community health promotion activities

Environmental Health
   8-18 Homes tested for radon
   8-19 Radon-resistant new home construction
   8-29 Global burden of disease

Heart Disease and Stroke
   12-1 Coronary heart disease (CHD) deaths
   12-7 Stroke deaths

Maternal, Infant, and Child Health
   16-1 Fetal and infant deaths
   16-6 Prenatal care
   16-10 Low birth weight and very low birth weight
   16-11 Preterm births
   16-17 Prenatal substance exposure

Oral Health
   21-6 Early detection of oral and pharyngeal cancers
   21-7 Annual examinations for oral and pharyngeal cancers

Public Health Infrastructure
   23-4 Data for all population groups
   23-5 Data for Leading Health Indicators, Health Status Indicators, and
      Priority Data Needs at tribal, state, and local levels

Respiratory Diseases
   24-1 Deaths from asthma
   24-2 Hospitalizations for asthma
   24-3 Hospital emergency department visits for asthma

Substance Abuse
   26-9 Substance-free youth
   26-16 Peer disapproval of substance abuse
   26-17 Perception of risk associated with substance abuse
LHC Action Team
Lancaster Health Improvement Partnership

Definition of Health—A state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity (World Health Organization).

Mission—To direct/manage the SHIP process in Lancaster County by setting community health priorities based on data analysis of community health and quality of life indicators.

Goals
1. Maintain representation on the State SHIP Committee
   - Set a two year length of service
   - Those currently serving will continue for two years
2. Establish and sustain a community collaborative.
3. Plan a Needs Assessment Process
   - Analysis of community health and quality of life indicators (HP 2010, LCIP Indicators, BRFSS, HRSA, PA Vital Statistics Data)
   - Inventory strengths and ID Gaps— to build on strengths
   - Identify Community Health Priorities
4. Develop and publicize health improvement strategies
   - Media involvement
5. Provide a community health priority review process for DOH contractees in Lancaster County.
6. Support and advocate for local health initiatives that fit within our priorities but that may not be supported by State and Federal plans.
7. Identify resources that address the priorities we have identified in the health improvement plan.

Action Team Participants:
Alice Yoder, Chair—Lancaster General Hospital
Phyllis Boyd—IU #13
Lisa Riffanacht—Special Kids Network
Ayesha Jafri—Lancaster Medical Society
Jim Kelly—Southeast Lancaster Health Services
Phyllis Campbell—Urban League
Donna Carr—Community Hospital of Lancaster
Carol Marsh—United Way of Lancaster County
Sean Flaherty—Franklin & Marshall College
Jonathan Fox—Human Relation Commission
Maureen Gallo—Lancaster Regional Medical Center
Kay Moyer—PA Department of Health

Appendix A

Team mission and goals

Pat Kadel—Lancaster County Planning Commission
Rick Kastner—Lancaster County Drug Commission
William Lafferty—Ephrata Community Hospital
Lilia Nice—Lancaster Healthy Communities
Audrey Atkins—Office of Representative Tom Creighton
Danielle Gentile, Jamie Brightbill—Franklin & Marshall Fellow and LHC staff
Phyllis Campbell—Urban League of Lancaster
Flor Sherbahn—Salud Hispana
Jennifer Thompson—St. Joseph Health Ministries
Terri Trimble—Welsh Mountain Health and Dental Services
Kim Wittle—Lancaster Council of Churches
Mike Sturla—State Representative (96th)

Additional thanks to:
Carolene Beachey, Sue Richards—IU #13
Bob Haigh—Lancaster Osteopathic Foundation
Dr. John Haun—St. Joseph Hospital/Lancaster Regional Medical Center
Patrice Bettel—Special Kids Network
Dr. John Laguna—Psychologist
Rebecca Rolnick, Katie Covello—Franklin & Marshall Fellows and LHC Staff
Kathie Benjamin—Southeast Lancaster Health Services
Jackie Burch—Lancaster County Office of the Aging
Susan Eckert, Barbara Guider—United Way
Claudia Gazsi—Lancaster Community Indicator Project, Lebanon Valley College
Leslie Hyson—Human Relation Commission
Stephen Fuhs—PA Department of Health
Cass Kennedy—Southeast AHEC
Mac Stacks—Community Action Program
Diane Tannenhill—Lancaster Community Indicator Project
Veronica Urdaneta—Epidemiologist
Monica Witmer—Lancaster Newspapers
Nancy Nehr—St. Joseph Health Ministries
Matt Fragaele, Pat Eckert—Interns from Franklin & Marshall College
Appendix B

Definitions of determinants of health

Biology refers to the individual’s genetic makeup (those factors with which he or she is born), family history (which may suggest risk for disease), and the physical and mental health problems acquired during life. Aging, diet, physical activity, smoking, stress, alcohol or illicit drug abuse, injury or violence, or an infectious or toxic agent may result in illness or disability and can produce a “new” biology for the individual.

Behaviors are individual responses or reactions to internal stimuli and external conditions. Behaviors can have a reciprocal relationship to biology; in other words, each can react to the other. For example, smoking (behavior) can alter the cells in the lung and result in shortness of breath, emphysema, or cancer (biology) that then may lead an individual to stop smoking (behavior). Similarly, a family history that includes heart disease (biology) may motivate an individual to develop good eating habits, avoid tobacco, and maintain an active lifestyle (behaviors), which may prevent his or her own development of heart disease (biology).

Personal choices and the social and physical environments surrounding individuals can shape behaviors. The social and physical environments include all factors that affect the life of individuals, positively or negatively, many of which may not be under their immediate or direct control.

Social environment includes interactions with family, friends, coworkers, and others in the community. It also encompasses social institutions, such as law enforcement, the workplace, places of worship, and schools. Housing, public transportation, and the presence or absence of violence in the community are among other components of the social environment. The social environment has a profound effect on individual health, as well as on the health of the larger community, and is unique because of cultural customs; language; and personal, religious, or spiritual beliefs. At the same time, individuals and their behaviors contribute to the quality of the social environment.

Physical environment can be thought of as that which can be seen, touched, heard, smelled, and tasted. However, the physical environment also contains less tangible elements, such as radiation and ozone. The physical environment can harm individual and community health, especially when individuals and communities are exposed to toxic substances, irritants, infectious agents, and physical hazards in homes, schools, and work sites. The physical environment also can promote good health, for example, by providing clean and safe places for people to work, exercise, and play.

Policies and interventions can have a powerful and positive effect on the health of individuals and the community. Examples include health promotion campaigns to prevent smoking; policies mandating child restraints and safety belt use in automobiles; disease prevention services, such as immunization of children, adolescents, and adults; and clinical services, such as enhanced mental health care. Policies and interventions that promote individual and community health may be implemented by a variety of agencies, such as transportation, education, energy, housing, labor, justice, and other venues, or through places of worship, community-based organizations, civic groups, and businesses.
The 467 Healthy People 2010 objectives are being tracked by 190 data sources. A major data source is defined as a data system responsible for tracking five or more Healthy People 2010 objectives. There are 23 data systems that meet these criteria. More than three-fifths (286) of the objectives are tracked with data from these sources.

### Number of Objectives Tracked by Healthy People 2010 Major Data Sources

<table>
<thead>
<tr>
<th>Data Sources</th>
<th>Number of Objectives Tracked</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Health Interview Survey (NHIS)</td>
<td>67</td>
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<tr>
<td>National Health and Nutrition Examination Survey (NHANES)</td>
<td>35</td>
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<tr>
<td>National Vital Statistics System—Mortality (NVSS-M)</td>
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<tr>
<td>National Survey of Family Growth (NSFG)</td>
<td>14</td>
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<tr>
<td>National Hospital Discharge Survey (NHDS)</td>
<td>11</td>
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<tr>
<td>Youth Risk Behavior Surveillance System (YRBSS)</td>
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<tr>
<td>HIV/AIDS Surveillance System</td>
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<tr>
<td>Behavioral Risk Factor Surveillance System (BRFSS)</td>
<td>9</td>
</tr>
<tr>
<td>National Household Survey on Drug Abuse (NHSDA)</td>
<td>8</td>
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<tr>
<td>School Health Policies and Programs Study (SHPPS)</td>
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<tr>
<td>National Vital Statistics System—Natality (NVSS-N)</td>
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<tr>
<td>National Profile of Local Health Departments (NPLHD)</td>
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<td>National Ambulatory Medical Care Survey (NAMCS)</td>
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<td>United States Renal Data System (USRDS)</td>
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<td>STD Surveillance System (STDSS)</td>
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<td>Medical Expenditure Panel Survey (MEPS)</td>
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<td>National Hospital Ambulatory Medical Care Survey (NHAMCS)</td>
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<td>Continuing Survey of Food Intake by Individuals (CSFII)</td>
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<tr>
<td>National Crime Victimization Survey (NCVS)</td>
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<td>1999 National Worksite Health Promotion Survey (NWHPS)</td>
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<td>State Tobacco Activities Tracking and Evaluation System (STATES)</td>
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<td>National Notifiable Disease Surveillance System (NNDSS)</td>
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<tr>
<td>Monitoring the Future Study (MTF)</td>
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Behavioral Risk Factor Surveillance System (BRFSS) is sponsored by U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP). It is a telephone interview done annually since 1984. It consists of a core of questions asked in all states, standardized optional questions on selected topics that are administered at the state’s discretion, a rotating core of questions asked every other year in all states, and state-added questions developed to address state-specific needs. Questions cover behavioral risk factors (e.g., alcohol and tobacco use), preventive health measures, HIV/AIDS, health status, limitation of activity, and health care access and utilization.
### Baselines for Age-Adjusted Mortality Objectives Using Rates Age Adjusted to 1940 and to 2000 Standards: United States, 1998

<table>
<thead>
<tr>
<th>Objective Number</th>
<th>Short Objective Text</th>
<th>Total Population</th>
<th>Male</th>
<th>Female</th>
<th>White</th>
<th>Black or African American</th>
<th>American Indian or Alaska Native</th>
<th>Asian or Pacific Islander</th>
<th>Hispanic or Latino 1</th>
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<tr>
<td>3.1</td>
<td>All cancer</td>
<td>1236</td>
<td>2024</td>
<td>1477</td>
<td>1055</td>
<td>1626</td>
<td>1210</td>
<td>1993</td>
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<td>3.2</td>
<td>Lung cancer</td>
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<td>576</td>
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<td>79.9</td>
<td>270</td>
<td>36.8</td>
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<td>3.3</td>
<td>Female breast cancer</td>
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<td>Cervical cancer</td>
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<td>Oropharyngeal cancer</td>
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<td>119.4</td>
<td>95.4</td>
<td>153.7</td>
<td>662</td>
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<td>Cirrhosis</td>
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<td>Drug-induced</td>
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<td>3.6</td>
<td>3.9</td>
<td>5.8</td>
<td>6.1</td>
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</table>
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Access: According to the Institute of Medicine, “The timely use of personal health services to achieve the best possible health outcomes. This definition includes both the use and effectiveness of health services. The concept of access also encompasses physical accessibility of facilities.

Activities of daily living (ADL): Personal care activities, such as bathing, dressing, eating, and getting around (with special equipment, if needed) inside the home.

Acute care facility: A health facility that provides care on a short-term basis. Included are community hospitals with an average length of stay of less than 30 days for all patients.

Aerobic: Conditions or processes that occur in the presence of, or requiring, oxygen.

Age adjustment: Using the direct method, is the application of age-specific rates in a population of interest to a standardized age distribution in order to eliminate differences in observed rates that result from age differences in the population composition. This adjustment is usually done when comparing two or more populations (such as race/ethnic groups) at one point in time or one population at two or more points in time. For some population groups, the age-adjusted rates are considerably different than crude rates. This happens because the population distribution of the group is quite different from the distribution of the standard population, which, for most objectives, is based on the projected year 2000 population for the entire United States. For example, for the Hispanic population (especially Mexican Americans) the age-adjusted rates for many outcomes and behaviors that are generally more frequent among the older population are considerably higher than the crude rates. This occurs because the Hispanic population has a much younger age distribution than the standard population.

AIDS: Acquired immunodeficiency syndrome, the most severe phase of infection with the human immunodeficiency virus (HIV). Persons infected with HIV are said to have AIDS when they get certain opportunistic infections or when their CD4+ cell count drops below 200.

Alcohol abuse: A maladaptive pattern of alcohol use that leads to clinically significant impairment or distress, as manifested by one or more of the following occurring within a 12-month period: recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home; recurrent alcohol use in physically hazardous situations; recurrent alcohol-related legal problems; continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol. In the literature on economic costs, alcohol abuse means any cost-generating aspect of alcohol consumption; this definition differs from the clinical use of the term, which involves specific diagnostic outcomes.

Alcohol dependence: A maladaptive pattern of alcohol use that leads to clinically significant impairment or distress, as manifested by three or more of the following occurring at any time in the same 12-month period: tolerance; withdrawal; often taking alcohol in larger amounts or over a longer period than was intended; persistent desire or unsuccessful efforts to cut down or control alcohol use; spending a great deal of time in activities necessary to obtain alcohol or recover from its effects; giving up or reducing important social, occupational, or recreational activities because of alcohol use; continued alcohol use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.

Alcohol-related crash: A motor vehicle crash in which either a driver or a nonmotorist (usually a pedestrian) had a measurable or estimated BAC of 0.01 grams per deciliter (g/dL) or above.

Atrial fibrillation (AF): The most common sustained irregular heart rhythm encountered in clinical practice. AF occurs when the two small upper chambers of the heart (the atria) quiver instead of beating effectively and blood cannot be pumped completely out of them when the heart beats, allowing the blood to pool and clot. If a piece of the blood clot in the atria becomes lodged in an artery in the brain, a stroke may result. AF is a risk factor for stroke and heart failure.

Baseline: Accurate, quantitative data at a stated point in time that marks the beginning of a trend.
Binge drinking: The National Household Survey on Drug Abuse defines binge drinking as drinking five or more drinks on the same occasion on at least one day in the past 30 days. The Monitoring the Future Study defines binge drinking as drinking five or more drinks on the same occasion during the past two weeks.

Blood alcohol concentration (BAC): The amount of alcohol in the bloodstream measured as a percentage, by weight, of alcohol in the blood in grams per deciliter (g/dL). Legal intoxication has been defined by states to occur at ranges from as low as 0.05 g/dL to as high as 0.10 g/dL.

Blood pressure: The force of the blood pushing against the walls of arteries. Blood pressure is given as two numbers that measure systolic pressure (the first number, which measures the pressure while the heart is contracting) and diastolic pressure (the second number, which measures the pressure when the heart is resting between beats). Blood pressures of 140/90 mmHg or above are considered high, while blood pressures in the range of 130–139/85–89 are high normal. Less than 130/85 mmHg is normal.

Body composition: The relative amount of body weight that is fat and nonfat.

Body mass index (BMI): Weight (in kilograms) divided by the square of height (in meters), or weight (in pounds) divided by the square of height (in inches) times 703.5. Because it is readily calculated, BMI is the measurement of choice as an indicator of healthy weight, overweight, and obesity.

Cancer screening: Checking for changes in tissue, cells, or fluids that may indicate the possibility of cancer when there are no symptoms.

Cancer: A term for diseases in which abnormal cells divide without control. Cancer cells can invade nearby tissue and can spread through the bloodstream and lymphatic system to other parts of the body.

Carcinoma: Cancer that begins in the epithelial tissue that lines or covers an organ.

Cardiorespiratory function: A health-related component of physical fitness that relates to the ability of the circulatory and respiratory systems to supply oxygen during physical activity.

Cardiovascular disease (CVD): Includes a variety of diseases of the heart and blood vessels: coronary heart disease (coronary artery disease, ischemic heart disease), stroke (brain attack), high blood pressure (hypertension), rheumatic heart disease, congestive heart failure, and peripheral artery disease.

Case management: Practice in which the service recipient is a partner in his or her recovery and self-management. Cerebrovascular disease affects the blood vessels supplying blood to the brain. Stroke occurs when a blood vessel bringing oxygen and nutrients to the brain bursts or is clogged by a blood clot. Because of this rupture or blockage, part of the brain does not get the flow of blood it needs, and nerve cells in the affected area die. Small stroke-like events, such as transient ischemic attacks (TIAs), which resolve in a day or less, are symptoms of cerebrovascular disease.

Cholesterol: A waxy substance that circulates in the bloodstream. When the level of cholesterol in the blood is too high, some of the cholesterol is deposited in the walls of the blood vessels. Over time, these deposits can build up until they narrow the blood vessels, causing atherosclerosis, which reduces the blood flow. The higher the blood cholesterol level, the greater is the risk of getting heart disease.

Blood cholesterol levels of less than 200 mg/dL are considered desirable. Levels of 240 mg/dL or above are considered high and require further testing and possible intervention. Levels of 200–239 mg/dL are considered borderline. Lowering blood cholesterol reduces the risk of heart disease.

Chronic drug use: Use of any heroin or cocaine more than 10 days in the past month.

Clinical care: The provision of health care services to individual patients by trained health care professionals.

Collaborating: Exchanging information, modifying activities, sharing resources and enhancing the capacity of another for mutual benefit and to achieve a common purpose.

Colonoscopy: An examination of the rectum and entire colon using a lighted instrument called a colonoscope. A colonoscope allows the physician to remove polyps or other abnormal tissue for examination under a microscope.

Community capacity: The characteristics of communities that affect their ability to identify, mobilize, and address social and public health problems.

Community health planning or community health improvement process: Helps a community mobilize to collect and use local data; set health priorities; and design, implement, and evaluate comprehensive programs that address community health and quality of life issues.

Community health promotion program: Includes all of the following: (1) community participation with representation from at least three of the following community sectors: government, education, business, faith organizations, health care, media, voluntary agencies, and the public; (2) community assessment, guided by a community assessment and planning model, to determine community health problems, resources, perceptions, and priorities for action; (3) targeted and measurable objectives to address at least one of the following: health outcomes, risk factors, public awareness, services, and protection; (4) comprehensive, multifaceted, culturally relevant interventions that have multiple targets for change; and (5) monitoring and evaluation processes to determine whether the objectives are reached.

Community water system: A public water system that provides water to at least 15 service connections used by year-round residents or that regularly serves at least 25 year-round residents.

Community-based program: A planned, coordinated, ongoing effort operated by a community that characteristically includes multiple interventions intended to improve the health status of members of the community.

Comparability: The extent to which an indicator measures the same thing across time or space, segments of a community or multiple communities.

Comprehensive primary care: All aspects of routine health care (preventive, diagnostic, and therapeutic) delivered by a trained health care provider.

Comprehensive work site health promotion programs: Refers to programs that contain the following elements: (1) health education that focuses on skill development and lifestyle behavior change in addition to information dissemination and awareness building, preferably tailored to employees’ interests and needs; (2) supportive social and physical work environments, including established norms for healthy behavior and policies that promote health and reduce the risk of disease, such as work site smoking policies, healthy nutrition alternatives in the cafeteria and vending services, and opportunities for
obtaining regular physical activity; (3) integration of the worksite program into the organization’s administrative structure; (4) related programs, such as employee assistance programs; and (5) screening programs, preferably linked to medical care service delivery to ensure follow-up and appropriate treatment as necessary and to encourage adherence. Optimally, these efforts should be part of a comprehensive occupational health and safety program.

Congestive heart failure (or heart failure): A condition in which the heart cannot pump enough blood to meet the needs of the body’s other organs. Heart failure can result from narrowed arteries that supply blood to the heart muscle and from other factors. As the flow of blood out of the heart slows, blood returning to the heart through the veins backs up, causing congestion in the tissues. Often swelling (edema) results, most commonly in the legs and ankles, but possibly in other parts of the body as well. Sometimes fluid collects in the lungs and interferes with breathing, causing shortness of breath, especially when a person is lying down.

Consumption: The amount of tobacco products consumed or used by the population. Consumption usually is measured in units, such as the number of cigarettes smoked or pounds of spit tobacco used over a given period of time.

Continuum of care: The array of health services and care settings that address health promotion; disease prevention; and the diagnosis, treatment, management, and rehabilitation of disease, injury, and disability. Included are primary care and specialized clinical services provided in community and primary care settings, hospitals, trauma centers, and rehabilitation and long-term care facilities.

Contraception (birth control): The means of pregnancy prevention. Methods include permanent methods (vasectomy for men and tubal ligation for women) and temporary methods (e.g., hormonal implant, injectable, birth control pill, emergency contraceptive pills, intrauterine device, diaphragm, female condom, male condom, spermicidal foam/cream/jelly, sponge, cervical cap, abstinence, natural family planning, calendar rhythm, and withdrawal).

Co-occurring disorders: The simultaneous presence of two or more disorders, such as the coexistence of a mental health disorder and substance abuse problem.

Co-occurring/comorbidity: In general, the existence of two or more illnesses—whether physical or mental—at the same time in a single individual. In this chapter, comorbidity specifically means the existence of a mental illness and a substance abuse disorder or a mental and a physical illness in the same person at the same time.

Coronary angiography (or arteriography) is used to explore coronary arteries and show blockages caused by atherosclerosis.

Coronary heart disease (CHD): A condition in which the flow of blood to the heart muscle is reduced. Like any muscle, the heart needs a constant supply of oxygen and nutrients that are carried to it by the blood in the coronary arteries. When the coronary arteries become narrowed or clogged, they cannot supply enough blood to the heart. If not enough oxygen-carrying blood reaches the heart, the heart may respond with pain called angina. The pain usually is felt in the chest or sometimes in the left arm or shoulder. When the blood supply is cut off completely, the result is a heart attack. The part of the heart muscle that does not receive oxygen begins to die, and some of the heart muscle is permanently damaged.

Cost-effective: Indicates that the cost of a particular intervention compares favorably to life-saving interventions associated with other diseases.
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High-density lipoprotein (HDL) cholesterol: This helps protect against heart disease (CHD). HDL is thought to carry cholesterol away from other parts of the body back to the liver for removal from the body. A low level of HDL increases the risk for CHD, whereas a high HDL level helps protect against CHD.

Health insurance: Any type of third party payment, reimbursement, or financial coverage for an agreed-upon set of health care services. Includes private insurance obtained through employment or purchased directly by the consumer, or health insurance provided through publicly funded programs, including Medicare, Medicaid, CHAMPUS/CHAMPVA, or other public hospital or physician programs.

Health literacy: The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

Health outcomes: The results or consequences of a process of care. Health outcomes may include satisfaction with care as well as the use of health care resources. Included are clinical outcomes, such as changes in health status and changes in the length and quality of life as a result of detecting or treating disease.

Health promotion: Any planned combination of educational, political, regulatory, and organizational supports for actions and conditions of living conducive to the health of individuals, groups, or communities.

Health: A state of physical, mental, and social well-being, and not merely the absence of disease and infirmity.

Healthy community: A community that is continuously creating and improving those physical and social environments and expanding those community resources that enable people to mutually support and improve each other in performing all the functions of life and in developing to their maximum potential.

Healthy public policy: Characterized by an explicit concern for health and equity in all areas of policy and by an accountability for health impact. The main aim of healthy public policy is to create a supportive environment to enable people to lead healthy lives by making healthy choices possible and easier for citizens. It makes social and physical environments health enhancing.

Heart disease: The leading cause of death and a common cause of illness and disability in the United States. Coronary heart disease and ischemic heart disease are specific names for the principal form of heart disease, which is the result of atherosclerosis, or the buildup of cholesterol deposits in the coronary arteries that feed the heart.

High blood pressure: A systolic blood pressure of 140 mmHg or greater or a diastolic pressure of 90 mmHg or greater. With high blood pressure, the heart has to work harder, resulting in an increased risk of a heart attack, stroke, heart failure, kidney and eye problems, and peripheral vascular disease.

High school completion rate (graduation rate): Refers to the percentage of persons aged 18 to 24 years who are not currently enrolled in high school and who report that they have received a high school diploma or the equivalent, such as a General Education Development certificate.
HIV (human immunodeficiency virus): A virus that infects and takes over certain cells of the immune system that are important in fighting disease.

HIV antiretrovirals: Drugs, such as zidovudine (AZT) and saquinavir, designed to attack HIV and prevent it from multiplying.

Homeless person: A person who lacks housing. The definition also includes a person living in transitional housing or a person who spends most nights in a supervised public or private facility providing temporary living quarters.

Household lead dust: Very fine particles containing lead that are usually caused by the deterioration of lead paint.

Index: A weighted combination of two or more indicators, designed to be a summary indicator that shows the general trend of a system. By combining a collection of indicators into an index, general trends can be depicted.

Indoor air quality (IAQ): The overall state of the air inside a building as reflected by the presence of pollutants, such as dust, fungi, animal dander, volatile organic compounds, carbon monoxide, and lead.

Infectious agents: Any organism, such as a virus, parasite, or bacterium, that is capable of invading the body, multiplying, and causing disease.

Infertility: Failure to conceive a pregnancy after 12 months of unprotected intercourse.

Inhalants: Fumes or gases from common household substances, such as glues, aerosols, butane, and solvents, that are inhaled to produce a high.

Injury: Unintentional or intentional damage to the body resulting from acute exposure to thermal, mechanical, electrical, or chemical energy or from the absence of such essentials as heat or oxygen.

Integrated Risk Information System (IRIS): This database, maintained by EPA, contains information on health hazards from over 5,000 substances.

Intimate partner violence: Actual or threatened physical or sexual violence or psychological and emotional abuse by an intimate partner.

Intimate partner(s): Refers to spouses, ex-spouses, boyfriends, girlfriends, and former boyfriends and girlfriends (includes same-sex partners). Intimate partners may or may not be cohabitating and need not be engaging in sexual activities.

Juvenile justice facility: Includes detention centers, shelters, reception or diagnostic centers, training schools, ranches, forestry camps or farms, halfway houses and group homes, and residential treatment centers for young offenders.

Latent TB infection: The state of being infected with the organism mycobacterium tuberculosis, but without signs or symptoms of active TB disease.

LDL (low-density lipoprotein): The so-called bad cholesterol. LDL contains most of the cholesterol in the blood and carries it to the tissues and organs of the body, including the arteries. Cholesterol from LDL is the main source of damaging buildup and blockage in the arteries. The higher the level of LDL in the blood, the greater is the risk for CHD.

Malignant: Cancerous.

Managed care organizations (MCOs): Refers to systems that integrate the financing and delivery of health care services to covered individuals by means of arrangements with selected providers to furnish health care services to members. Managed care includes health maintenance organizations, preferred provider organizations, and point-of-service plans.

Managed care: According to the Institute of Medicine, “a set of techniques used by or on behalf of purchasers of health care benefits to manage health care costs by influencing patient care decisionmaking through case-by-case assessments of the appropriateness of care prior to its provision.”

Mental health services: Diagnostic, treatment, and preventive care that helps improve how persons with mental illness feel both physically and emotionally, as well as how they interact with other persons. These services also help persons who have a strong risk of developing a mental illness.

Mental illness: The term that refers collectively to all diagnosable mental disorders. Mental disorders are health conditions characterized by alterations in thinking, mood, or behavior (or some combination thereof) that are all mediated by the brain and associated with distress or impaired functioning, or both. Mental disorders spawns a host of human problems that may include personal distress, impaired functioning and disability, pain, or death. These disorders can occur in men and women of any age and in all racial and ethnic groups. They can be the result of family history, genetics, or other biological, environmental, social, or behavioral factors that occur alone or in combination.

Moderate physical activity: Activities that use large muscle groups and are at least equivalent to brisk walking. In addition to walking, activities may include swimming, cycling, dancing, gardening and yardwork, and various domestic and occupational activities.

Multiple sex partners: More than one partner in the prior six months.

National Ambient Air Quality Standards (NAAQS): Standards set by EPA for the level of common air pollutants allowed by the Clean Air Act.

National Notifiable Disease Surveillance System (NNDSS): Tracking system that state health departments use to report cases of selected diseases to CDC. (See Reportable disease).

NCUTLO: National Committee on Uniform Traffic Laws and Ordinances.

Nicotine dependency: Highly controlled or compulsive use, use despite harmful effects, withdrawal upon cessation of use, and recurrent drug craving.

Nonattainment area: A locality where air pollution levels persistently exceed EPA National Ambient Air Quality Standards.

Nonpoint source: The source of runoff water coming from an area such as a yard, parking lot, pasture, or other urban or agricultural area.

Notifiable condition: A disease or risk factor that is reported to the Centers for Disease Control and Prevention by the states and the District of Columbia.

Nuclear scanning: Used to show heart damage and expose problems in the heart's pumping action. A scanning camera shows nuclear material taken up by the heart (healthy areas) and not taken up (damaged areas).

Objective: A defined result. Objectives can be considered intermediate or programmatic. They do not always reflect the ultimate change sought.

Opportunistic infections: Infections that take advantage of the opportunity offered when a person's immune system has been weakened by HIV infection. At least 25 medical conditions, including bac-
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Ozone: Ozone occurs naturally in the stratosphere and provides a protective layer high above the earth. At ground-level, however, ambient ozone is the prime ingredient of smog. Ambient ozone refers to ozone in the troposphere—the air that people breathe—which is different from ozone in the stratosphere, the hole in the ozone layer. Ozone is not emitted directly into the air but is formed readily in the atmosphere, usually during hot summer weather, from volatile organic compounds emitted by motor vehicles, chemical plants, refineries, factories, consumer and commercial products, other industrial sources, trees, and from nitrogen oxides emitted by motor vehicles, power plants, and other sources of combustion. Changing weather patterns contribute to yearly differences in ozone concentrations from city to city.

Pandemic: An epidemic over a large area or country.

Pap (Papanicolaou) test: Microscopic examination of cells collected from the cervix. The Pap test is used to detect cancer, changes in the cervix that may lead to cancer, and noncancerous conditions, such as infection or inflammation.

Parity/mental health parity: Equivalent benefits and restrictions in insurance coverage for mental health services and for other health services.

Particulate matter: General term used for a mixture of solid particles and liquid droplets found in the air. These particles, which come in a wide range of sizes, originate from "built" and natural sources. Fine particles (PM2.5) result from fuel combustion from motor vehicles, power generation, and industrial facilities, as well as from residential fireplaces and wood stoves. Coarse particles (PM10) generally are emitted from other sources, such as vehicles traveling on unpaved roads, materials handling, and crushing and grinding operations, as well as windblown dust.

Patient barrier: Any mental, physical, or psychosocial condition that prevents an individual from accessing needed health care. Examples include attitudes or biases, mental disorders or illnesses, behavioral disorders, physical limitations, cultural or linguistic factors, sexual orientation, and financial constraints.

Patient day: A day or part of a day for which a patient was hospitalized.

Per capita water use: The average amount of water used per person during a standard period, generally per day. In the United States, this measure usually is reported in gallons per day.

Physical activity: Bodily movement that is produced by the contraction of skeletal muscle and that substantially increases energy expenditure.

Physical fitness: A set of attributes that persons have or achieve that relates to the ability to perform physical activity. Performance-related components of fitness include agility, balance, coordination, power, and speed. Health-related components of physical fitness include body composition, cardiorespiratory function, flexibility, and muscular strength/endurance.

Point source: The source of water coming from a specific location, such as a drain pipe from a wastewater treatment plant or an industrial plant.

Precision: The fineness of a measurement.

Premature death: A death that occurs earlier than the life expectancy for most members of the population.

Prevalence: A proportion of persons in a population who are infected, at a specified point in time or over a specified period of time, with HIV.

Primary care provider: A physician who specializes in general and family practice, general internal medicine, or general pediatrics, or a nonphysician health care provider, such as a nurse practitioner, physician assistant, or certified nurse midwife.

Primary care: According to the Institute of Medicine, “The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

Primary enforcement: A stipulation of a safety belt use law that allows law enforcement officials to stop a driver solely on the basis of a safety belt law violation.

Primary prevention: Health care services, medical tests, counseling, and health education and other actions designed to prevent the onset of a targeted condition. Routine immunization of healthy individuals is an example of primary prevention.

Prophylaxis: Something that guards against or prevents disease.

Prophylactic: Measures designed to prevent the spread of disease and preserve health; protective or preventive treatment.

Provider barriers: Any mental, physical, psychosocial, or environmental condition that prevents or discourages health care providers from offering preventive services. Examples of provider barriers include a poor practice environment, lack of knowledge, and lack of efficacy studies.

Provider referral: Formerly called contact tracing, the process whereby health department personnel directly and confidentially notify the sex partners of infected individuals about their exposure to a sexually transmitted disease for the purposes of education, counseling, and referral to health care services.

PSA (prostate-specific antigen) test: A test that measures the level of an enzyme (PSA) in the blood that increases due to diseases of the prostate gland, including prostate cancer.

Quality of life: An expression that, in general, connotes an overall sense of well-being when applied to an individual and a pleasant and supportive environment when applied to a community. On the individual level, health-related quality of life (HRQOL) has a strong relationship to a person's health perceptions and ability to function. On the community level, HRQOL can be viewed as including all aspects of community life that have a direct and quantifiable influence on the physical and mental health of its members.

Quality: Simply stated, it is doing the right thing, for the right patient, at the right time, with the right outcome.

Rape: Forced sexual intercourse, including both psychological coercion and physical force. Forced sexual intercourse means vaginal, anal, or oral penetration by the offender(s) and includes incidents of penetration by a foreign object. Also included are attempted rapes, male and female victims, and heterosexual and homosexual rape.

Registry of Toxic Effects of Chemical Substances (RTECS®): Maintained by the National Institute for Occupational Safety and Health, this database contains information on the toxic effects of chemical substances. The list of substances includes drugs, food additives, preservatives, ores, pesticides, dyes, detergents, lubricants, soaps, plastics, extracts from plant and animal sources, plants or animals that are toxic by contact or consumption, and industrial intermediates and waste products from production processes.
Reportable disease: A disease for which there are legal requirements for reporting and notification to public health authorities. In the United States, requirements for reporting diseases are mandated by state laws or regulations, and the list of reportable diseases in each state differs.

Resilience: Manifested competence in the context of significant challenges to adaptation or development.

Risk factor: Something that increases a person’s chance of developing a disease.

Schizophrenia: A mental disorder lasting for at least six months, including at least one month with two or more active-phase symptoms. Active-phase symptoms include delusions, hallucinations, disorganized speech, and grossly disorganized or catatonic behavior. Schizophrenia is accompanied by marked impairment in social or occupational functioning.

Secondary prevention: Measures such as health care services designed to identify or treat individuals who have a disease or risk factors for a disease but who are not yet experiencing symptoms of the disease. Pap tests and high blood pressure screening are examples of secondary prevention.

Secondhand smoke: A mixture of the smoke exhaled by smokers and the smoke that comes from the burning end of the tobacco product.

Sedentary: Denotes a person who is relatively inactive and has a lifestyle characterized by a lot of sitting.

Serious emotional disturbance (SED): A diagnosable mental disorder found in persons from birth to age 18 years that is so severe and long-lasting that it seriously interferes with functioning in family, school, community, or other major life activities.

Serious mental illness (SMI): A diagnosable mental disorder found in persons aged 18 years and older that is so long-lasting and severe that it seriously interferes with a person's ability to take part in major life activities.

Seronegative: Indicates that a person’s blood lacks antibodies to a specific infectious agent, such as HIV.

Seropositive: Indicates that a person’s blood contains antibodies to infections, such as HIV.

Serostatus: The result of a blood test for the antibodies that the immune system creates to fight specific diseases.

Serum cotinine: A biological marker for tobacco use and exposure to environmental tobacco smoke measured in the blood. Cotinine is a breakdown product of nicotine.

Sexual assault: A wide range of victimizations separate from rape and attempted rape. Included are attacks or attempted attacks of unwanted sexual contact between the victim and the offender that may or may not involve force and includes grabbing or fondling. Verbal threats also are included.

Sigmoidoscopy: A procedure in which the physician or health care provider looks inside the rectum and the lower part of the colon through a flexible lighted tube. During the procedure, the physician or health care provider may collect samples of tissues or cells for closer examination.

Social capital: The process and conditions among people and organizations that lead to accomplishing a goal of mutual social benefit, usually characterized by four interrelated constructs: trust, cooperation, civic engagement, and reciprocity.

Stress test: Records the heart beat while exercising and is done because some problems only show up when the heart is working hard. These tests are not completely reliable because of false positives and false negatives.

Stroke: A form of cerebrovascular disease that affects the arteries of the central nervous system. A stroke occurs when blood vessels bringing oxygen and nutrients to the brain burst or become clogged by a blood clot or some other particle. Because of this rupture or blockage, part of the brain does not get the flow of blood it needs. Deprived of oxygen, nerve cells in the affected area of the brain cannot function and die within minutes. When nerve cells cannot function, part of the body controlled by these cells cannot function either.

Subepidemic: The morbidity that occurs within a proportion of the population infected by the epidemic.

Substance abuse: The problematic consumption or illicit use of alcoholic beverages, tobacco products, and drugs, including misuse of prescription drugs.

Surveys: Methods of polling a group or population to estimate norms and distribution of characteristics from a sample, using observations, questionnaires, or interviews.

System barriers: Conditions within a health care system that prevent people from accessing needed services or prevent health care providers from delivering those services. System barriers include physical, cultural, linguistic, and financial barriers as well as the availability of health care facilities or providers with special skills, such as eye, ear, nose, and throat specialists.

Tertiary prevention: Preventive health care measures or services that are part of the treatment and management of persons with clinical illnesses. Examples of tertiary prevention include cholesterol reduction in patients with coronary heart disease and insulin therapy to prevent complications of diabetes.

Toxic Release Inventory (TRI): EPA’s list of more than 600 designated chemicals that threaten health and the environment. Authorized under the Emergency Planning and Community Right-To-Know Act (EPCRA) of 1986, this system requires manufacturers to report releases of these chemicals to EPA and State governments. EPA compiles the data in an online, publicly accessible national computerized database.

TOXLINE: A collection of online information on drugs and other chemicals maintained by the National Library of Medicine.

Transit: Represents what used to be called “mass transit.” The 1990 Nationwide Personal Transportation Survey (NPTS/U.S. Department of Transportation) included the following modes in its transit count: bus, subway, or elevated rail; commuter rail; streetcar; and trolley. The 1995 NPTS characterizes a “trip” as travel to a destination (e.g., work site). Travel to work, for instance, that includes two stops along the way (trip chains) would constitute three “trips.”
Trauma registry: A collection of data on patients who receive hospital care for certain types of injuries, such as blunt or penetrating trauma or burns. Such collections are designed primarily to ensure quality care in individual institutions and trauma systems but also provide useful data for the surveillance of injury and death.

Universal preventive interventions: Interventions targeted to the public or a whole population group that have not been identified on the basis of individual risk. The intervention is desirable for everyone in that group. Universal interventions have advantages in terms of cost and overall effectiveness for large populations.

Urban sprawl: Unplanned and inefficient development of open land.

Usual source of care: A particular doctor's office, clinic, health center, or other health care facility to which an individual usually would go to obtain health care services. Having a usual source of care is associated with improved access to preventive services and follow-up care.

Vaccine Adverse Event Reporting System (VAERS): A passive surveillance system that monitors vaccine safety by collecting and analyzing reports of adverse events following immunization from vaccine manufacturers, private practitioners, state and local public health clinics, parents, and individuals who receive vaccines. CDC and the Food and Drug Administration work together to implement VAERS.

Vaccines: Biological substances used to stimulate the development of antibodies and thus confer active immunity against a specific disease or number of diseases.

Validity: How well an indicator represents what one intends to measure. It is similar to accuracy, but refers to the relation between the measurement and its underlying concept.

Vector-borne diseases: Illnesses that are transmitted to people by organisms, such as insects.

Vigorous physical activity: Rhythmic, repetitive physical activities that use large muscle groups at 70 percent or more of maximum heart rate for age. An exercise heart rate of 70 percent of maximum heart rate for age is about 60 percent of maximal cardiorespiratory capacity and is sufficient for cardiorespiratory conditioning. Maximum heart rate equals roughly 220 beats per minute minus age. Examples of vigorous physical activities include jogging/running, lap swimming, cycling, aerobic dancing, skating, rowing, jumping rope, cross-country skiing, hiking/backpacking, racquet sports, and competitive group sports (for example, soccer and basketball).

Violence: The intentional use of physical force or power, threatened or actual, against another person or against oneself or against a group of people, that results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation.

Viral STDs: Refer to the sexually transmitted viral infections—HIV infection, genital herpes, and HPV infection. Initial infections with these organisms may be asymptomatic or may cause only mild symptoms. Hepatitis B virus and hepatitis C virus can be transmitted through sexual activity.

Vulnerable and at-risk populations: High-risk groups of people who have multiple health and social needs. Examples include pregnant women, people with human immunodeficiency virus infection, substance abusers, migrant farm workers, homeless people, poor people, infants and children, elderly people, people with disabilities, people with mental illness or mental health problems or disorders, and people from certain ethnic or racial groups who do not have the same access to quality health care services as other populations.

Water-borne disease outbreaks: Includes only outbreaks from infectious agents and chemical poisoning incidents in which two or more people experience a similar illness after consumption or use of water intended for drinking and epidemiologic evidence implicates water as the source of illness. The stipulation that at least two people be ill is waived for single cases of laboratory-confirmed, primary amebic meningoencephalitis and for single cases of chemical poisoning if water-quality data indicate contamination by the chemical.

Years of potential life lost (YPLL): A statistical measure used to determine premature death. YPLL is calculated by subtracting an individual's age at death from a predetermined life expectancy. The Centers for Disease Control and Prevention generally uses 75 years of age for this purpose (e.g., a person who died at aged 35 years would have a YPLL of 40).
The following are contributors to the operational budget of Lancaster Healthy Communities during the current budget year (2002). This funding makes it possible for LHC to support, staff, and facilitate projects in collaboration with other community organizations.

Franklin & Marshall College (Learn and Serve)
Lancaster General Hospital
Pennsylvania Department of Health
St. Joseph Health Ministries

Additional operational funding and in-kind services have been provided by:
Community Hospital of Lancaster
Lancaster Regional Medical Center
LGH—Susquehanna Division
United Way of Lancaster County

Current members of the LHIP Action Team represent the following organizations and institutions:
Community Hospital of Lancaster
Ephrata Community Hospital
Franklin & Marshall College
Human Relations Commission
Lancaster Community Indicator Project
Lancaster Council of Churches
Lancaster County Chamber of Commerce and Industry
Lancaster County Drug and Alcohol Commission
Lancaster County Planning Commission
Lancaster General Hospital
Lancaster Lebanon IU#13
Lancaster Medical Society
Offices of State Representatives Tom Creighton and Mike Sturla
PA Department of Health
Salud Hispana
Southeast Lancaster Health Services
Special Kids Network
St. Joseph Health Ministries
United Way of Lancaster County
Urban League of Lancaster
Welsh Mountain Health and Dental Services
In 1999, Lancaster Healthy Communities was chosen as one of the seven original pilot partners by the Pennsylvania Department of Health in developing a State Health Improvement Plan (SHIP). This new State Health Planning strategy focused on developing local health priorities that the state and federal government would then incorporate into their own policy and funding strategies. In 2000, LHC convened local partners to begin a data-driven, evidence-based preliminary analysis of the health status of Lancaster County using Healthy People 2010 as a lynchpin to federal and state objectives. The goal was to set forth a local health improvement plan that would focus attention on maintaining strategies that were working and highlighting areas that needed community attention. Our local effort is now known as the Lancaster Health Improvement Partnership (LHIP).

We looked at data from Health Resources and Services Administration (HRSA), The Department of Health, The State of the Child, and the Behavioral Risk Factor Surveillance Survey. We compared local results with the objectives found in the national health plan (Healthy People 2010), national and state trends, and with geographically adjacent and demographically peer counties in Pennsylvania (as defined by HRSA). We determined the areas needing further research and we asked experts to join in our analysis. Often we were motivated to look at additional data sources because of the sheer lack of reliable local data and information on an issue. We had an epidemiologist evaluate our work. The epidemiologist looked at data reviewed by LHC and supplemented it with information from Healthy People 2010 (HP 2010), the PA Behavioral Risk Surveillance System, the U.S. Census, the PA Health Care Containment Council (PHC4), and the PA Department of Health’s Health Statistics. The reference counties referred to in this report include Chester, York, Berks, Dauphin, Lebanon, Lehigh, and Northampton counties. As a result, other areas of concern were then highlighted for deeper investigation. The criteria we used to choose our indicators and specific measures is available in the introduction to the full report.

We chose indicators based on leading indicators proposed by HP 2010 and the National Institute of Medicine study groups that put together the original lists from which the HP 2010 indicators were chosen. We believe leading indicators are useful because they help us to focus attention on a small number of key health and social issues. In that way we can motivate actions that work to change the basic factors that really impact and influence our personal and community health. And by having a wide variety of agencies, organizations, diverse populations groups, and community institutions focusing on a small number of indicators, we not only have a greater impact on the community-selected issues but also, by acting together, we reinforce a strong community identity.

We looked at the 467 target objectives that measured various aspects of the focus areas set by HP 2010 to help gauge our performance but also to set our own standards.

We diverged from HP 2010 by including Heart Disease and Stroke, Cancer Prevention and Screening, and Cognitive Development. Local data strongly supported that additional attention be paid to these areas to improve local health status.
Cancer
Reduce the number of new cancer cases as well as the illness, disability, and death caused by cancer.

Cognitive Development
Promote a physical and emotional environment that provides for greatest possible intellectual development in infants and growing children.

Heart Disease and Stroke
Improve cardiovascular health and quality of life through the prevention, detection, and treatment of risk factors for heart disease and stroke.

Lancaster County is fortunate to be among the wealthiest and healthiest counties in the state. That means that we do pretty well when we analyze our general health status. We often rank below our peer counties in both incidence and mortality, but there are pockets of problems. These problems are often related to access—systemic, economic and cultural—but not exclusively. We must each take responsibility for lifestyle choices that affect our short, and long-term personal health.

The first issue is wrapped up with the general state of health care across the United States and Pennsylvania specifically. The shortage of health care professionals (nurses, dentists, specialists, psychiatrists) is hampering our community's ability to deliver what we know is the best care and treatment for our community. Lack of tort reform and inadequate reimbursement for services are eating at the economic sustainability of health care systems and impacting the ability of physicians to practice medicine in Pennsylvania. Managed care has restricted the amount of time physicians spend with each patient. This adds up to precious little time being spent on prevention and education, which were to be the hallmarks of the HMO’s strong primary care system. The start-up and roll-out of the Health Choices (managed care program) for the Lancaster County Medicaid population is progressing. We will be able to provide some analysis of its effectiveness in maintaining access to services in our next report.

Additionally, our lack of good health surveillance systems and consistent equivalent data collection across provider networks hampers the development of real safety nets and standardized protocols that would be vital in times of emergency such as bio-terrorist attack. Often it is difficult to analyze what the exact rates are for target populations because local data is not collected in a uniform and comparable manner or the information is not broken down in small enough data bits to allow for proper analysis. For example, previous Behavioral Risk Factor Surveillance Surveys (that tell us about people’s behaviors related to prevention and intervention) were based on such a small sample of Lancaster County residents that it was not statistically reliable. This lack of data makes it difficult to clearly identify causes for disparities in health outcomes, let alone address them in a focused and scientific manner.

Finally, stronger prevention and education support networks are critical to improving the community’s and individuals’ health. It is important that we find the resources to continue ongoing prevention work and build on the successes we have achieved. We cannot be complaisant in the face of the changing health care system and market place. We have to demand that prevention and education be given their due when budgets are being decided. The long-term positive effects will be reflected not only on the bottom lines of businesses and the health care systems but in the better quality of life that will be enjoyed by individuals who are healthier and live more productive lives.
Access to Care

Health care systems in the county are abundant and costs for hospital and nursing home stays are lower than the state's average. Community/migrant health centers are available.

Health care professionals and specialists (particularly psychiatrists and dentists) are needed to serve everyone. There are very few minority professionals practicing in Lancaster County.

As in other PA counties, specialists have been closing practices due to malpractice insurance costs and the inability to provide good care under the current reimbursement structures.

Overall poverty levels in Lancaster County are below the national, state, and most reference counties.

Poverty rates for African Americans and Hispanics are much higher than for majority population, and poverty is a major risk factor for all health conditions.

Medicaid in PA does not provide preventive dental care—only emergency dental services.

The insured rate is higher than most referent counties, though it is slightly lower than the statewide rate. The HP 2010 objective calls for 100% health care insurance coverage. The percentage of jobs in the county offering health care benefits is decreasing.

High school graduation rates are lower than the state average, lower than reference areas, and worse than HP 2010 goals.

Drop-out rates for minority individuals was much higher than for whites and above HP2010 goals.

Recommendations

- Advocate for a myriad of reforms that will stabilize malpractice insurance costs.
- Develop a community coalition that will develop a plan to recruit identified professionals to Lancaster County.
- Work with the Business Group on Health and government entities to challenge insurance providers to develop products that include prevention, mental health, dental, eye care, and pharmaceutical coverage at a reasonable cost.
- Continue to support and grow Healthy Beginnings Plus and Nurse Practitioner Partnership programs so that all mothers under 20 receive support through the first two years of their baby's life.
- Continue to support efforts at every level to provide all children with 100% access to health care services and an ongoing source of primary care.
- Support the new local initiatives by Welsh Mountain Dental and Medical Clinic and Lancaster Community Health Plan to increase access to quality oral health services for all in need of services.
- Continue to support school districts' efforts to increase graduation and literacy rates.

Cancer

The overall cancer mortality rate (age-adjusted—116/100,000) is lower than that of the state overall, most referent areas, and the HP 2010 objective of 159/100,000.

All cancer rates are below the state and local rates.

Bladder and kidney cancer rates seem to be elevated above many of the reference counties.

The death rate from breast cancer, however, is higher than the state, each surrounding county, and considerably higher than the HP 2010 objective of 22.2/100,000 women.
The incidence rate for colon cancer is lower than the state and referenced counties but the mortality rates for men and women are higher than our peer and neighboring counties and the HP 2010 objective. We are slightly lower in incidence and mortality rates than the state. Colorectal cancers are the second leading cause of cancer deaths in Lancaster County.

Though lung cancer is the third leading cause of death from cancer in Lancaster County, the death rate is below the state and local level but higher than the HP 2010 objective.

**Recommendations**

- Work with the local chapter of the American Cancer Society to improve community outreach efforts about prevention and early detection of cancer in the minority communities.

- Establish study groups that will analyze incidence and mortality rates for breast and colorectal cancers, develop strategies to address the disparities, and work to implement the plan.

- Support efforts to combine the local Cancer Registry data with GIS mapping capabilities.

- Develop a prevention campaign that emphasizes diet and exercise.

The rate of early prenatal care in Lancaster County is lower than the average for the state and most reference counties, and considerably lower than the Healthy People 2010 objective of 90%.

Breakdown by race and ethnicity indicates that all groups are below the HP 2010 objective for early prenatal care but only Caucasians are below the state average for their ethnic group.

Rates of low birth weight births, very low birth weight births, and premature births in Lancaster County are lower than the rates for the state and most reference counties. In fact, the rates are at or below the HP 2010 objectives.

Infant mortality, while lower than the state average, is higher than much of the reference counties and considerably higher than the HP 2010 objectives for both white and black infants.

The rate of eligible children enrolled in Head Start is lower than state average and most referenced counties.

The regulated childcare spaces per 100 children under 14 who are in need is lower than the state average and referenced counties.

**Recommendations**

- Continue supporting and growing more outreach efforts that encourage early and ongoing women's health care and pregnancy care.

- Regularly review the findings of the Child Death Review Team and encourage them to investigate infant mortality data in Lancaster County.

- Support the United Way of Lancaster County initiative—Success By Six—to increase quality childcare and health care options for children and their families.
Wildlife-associated infections (Lyme disease and rabies) are below the state rate and the HP 2010 objectives.

Rates of infection from contaminated food and water (campylobacter, giardiasis, hepatitis A, salmonellosis, and shigellosis) are elevated over the state average and most referent counties and worse than HP 2010 objectives.

The rate for hepatitis A is below the HP 2010 objective; the rates for campylobacter and salmonellosis are higher than the HP 2010 objective and higher than reference counties. While these infections are generally self-limiting, serious morbidity is possible for residents of advanced age, the very young, and those who are otherwise immuno-suppressed.

Lancaster County has been regularly classified by EPA as a non-attainment area, since 1997, for poor air quality, which means that we fail to meet the HP 2010 objective.

**Recommendations**

- Infection linked to food and water contamination suggests close examination of the county's food, water, and sewage systems. On-lot systems should be part of this study.
- Support the efforts of the Susquehanna Valley Ozone Action Partnership to reduce air pollution through a variety of activities and educational efforts.
- Advocate for transportation, road, and community plans that support individuals' efforts to car pool, bus, bike, or walk to work, school, shop or for recreation, thereby reducing vehicle miles traveled by families and individuals.
- Support an effort to study the effects of commercial and home use of pesticides and herbicides on county watersheds.

Heart disease is the overall leading cause of death in Lancaster County. While the death rate is lower than the state rate and the rates for most reference counties, at 200.2/100,000 residents, it is well above the HP 2010 objective of 166/100,000 residents.

Black males and females in Lancaster County have much higher age-adjusted mortality rates due to CHD than whites in Lancaster County. The rates here are higher than state and national rates.

Death from stroke in Lancaster County is reported at 59.8/100,000 residents, which is lower than the state and a few reference counties. It is above the HP 2010 objective, which stands at 48/100,000.

**Recommendations**

- Convene a group to study the mortality rates for heart disease and stroke for Lancaster County.
- Support the efforts of the local chapters of the American Heart Association and Stroke Association to raise awareness of the risk factors and early signs of stroke and heart attack.
- Continue to support workplace and neighborhood efforts to develop safe places for people of all ages to walk, exercise, and be physically active.
- Advocate for changes in pharmaceutical coverage so that medications that prevent heart disease and stroke are available to those at risk.
Immunization

Average annual rates of infectious diseases in Lancaster County are generally low, but a few diseases stand out as above average for the state or region or are diseases which could be prevented through vaccination.

Other vaccine preventable diseases, including measles, pertussis, congenital rubella, and H. flu, are either not reported or reported at a very low level, generally below the state and referent county rates. However, since these diseases are vaccine preventable, reported rates should essentially be zero.

Deaths from pneumonia and influenza are lower than the state average and three of the reference counties.

The tuberculosis rate is below the state and most referent county rates, though slightly elevated over the HP 2010 objectives there are indications, however, that non-symptomatic TB may be on the rise.

Recommendations

- Vaccination programs could eliminate most morbidity from hepatitis A and B, influenza, pneumococcal disease, H. flu, and pertussis. Community outreach programs that are culturally sensitive should be financially supported wherever possible.
- Hospitals should consider using ER's as a place to increase vaccination rates for all populations.
- Support a community effort to collect information on immunization compliance at every age level and in private schools.
- A plan to quickly and systematically immunize all in the community should be developed as part of emergency planning for bio-terrorist attack.

Injury and Violence

The rate of unintentional injury in Lancaster County is lower than the overall state rate, but is higher than the reference counties and the HP 2010 objective.

Unintentional injury rates for those 25–44 are higher in Lancaster County than for our peers, the state, and HP 2010 objectives.

Mortality from motor vehicles is lower in Lancaster County than the state overall and also for most reference counties.

The rate of hospitalization from motor vehicle accidents is higher in Lancaster County than most referent counties, indicating a high incidence of severe motor vehicle accidents. The age group with highest rate of hospitalization from motor vehicle accidents is the 15–34 age group.

The rate of overall child (1–19 years of age) death is higher than the state average and the rate for much of the reference area.

The rate of overall child (1–19 years of age) death for African American and Hispanic children is lower than the state average.

Violence in the form of homicide is below the average for the state, most reference counties, and the HP 2010 objective.

Recommendations

Data must be collected that separates occupational and non-occupational injuries. In order to target prevention efforts, the nature of injuries must be known. This is very important if we are to do prevention work within specific age groups.

Emergency department (ED) patient records and hospital discharge systems are an important source of public health surveillance, and we need to begin collecting data from pre-emergency room sources (EMT). Because of the volume and case mix of patients they treat, EDs are well positioned to provide data on cause and severity of injuries.
Primary care physicians can be instrumental in screening for family violence issues that range from child and spousal abuse to elder abuse. Training and efficient tools must be shared with physicians to maximize the limited time they have with patients.

Develop and implement anti-violence curriculum that can be used with pre-K and kindergarten students. Strategies for reducing violence should begin early in life, before violent beliefs and behavioral patterns can be adopted.

Violence prevention programs for youth need to focus on strategies that reduce involvement in physical fighting and bullying. Entire communities must be prepared to establish and maintain behavior standards that discourage violence everywhere.

Respite care and respite opportunities for families in crisis, mediation services and training, shelters for runaway teens, drug and alcohol prevention, and intervention programs are all in short supply, but they are very effective ways to mitigate community violence.

There is no way to accurately count those suffering from mental illnesses locally. Accurate accounting of the incidence of illness locally may enable our community to calculate its impact on productivity, which may, in turn, help to build our political and societal will to deal with mental illness more effectively. We may then be able to adequately recruit and train enough professionals to deal with the challenges our families, businesses, and communities face. All but one item below is a general statement that pertains to Lancaster County as well as the nation.

- The rate of suicide was less than the state average and all other reference counties, yet it was higher than the HP 2010 objective.
- Lancaster County has few psychiatrists and fewer child psychiatrists. Psychologists are also in high demand. Waiting lists are long, and many psychotropic prescriptions are written by family physicians without psychiatric consultation.
- Close to six percent of the adult U.S. population use the general medical sector for mental health care, with an average of about four mental health visits per year—far lower than the average of 14 visits per year found in the specialty medical sector. (Regier, D.A.; Narrow, W.; Rae, D.S.; et al. “The de facto U.S. mental and addictive disorders service system. Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services.” Archives of General Psychiatry 50:85–94, 1993.)
- In 1998, the Mental Health Parity Act (P.L. 104–204) was implemented to help increase access to care. (The term “parity” or “mental health parity” refers generally to insurance coverage for mental health services that includes the same benefits and restrictions as coverage for other health services.) Although the Federal Mental Health Parity Act is quite limited in reducing insurance coverage discrepancies between physical and mental disorders, 53 percent of the U.S. population is now covered by state mental health parity laws.

Recommendations
- Provide efficient screening tools and training opportunities for Primary Care Practitioners on mental health issues.
- Survey the number of Primary Care Practitioners who attended training on mental health issues, psychotropic meds, and systemwide mental health referrals.
- Track the number of bicultural/bilingual mental health professionals.
- Implement a mandatory process at Barnes Hall and within Juvenile Probation and Parole to increase the number of juveniles in the juvenile justice system being screened for mental health problems, drug and alcohol abuse, and learning disabilities to 100%.
Support a community coalition to develop a plan to prioritize the most critical mental health issues in Lancaster County, including the coordination of services.

Work with business groups to increase percentage of employers who provide health insurance and who have some kind of Employee Assistance Program or contracted service for such.

- The rates of sexually transmitted infections (syphilis, chlamydia, and gonorrhea) are below the state average and generally lower than the referent counties.

- Rates for both AIDS and STDs are higher than the HP 2010 goals. The AIDS rate is lower than the state average and many of the referent counties. Since HIV infection is not reportable, it is difficult to determine the significance of HIV in the county. However, available incidence data for STDs and AIDS/HIV in the minority community suggests a great disparity in all rates.

- The rate of hepatitis B infection is above both the state average and that for referent areas and higher than HP 2010 objectives.

- The overall rate of induced abortion for the county is approximately 9%. The induced abortion rate is considerably lower than the state (19%) and each reference county.

- Despite the low level of induced abortion, at least 10% of the county's pregnancies are deemed unwanted.

- Teen pregnancy rates are lower than the state, most reference county rates, and the HP 2010 objective. But given the risks associated with teen motherhood—for themselves and their children—this should be even better.

- Of all births to Hispanic and African American women of Lancaster County, almost one-third were to unmarried women under 20 years of age.

**Recommendations**

- Develop more programs that help parents become better at imparting information.

- As the main source of STD information for most teenagers, school-based interventions should be developed to inform young people about STD exposure and transmission issues and to motivate them to modify their behaviors.

- Investigate combining school-based health information and school-based health service programs as a prevention and intervention strategy.

- Mass media campaigns have been effective in bringing about significant changes in awareness, attitude, knowledge, and behaviors for other health problems, such as smoking. Consider a campaign around responsible sexual behavior.

- Introduce Peter Benson, Ph.D., Search Institute-based programs: 40 developmental assets with outcome-based data. Having these assets within your community decreases the rates of teen pregnancy.

- More community health centers/clinics with women's health practitioners and services need to be located in high-risk areas. Provide services within walking distance or on bus routes.

- Provide more parenting programs for teens to break the cycle and prevent a second birth.

- Prosecute statutory rape.

- Provide timely service and reduced waiting time for teens that are looking for services.

- More integration between HIV and STD services, especially in agencies which provide HIV outreach education and among adolescents.
Increase the numbers of bilingual persons fluent in both Spanish and English to deal with all STDs and HIV/AIDS.

Develop more detailed and accurate statistical gathering procedures. Although it may be beneficial to look at AIDS mortality, the common concern is addressing the issues of those individuals living with the virus.

Next year LHIP will release a report based on a Behavioral Risk Factor Surveillance Survey that was conducted in Lancaster County in 2002. That report will have a great deal of data related to the following Leading Health Indicators. We did not feel that the samples of Lancaster County that had been done in the past were significant enough to provide accurate data. Therefore, we did not use past BRFSS data for Lancaster County in this report. We look forward to bringing you those results and having more pointed recommendations at that time.

- The proportion of adults defined as obese by a BMI of 30 or greater has increased from 14.5 percent to 22.5 percent.
- A similar increase in overweight and obesity also has been observed in children above age 6 years in both genders and in all population groups.
- Children who eat poorly, but are not overweight, are at risk for being overweight as an adult and also of developing diseases associated with a high-fat, high-caloric diet.

Recommendations

- A concerted public effort will be needed to prevent further increases of overweight and obesity. LHIP will convene an action group around the issues of Nutrition and Overweight and Physical Activity to begin assessing local data and developing a campaign strategy to highlight the importance of these behaviors to fundamental health risks.
- Health care providers, health plans, and managed care organizations need to be alert to the development of overweight and obesity in their clients and should provide information concerning the associated risks.
- Health care professionals as well as those training to be primary care physicians need more training related to diet, nutrition, and exercise.
- Preventive counseling related to diet and nutrition must be reimbursable for consumers and physicians.
- Over the years, the recognition of the consequences of food insecurity (limited access to safe, nutritious food) has led to the development of national measures and surveys to accessibility to fresh food, hunger, and the ability to assess disparities. Lancaster County should begin developing such measures locally.

- The state of Pennsylvania is in the process of accepting new Academic Standards for Health, Safety, and Physical Education proposed by the PA Department of Education. These standards are for all grade levels.
- Data to evaluate access and availability of community fitness facilities are not available.
- People with mental/physical disabilities are less physically active than people without disabilities.
- By age 75, one in three men and one in two women engage in no regular physical activity.
Addendum I: A Plan for Creating a Healthy Lancaster Community

**Recommendations**

- Daily, adaptive physical education programs should be available for children with special needs.
- Lobby school boards and legislatures to develop a well-designed health education curriculum that can help students develop the knowledge, attitudes, behavioral skills, and confidence needed to adopt and maintain physically active lifestyles.
- Work with the PTOs to develop an educational campaign highlighting the need for parents and educators to become role models.
- Develop a campaign to reinvigorate the Presidential Fitness Awards for students and the promotion of physical activity and fitness in children and adolescents.
- Primary care providers must increase their counseling of patients about the need to participate in physical activity.
- Ensure that facilities are accessible to people with disabilities.
- Increase worksite fitness programs.
- Develop a campaign to increase physical activity in the workforce that is community-wide in scope and emphasizes community fitness and health.

The Pennsylvania Youth Survey, which measured levels of substance use and related risk factors among middle school and high school students, was conducted in Lancaster County during April and May 2000. A total of 6,404 students in 6th through 12th grade from seven public school districts and three private schools participated. (This is not considered a good enough sampling by local experts, who would like to do a survey more in line with the National Youth Survey or National Household Survey on Drug Abuse.) However, it is difficult to get school districts to agree to yet another survey or even to one survey. BRFSS should help us gather more information on adult use.

- 12% of 6th graders (Lancaster) reported using alcohol over the past 30 days, which is worse than the HP 2010 goal of 11% for all 12 to 17 year olds for all illicit drugs.
- 24% of 8th graders (Lancaster) reported using alcohol over the past 30 days, which is worse than the HP 2010 goal of 11% for all 12 to 17 year olds for all illicit drugs and worse than the national baseline of 19%.
- 39% of 10th graders (Lancaster) reported using alcohol over the past 30 days, which is worse than the HP 2010 goal of 11% for all 12 to 17 year olds for all illicit drugs and is worse than the national baseline of 19%.
- 4% of 6th graders (Lancaster) reported using any illicit drugs over the past 30 days, which is better than the HP 2010 goal of 11% for all 12 to 17 year olds.
- 9% of 8th graders (Lancaster) reported using any illicit drugs over the past 30 days, which is better than the HP 2010 goal of 11% for all 12 to 17 year olds.
- 13% of 10th graders (Lancaster) reported using any illicit drugs over the past 30 days, which is better than the HP 2010 goal of 11% for all 12 to 17 year olds and worse than the national baseline of 10%.
- 6th and 8th grade marijuana use was better than the baseline of 8.3% but worse than the goal of .7% admitting to using marijuana.
- 20% of 10th graders reported using marijuana over the past 30 days, which is worse than the national baseline rate and the HP 2010 goal.
- PA binge drinking in adults is higher than national rates and above HP 2010 goals.
**Recommendations**

- States could require periodic server training or use the regulatory authority of alcohol distribution licensing to mandate a minimal level of training for individual servers.
- Colleges should institute a requirement that college students reporting to student health services following a binge drinking incident receive an alcohol screening that would identify the likelihood of a health risk.
- The state of Pennsylvania should continue to restrict all marketing to underage populations, including limiting advertisements and promotions. Although alcohol advertising has been found to have little or no affect on overall consumption, this strategy may reduce the demand that results in illicit purchase or binge consumption.
- Advocate for a medical approach to substance abuse treatment that includes adequate reimbursement for clinically necessary services through funding mechanisms such as the Substance Abuse Prevention and Treatment Services Block Grant and Medicaid or private insurers.
- Develop more appropriate settings and care for dually-diagnosed patients.

**Tobacco Use**

- The smoking rate for Pennsylvania is about twice the HP 2010 goal.
- Hispanics (18 percent) and Asians or Pacific Islanders (13 percent) are less likely to smoke than other groups.
- Persons with 9 to 11 years of education (38 percent) have significantly higher levels of smoking than individuals with 8 years or less of education or 12 years or more. Individuals with 16 or more years of education have the lowest smoking rates (11 percent).
- Individuals who are poor are significantly more likely to smoke than individuals of middle or high income (34 percent compared to 21 percent).
- National data reveals high levels of tobacco use among college students. In 1995, 29 percent of college students smoked in the previous month (28 percent of females and 30 percent of males).
- By the late 1980s, smoking rates among white teens were more than triple those of African American teens. In recent years, smoking has started to increase among African American male teens. In 1997, 40 percent of white high school females were smokers.
- African American female teens continue to have lower smoking rates than all peer groups (17 percent of African American high school females).

**Recommendations**

- Support the ongoing efforts of the Tobacco Free Coalition of Lancaster County.
- Work with business groups to increase smoking cessation programs through the workplace.
- Develop an anti-smoking campaign that addresses personal and insurance costs as well as quality of life issues.
- Support the excise tax on tobacco products.
- Encourage local colleges to aggressively market smoking cessation programs.
- Lobby the state legislature for a comprehensive approach to tobacco use cessation from the health care cost impact perspective—it’s good for business.
- Support and encourage restaurants and bars that are or wish to become non-smoking establishments.
- Support the elimination of “preemption” by the state that was added by the state legislature in 1988 as part of the PA State Indoor Air Act.
LHIP is convening four work groups to begin new efforts or to determine how we can best support current initiatives: Cancer, Mental Health, Physical Activity and Weight, and Stroke. The nature of our work with each of these groups will be determined by the current capacity of the community to respond to the target issue.

Additionally, we will be analyzing the data from the Lancaster County 2002 BRFSS that we commissioned and preparing a report for the community. Again, we will compare ourselves with state and national data. We will convene appropriate experts from the community to discuss how the behaviors that were reported affect or can affect the design of health improvement programming. We will also work on charting trends for some of the data we have already collected in this report.
Addendum J: Current and Past Experts

Current Experts

CHNA Task Force subcommittee members (as of 9/12)

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
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<tbody>
<tr>
<td>Dr. Perry Arqires</td>
<td>Mission &amp; Community Benefit Committee Member</td>
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<tr>
<td>Eboni Bryant</td>
<td>Manager CTG Program</td>
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<td>Susan Eckert</td>
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<td>Mike Horst</td>
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<td>Dr. Chris Lupold</td>
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<td>Pete Mumma</td>
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<td>Susan Sample</td>
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<td>John Snader</td>
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<td>Benwood Yost</td>
<td>Director F&amp;M Center for Opinion Research</td>
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<td>Stacy Youcis</td>
<td>Vice President LG Operations</td>
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<tr>
<td>Tim Zellers</td>
<td>Vice President LG Cardiovascular Service Line</td>
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Lancaster County Community Transformation Grant Leadership Team (as of 12/12)

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<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Linda Aleci</td>
<td>Local Economy Center, Franklin &amp; Marshall College</td>
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<tr>
<td>Thomas Baldridge</td>
<td>Lancaster Chamber of Commerce</td>
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<tr>
<td>Jan Bergen</td>
<td>Lancaster General Health</td>
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<tr>
<td>Cynthia Burkhart</td>
<td>Lancaster-Lebanon Intermediate Unit 13</td>
</tr>
<tr>
<td>Rev Lou Butcher</td>
<td>Bright Side Baptist Church</td>
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<tr>
<td>Paul Casale</td>
<td>Lancaster City &amp; County Medical Society</td>
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<tr>
<td>Al Duncan</td>
<td>Thomas E Strauss Inc</td>
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<td>Ralph Goodno</td>
<td>Lancaster County Conservancy</td>
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<tr>
<td>Carlos Graupera</td>
<td>Spanish American Civic Association</td>
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<tr>
<td>Richard Gray</td>
<td>City of Lancaster</td>
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<tr>
<td>Cheryl Holland-Jones</td>
<td>Crispus Attucks Community Center</td>
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<tr>
<td>Patrick Jinks</td>
<td>United Way of Lancaster County</td>
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<tr>
<td>Michael LaSala</td>
<td>Lancaster Inter-Municipal Committee</td>
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<tr>
<td>James Machado</td>
<td>Heart of Lancaster Regional Medical Center</td>
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<tr>
<td>Scott Martin</td>
<td>Lancaster County, Pennsylvania</td>
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<tr>
<td>Bob Moore</td>
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<td>John Porter</td>
<td>Ephrata Community Hospital</td>
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<td>Brian Wyant</td>
<td>PA Department of Health</td>
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### Addendum J: Current and Past Experts

**Lancaster Health Improvement Partnership Members (as of 8/2012)**

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<th>Name</th>
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<tbody>
<tr>
<td>Jan Baily</td>
<td>Mental Health America</td>
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<tr>
<td>Trisha Banker</td>
<td>County of Lancaster</td>
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<tr>
<td>Steve Batchelor</td>
<td>Ephrata Community Hospital</td>
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<tr>
<td>Jeff Blystone</td>
<td>Department of Health</td>
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<td>Zoe Bracci</td>
<td>Albright Life</td>
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<td>Eboni Bryant</td>
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<tr>
<td>Jacqueline Burch</td>
<td>Lancaster County Office of Aging</td>
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<tr>
<td>Connor Burns</td>
<td>Franklin &amp; Marshall</td>
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<td>Michael Chrzanowski</td>
<td>PALCO</td>
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<tr>
<td>Ken Culton</td>
<td>Department of Health</td>
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<td>Gail Dennis</td>
<td>Lancaster General Health</td>
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<tr>
<td>Susan Eckert</td>
<td>Partnership for Public Health</td>
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<tr>
<td>Colleen Elmer</td>
<td>Water Street Health Ministries</td>
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<tr>
<td>Vicki Gillmore</td>
<td>Masonic Villages/Lanc. Senior Services</td>
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<tr>
<td>Beth Good</td>
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<td>Phil Goropoulos</td>
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<td>Toni Harman</td>
<td>United HealthCare</td>
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<td>Rick Kastner</td>
<td>Lancaster County Drug &amp; Alcohol Commission</td>
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<td>Melody Keim</td>
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<td>Dave Koser</td>
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<tr>
<td>Mary Levasseur</td>
<td>Tobacco-Free Coalition-LGH</td>
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<td>Janeen Maxwell</td>
<td>Holleran</td>
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<td>Lisa McCracken</td>
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<td>Kirk Miller</td>
<td>Franklin &amp; Marshall College</td>
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<td>Diane Newport</td>
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<tr>
<td>Brenda Pittman</td>
<td>Lancaster Emergency Management Assoc.</td>
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<tr>
<td>Jamie G. Quinn</td>
<td>American Cancer Society</td>
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<tr>
<td>Bonnie Reid</td>
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<tr>
<td>Sean Reynolds</td>
<td>St. Joseph Health Ministries</td>
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<tr>
<td>Lisa Riffanacht</td>
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<tr>
<td>Jim Schmucker</td>
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<td>Donita Sturgis</td>
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<td>Allison Weber</td>
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<td>Tamara Wurst</td>
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Addendum J: Current and Past Experts

Tobacco-Free Coalition of Lancaster County (as of 12/12)

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<tr>
<td>Mary Ross</td>
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<td>Susan Russo</td>
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<tr>
<td>Julia Sensenig</td>
<td>HACC Nursing Program</td>
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<td>Katherine Shambaugh</td>
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<td>Angela Trout</td>
<td>YWCA Lancaster</td>
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Lighten Up Lancaster County Coalition (active organizations as of 12/12)

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<td>League of Lancaster Bicyclists</td>
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<td>Lancaster County Solid Waste Management Authority</td>
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<td>Engle Publishing</td>
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<td>Highmark</td>
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<td>Eastern Market</td>
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<tr>
<td>Lancaster County Planning Commission</td>
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<td>Hands on House</td>
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</table>
# Addendum J: Current and Past Experts

## Other Experts Consulted (as of 12/12)

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kevin Stewart</td>
<td>Director of Environmental Health, American Lung Association of the Mid-Atlantic</td>
</tr>
<tr>
<td>Rebecca Bush</td>
<td>Quality Care Coordinator, Lancaster General Health</td>
</tr>
<tr>
<td>Megan Gross</td>
<td>Lancaster General Research Institute</td>
</tr>
<tr>
<td>Christian Hermansen</td>
<td>Assistant Deputy Director, Downtown Family Medicine</td>
</tr>
<tr>
<td>Kevin Lorah</td>
<td>Medical Director, Women and Babies Hospital - Neonatology Physicians</td>
</tr>
<tr>
<td>Tammy Ober</td>
<td>CEO, Lancaster Rehabilitation Hospital</td>
</tr>
<tr>
<td>Jon Bentz</td>
<td></td>
</tr>
<tr>
<td>Regina Bissett</td>
<td>Supervisor of Surgical Research, LGH Surgical Services</td>
</tr>
<tr>
<td>Pam Harnish</td>
<td>Clinical Supervisor, Downtown Family Medicine</td>
</tr>
<tr>
<td>Audrey Martin</td>
<td>Med Home Prog Social Worker, Downtown Family Medicine</td>
</tr>
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## Past Experts

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Audrey Atkins</td>
<td>Office of Representative Tom Creighton</td>
</tr>
<tr>
<td>Phyllis Boyd</td>
<td>IU#13</td>
</tr>
<tr>
<td>Jamie Brightbill</td>
<td>Franklin &amp; Marshall College</td>
</tr>
<tr>
<td>Phyllis Campbell</td>
<td>Urban League</td>
</tr>
<tr>
<td>Donna Carr</td>
<td>Community Hospital of Lancaster</td>
</tr>
<tr>
<td>Sean Flaherty</td>
<td>Franklin &amp; Marshall College</td>
</tr>
<tr>
<td>Jonathan Fox</td>
<td>Human Relation Commission</td>
</tr>
<tr>
<td>Maureen Gallo</td>
<td>Lancaster Regional Medical Center</td>
</tr>
<tr>
<td>Danielle Gentile</td>
<td>Franklin &amp; Marshall College</td>
</tr>
<tr>
<td>Ayesha Jafri</td>
<td>Lancaster Medical Society</td>
</tr>
<tr>
<td>Pat Kadel</td>
<td>Lancaster County Planning Commission</td>
</tr>
<tr>
<td>Rick Kastner</td>
<td>Lancaster County Drug Commission</td>
</tr>
<tr>
<td>Jim Kelly</td>
<td>Southeast Lancaster Health Services</td>
</tr>
<tr>
<td>William Lafferty</td>
<td>Ephrata Community Hospital</td>
</tr>
<tr>
<td>Carol Marsh</td>
<td>United Way of Lancaster County</td>
</tr>
<tr>
<td>Kay Moyer</td>
<td>PA Department of Health</td>
</tr>
<tr>
<td>Lila Nice</td>
<td>Lancaster Healthy Communities</td>
</tr>
<tr>
<td>Lisa Riffanacht</td>
<td>Special Kids Network</td>
</tr>
<tr>
<td>Flor Sherbahn</td>
<td>Salud Hispana</td>
</tr>
<tr>
<td>Mike Sturla</td>
<td>State Representative (96th)</td>
</tr>
<tr>
<td>Jennifer Thompson</td>
<td>St. Joseph Health Ministries</td>
</tr>
<tr>
<td>Terri Trimble</td>
<td>Welsh Mountain Health and Dental Services</td>
</tr>
<tr>
<td>Kim Wittle</td>
<td>Lancaster Council of Churches</td>
</tr>
<tr>
<td>Alice Yoder</td>
<td>Lancaster General Hospital</td>
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Addendum K: Current LGH Community Health and Wellness Programs

Access to Care

• Amish Outreach
• CHIP Outreach
• Dental Access Lancaster County (DALCO) provides dental care to those who are uninsured
• Child immunization clinic (ChildProtect)
• Harm Reduction Coalition
• Immunization Coalition
• Lancaster County Children’s Alliance
• Latino/a Outreach
• PAP tests, STD screenings, and birth control
• Project Access Lancaster County (PALCO) provides health care to those who are uninsured
• Refugee Health Clinic
• School Based Health Clinic with the School District of Lancaster
• Suboxone Clinic

Mind Body/Integrative Programs

• Mindfulness-Based Stress Reduction
• Qigong
• Shake it Up Zumba and Dance
• Weight Training for Women
• Yoga for Beginners
• Yoga for Life
• Zumba Gold

Obesity/Healthy Weight Management

• Adult obesity behavioral modification program (L.E.A.R.N.)
• Bariatric Physician Specialists
• Childhood obesity behavioral modification program (Shapedown)
• Color Me Healthy, in partnership with the Pennsylvania Departments of Health (DOH), Education (PDE), and Public Welfare (DPW), aims to teach preschoolers (between four and five years of age) the importance of healthy eating and physical activity
• Diabetes Education
• Health Coaching
• Lighten Up Lancaster County
• Shopping Tours
• Weight Watchers at Work
• Weight Training for Women
## Support Groups

<table>
<thead>
<tr>
<th>Service Line</th>
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</table>
| **Cardiology** | • Healthy Hearts Support Group  
 |          | • Pulmonary Hypertension Support Group  |
| **Musculoskeletal** | • Multiple Sclerosis Support Group  
 |          | • Fibromyalgia Awareness and Education Group  |
| **Oncology** | • Breast Cancer Groups  
 |          | • Survivorship: Life After Cancer  
 |          | • Journaling for Healing  
 |          | • Leukemia, Lymphoma Support Group  
 |          | • The Iris Connection Support Group for Women with Breast Cancer  
 |          | • Us Too! Prostate Cancer Community Network  
 |          | • Us Too! Women Only for wives of Prostate Cancer Survivors  
 |          | • Women’s Cancer Courage of Lancaster, PA is a support program run by and for women with metastatic cancers  |
| **Women’s Health** | • Bedrest Buddies Support Group  
 |          | • Pregnancy After Loss Support Group  
 |          | • Postpartum Depression Support  
 |          | • Share PALS (pregnancy after loss) Support Group  
 |          | • Share Early Loss Support Group for those lives who are touched by the death of a baby (less than 16 weeks)  
 |          | • Share Late Loss Support Group for those who are touched by the death of a baby (16 weeks or later)  
 |          | • Type 1 Diabetes Women’s Community Group  |
| **Neuroscience** | • Brain Tumor Community Support Group  
 |          | • Epilepsy Community Group  
 |          | • Memory Loss Support Group  
 |          | • Stroke Survivorship Support Group  
 |          | • Neuropathy Resource Group  |
| **Others** | • Amputee Support Team  
 |          | • Autism Support Group in Spanish  
 |          | • Surgical Weight Loss Support Group  
 |          | • Lupus support Group  
 |          | • Adult Type 2 Diabetes Support Group  
 |          | • American Lung Association Better Breathers Club is a support groups for people with chronic lung disease and their love ones  |
Addendum K: Current LGH Community Health and Wellness Programs

Tobacco
- Individual Tobacco Cessation Counseling
- Group tobacco Cessation: Freedom From Smoking
- Tobacco Use Prevention (LifeSkills)
- Tobacco Free Coalition of Lancaster County

Trauma/Safety
- Comprehensive care clinic for HIV and AIDS patients
- Child sexual assault center
- Child Death Review Team
- Drinking, Drugs, and Driving: an evening program with group discussion and a tour of the trauma areas
- Falls prevention program
- Farm Safety Day
- Harm reduction coalition
- Lead coalition
- Program that provides smoke detectors installed with education on fire safety
- SafeKids Car Seat Safety Checks
- School-based health clinics
- Think First, a national evidence-based program aimed to help people learn to reduce their risk for injury.

Women’s Health
- Domestic Violence education/referrals
- Mammograms (Susan G Komen for the Cure Grant)
- Healthy Women breast cancer and cervical cancer screening
- Menopause Counseling
Overview of a Community Dashboard for Lancaster County, Pennsylvania
Abstract

This document provides an overview of findings from a community health needs assessment (CHNA) conducted on behalf of Lancaster General Hospital, Lancaster Rehabilitation Hospital, Women & Babies Hospital and Ephrata Community Hospital. The assessment was conducted for Lancaster County, which is the targeted population for all four hospitals. The assessment uses information from secondary data sources to identify health issues of consequence to the community. Estimates are presented for selected demographic and health indicators, including access to health care, health-related behavioral risks, prevention behaviors, health conditions, and vital statistics related to cancer, communicable disease, maternal health, mental health, mortality, and hospitalizations. Selected economic, education, environment, public safety, and transportation estimates are also presented. The CHNA presents Lancaster County as a community with notable strengths, not the least of which is a strong health care infrastructure and a healthy economy. But weaknesses are also evident. The assessment finds that Lancaster County’s physical environment may contribute to poor health and that cancer rates are a bit higher than in other US counties. The assessment also shows that even some indicators that, at first glance, put the county in a favorable position must be considered problems. For example, although the county rate for being obese is comparatively good, there are still far too many obese county residents considering the costs associated with obesity. The same is true for tobacco use, binge drinking, exercise and diet, each of which contributes significantly to chronic disease. Community-level policy interventions are recommended to address these issues.

This overview was written by Berwood Yost, Floyd Institute for Public Policy, Franklin and Marshall College. The Floyd Institute comprises the Center for Opinion Research, the Center for Politics and Public Affairs, and the Local Economy Center. The Center for Opinion Research provides comprehensive survey research services to both the college and outside organizations, including educational institutions, government agencies, the media, private corporations, and nonprofit groups. These capabilities encompass all aspects of survey and market research, including survey design and administration, data collection and analysis, program evaluation, and focus group facility rental and recruiting services.

The Center’s expertise covers a wide range of research areas, including healthcare, public policy, education, marketing and advertising, and human behavior. Drawing on a deep knowledge of the various policy areas, they offer informed and thoughtful opinions about what survey results mean, guiding clients as they use the information to answer important questions and make strategic decisions.

Over the years, the Center has established a reputation for outstanding accuracy and reliability and insightful data analysis. They are recognized as a particularly valuable source of information for those involved in public policy, and have become a primary resource for government agencies and media organizations seeking objective information about the major issues facing the Commonwealth of Pennsylvania. They are the home to the nationally recognized Franklin & Marshall College Poll, the oldest Pennsylvania statewide poll exclusively directed and produced in the state1.

Publication was supported by Cooperative Agreement 1US8DP003612-01 from The Centers for Disease Control and Prevention. Its contents are solely the responsibility of the author and do not necessarily represent the official views of the Centers for Disease Control and Prevention.

1 Information about the Floyd Institute for Public Policy was retrieved from Franklin & Marshall College’s website and can be found at www.fandm.edu/opinionresearch.
# Addendum L: Lancaster County Community Health Needs Assessment

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This document provides an overview of findings from a community health needs assessment (CHNA) conducted on behalf of Lancaster General Hospital, Lancaster Rehabilitation Hospital, Women & Babies Hospital and Ephrata Community Hospital. The assessment was conducted for Lancaster County, which is the targeted population for all four hospitals. The assessment uses information from secondary data sources to identify health issues of consequence to the community. Estimates are presented for selected demographic and health indicators, including access to health care, health-related behavioral risks, prevention behaviors, health conditions, and vital statistics related to cancer, communicable disease, maternal health, mental health, mortality, and hospitalizations. Selected economic, education, environment, public safety, and transportation estimates are also presented. Estimates for all indicators are publicly available from the Lancaster County Community Health Needs Assessment web portal, www.lghealth.org/countyhealthdata or www.ephratahospital.org/CommunityHealthNeeds. The web portal provides technical information about the data sources used as the basis for the estimates and the statistical methods used to identify changes in the estimates compared to previous time periods. It also identifies whether Lancaster County’s estimates are better or worse than estimates for other Pennsylvania and/or US counties. All data and statistical analyses presented in this summary were gathered by the Healthy Communities Institute, unless specifically noted. Errors of interpretation or analysis are solely the responsibility of the author.

Overview of Findings
Lancaster County tends to perform better than other counties on health care access indicators. Most adults have a usual source of health care, many have insurance, and the county has ample primary care providers. Health insurance coverage of children is the one indicator where Lancaster tends to perform more poorly than expected, but the trend in the county is for increased coverage of children. The strength of the health care
infrastructure is confirmed by several recent studies that place access and affordability for Lancaster County in the top quartile of all health referral regions in the United States\(^2\) and Pennsylvania.\(^3\)

The county and its residents have fewer negative health behaviors, at least from a comparative standpoint, than residents of other counties. Fewer county residents smoke or drink compared to the state and nation, and rates of obesity are comparable to state and national rates. The Commonwealth Fund report places the county within its top quartile for the potential to lead healthy lives and the 2012 County Health Rankings place Lancaster 7th out of 67 Pennsylvania counties for its citizens’ positive health behaviors.

Cancer incidence and cancer and stroke death rates may be the greatest comparative health concern for county residents. The all-cancer incidence rate of 469.6 per 100,000 places Lancaster County in the third quartile of US counties, with specific cancer incidence rates (for breast cancer, cervical cancer, colorectal cancer, and prostate cancer) and cancer death rates (for breast cancer and colorectal cancer) also falling within the third quartile. The age-adjusted death rate for stroke, 43.8 per 100,000, is also in the third quartile. The county meets none of the Healthy People 2020 targets for cancer, heart disease, or stroke death rates. The county trends for these rates are stable, signaling no significant improvement in recent years. The one cancer screening measure included in the CHNA data, colon cancer screening for those over 50 years of age, places Lancaster in the worst quartile of Pennsylvania counties.

The county ranks in the best half of Pennsylvania counties on most maternal, fetal and infant health measures, most prevention and safety measures, and most immunization and infectious disease measures. There are two areas of relative concern within this category of indicators. First, the county has among the highest Chlamydia and gonorrhea incidence rates in the state. Second, it also has one of the lowest early prenatal care rates among the state’s counties, well below the Healthy People 2020 target for this indicator.

\(^2\) The Commonwealth Fund. Rising to the Challenge: Results from a Scorecard on Local Health System Performance, March 2012.
\(^3\) Robert Wood Johnson Foundation. County Health Rankings and Roadmaps. 2012 County Health Rankings.
Lancaster County appears strong economically, but shows some weakness on environmental and social measures. Economic measures place Lancaster County among the best fifty percent of US counties in terms of unemployment rates, incomes, foreclosures, poverty, and educational attainment. However, the county scores among the worst quartile of US counties in terms of its air pollution. Lancaster County also falls below other US counties on food access for its low-income residents. The 2012 county health rankings place Lancaster 64th out of Pennsylvania’s 67 counties for its physical environment. This includes measures of air pollution and access to healthy foods, recreational facilities, and fast food restaurants.

Community health needs assessments normally include some discussion of health disparities (i.e., gaps in access, conditions, or behaviors that are larger for some demographic groups than for others). Unfortunately, the data gathered for the community dashboard provides limited information about such disparities because it provides data only by age, race, and gender. This leaves out, for instance, disparity analyses for those living in poverty or with low-incomes – attributes that normally reveal differential outcomes related to health care access, health conditions, and prevention behaviors. The limited data on health disparities provided in the community dashboard is included in Appendix A. Generally speaking, the data show that health care access, health behaviors, and health conditions often have different rates for different age, gender, and racial groups. As such, health priorities and intervention strategies should be created with at least some consideration of the differential effects these characteristics may have on providing better health. However, many partners who assisted in the development of this report represent most of the minority populations (see experts listed in appendix B).

Each of the hospitals will complete a health improvement plan that describes how they intend to address the needs, the reasons those needs were selected, and the strategies by which the hospital plans to address the selected needs. The plans will be posted on each hospital’s website and the hospitals will have hard copies available upon request, by July 1, 2013.
Defining Community Health Needs

Conducting a community health needs assessment to identify a community’s strengths and weaknesses is appealing because it affirms a community-spirited, can-do attitude that says we can know the problems our communities face and offer solutions that solve them. But which needs should a community address given limited resources? Should it consider those problems where the community performs poorly relative to other communities? Should it consider those problems that affect the most people? Should it consider those problems that adversely affect some groups more than others? Should it consider those problems that contribute most to wasted lives and dollars?

The community health needs assessment was conducted in partnership with Lancaster Health Improvement Partnership (LHIP) and its partner organizations. Experts in the various aspects of public health provided comments and recommendations based on county data and the clients they represent. Appendix B lists the LHIP partners.

The next few paragraphs consider setting priorities based on the number of people affected by these health problems and those preventable health problems that contribute most to years of life lost and wasted dollars. This section does not discuss setting priorities based on relative performance since the preceding data and the analyses that follow in the Selected Highlights and Appendix provide detailed information about Lancaster County’s performance relative to other counties.
Residents Affected

Figure 1 presents estimates of the top twenty health-related indicators by number of county residents affected. Using these estimates as a guide to prioritizing county health needs would likely produce a different list of priorities than would an assessment of comparative performance with other counties. Many county residents suffer the consequences of obesity, poor physical and mental health, lack of health insurance, smoking, drinking, and poor social and emotional support, among others, although the county performs comparatively well on all these measures.

Figure 1. Estimates of Lancaster County Residents Affected by Selected Health Indicators
Health Risks

Chronic, non-communicable diseases such as cardiovascular disease, cancer, chronic respiratory disease, and diabetes pose a tremendous health burden throughout the world and within the Lancaster community. Behaviors such as tobacco use, alcohol use, poor diet and physical inactivity are the primary risk factors for chronic, non-communicable disease and many Lancaster County residents are at-risk for these conditions due to their lifestyle choices. These behaviors have large social and economic costs. The estimated costs of obesity in the United States in 2008 were $147 billion. During 2000 – 2004, the estimated health-related economic costs of smoking were $193 billion. Although fewer Lancaster County residents smoke or drink compared to residents of the state and nation and more have health insurance, the estimates for diabetes, hypertension, high cholesterol, physical activity, nutrition and weight are similar in the aggregate (see Figure 2).

Prioritizing based on health risk produces a result similar to that based on the number of people affected and dissimilar to one based on a comparison to other counties. Here again, health conditions and behaviors that are relatively favorable for the Lancaster community still show the possibility of significant long-term risk for the community.

Figure 2. Risk Factors for Chronic Disease: Lancaster Compared to Pennsylvania and the United States

Data Source: Behavioral Risk Factor Surveillance System Surveys; Centers for Disease Control
A Community Approach to Health

The data included in this community health assessment primarily focus on individuals, the incidence and prevalence of specific diseases, conditions, attitudes, and behaviors present within the local community, but such data represent only part of the story. There are multiple influences on community health and multiple barriers to health improvement. Identifying, documenting, and addressing these multiple influences and barriers are as necessary for improving a community’s health as is understanding individual-level data. This means that communities must address multiple factors impacting health through policy interventions that emphasize the undeniable interaction between individual characteristics and environmental context influencing health behaviors. For example, efforts to educate people on the importance of exercise will do little to change behaviors if people lack safe, affordable, and accessible places to exercise.

Lancaster County is fortunate to have been awarded a Community Transformation Grant (CTG) from the Centers for Disease Control and Prevention (CDC) that is designed to create community solutions to the problems created by chronic disease and their underlying risk factors. The national goal of the Community Transformation Grant program is to create healthier communities by making healthy living easier and more affordable.

The Lancaster County CTG program is focused on improving weight, nutrition, and physical activity; reducing tobacco use; and providing access to quality clinical preventive services through community-level, policy-based interventions. The Community Transformation Grant provides Lancaster County with support and guidance to engage organizations that represent the entire community, including education, transportation, business, government, and faith-based organizations, to implement policy, systems, and environmental change that should improve health outcomes among all community members.
Demographic Change
The data in this section of the report for 2000 – 2010 come from data available through the US Census Bureau unless otherwise noted. Demographic data provided on the CHNA web portal and for 2012 in this summary were provided by Claritas, Inc.

Population Growth
Lancaster County’s population is growing faster than the state’s population. Between 2000 and 2010 Lancaster County grew by 10%, increasing from 470,658 to 519,445 residents. Population growth was three percent (3%) in Pennsylvania and ten percent (10%) for the nation during the same time period. Population growth increases demand for health services and produces a net increase in the number of people with a chronic condition (or engaging in a specific health behavior), for example, even when the proportion of the population living with the condition remains stable. County population growth has helped produce a more educated and diverse community. Still, the proportion of adults with a college education (23%) is below the national rate (39% in 2010) and nearly nine in ten (88%) residents are white.

Figure 3. Lancaster County Population Growth 2000 – 2010
Age
The population in Lancaster County is slightly older in 2012 than it was in 2000. The median age for Lancaster County increased from 36.1 years in 2000 to 37.8 years in 2012. Children younger than 18 years of age are a larger share of the population in 2012 (34%) than in 2000 (27%) while the proportion of residents 65 years of age or older increased slightly from 14% to 14.6%. An older population generally means increased demand for health care services and increasing prevalence of chronic conditions.

Poverty
Counties with higher poverty rates tend to have poor access to health care, lower rates of preventive care, higher rates of avoidable hospital admissions and poorer health outcomes in general. The poverty rate in Lancaster County increased from 6.5% of individuals in 2000 to 9.7% of individuals in 2010, a 49% increase. Pockets of poverty cluster throughout the county and affect both urban and rural communities (Figure 4).

Figure 4. Poverty Rates in Lancaster County by Municipality, 2005 – 2009

7 See, for example, The Commonwealth Fund Scorecard on Local Health System Performance, 2012.
Access

Access to health services is generally better in Lancaster County than other US counties. Nine in ten (93%) adults have a usual source of health care and more than four in five (84%) have health insurance (Figure 5). The proportion of children with health insurance in Lancaster County (85%) is much lower than other US counties. The trends for adults with a usual source of care and for children with health insurance have improved compared to previous time periods. Health insurance coverage estimates for both adults and children do not meet Healthy People 2020 goals.

Figure 5. Adults 18 – 64 with No Health Insurance 2001 – 2010, Lancaster County and Pennsylvania

8 The terminology used to judge the relative performance of Lancaster County compared to other Pennsylvania or United States counties has a specific meaning. If the report states that Lancaster County is better than comparable counties it means that the county scores among the best 50th percentile of comparable counties (which could be a high or low scores, depending on the indicator). If the report states that Lancaster County is worse than comparable counties it means the county scores in the 50th to 75th percentile of comparable counties. If the report states that Lancaster County is much worse than comparable counties it means the county scores in the worst 25th percentile of all comparable counties. Trends are mentioned if they have either improved or worsened compared to the previous time period and comparisons to Healthy People 2020 goals are made where applicable.
Behaviors

Exercise, Nutrition and Weight

Rates of obesity and overweight for Lancaster County adults and children are comparable to other Pennsylvania counties (Figure 6). Nearly two in three (64%) adults and a third of 6 – 11 (29%) and 12 – 19 year olds (30%) are overweight or obese. More children are overweight and obese compared to previous estimates. The county meets the Healthy People 2020 goals for obesity among both children and adults. There are nearly 223,000 adults and 30,000 children who are overweight or obese living in Lancaster County.

Figure 6. Adults who are Overweight or Obese 2001 – 2010, Lancaster County and Pennsylvania
Substance Abuse

Fewer Lancaster County adults report binge drinking (9%) or smoking (13%) compared to adults in other Pennsylvania counties. The county estimates for binge drinking meet the Healthy People 2020 goal, but smoking rates in the county do not. More than 31,000 adults in Lancaster County report binge drinking and more than 45,000 are daily smokers. Significantly fewer Lancaster County adults were smoking in 2010 than 2001 and the decline in adult smoking has been faster for the county than the state (Figure 7). Lancaster County’s age-adjusted death rate due to drug use (9.9 per 100,000) is lower than the rate in other Pennsylvania counties. The death rate due to drug use meets the Healthy People 2020 goal of 11.3 per 100,000.

Figure 7. Adults who Smoke 2001 – 2010, Lancaster County and Pennsylvania
Conditions

Cancer
The incidence rate for all cancers is higher in Lancaster County (469.6 per 100,000) than it is for other US counties, although it is comparable to other Pennsylvania counties (Figure 8). Specific cancers with relatively high incidence rates include breast cancer, cervical cancer, colorectal cancer, and prostate cancer. The age-adjusted death rate due to all cancers in Lancaster County is comparable to other US counties (180.2 per 100,000). Age-adjusted death rates for breast cancer and colorectal cancer are higher than in other US counties. The age-adjusted death rates for all cancers in Lancaster County do not meet Healthy People 2020 goals.

Colon cancer screening rates for Lancaster County residents who are older than 50 (46%) are among the lowest in the state.

Figure 8. Age-Adjusted Cancer Incidence Rates 1990 – 2008, Lancaster County and Pennsylvania
**Diabetes**
Diabetes rates among children and adults in Lancaster are lower than other Pennsylvania counties. The age-adjusted death rate due to diabetes is also lower than other Pennsylvania counties.

**Heart Disease and Stroke**
The incidence rate for Lancaster County adults who have experienced a heart attack, coronary heart disease or stroke (11%) is better than other Pennsylvania counties. The age-adjusted death rate due to coronary heart disease is better in Lancaster than other Pennsylvania counties, but the age-adjusted death rate for stroke is worse (Figure 9). Lancaster County death rates for heart disease and stroke do not meet Healthy People 2020 goals.

**Figure 9. Stroke Death Rate 2001 – 2009, Lancaster County and Pennsylvania**
Mental Health and Mental Disorders
The age-adjusted death rate due to suicide (7.5 per 100,000) is lower in Lancaster County than in other Pennsylvania counties. Pennsylvania meets the Healthy People 2020 goals of 10.2 per 100,000 deaths due to suicide.

Lancaster County adults have fewer poor mental health days and better social support than residents of other Pennsylvania counties.

Respiratory Diseases
Lancaster County has a smaller proportion of adults (13%) and children (7%) with asthma than other Pennsylvania counties. Fewer children have asthma compared to 2007 – 2008.

Vital Statistics
Immunizations and Infectious Diseases
Lancaster County has lower death rates due to HIV (1.5 per 100,000) and influenza and pneumonia (13.4 per 100,000) than other Pennsylvania counties. Lancaster County’s HIV death rate meets the Healthy People 2020 goal of 3.3 per 100,000.

Lancaster County has much higher rates of Chlamydia and gonorrhea compared to other Pennsylvania counties. The Chlamydia rate is lower compared to 2008 but the gonorrhea rate is higher.

The pneumonia vaccination rate (75%) and influenza vaccination rate (81%) for Lancaster County adults over 65 years of age are higher than in other Pennsylvania counties. Neither rate meets the Healthy People 2020 target of 90% for pneumonia and influenza vaccination.
Maternal, Fetal and Infant Health

Rates for most maternal, fetal and infant health indicators are better in Lancaster County than in other Pennsylvania counties. The one exception is that fewer mothers in Lancaster County receive early prenatal care (64%) than do mothers in other Pennsylvania counties (Figure 10). The teen birth rate in Lancaster County (12.4 per 1,000 15 – 17 year olds) is lower than other Pennsylvania counties. The teen birth rate declined from 16.7 per 1,000 15 – 17 year olds in 2009.

Lancaster County’s rate for low birth weight babies (7%) meets the Healthy People 2020 goal for low birth-weight babies, which is 8%.

Lancaster County does not meet the Healthy People 2020 goals for infant mortality (7.2 per 1,000 live births compared to a target of 6.0 per 1,000 live births).

Lancaster County meets the Healthy People 2020 goal for mothers who breastfeed, but does not meet the goals for early prenatal care or for not smoking during pregnancy.

Figure 10. Prenatal Care in First Trimester 1990 – 2009, Lancaster County and Pennsylvania

![Graph showing prenatal care rates over time]
Prevention and Safety
Death rates due to falls (7.4 per 100,000), firearms (5.7 per 100,000), and unintentional injuries (37.7 per 100,000) in Lancaster County are lower than in other Pennsylvania counties. The death rate due to firearms meets the Healthy People 2020 goal (9.2 per 100,000), but the death rates due to falls and unintentional injuries do not.

Economy and Environment
Economy
Lancaster County tends to have strong economic indicators. Rates of unemployment (6%), foreclosure (2%), homeownership (67%), and poverty (10%) are better than US other counties. Lancaster County has a higher rate of households with public assistance (2%) compared to other US counties. Compared to residents of other US counties, fewer county residents eligible for public assistance participate in the federal Supplemental Nutrition Assistance Program (SNAP).

Environment
Lancaster County has much higher rates of annual ozone air quality days (5) and annual particle pollution days (4) than other US counties, both indicators of poor air quality. Annual releases of carcinogens and persistent, bio-accumulative, and toxic chemicals (PBTs) in Lancaster County declined compared to 2009.

Public Safety
The violent crime rate (182.1 per 100,000) and child abuse rate (6.9 per 1,000 children under 18) in Lancaster County are below the rates in other Pennsylvania counties. The child abuse rate in Lancaster County has increased since 2009. The child abuse rate in Lancaster County meets the Healthy People 2020 goal of 8.5 per 1,000 children.

Transportation
The proportion of Lancaster County households without a car and more than one mile from a grocery store (4%) is higher than other US counties. The number of SNAP certified stores per 1,000 residents is lower than in other US counties. The proportion of Lancaster County households without a private vehicle is much higher than in other US counties. One in ten Lancaster County households (10%) does not own a private vehicle. The rate of private vehicle ownership is the same as it was in 2000. The number of workers in Lancaster County who walk to work (4%) is higher than other US counties and exceeds the Healthy People 2020 target of 3%. Few workers in Lancaster County use public transportation (1%) for their commute which is well below the Healthy People 2020 target of 6%.
The Community Health Needs Assessment presents Lancaster County as a community with notable strengths, not the least of which is a strong health care infrastructure and a healthy economy. However, weaknesses are also evident. This assessment finds that Lancaster County’s physical environment may contribute to poor health and that cancer rates are a bit higher than in other US counties. The assessment also shows that even some indicators that, at first glance, put the county in a favorable position must be considered problems. For example, although the county rate for being obese is comparatively good, there are still far too many obese county residents considering the costs associated with obesity. The same is true for tobacco use, binge drinking, exercise and diet, each of which contributes significantly to chronic disease.

Each year, chronic diseases such as heart disease, cancer, and diabetes are responsible for millions of premature deaths among Americans. Tobacco use is the leading cause of premature and preventable death in the United States. Tobacco-free living reduces a person’s risk of developing heart disease, various cancers, chronic obstructive pulmonary disease, periodontal disease, asthma and other diseases, and of dying prematurely. Tobacco-free living means avoiding use of all types of tobacco products – such as cigarettes, cigars, smokeless tobacco, pipes and hookahs – and also living free from secondhand smoke exposure.

Physical inactivity is one reason that one in three adults, and one in seven children, is obese. Regular physical activity is one of the most important behaviors people can engage in to improve their health. Physical activity strengthens bones and muscles, reduces stress and depression, and makes it easier to maintain a healthy body weight. Even people who do not lose weight get substantial benefits from regular physical activity, including lower rates of high blood pressure, diabetes, and cancer. Eating healthy can help reduce people’s risk for heart disease, high blood pressure, diabetes, osteoporosis, and several types of cancer, as well as help them maintain a healthy body weight.

The Community Health Needs Assessment makes it clear that the Lancaster Community must take substantive and swift action to reduce community risk factors that contribute most to death and disease.
Through the use of the Healthy Communities Institute (www.LGHealth.org/CommunityHealthdata), Lancaster General Health has identified a number of indicators in Lancaster County that are worse than the state of Pennsylvania or the Nation. The following indicators have been identified as indicators that need attention:

- Children with health insurance
- Colon cancer screening
- Chlamydia incidence rate
- Gonorrhea incidence rate
- Mothers who received early prenatal care
- Annual ozone air quality
- Annual particle pollution
- Households without a vehicle

A number of Lancaster General Health initiatives and community initiatives are in place to address the indicators above. More information on the actions LGH is taking to ensure that these indicators are addressed and do not worsen can be found in Lancaster General Health's 2012-2016 Implementation Plan.

Lancaster General Health, along with community partners, established priorities based on the following criteria:

- Percentage of the population affected
- Increase in percentage/number
- Is the problem in Lancaster greater than it is in the region, Pennsylvania, or nationally?
- The consequences of not addressing the issue
- Is the problem a cause of other problems?
- The ability to influence the health need
A ranking of health indicators based on the criteria above, Lancaster General Health determined that it will focus its efforts in the years 2013-2016 on the following priorities:

1. Increase the number of people at a healthy weight (reduce obesity)
2. Reduce the use of tobacco
3. Improve mental health with a focus on depression and anxiety

**Increase the number of people at a healthy weight**

Since 2007, Lancaster General Health has been focusing on reducing the number of individuals in Lancaster County who are obese and overweight. Understanding that no one organization could fight the obesity epidemic alone, LG Health convened over 75 groups, organizations, schools, businesses, government officials, and faith based communities to form a coalition, now known as Lighten Up Lancaster County (LULC). As a large and growing community coalition, with a membership list of over five hundred individuals, LULC continues to raise awareness of the obesity epidemic in Lancaster County and works to serve as a resource for individuals and companies to make the healthy choice the easy choice. LG Health continues to serve as the primary convener and funder. LG Health's strategic approach to Healthy Weight Management is planned using national, state and local data and engages community stakeholders to utilize evidenced-based best practices around policy, systems, and environmental changes. This is demonstrated by the convened community coalition, LULC.

Other resources available to Lancaster County residents include County rails-to-trails, recreation centers, Southern End Community Association, the YMCA, healthy weight management classes, and Buy Fresh Buy Local.

**Reduce the use of tobacco**

Anticipating the Pennsylvania Tobacco Master Settlement in 2000, LG Health convened community partners to begin to develop a comprehensive approach to reduce the number of youth and adults who use tobacco products. These community partners are now known as the Tobacco-Free Coalition of Lancaster County. The Tobacco-Free Coalition of Lancaster County is a group dedicated to decreasing tobacco use, illness, and death related to tobacco use in our community. LG Health, one of the founders of the coalition currently serves as chair for the coalition. The coalition identifies needs and raises county awareness about tobacco issues, organize local volunteers to participate in regional events, engage local business leaders, insurers and legislators, and link residents of Lancaster County to prevention and cessation resources. The mission of the coalition is to prevent young people from using tobacco, provide resources for people to quit their use of tobacco, eliminate tobacco-smoke pollution and educate legislators regarding tobacco. Tobacco-Free Coalition of Lancaster County has launched a number of
different countywide programs and initiatives and serves as a support for community organizations and events that promote the coalition’s mission. The Tobacco-Free Coalition of Lancaster County includes concerned community members and organizations throughout the county who provide tobacco prevention and cessation programs:

- American Cancer Society
- American Lung Association
- Community Members
- Compass Mark
- Council on Drug and Alcohol Abuse
- Ephrata Community Hospital
- Lancaster General Hospital
- YWCA of Lancaster

**Improve mental health with a focus on depression and anxiety**

This is the first year LG Health will set out to strategically develop a plan related to mental health needs in Lancaster County. As with tobacco use and obesity, the first year will be exploratory. We will learn from our partners and the community to locally develop a plan that will have a meaningful impact on mental health in Lancaster County. Existing organizations that work to improve the mental health of Lancaster County residents are Mental Health America and Philhaven.

**Existing Health Care Facilities and Resources Within the Community**

In addition to the efforts of Lancaster General Health, a number of other healthcare facilities and community resources are available to Lancaster County residents. See appendix C for locations.
Healthy Communities Institute (HCI) provides demographic and secondary data on health, health determinants, and quality of life topics. Data is typically presented in comparison to the distribution of counties, state average, national average, or Healthy People 2020 targets. Data is primarily derived from state and national public health sources.

About HCI Provided Data¹
Healthy Communities Institute (HCI) provides demographic and secondary data on health, health determinants, and quality of life topics. Data is typically presented in comparison to the distribution of counties, state average, national average, or Healthy People 2020 targets. Data is primarily derived from state and national public health sources. HCI also provides a database of promising practices from a variety of sources, including the Centers for Disease Control and Prevention.

Framework for Indicator/Data and Topic Selection²
The framework for indicator selection within the Health category is based on the Department of Health and Human Services (DHHS) Healthy People initiative. Healthy People establishes science-based national objectives for improving the health of the nation. The initiative establishes benchmarks every ten years and tracks progress toward these achievable goals. This framework encourages collaboration across sectors and allows communities to track important health and quality of life indicators focusing on general health status, health-related quality of life and well-being, determinants of health and disparities.

The Health subcategories are based on the Healthy People framework, and multiple indicators across the health sub-topics that correspond with Healthy People targets have been chosen (based on data availability, reliability and validity from the source).

¹ Provided by Healthy Communities Institute (www.healthycommunitiesinstitute.com)
² Provided by Healthy Communities Institute (www.healthycommunitiesinstitute.com)
Hospital utilization indicators are based on the Agency for Healthcare Research and Quality (AHRQ)’s Prevention Quality Indicators (PQIs), which are a set of definitions for preventable causes of admission. These measures can be used with hospital inpatient discharge data to identify quality of care for “ambulatory care sensitive conditions.” These indicators are important for communities to identify where prevention needs to be focused and can help lead to evidence-based community benefit planning. Ambulatory care sensitive conditions are also tracked by Healthy People.

Indicators in the other categories were selected according to national consensus and feedback from a wide set of advisors, public health officials, health departments, and local stakeholders from various sectors in the community. For example, the education indicators are based on the National Center for Health Research and Statistics and United Way of America, and the standards and goals they set forth to help track educational attainment in the U.S. Economic indicators were selected in conjunction with economic development and chamber of commerce input. All of the selected indicators have gone through a vetting process where HCI’s advisory board, as well as stakeholders in communities who have implemented HCI systems, provide feedback to refine the core indicators in order to best reflect local priorities.

The indicator selection process evolves over time with changing health priorities, new research models and national benchmarks. HCI continues to incorporate models and standards from nationally recognized institutions such HHS’s Healthy People, AHRQ’s PQI’s, EPA Air Quality standards, National Center for Education Research and Statistics’ priorities, United Way, and United States Department of Agriculture’s Food Atlas, among many others.

These sources include, but are not limited to, the following:

- AIRNow
- American Community Survey
- American Lung Association
- Annie E. Casey Foundation
- County Health Rankings
- National Cancer Institute
- National Center for Education Statistics
- Pennsylvania Behavioral Risk Factor Surveillance System
- Pennsylvania Department of Education
HCI also provides a database of promising practices from a variety of sources, including the Centers for Disease Control and Prevention.

All of the HCI content is presented in a public web platform that also serves as a publishing tool for components of the Community Health Needs Assessment.
## Table A-1 Health Care Access: Estimates, Comparisons, Trends and Goals

<table>
<thead>
<tr>
<th>Access to Health Services</th>
<th>Performance (% rate or value)</th>
<th>Trend (previous value)</th>
<th>Healthy People 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults with a Usual Source of Health Care</td>
<td>93%</td>
<td>92%</td>
<td>84%</td>
</tr>
<tr>
<td>Adults with Health Insurance*</td>
<td>84%</td>
<td>85%</td>
<td>100%</td>
</tr>
<tr>
<td>Children (0 - 17 years of age) with Health Insurance*</td>
<td>85%</td>
<td>84%</td>
<td>100%</td>
</tr>
<tr>
<td>Primary Care Provider Rate (per 100,000 people)*</td>
<td>120</td>
<td>114</td>
<td></td>
</tr>
</tbody>
</table>

Green shading in the performance column means Lancaster County rates are in the top 50 percent of comparison counties for the estimate; yellow shading means the county rates in the 51st to 75th percentile; red shading means the county rates are in the lowest quartile; no color means that no comparison data is available.

Green shading for the trend column means the Lancaster County rates have moved in a favorable direction compared to the most recent prior estimate; red shading means the county has moved in an unfavorable direction compared to the most recent prior estimate; blue shading means there has been no change; no color means there is no previous data available.

Green shading for the Healthy People 2020 column means that Lancaster County has met the goal; red shading means the county has not met the goal; no shading means there is no goal for the estimate.

All comparisons are to Pennsylvania counties unless noted. An asterisk (*) means the comparison is to US counties.
Table A-2 Health Behaviors: Estimates, Comparisons, Trends and Goals

<table>
<thead>
<tr>
<th>Exercise, Nutrition, &amp; Weight</th>
<th>Comparison (% or value)</th>
<th>Trend (previous value)</th>
<th>Healthy People 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults who are Obese</td>
<td>28%</td>
<td>27%</td>
<td>31%</td>
</tr>
<tr>
<td>Adults who are Overweight or Obese</td>
<td>64%</td>
<td>62%</td>
<td></td>
</tr>
<tr>
<td>Children who are Obese: Grades K-6</td>
<td>15%</td>
<td>14%</td>
<td>16%</td>
</tr>
<tr>
<td>Children who are Overweight or Obese: Grades K-6</td>
<td>29%</td>
<td>28%</td>
<td></td>
</tr>
<tr>
<td>Teens who are Obese: Grades 7-12</td>
<td>15%</td>
<td>15%</td>
<td>16%</td>
</tr>
<tr>
<td>Teens who are Overweight or Obese: Grades 7-12</td>
<td>30%</td>
<td>29%</td>
<td></td>
</tr>
<tr>
<td>Substance Abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults who Binge Drink</td>
<td>9%</td>
<td>11%</td>
<td>24%</td>
</tr>
<tr>
<td>Adults who Smoke</td>
<td>13%</td>
<td>15%</td>
<td>12%</td>
</tr>
<tr>
<td>Age-Adjusted Death Rate due to Drug Use (per 100,000)</td>
<td>9.9</td>
<td>8.7</td>
<td>11.3</td>
</tr>
</tbody>
</table>

Green shading in the performance column means Lancaster County rates are in the top 50 percent of comparison counties for the estimate; yellow shading means the county rates in the 51st to 75th percentile; red shading means the county rates are in the lowest quartile; no color means that no comparison data is available.

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### Table A-3 Health Conditions: Estimates, Comparisons, Trends and Goals

<table>
<thead>
<tr>
<th>Health Condition</th>
<th>Comparison (%)</th>
<th>Trend (previous value)</th>
<th>Healthy People 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cancer</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age-Adjusted Death Rate (per 100,000 females) due to Breast Cancer*</td>
<td>24.3</td>
<td>24.9</td>
<td>20.6</td>
</tr>
<tr>
<td>Age-Adjusted Death Rate (per 100,000) due to Cancer*</td>
<td>180.2</td>
<td>181.1</td>
<td>160.6</td>
</tr>
<tr>
<td>Age-Adjusted Death Rate (per 100,000) due to Colorectal Cancer*</td>
<td>18.5</td>
<td>19.3</td>
<td>14.3</td>
</tr>
<tr>
<td>Age-Adjusted Death Rate (per 100,000) due to Lung Cancer*</td>
<td>46.0</td>
<td>46.7</td>
<td>45.5</td>
</tr>
<tr>
<td>Age-Adjusted Death Rate (per 100,000 males) due to Prostate Cancer*</td>
<td>22.2</td>
<td>21.3</td>
<td>21.2</td>
</tr>
<tr>
<td>All Cancer Incidence Rate (per 100,000)*</td>
<td>469.6</td>
<td>473.5</td>
<td></td>
</tr>
<tr>
<td>Breast Cancer Incidence Rate (per 100,000 females)*</td>
<td>118.8</td>
<td>118.1</td>
<td></td>
</tr>
<tr>
<td>Cervical Cancer Incidence Rate (per 100,000 females)*</td>
<td>8.5</td>
<td>8.9</td>
<td></td>
</tr>
<tr>
<td>Colon Cancer Screening (50 years of age and older)</td>
<td>46%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorectal Cancer Incidence Rate (per 100,000)*</td>
<td>51.0</td>
<td>53.0</td>
<td>38.6</td>
</tr>
<tr>
<td>Lung and Bronchus Cancer Incidence Rate (per 100,000)*</td>
<td>57.2</td>
<td>57.5</td>
<td></td>
</tr>
<tr>
<td>Oral Cavity and Pharynx Cancer Incidence Rate (per 100,000)*</td>
<td>8.3</td>
<td>8.5</td>
<td></td>
</tr>
<tr>
<td>Prostate Cancer Incidence Rate (per 100,000 males)*</td>
<td>150.9</td>
<td>154.9</td>
<td></td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults with Diabetes</td>
<td>8%</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>Age-Adjusted Death Rate (per 100,000) due to Diabetes</td>
<td>15.5</td>
<td>18.0</td>
<td></td>
</tr>
<tr>
<td>Children with Type 1 Diabetes</td>
<td>0.29%</td>
<td>0.31%</td>
<td></td>
</tr>
<tr>
<td>Children with Type 2 Diabetes</td>
<td>0.03%</td>
<td>0.03%</td>
<td></td>
</tr>
<tr>
<td><strong>Heart Disease &amp; Stroke</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults who Experienced a Heart Attack, Coronary Heart Disease, or a Stroke</td>
<td>11%</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Age-Adjusted Death Rate (per 100,000) due to Cerebrovascular Disease (Stroke)</td>
<td>43.8</td>
<td>43.5</td>
<td>33.8</td>
</tr>
<tr>
<td>Age-Adjusted Death Rate (per 100,000) due to Coronary Heart Disease</td>
<td>112.4</td>
<td>108.7</td>
<td>100.8</td>
</tr>
<tr>
<td><strong>Mental Health &amp; Mental Disorders</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age-Adjusted Death Rate (per 100,000) due to Suicide</td>
<td>7.5</td>
<td>8.5</td>
<td>10.2</td>
</tr>
<tr>
<td>Poor Mental Health Days</td>
<td>31%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Poor Social and Emotional Support</td>
<td>8%</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td><strong>Respiratory Diseases</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults with Asthma</td>
<td>13%</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>Children with Asthma</td>
<td>7%</td>
<td>12%</td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Category</th>
<th>Comparison (%, rate, or value)</th>
<th>Trend (previous value)</th>
<th>Healthy People 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family Planning</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teen Birth Rate (per 1,000 ages 15 - 17)</td>
<td>12.4</td>
<td>16.7</td>
<td></td>
</tr>
<tr>
<td><strong>Food Safety</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salmonella Incidence Rate (per 100,000)</td>
<td>8.9</td>
<td>12.7</td>
<td>11.4</td>
</tr>
<tr>
<td><strong>Immunizations &amp; Infectious Diseases</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age-Adjusted Death Rate (per 100,000) due to HIV</td>
<td>1.5</td>
<td>1.6</td>
<td>3.3</td>
</tr>
<tr>
<td>Age-Adjusted Death Rate (per 100,000) due to Influenza and Pneumonia</td>
<td>13.4</td>
<td>14.1</td>
<td></td>
</tr>
<tr>
<td>Chlamydia Incidence Rate (per 100,000)</td>
<td>216</td>
<td>231.1</td>
<td></td>
</tr>
<tr>
<td>Gonorrhea Incidence Rate (per 100,000)</td>
<td>64.4</td>
<td>56.1</td>
<td></td>
</tr>
<tr>
<td>Influenza Vaccination Rate 65+</td>
<td>81%</td>
<td>77%</td>
<td>90%</td>
</tr>
<tr>
<td>Lyme Disease Incidence Rate (per 100,000)</td>
<td>2.8</td>
<td>13.3</td>
<td></td>
</tr>
<tr>
<td>Pneumonia Vaccination Rate 65+</td>
<td>75%</td>
<td>73%</td>
<td>90%</td>
</tr>
<tr>
<td><strong>Maternal, Fetal &amp; Infant Health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Babies with Low Birth Weight (per 1,000 live births)</td>
<td>7%</td>
<td>6%</td>
<td>8%</td>
</tr>
<tr>
<td>Babies with Very Low Birth Weight: Singleton Births (per 1,000 live births)</td>
<td>1%</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Infant Mortality Rate (per 1,000 live births)</td>
<td>7.2</td>
<td>6.4</td>
<td>6.0</td>
</tr>
<tr>
<td>Mothers who Breastfeed</td>
<td>83%</td>
<td>80%</td>
<td>82%</td>
</tr>
<tr>
<td>Mothers who did not Smoke During Pregnancy</td>
<td>87%</td>
<td>87%</td>
<td>99%</td>
</tr>
<tr>
<td>Mothers who Received Early Prenatal Care</td>
<td>64%</td>
<td>65%</td>
<td>78%</td>
</tr>
<tr>
<td>Mothers who Received No Prenatal Care</td>
<td>0.3%</td>
<td>0.3%</td>
<td></td>
</tr>
<tr>
<td>Preterm: Singleton Births (per 1,000 live births)</td>
<td>7%</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td><strong>Prevention &amp; Safety</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age-Adjusted Death Rate (per 100,000) due to Falls</td>
<td>7.4</td>
<td>6.3</td>
<td>7.0</td>
</tr>
<tr>
<td>Age-Adjusted Death Rate (per 100,000) due to Firearms</td>
<td>5.7</td>
<td>6.1</td>
<td>9.2</td>
</tr>
<tr>
<td>Age-Adjusted Death Rate (per 100,000) due to Unintentional Injuries</td>
<td>37.7</td>
<td>37.8</td>
<td>36.0</td>
</tr>
</tbody>
</table>

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### Table A-5 Social Context: Estimates, Comparisons, Trends and Goals

<table>
<thead>
<tr>
<th></th>
<th>Comparison</th>
<th>Trend</th>
<th>Healthy People 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(%) or value</td>
<td>(previous value)</td>
<td></td>
</tr>
<tr>
<td><strong>Economy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployed Workers (16 and older) in Civilian Labor Force*</td>
<td>6%</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>Households with Public Assistance*</td>
<td>2%</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>Foreclosure Rate*</td>
<td>2%</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>Homeownership*</td>
<td>67%</td>
<td>68%</td>
<td></td>
</tr>
<tr>
<td>Renters Spending 30% or More of Household Income on Rent*</td>
<td>46%</td>
<td>44%</td>
<td></td>
</tr>
<tr>
<td>Median Household Income (dollars)*</td>
<td>$54,765</td>
<td>$54,893</td>
<td></td>
</tr>
<tr>
<td>Per Capita Income (dollars)*</td>
<td>$25,854</td>
<td>$25,813</td>
<td></td>
</tr>
<tr>
<td>Children Living Below Poverty Level*</td>
<td>14%</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Families Living Below Poverty Level*</td>
<td>7%</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>Low-Income Persons (less than 200% of poverty) who are SNAP Participants*</td>
<td>29%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>People 65+ Living Below Poverty Level*</td>
<td>7%</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>People Living 200% Above Poverty Level*</td>
<td>73%</td>
<td>74%</td>
<td></td>
</tr>
<tr>
<td>People Living Below Poverty Level*</td>
<td>10%</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>Students Eligible for the Free Lunch Program*</td>
<td>23%</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Young Children (ages 0 - 5) Living Below Poverty Level*</td>
<td>16%</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School Dropouts</td>
<td>1%</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>People 25+ with a Bachelor's Degree or Higher*</td>
<td>23%</td>
<td>23%</td>
<td></td>
</tr>
<tr>
<td>Student-to-Teacher Ratio*</td>
<td>14.5</td>
<td>14.9</td>
<td></td>
</tr>
<tr>
<td><strong>Environment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Ozone Air Quality (days)*</td>
<td>5</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Annual Particle Pollution (days)*</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Daily Ozone Air Quality*</td>
<td>36</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>Daily Particle Pollution*</td>
<td>20</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Recognized Carcinogens Released into Air (pounds)*</td>
<td>129,271</td>
<td>130,996</td>
<td></td>
</tr>
<tr>
<td>Farmers Market Density (per 1,000 residents)*</td>
<td>0.02</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fast Food Restaurant Density (per 1,000 residents)*</td>
<td>0.60</td>
<td>0.59</td>
<td></td>
</tr>
<tr>
<td>Grocery Store Density (per 1,000 residents)*</td>
<td>0.21</td>
<td>0.21</td>
<td></td>
</tr>
<tr>
<td>Households without a Car and &gt; 1 Mile from a Grocery Store*</td>
<td>4%</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>Low-Income and &gt; 1 Mile from a Grocery Store*</td>
<td>11%</td>
<td>11%</td>
<td></td>
</tr>
<tr>
<td>Recreation and Fitness Facilities (per 1,000 residents)*</td>
<td>0.13</td>
<td>0.13</td>
<td></td>
</tr>
<tr>
<td>SNAP Certified Stores (per 1,000 residents)*</td>
<td>0.6</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>PBT Released (pounds)*</td>
<td>24,601</td>
<td>58,631</td>
<td></td>
</tr>
<tr>
<td><strong>Public Safety</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violent Crime Rate (per 100,000)</td>
<td>182.1</td>
<td>165.8</td>
<td></td>
</tr>
<tr>
<td>Age-Adjusted Death Rate (per 100,000) due to Motor Vehicle Collision*</td>
<td>11.5</td>
<td>14.7</td>
<td>12.4</td>
</tr>
<tr>
<td><strong>Social Environment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Abuse Rate (per 1,000 children)</td>
<td>6.9</td>
<td>6.4</td>
<td>8.5</td>
</tr>
<tr>
<td>Single-Parent Households*</td>
<td>22%</td>
<td>21%</td>
<td></td>
</tr>
<tr>
<td><strong>Transportation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Travel Time to Work (minutes)*</td>
<td>21.9</td>
<td>21.9</td>
<td></td>
</tr>
<tr>
<td>Workers who Drive Alone to Work*</td>
<td>79%</td>
<td>79%</td>
<td></td>
</tr>
<tr>
<td>Workers who Walk to Work*</td>
<td>4%</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>Households without a Vehicle*</td>
<td>10%</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>Workers Commuting by Public Transportation*</td>
<td>1%</td>
<td>1%</td>
<td>8%</td>
</tr>
</tbody>
</table>

Green shading in the performance column means Lancaster County rates are in the top 50 percent of comparison counties for the estimate; yellow shading means the county rates in the 51st to 75th percentile; red shading means the county rates are in the lowest quartile; no color means that no comparison data is available.

Green shading for the trend column means the Lancaster County rates have moved in a favorable direction compared to the most recent prior estimate; red shading means the county has moved in an unfavorable direction compared to the most recent prior estimate; blue shading means there has been no change; no color means there is no previous data available.

Green shading for the Healthy People 2020 column means that Lancaster County has met the goal; red shading means the county has not met the goal; no shading means there is no goal for the estimate.

All comparisons are to Pennsylvania counties unless noted. An asterisk (*) means the comparison is to US counties.
### Table A-6 Estimates of Population Affected by Selected Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Count</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults who are Overweight or Obese</td>
<td>252,977</td>
<td>2012 adults (n=395,276)</td>
</tr>
<tr>
<td>Workers who Drive Alone to Work (aged 16 or older)</td>
<td>210,635</td>
<td>16+ workers (n=267,303)</td>
</tr>
<tr>
<td>Poor Physical Health Days</td>
<td>130,441</td>
<td></td>
</tr>
<tr>
<td>Poor Mental Health Days</td>
<td>122,536</td>
<td></td>
</tr>
<tr>
<td>Adults who are Obese</td>
<td>110,677</td>
<td></td>
</tr>
<tr>
<td>Adults with no Health Insurance</td>
<td>62,849</td>
<td></td>
</tr>
<tr>
<td>Adults with Asthma</td>
<td>51,386</td>
<td></td>
</tr>
<tr>
<td>Adults who Smoke</td>
<td>51,386</td>
<td></td>
</tr>
<tr>
<td>Adults who Experienced a Heart Attack, Coronary Heart Disease, or a Stroke</td>
<td>43,480</td>
<td></td>
</tr>
<tr>
<td>Self-Reported General Health Assessment: Poor or Fair</td>
<td>39,528</td>
<td></td>
</tr>
<tr>
<td>Adults who Binge Drink</td>
<td>35,575</td>
<td></td>
</tr>
<tr>
<td>Adults with Diabetes</td>
<td>31,622</td>
<td></td>
</tr>
<tr>
<td>Poor Social and Emotional Support</td>
<td>31,622</td>
<td></td>
</tr>
<tr>
<td>Adults with no Usual Source of Health Care</td>
<td>27,669</td>
<td></td>
</tr>
<tr>
<td>Unemployed Workers in Civilian Labor Force, 16 or older</td>
<td>24,739</td>
<td>16 and older</td>
</tr>
<tr>
<td>Children with no Health Insurance</td>
<td>20,389</td>
<td>0 - 17 years of age</td>
</tr>
<tr>
<td>Persons without a Vehicle</td>
<td>19,134</td>
<td>households</td>
</tr>
<tr>
<td>Children Living Below Poverty Level</td>
<td>18,138</td>
<td>0 - 17 years of age</td>
</tr>
<tr>
<td>Teens who are Overweight or Obese: Grades 7-12</td>
<td>17,825</td>
<td>ages 12 - 19</td>
</tr>
<tr>
<td>Children who are Overweight or Obese: Grades K-6</td>
<td>12,341</td>
<td>ages 6 - 11</td>
</tr>
<tr>
<td>Workers who Walk to Work (workers 16 and older)</td>
<td>9,623</td>
<td>16+ workers (n=267,303)</td>
</tr>
<tr>
<td>Children with Asthma</td>
<td>8,606</td>
<td>0 - 17 years of age</td>
</tr>
<tr>
<td>People 65+ Living Below Poverty Level</td>
<td>5,260</td>
<td>65 and older</td>
</tr>
<tr>
<td>Residents using Public Assistance</td>
<td>4,537</td>
<td>households</td>
</tr>
<tr>
<td>All Cancer Incidence Rate</td>
<td>1,856</td>
<td>per 100,000</td>
</tr>
<tr>
<td>Child Abuse Rate</td>
<td>914</td>
<td>per 1,000 under 18</td>
</tr>
<tr>
<td>Chlamydia Incidence Rate</td>
<td>854</td>
<td>per 100,000</td>
</tr>
<tr>
<td>Violent Crime Rate</td>
<td>720</td>
<td>per 100,000</td>
</tr>
<tr>
<td>Age-Adjusted Death Rate due to Cancer</td>
<td>712</td>
<td>per 100,000</td>
</tr>
<tr>
<td>Babies with Low Birth Weight</td>
<td>501</td>
<td>2009 7,258 live births</td>
</tr>
<tr>
<td>Age-Adjusted Death Rate due to Coronary Heart Disease</td>
<td>444</td>
<td>per 100,000</td>
</tr>
<tr>
<td>Children with Type 1 Diabetes</td>
<td>384</td>
<td>0 - 17 years of age</td>
</tr>
<tr>
<td>Teen Birth Rate</td>
<td>290</td>
<td>per 1,000 ages 15 - 17</td>
</tr>
<tr>
<td>Gonorrhea Incidence Rate</td>
<td>255</td>
<td>per 100,000</td>
</tr>
<tr>
<td>Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)</td>
<td>173</td>
<td>per 100,000</td>
</tr>
<tr>
<td>Age-Adjusted Death Rate due to Unintentional Injuries</td>
<td>149</td>
<td>per 100,000</td>
</tr>
<tr>
<td>Babies with Very Low Birth Weight: Singleton Births</td>
<td>73</td>
<td>2009 7,258 live births</td>
</tr>
<tr>
<td>Age-Adjusted Death Rate due to Diabetes</td>
<td>61</td>
<td>per 100,000</td>
</tr>
<tr>
<td>Age-Adjusted Death Rate due to Influenza and Pneumonia</td>
<td>53</td>
<td>per 100,000</td>
</tr>
<tr>
<td>Infant Mortality Rate</td>
<td>52</td>
<td>per 1,000 live births</td>
</tr>
<tr>
<td>Age-Adjusted Death Rate due to Motor Vehicle Collisions</td>
<td>45</td>
<td>per 100,000</td>
</tr>
<tr>
<td>Children with Type 2 Diabetes</td>
<td>40</td>
<td>0 - 17 years of age</td>
</tr>
<tr>
<td>Age-Adjusted Death Rate due to Drug Use</td>
<td>39</td>
<td>per 100,000</td>
</tr>
<tr>
<td>Salmonella Incidence Rate</td>
<td>35</td>
<td>per 100,000</td>
</tr>
<tr>
<td>Age-Adjusted Death Rate due to Suicide</td>
<td>30</td>
<td>per 100,000</td>
</tr>
<tr>
<td>Age-Adjusted Death Rate due to Falls</td>
<td>29</td>
<td>per 100,000</td>
</tr>
<tr>
<td>Age-Adjusted Death Rate due to Firearms</td>
<td>23</td>
<td>per 100,000</td>
</tr>
<tr>
<td>Lyme Disease Incidence Rate</td>
<td>11</td>
<td>per 100,000</td>
</tr>
<tr>
<td>Age-Adjusted Death Rate due to HIV</td>
<td>6</td>
<td>per 100,000</td>
</tr>
</tbody>
</table>

The population base used to estimate the number of county residents affected by an indicator differs depending on the indicator. For most estimates, the calculation is based on the total number of adults residing in the county during 2012 (N=395,276). Other bases include: workers (the employed workforce aged 16 and older N=405,556); children (ages 0 - 17 N=132,392); teens (ages 15 - 17 N=23,406); children in grades 7 - 12 (N=59,417); children in grades K - 6 (N=42,556); adults over 65 (N=77,356); households (N=197,256); and live births (N=7,258).
Table A-7 Health Disparities: Groups with Lowest Estimated Rates for Selected Indicators

<table>
<thead>
<tr>
<th>Access to Health Services</th>
<th>Age</th>
<th>Gender</th>
<th>Race</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults with a Usual Source of Health Care</td>
<td>18 - 44</td>
<td>male</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cancer</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age-Adjusted Death Rate due to Cancer</td>
<td></td>
<td>female</td>
<td>API, Hisp</td>
</tr>
<tr>
<td>Age-Adjusted Death Rate due to Colorectal Cancer</td>
<td></td>
<td>female</td>
<td>white</td>
</tr>
<tr>
<td>All Cancer Incidence Rate</td>
<td></td>
<td>female</td>
<td>black</td>
</tr>
<tr>
<td>Breast Cancer Incidence Rate</td>
<td></td>
<td>male</td>
<td></td>
</tr>
<tr>
<td>Colon Cancer Screening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorectal Cancer Incidence Rate</td>
<td></td>
<td>female</td>
<td>white</td>
</tr>
<tr>
<td>Lung and Bronchus Cancer Incidence Rate</td>
<td></td>
<td>female</td>
<td>white</td>
</tr>
<tr>
<td>Oral Cavity and Pharynx Cancer Incidence Rate</td>
<td></td>
<td>female</td>
<td></td>
</tr>
<tr>
<td>Prostate Cancer Incidence Rate</td>
<td></td>
<td></td>
<td>white</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diabetes</th>
<th>18 - 44</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults with Diabetes</td>
<td></td>
<td>female</td>
<td></td>
</tr>
<tr>
<td>Age-Adjusted Death Rate due to Diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Exercise, Nutrition, & Weight                      | 18 - 44 | male   |
|----------------------------------------------------|---------|--------|-------|
| Adults who are Obese                               |         |        |

| Food Safety                                        | 15 - 34 | male   |
|----------------------------------------------------|---------|--------|-------|
| Salmonella Incidence Rate                          |         |        |

| Heart Disease & Stroke                             | 18 - 44 | female |
|----------------------------------------------------|---------|--------|-------|
| Adults who Experienced a Heart Attack, Coronary Heart Disease, or a Stroke |         |
| Age-Adjusted Death Rate due to Coronary Heart Disease |         |
| Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke) |        |

<table>
<thead>
<tr>
<th>Immunizations &amp; Infectious Diseases</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age-Adjusted Death Rate due to Influenza and Pneumonia</td>
<td>female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlamydia Incidence Rate</td>
<td>35+</td>
<td>male</td>
<td></td>
</tr>
<tr>
<td>Gonorrhea Incidence Rate</td>
<td>35+</td>
<td>male</td>
<td></td>
</tr>
<tr>
<td>Pneumonia Vaccination Rate 65+</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maternal, Fetal &amp; Infant Health</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Babies with Low Birth Weight</td>
<td>30 - 34</td>
<td>white</td>
<td></td>
</tr>
<tr>
<td>Mothers who Breastfeed</td>
<td>15 - 17</td>
<td>black</td>
<td></td>
</tr>
<tr>
<td>Mothers who did not Smoke During Pregnancy</td>
<td>18 - 19</td>
<td>black</td>
<td></td>
</tr>
<tr>
<td>Mothers who Received Early Prenatal Care</td>
<td>15 - 17</td>
<td>black</td>
<td></td>
</tr>
</tbody>
</table>

| Mental Health & Mental Disorders                   | 65 +   | male   |
|----------------------------------------------------|--------|--------|-------|
| Poor Mental Health Days                            |        |        |       |
| Poor Social and Emotional Support                  | 45 - 64 | female |

<table>
<thead>
<tr>
<th>Prevention &amp; Safety</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age-Adjusted Death Rate due to Falls</td>
<td></td>
<td>female</td>
<td></td>
</tr>
<tr>
<td>Age-Adjusted Death Rate due to Unintentional Injuries</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Respiratory Diseases                               | 45 +   | male   |
|----------------------------------------------------|--------|--------|-------|
| Adults with Asthma                                  |        |        |       |
Table A-7 Health Disparities: Groups with Lowest Estimated Rates for Selected Indicators

<table>
<thead>
<tr>
<th>Substance Abuse</th>
<th>Age</th>
<th>Gender</th>
<th>Race</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults who Binge Drink</td>
<td>65+</td>
<td>female</td>
<td></td>
</tr>
<tr>
<td>Adults who Smoke</td>
<td>65+</td>
<td>female</td>
<td></td>
</tr>
<tr>
<td>Age-Adjusted Death Rate due to Drug Use</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Wellness & Lifestyle                     |      |        |      |
| Poor Physical Health Days                | 18-44| male   |      |
| Self-Reported General Health Assessment: Poor or Fair | 18-44| male   |      |

| Public Safety                           |      |        |      |
| Age-Adjusted Death Rate due to Motor Vehicle Collisions |      | female |      |
Appendix B: Expert Input

Jan Baily, Executive Director, Mental Health America of Lancaster County (Mental Health)
Mental Health America of Lancaster County (MHALC) is part of a nation-wide voluntary organization dedicated to promoting mental health, preventing mental illness and contributing to the quality of life of persons suffering from mental and emotional problems. This organization works with individuals of all ages, races, and socioeconomic statuses to address their mental health needs.

Trisha Banker, Human Resources Program Coordinator, County of Lancaster (County Government)
The County of Lancaster works to improve the health and well-being of all Lancaster County residents.

Scott Martin, County Commissioner, County of Lancaster
The County acts as an agent of the Commonwealth for those functions which are specified by State law. To carry out those functions, three County Commissioners are elected every four years. The County of Lancaster works to improve the health and well-being of all Lancaster County residents.

Steve Batchelor, MS, Director of Wellness Services, Ephrata Community Hospital (Hospital)
Ephrata Community Hospital, a nonprofit hospital in Lancaster County, Pennsylvania, strives to assure community access to quality, compassionate, and cost-effective health care. The hospital’s primary service area is northern Lancaster County. The Wellness Center focuses on health and wellness services to reduce chronic disease.

John Porter, President & Chief Executive Officer, Ephrata Community Hospital (Hospital)
Ephrata Community Hospital, a nonprofit hospital in Lancaster County, Pennsylvania, strives to assure community access to quality, compassionate, and cost-effective health care. The hospital’s primary service area is northern Lancaster County. The Wellness Center focuses on health and wellness services to reduce chronic disease.

Jeff Blystone, Acting Director, Bureau of Community Health Systems, Pennsylvania Department of Health (Health Department)
The Pennsylvania Department of Health works to improve the health of all residents of Pennsylvania and works to support halt and wellness efforts in Lancaster County.

2 Mental Health America: www.mhalancaster.org
3 Lancaster County: www.co.lancaster.pa.us/lanco/cwp/view.asp?a=513&q=518430&lancoNav=|
Susan Sines, RN BSN MSN (c) Community Health Nurse, Pennsylvania Department of Health (Health Department)
The Pennsylvania Department of Health works to improve the health of all residents of Pennsylvania and works to support health and wellness efforts in Lancaster County.

Cynthia Sears, RN BSN, Community Health Nurse, Pennsylvania Department of Health (Health Department)
The Pennsylvania Department of Health works to improve the health of all residents of Pennsylvania and works to support health and wellness efforts in Lancaster County.

Ken Culton, RN, Community Health Nurse HIV/AIDS/STD, Pennsylvania Department of Health (Health Department)
The Pennsylvania Department of Health works to improve the health of all residents of Pennsylvania and works to support health and wellness efforts in Lancaster County, specifically Sexually Transmitted Diseases.

Steve Fuhs, Southeast District Executive Director, Pennsylvania Department of Health (Health Department)
The Pennsylvania Department of Health works to improve the health of all residents of Pennsylvania and works to support health and wellness efforts in Lancaster County.

Zoe Bracci, Marketing and Education Coordinator, Albright Life (Elderly)
Albright Care Services is a faith-based non-profit corporation serving Pennsylvania’s entire Susquehanna Valley. Albright Care Services provides services to Lancaster through the new LIFE (Living Independently for Elders) Centers. LIFE is Pennsylvania’s version of the nationally recognized Program of All-Inclusive Care for the Elderly (PACE)⁴. Albright Life focuses on the health and well-being of the elderly population in Lancaster County.

⁴ Albright Life: www.albrightcare.org/page.asp?tid=78&name=About-Albright
Eboni Bryant, MS MBA, Lancaster County Community Transformation Grant Manager (Public Health)
The Centers for Disease Control and Prevention (CDC) continues its long-standing dedication to improving the health and wellness of all Americans through the Community Transformation Grant (CTG) Program. CTG supports state and local government agencies, tribes and territories, nonprofit organizations, and communities across the country. The Lancaster County Community Transformation Grant works to reduce chronic disease in Lancaster County among all residents, especially those of low income and the despaired populations.

Jacqueline Burch, MSW LSW, Executive Director, Lancaster County Office of Aging (Elderly)
The Lancaster County Office of Aging works with the elderly population in Lancaster County.

Gail Dennis, Grants Program Manager, Lancaster General Health (Hospital)
The Grants Department at Lancaster General Health works with community organizations to write and secure grant funding for health and wellness initiatives in Lancaster County.

Alice Yoder, RN MSN, Director of Community Health, Lancaster General Health (Health-System)
Lancaster General Health, a non-profit health system in Lancaster County, Pennsylvania, strives to improve the health and wellness of all Lancaster County residents. The wellness center works to serve low-income, despaired populations, to reduce chronic disease in Lancaster County.

Jan Bergen, President of LG Health Network, Lancaster General Health (Health System)
Lancaster General Health, a non-profit health system in Lancaster County, Pennsylvania, strives to improve the health and wellness of all Lancaster County residents. The wellness center works to serve low-income, despaired populations, to reduce chronic disease in Lancaster County.

5 Centers for Disease Control and Prevention Community Transformation Grant: www.cdc.gov/communitytransformation
Susan C. Eckert, Project Manager, Partnership for Public Health (Public Health)
The Partnership for Public Health in Lancaster County exists to find unique local solutions to the public health challenges the county faces. In the face of increasing threats of disease outbreaks, municipalities struggling to resolve sewer challenges, and decreasing resources from State departments to provide services in our county, the Partnership is committed to a public/private partnership that reduces fragmentation and improves the health of residents. The Partnership relies on the engagement of diverse organizations that provide the underlying support needed to ensure its success. The Partnership for Public Health works to improve the health of the despaired populations in Lancaster County.

Colleen Elmer, BSW MSW MBA, Executive Director, Water Street Health Services (Homelessness)
Water Street Health Services focuses on one segment of this population: the working poor or homeless. These individuals and families often make less than $150 per week and cannot afford the co-payments at other safety net providers. Water Street Health Services is the only free clinic in Lancaster City where residents living in poverty with an income too high to receive public health insurance and yet not enough to buy private health insurance find relief from pain for their medical or dental crisis. Water Street Health Services works with the despaired, low-income individuals in Lancaster County, especially those living in Lancaster City.

Miora Gaul, MPH, Director of Lancaster City Services, Susquehanna Valley Pregnancy Services (Pregnancy Services)
Susquehanna Valley Pregnancy Services exists to share the gospel of Jesus Christ and uphold the sanctity of human life through sexual integrity education, unplanned pregnancy intervention, and post-abortion restoration. Susquehanna Valley Pregnancy services works especially with women.

Vicki Gillmore, RN PhD NHA, Executive Director, Masonic Village at Elizabethtown (Elderly)
Masonic Village at Elizabethtown is more than a continuing care retirement community. In addition to serving more than 1,700 individuals, they also operate a children’s home and numerous other community services. On-campus amenities and activities include lifelong learning programs, a wellness center, an art studio/club, the Grey Lions of Elizabethtown (a Penn State Alumni Interest Group), religious programs and services, and a travel club. While their villages are built upon and strengthened by Masonic values, their communities are committed to serving Masons and non-Masons alike. Regardless of an individual’s financial situation, there is an affordable option for most individuals. Masonic Villages works with the wellness of their residents, who are mostly elderly.

6 Partnership for Public Health: www.partnershipforpublichealth.org/partnership.html
7 Water Street Health Services: www.wsm.org/healthservices
8 Susquehanna Valley Pregnancy Services: www.svps.org/AboutUs.aspx
9 Masonic Villages: www.masonicvillagespa.org/elizabethtown
Stacy Schroder, M.Ed CEASI, Wellness Director, Masonic Village at Elizabethtown (Elderly)
Masonic Village at Elizabethtown is more than a continuing care retirement community. In addition to serving more than 1,700 individuals, they also operate a children’s home and numerous other community services. On-campus amenities and activities include lifelong learning programs, a wellness center, an art studio/club, the Grey Lions of Elizabethtown (a Penn State Alumni Interest Group), religious programs and services, and a travel club. While their villages are built upon and strengthened by Masonic values, their communities are committed to serving Masons and non-Masons alike. Regardless of an individual’s financial situation, there is an affordable option for most individuals10. Masonic Villages works with the wellness of their residents, who are mostly elderly.

Esther Good, River of Life Health Center (Faith Based- Low Income)
River of Life Health Center provides primary healthcare services, with dignity and respect, to underserved, uninsured and underinsured residents of regions within Pennsylvania with the help of qualified health volunteers and staff, and has the vision to empower local churches in other communities to do the same11. River of Life Health Center works to provide care to the despained populations in Lancaster County, including those who are of low-income, under and uninsured.

Phil Goropoulos, MNM Certificate of LGBT Health, President/CEO, Alder Health Services (HIV)
Alder Health Services is dedicated to improving the health of individuals living with HIV/AIDS, members of the lesbian, gay, bisexual and transgender community and those struggling with addiction in the South Central Pennsylvania region. All HIV-related services are provided at no-cost to the participant. Primary medical care and mental health counseling services are available on a sliding fee scale. While many insurance plans are accepted, insurance is not necessary to access the services of Alder Health12.

Rick Kastner, Executive Director, Lancaster County Drug & Alcohol Commission (Drug & Alcohol)
The Lancaster County Drug and Alcohol Commission has been serving the community for more than 35 years, fulfilling our mission to provide access to high quality, community-based drug and alcohol prevention/education services for all citizens and treatment services to uninsured and under-insured, low-income citizens in an efficient and cost effective manner in the County of Lancaster, PA13. Lancaster County Drug & Alcohol Commission works with individuals struggling with addiction.

10 Masonic Villages: www.masonicvillagespa.org/elizabethtown
11 River of Life Health Center: www.facebook.com/RiverOfLifeHealth#!/RiverOfLifeHealth/info
13 Lancaster County Drug & Alcohol Commission: www.co.lancaster.pa.us/lanco/cwp/view.asp?q=379662&lanconav_GID=991
Melody Keim, VP, Programs & Initiatives, Lancaster County Community Foundation (Philanthropy)

The Community Foundation invests in the future of our community. Since 1924 they have been helping people establish permanent funds for the causes they care about and making grant investments to organizations that create a stronger and more vibrant quality of life for all of us. Today they hold nearly $70 million dollars in community assets that help support Lancaster every year. These resources are unique because they mean that this year, and every year, the Community Foundation will invest a portion of this money back into community benefit organizations and the emerging needs of Lancaster County. Their mission is to advance the vitality and well-being of the people of Lancaster County by inspiring generosity and by being responsible stewards of gifts for today and tomorrow and vision is to create extraordinary community through inspired giving for sustainable, meaningful impact. The Community Foundation works to provide funding and resources to organizations that improve the health of Lancaster County residents14.

Dave Koser, Program Associate, Lancaster County Community Foundation (Philanthropy)

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14 15 Lancaster County Community Foundation: www.lancfound.org/about-us/
Carol Kuntz, Chief Operating Director/COO, Compass Mark (Drug & Alcohol)
Since 1966, Compass Mark has been leading the way in all aspects of substance abuse education, prevention and intervention as the Council on Drug & Alcohol Abuse. Compass Mark continues their commitment to guide individuals and families on a journey toward lives free from substance abuse and full of promise. From those personally struggling with addiction, to those seeking help for others or looking to prevent problems in the first place, Compass Mark has the resources to help direct children, teens and adults on a healthy, successful life path. Compass Mark has customized skill-building programs that can be taken anywhere there is a demand. All programs are designed to help individuals face life’s challenges with the strength to make positive decisions that lead to unshakable families, productive workplaces and safe, flourishing communities. Compass Mark works with individuals of all ages living in Lancaster County.

Mary LeVasseur, Chair Person, Tobacco-Free Coalition
Tobacco-Free Coalition of Lancaster County is a group of people united by common concern over tobacco use in Lancaster County, PA. Their mission is to prevent young people from using tobacco, to provide resources for people to quit their tobacco use, and eliminate of tobacco-smoke pollution. The Tobacco-Free Coalition of Lancaster County works with the individuals in Lancaster County impacted by tobacco use.

Janeen Maxwell, MPH CHES, Health & Human Services Consultant, Holleran (Data Analysis)
Holleran's mission is to provide research services to not-for-profit organizations to help them better understand the perceptions and needs of their stakeholders so they can achieve their mission of excellence. Holleran works to improve the health of all Lancaster County residents.

Lisa McCraken, MA, President, Holleran (Data Analysis)
Holleran's mission is to provide research services to not-for-profit organizations to help them better understand the perceptions and needs of their stakeholders so they can achieve their mission of excellence. Holleran works to improve the health of all Lancaster County residents.

Kirk Miller, MS PhD, Professor of Biology, Franklin & Marshall College (Public Health)
Franklin & Marshall College is a private liberal arts college in Lancaster County. Franklin & Marshall works to improve the health of students and to prepare students for a career in public health and medicine.

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16 Compass Mark: www.compassmark.org/about_us.html
17 18 Holleran: www.holleranconsult.com/about-us.php
Berwood Yost, Director, Floyd Institute for Public Policy, Franklin & Marshall College
(Data Analysis)
The Floyd Institute for Public Policy and Analysis was created to provide students with an opportunity to apply skills they gain in public policy and research methods courses to significant questions of public policy at the national, state or local levels. The Floyd Institute works to determine health needs of Lancaster County residents.

Linda Aleci, PhD, Coordinator, Local Economy Center, Franklin & Marshall College
The Franklin & Marshall Local Economy Center (LEC) serves the research needs of the Lancaster community and the curricular needs of Franklin & Marshall students. It provides learning opportunities for students interested in studying local economies and supports the economic development work of the community. It is the mission of the Center to offer students opportunities for primary research on the Lancaster economy and to enable the community's diverse constituencies to work together toward effective, inclusive, and sustainable economic-development strategies. Through its activities and publications, the center: Promotes community awareness of economic development matters, enlists students and faculty to meet the research needs of the community's economic development constituencies, and brings the best available thinking and practices to the attention of the community.

Jaime G. Quinn, Community Resource Navigator, American Cancer Society (Cancer Prevention)
The American Cancer Society in Lancaster County works to prevent Lancaster County residents from developing cancer, and providing assistance to residents impacted by cancer.

Bonnie Reid, Community Health Liaison, AmeriHealth Mercy Health Plan (Health Plan- Low Income)
AmeriHealth Mercy Health Plan is a Medical Assistance (Medicaid) managed care health plan working to improve the health of those individuals on medical assistance.

Sean Reynolds, MS CFRE, President & CEO, St. Joseph Health Ministries (Faith Based and Children)
St. Joseph Health Ministries was formed in 2000 to continue and build upon the health ministry that was unwavering since the hospital’s founding. For the last 11 years, St. Joseph Health Ministries has been driven by this mission to help those who need help the most – children from economically disadvantaged families whose healthcare needs have not been fulfilled.

19 The Floyd Institute for Public Policy: www.fandm.edu/the-floyd-institute-for-public-policy-and-analysis
20 Local Economy Center: www.fandm.edu/lec
Lisa Riffanacht, Executive Director, Project Access Lancaster County (Low-Income)
Project Access Lancaster County (PALCO), a program of the Lancaster County Medical foundation, began in 2007 out of a concern of the local medical community for the uninsured in Lancaster County. PALCO’s mission is to provide a coordinated healthcare network of volunteer physicians, other health care providers, hospital services, diagnostic services and pharmaceutical assistance for the low income uninsured residents of Lancaster County. PALCO provides a health care bridge for people who cannot afford health insurance, but who do not qualify for Medical Assistance, Veterans Benefits, or Medicare. In the first four years of operation, PALCO has served over 3,400 participants21.

Karen Schloer, CEO, Boys & Girls Club of Lancaster (Low-Income Children)
The Boys & Girls Club of Lancaster has been a premier provider of youth services in Lancaster since 1939. The Mission of Boys & Girls Club of Lancaster is to enable all young people, especially those who need them most, to become productive, caring, responsible adults. They provide an environment where members can achieve: positive self-identity, a healthy lifestyle, a strong character, educational success, and social competency22.

Jim Schmucker, Executive Director, Lancaster County Business Group on Health
Lancaster County Business Group on Health works to improve the health of businesses in Lancaster County.

Kelly Schober, Executive Director, Lancaster City & County Medical Society (Health)
The Lancaster City and County Medical Society addresses the issues facing the medical profession today and works to preserve the physician-patient relationship. They work with the healthcare providers to improve the health of the Lancaster County residents they serve.

Beth Koser Schwartz, BSN MSN (c), Facilitator, Lighten Up Lancaster County
Lighten Up Lancaster County is a group of concerned individuals whose members include stay-at-home parents, students, educators, wellness professionals, healthcare providers, local government officials, food service employees, recreation/fitness facilities, non-profits and businesses. Each member brings different experiences and perspectives to the table, but their unifying purpose is to develop, implement, and promote local policies and programs that make being healthy easy. Lighten Up Lancaster County works to improve the health of Lancaster County residents as it relates to being at a healthy weight.

21 Project Access Lancaster County: www.palcolancaster.org/home.html
22 Boys & Girls Club Lancaster: www.bgclanc.org/
Hilda Shirk, PhD MSW, CEO, SouthEast Lancaster Health Services (Low-Income)
Their mission is to provide medical and dental care to all members of our community—moms, dads, children, grandparents, adults, teens, and babies who have no insurance, who have little or no income and those who cannot find affordable healthcare elsewhere. When a fellow Lancastrian is vulnerable and sick, SouthEast Lancaster Health is honored to restore their wellness. SouthEast is a Federally Qualified Health Center (FQHC) focused on serving the underserved in Lancaster County.

Donita Sturgis, BSN MSN, President, Hope Within Ministries (Faith-Based)
Hope Within Ministries, incorporated in 2002, is a Christian, faith-based, non-profit organization. The mission of Hope Within is to demonstrate the love and proclaim the Gospel of Jesus Christ. Through the operation of Hope Within Community Health Center, their first major endeavor, they deliver free primary healthcare services to the medically uninsured of Lancaster and Dauphin Counties in Pennsylvania.

Joanne Sullivan, Executive Director, Pennsylvania Immunization Coalition
The Pennsylvania Immunization Coalition (PAIC) is an organization of volunteers consisting of individuals and organizations that have an interest in advancing the mission of timely and effective immunizations for all Pennsylvania residents.

Terri Trimble, CEO, Welsh Mountain Health Centers (Low-Income)
Welsh Mountain Health Centers was founded in 1972 and incorporated in 1973 to “provide quality, family-centered health services to all members of the community, especially those who encounter barriers to care”. Welsh Mountain Medical & Dental Center is a Federally Qualified Health Center (FQHC) receiving annual support from the United States Department of Health & Human Services.

Sandra Valdez, Associate Director, Spanish American Civic Association (SACA)/Nuestra Clinica (Latino Community)
The Spanish American Civic Association (SACA), SACA Development Corporation and SACA Broadcasting Corporation have long been committed to the empowerment of the Latino community through a strenuous process of self-help and self-development and throughout that process, the betterment of the entire Lancaster community. Now more than ever, the Latino community needs to invest in itself and the general community is encouraged to invest in our efforts at community development.

23 SouthEast Lancaster Health Services: www.selhs.org/about-us/
24 Hope Within Ministries: www.hopewithin.com/about.htm
25 Pennsylvania Immunization Coalition: www.immunizepa.org/about/mission-vision-goals
26 Welsh Mountain Health Centers: www.welshmountain.com/index.html
27 Spanish American Civic Association: www.sacapa.org/about.html
Allison Weber, Director of Community Relations and Education, Spanish American Civic Association (SACA) (Latino Community)
The Spanish American Civic Association (SACA), SACA Development Corporation and SACA Broadcasting Corporation have long been committed to the empowerment of the Latino community through a strenuous process of self-help and self-development and throughout that process, the betterment of the entire Lancaster community. Now more than ever, the Latino community needs to invest in itself and the general community is encouraged to invest in our efforts at community development\(^{27}\).

Carlos Graupera, President, Spanish American Civic Association (Latino Community)
The Spanish American Civic Association (SACA), SACA Development Corporation and SACA Broadcasting Corporation have long been committed to the empowerment of the Latino community through a strenuous process of self-help and self-development and throughout that process, the betterment of the entire Lancaster community. Now more than ever, the Latino community needs to invest in itself and the general community is encouraged to invest in our efforts at community development\(^ {28}\).

Sharon Wasneuski, Women Infants & Children Director, CAP-WIC (Low-Income)
The WIC Program provides nutritious foods, nutrition education and health screenings to income-eligible pregnant, postpartum and breastfeeding women, and to infants and children up to age five who are at nutritional risk. All program participants receive nutrition education regarding appropriate foods to eat during pregnancy, breastfeeding, infancy and childhood to promote optimal growth and development\(^ {29}\). WIC focuses on the health of women, infants, and children in Lancaster County.

Tamara Worst, HIV Provider Relations Manager, Family Health Council of Central Pennsylvania (HIV)
The Family Health Council of Central Pennsylvania is a private, not-for-profit organization dedicated to improving health, preventing disease, and promoting wellness. Founded in 1973, the Council oversees and supports a diverse, 28-county network of organizations providing a range of vital services and care to thousands of women, men, children and adolescents each year. Services include women’s health care, cancer screening and education, nutrition advice and healthy foods, and HIV/AIDS support services\(^ {30}\).

\(^{27}\) Spanish American Civic Association: www.sacapa.org/about.html
\(^{28}\) Spanish American Civic Association: www.sacapa.org/about.html
\(^{29}\) Women Infants & Children: www.bm-cap.org/wic.htm
\(^{30}\) Family Health Council of Central Pennsylvania: www.fhccp.org/about.shtml
Tom Baldrige, President, Lancaster Chamber of Commerce (Employees)
The Lancaster Chamber of Commerce & Industry is a dynamic membership organization rich in history and comprised of nearly 2,400 community-minded businesses totaling to nearly 115,000 employees collectively working to make Lancaster County a great place to live, work and do business. The Chamber boasts an impressive menu of services aimed at helping business leaders and professionals connect, learn and grow, while leveraging the collective power of this group to weigh in on legislative and community issues that affect Lancaster County’s business climate and quality of life31.

Cynthia Burkhart, PhD, Executive Director, Lancaster-Lebanon Intermediate Unit 13 (Schools)
Lancaster-Lebanon Intermediate Unit 13 (IU 13) strives to improve student learning by providing both direct educational services and educational support services for Lancaster and Lebanon counties’ 22 school districts, as well as for adult education students, nonpublic schools, and preschoolers and their families32.

Rev. Lou Butcher, President/CEO, Bright Side Baptist Church (Faith-Based- African American)
The mission of Bright Side Baptist Church is to present the Gospel of Jesus Christ to all; To fulfill religious and educational needs; to allow for the continued spiritual and physical growth of our Church body and to provide outreach programs and services to the community. With the help of God and our brothers and sisters, we shall also endeavor to donate time, energy and necessary funding to carry out the ministries of our Church33.

Paul Casale, MD, President, Lancaster City & County Medical Society (Health)
The Lancaster City and County Medical Society addresses the issues facing the medical profession today and works to preserve the physician-patient relationship. They work with the healthcare providers to improve the health of the Lancaster County residents they serve.

Al Duncan, Chief Executive Officer, Thomas E Strauss Inc (Employer)
Thomas E Strauss Inc. owns and operates multi restaurant and hotel establishments.

Ralph Goodno, President & CEO, Lancaster County Conservancy
The mission of the Lancaster County Conservancy is to save and steward the ecosystems and landscapes upon which we depend for food, clean water and air, economic and public health, and the restoration of soul and spirit34.

31 Lancaster Chamber of Commerce: www.lancasterchamber.com/
32 Lancaster Lebanon Intermediate Unit 13: www.iu13.org/Pages/default.aspx
33 Bright Side Baptist Church: www.brightsidebc.org/
34 Lancaster Conservancy: www.lancasterconservancy.org/vision.htm
Richard Gray, Mayor, City of Lancaster (City Government)

Cheryl Holland-Jones, Executive Director, Crispus Attucks Community Center (African-American, Low-Income)
The mission of Crispus Attucks Community Center is to improve the quality of life for youth and families in Lancaster by providing services that promote community prosperity, physical and mental health, and by offering programs and cultural events which preserve the African American heritage35.

Patrick Jinks, President, United Way of Lancaster County (Social Service)
United Way of Lancaster County is run by a partnership of dedicated staff and volunteers who work together to make our community a better place to live. Coming from all backgrounds and walks of life, our staff and volunteer leadership are helping to lead Lancaster County to a brighter future36.

James Machado, FACHE, Administrator, Heart of Lancaster Regional Medical Center (Hospital)
Heart of Lancaster Regional Medical Center, a for-profit hospital in Lancaster County, Pennsylvania, strives to improve the health and wellness of all Lancaster County residents.

Bob Moore, FACHE, Chief Executive Officer, Lancaster Regional Medical Center (Hospital)
Lancaster Regional Medical Center, a for-profit hospital in Lancaster County, Pennsylvania, strives to improve the health and wellness of all Lancaster County residents.

35 Crispus Attucks Community Center: www.cacc-lancaster.org/?page_id=28
36 United Way of Lancaster County: www.uwlanc.org/who-we-are
Lancaster General Health has identified the health care facilities and resources available, both by Lancaster General Health and by other community organizations, to Lancaster County residents. The map below indicates Lancaster General Health primary care practices, Lancaster General Hospitals, Federally Qualified Health Centers (FQHC), free clinics, other community hospitals, and recreation centers in the county. Project Access Lancaster County (PALCO) is another vital resource to the uninsured community. PALCO is the virtual coordination of providers for the uninsured.

At these locations, residents receive preventive care and sick care. All organizations indicated on this map collaborate to improve the health of Lancaster County residents of all ages.
Lancaster County
Building a Model of Prosperity for the 21st Century

Sponsored by:
The Lancaster Chamber of Commerce & Industry
The Lancaster County Community Foundation
United Way of Lancaster County
The County of Lancaster
Building A Prosperous Community

Sharing a vision of Lancaster County being “a model of prosperity for 21st century America,” The Lancaster Chamber of Commerce & Industry, the Lancaster County Community Foundation, United Way of Lancaster County, and the County of Lancaster formed a partnership to develop a program to monitor how the county is doing in realizing this vision. The program evolved into a prosperity indicators project called Building A Prosperous Community.

The project is designed to…

• Provide a benchmark of the county’s current state
• Identify the areas that most deserve the community’s attention as we work toward prosperity
• Monitor the progress that is made in achieving our vision for the community.

This report presents the initial set of indicators. To put the findings in perspective, indicators are shown for multiple years and, where appropriate, comparisons are made to the state of Pennsylvania and adjacent counties.

The community and organizations are encouraged to use the report as the basis for discussions on where we are, where we want to go, and how to get there. It is anticipated that the findings will be the foundation for program actions and policies designed to move Lancaster County closer to the goal of being a model of prosperity.

We are excited to share our vision for Lancaster County with the community.

Tom Baldrige, The Lancaster Chamber of Commerce & Industry
Sam Bressi, The Lancaster County Community Foundation
Patrick Jinks, United Way of Lancaster County
Commissioner Scott Martin, The County of Lancaster
Prosperity – A Multi-Dimensional Concept

Realizing that our organizations have a common vision for the community was the first and relatively easy step. The next question presented more of a challenge. That question was “what indicators should be used to measure and monitor the state of our prosperity?” To define these indicators, the partners undertook a multi-stage process.

First, we had to decide how broad the definition of “prosperity” should be. We agreed the concept involves more dimensions than just economic prosperity. After much discussion and research, six dimensions of prosperity were identified. Taken together, these compose our Prosperity Index. The dimensions are:

• Well Being of People
• Education
• Economic Engine
• Health & Safety
• Community & Culture
• Physical Environment

Individual Indicators

The selection of the individual indicators for each dimension of prosperity was guided by five criteria.

• Content validity – It is important that each dimension has indicators that cover as much of that dimension as possible. There is a needed balance between the number of indicators and having a comprehensive measure of a dimension.

• Trend analysis – This is the first of what will become an annual report. By tracking the indicators over time, it will be possible to assess the extent to which the county is changing. To be able to do this, it is critical that the same information is available for each indicator over time. Depending upon the source of the data for an indicator, the time period will vary. For example, some measures may not exist on an annual basis.

• Understandability – To be of maximum value, the measures in the report should be easily understood by the entire community. While some esoteric measures may do a better job than selected indicators, little is gained if persons do not understand what the indicator is measuring.

• Actionable – A desired outcome of Building A Prosperous Community is providing direction to organizations and governments to take action in areas needing improvement. To enhance the likelihood of this occurring, each indicator was reviewed to be certain it is amenable to change as the result of organized efforts.

• Best practices – Indicator programs exist in many other communities. A review of what these other communities are using for indicators offered some guidance to the selection of our indicators.
Comparisons Over Time and With Other Counties

This study constitutes a baseline which can be used to track future changes in the county. Where possible, comparisons with previous years are also shown. This permits an historical examination of how the county has changed.

It is always interesting to examine data for a county in comparison to other geographical entities. Comparisons with other geographies can reveal how well we are doing relative to others. Where possible, comparisons are made to the state of Pennsylvania and the surrounding counties of Berks, Chester, Dauphin, Lebanon, and York. For the county comparisons, Lancaster County is given a rank to indicate its position relative to the other counties. With six counties, the rank can range from 1 to 6. The lower the rank, the better Lancaster County is compared to the other counties.

When comparisons are done, the uniqueness of Lancaster County needs to be recognized.

First, the population of Amish and Mennonites within the county has been estimated at 35,000. This has an impact when discussing topics like educational attainment since formal education for these groups terminates at the end of eighth grade. An adjustment is made for this in the report. However, this can still have an effect on comparisons with other counties or the state.

Second, comparisons of income data must be done with the realization that the cost of living in Lancaster County is lower than in places such as greater Philadelphia. It is estimated that a resident in our county can earn about 16 percent less than someone in greater Philadelphia and still have the same standard of living.

Indicator Status

In the summary at the end of the report, red and green arrows are used to show positive (green) or negative (red) trends, and the direction of the arrow indicates either an upward or downward trend. When a clear trend does not exist, a horizontal arrow is displayed.

It is expected that our conclusions will lead to community dialogue. This will expand the project from the four partners to a community-wide enterprise.

Each year Building A Prosperous Community will be updated. The next set of indicators will be used to assess the progress being made in achieving the goal of Lancaster County being “a model of prosperity for 21st century America.”
The Indicators

The six dimensions and the indicators for each dimension are presented below.

**Well Being of People**

A prosperous community should offer all residents a basic quality of life. Residents should have the financial resources to meet their families’ basic needs. Persons should live in an environment that provides a sense of opportunity now and in the future. No one should feel deprived of the potential for advancement and improvement. Affordable housing should be available to residents.

<table>
<thead>
<tr>
<th>Well Being of People Indicators</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeal of Lancaster County as a place to live</td>
<td>Percentage change in the county population due to persons moving into the county</td>
</tr>
<tr>
<td>Life Satisfaction Index</td>
<td>Percent of people who are satisfied with their life</td>
</tr>
<tr>
<td>Real income</td>
<td>Comparison of annual change in median household income compared to change in inflation (Consumer Price Index)</td>
</tr>
<tr>
<td>Relative affluence</td>
<td>Percentage of residents above poverty level</td>
</tr>
<tr>
<td>Housing affordability</td>
<td>Percentage of household income spent on housing costs</td>
</tr>
<tr>
<td>Teen pregnancy</td>
<td>Percentage of births to women under 18</td>
</tr>
</tbody>
</table>

**Education**

Education continues to be one of the best avenues for an individual to have a good job and a decent standard of living. Without the advantage of a good education, it is difficult to have any measure of success in our society. It is critical that the importance of education is emphasized at an early age. Research has shown that students who are below their reading level by the time they reach third grade are significantly more likely than others to not graduate from high school. Unfortunately, parents who are not educated are less likely to teach their children about the value of education. Children’s educational attainment is closely related to their parents’ education level. At the community level, an educated workforce is required to remain competitive.

<table>
<thead>
<tr>
<th>Education Indicators</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>School readiness</td>
<td>Percentage of children enrolled in pre-K publicly funded programs; school readiness at local district level</td>
</tr>
<tr>
<td>Academic achievement</td>
<td>Percentage of students who score proficient/advanced on PSSA math and reading tests (3rd, 8th, 11th grades)</td>
</tr>
<tr>
<td>High school graduation rate</td>
<td>4 year cohort 2009-2010 graduation rate – school level</td>
</tr>
<tr>
<td>Postsecondary school plans</td>
<td>Percentage of high school graduates with plans for postsecondary education</td>
</tr>
<tr>
<td>Educational attainment</td>
<td>Percentage of population with bachelor degrees or higher Percentage of population with graduate or professional degrees</td>
</tr>
</tbody>
</table>
Economic Engine

A healthy economy is a key driver of a prosperous community. Thriving business operations offer residents opportunities for gainful employment. A diverse economy minimizes the effects on the community when one industry experiences a downturn. An economically prosperous community encourages business expansion, the creation of new businesses, and the attraction of businesses and persons from outside the county.

<table>
<thead>
<tr>
<th>Economic Indicators</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployment rate</td>
<td>• Percentage of civilian labor force that is unemployed</td>
</tr>
<tr>
<td>Business growth</td>
<td>• Number of firms/business establishments</td>
</tr>
<tr>
<td>Industry mix</td>
<td>• Business establishments by industry</td>
</tr>
<tr>
<td>Patents</td>
<td>• Number of patents granted</td>
</tr>
<tr>
<td>Minority owned businesses</td>
<td>• Percentage of all businesses and employer businesses owned by blacks, Hispanics, and women</td>
</tr>
<tr>
<td>Building permits</td>
<td>• Residential housing building permits</td>
</tr>
</tbody>
</table>

Health & Safety

The concept of prosperity should encompass one’s health and safety. Persons should understand the importance of making healthy decisions to be able to live life to its fullest. A prosperous community should be a fit community. Finally, all residents should be able to live in a safe environment without fear of being a victim of crime.

<table>
<thead>
<tr>
<th>Health &amp; Safety Indicators</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to health care</td>
<td>• Health insurance coverage</td>
</tr>
<tr>
<td>Health status</td>
<td>• Percentage of residents with good physical and mental health</td>
</tr>
<tr>
<td>Obesity</td>
<td>• Percentage of obese adults and children</td>
</tr>
<tr>
<td>Low birth weight</td>
<td>• Percentage of births under 2500 grams</td>
</tr>
<tr>
<td>Crime rates</td>
<td>• Violent and property crime rates</td>
</tr>
</tbody>
</table>
Community & Culture

A strong community is dependent upon its residents being actively involved in the community. Civic engagement is an indication that persons feel committed to the place where they live. Being involved in the community not only benefits the community, it also benefits the individuals who are involved by expanding their social networks and giving them intrinsic rewards.

A prosperous community should be able to offer its residents opportunities to experience the arts and culture. As leisure time activities, these types of experiences enrich the population by expanding its horizons.

<table>
<thead>
<tr>
<th>Community &amp; Culture Indicators</th>
<th>Measure</th>
</tr>
</thead>
</table>
| Voting                        | • Percentage of registered voters  
                              | • Percentage of registered voters who participated in the most recent general elections |
| Volunteering                  | • Percentage of residents who engaged in any type of volunteering activity |
| Charitable giving             | • Charitable contributions as percentage of income |
| Arts participation and affordability | • Percentage of Lancaster County residents who visited Lancaster City for any arts, cultural, or historical activity  
                              | • Percentage residents rating this type of activity as being affordable |
| Population diversity          | • Percentage of different racial and ethnic groups living in the county |
| Creative Class Index          | • Percent of occupations in creative occupations |

Physical Environment

Increasingly, communities are recognizing and embracing the concept of sustainability of the physical environment. A clean environment should be a goal for all communities. Activities and planning should exist to preserve the physical environment for future generations.

<table>
<thead>
<tr>
<th>Physical Environment Indicators</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Air quality</td>
<td>• Percentage of days with unhealthy air quality</td>
</tr>
<tr>
<td>Water quality</td>
<td>• Percentage of streams of low and high quality</td>
</tr>
<tr>
<td>Preserved space</td>
<td>• Percentage of natural land preserved</td>
</tr>
<tr>
<td>Time spent commuting</td>
<td>• Number of minutes required to get to work</td>
</tr>
<tr>
<td>Recycling</td>
<td>• Tons recycled</td>
</tr>
</tbody>
</table>
Well Being of People
Well Being of People

Appeal of Lancaster County

A prosperous community should attract new residents either through employment opportunities or as a place from which to commute. From 2000 to 2010, the population of the county increased by 10.4 percent. In comparison, the population of the entire state grew by 3.4 percent. Of course, some growth can be attributed to the birth rate of county residents. This is not entirely the case.

From 2006 to 2008, the average annual general fertility rate for the county (71.6 per 1000 women 15-44) was indeed higher than the state (60.1). However, over the past three years, 4.3 percent of our current residents moved into the county from another county or from out of state. The percentage of persons moving into Pennsylvania during the same time period was 2.3 percent.

Life Satisfaction

The 2011 Gallup-Healthways Well-Being Index reported that, of the 190 Metropolitan Statistical Areas in the United States surveyed, Lancaster has the highest Well-Being Index.

The Well-Being Index is composed of six sub-indices – life evaluation, emotional health, physical health, healthy behavior, work environment, and basic access to necessary amenities.

Findings are based on telephone interviews conducted with random samples of adults 18 and older.

Well-Being Index

<table>
<thead>
<tr>
<th>Metropolitan area</th>
<th>Well-Being Index Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lancaster, PA</td>
<td>72.9</td>
</tr>
<tr>
<td>Charlottesville, VA</td>
<td>72.5</td>
</tr>
<tr>
<td>Ann Arbor, MI</td>
<td>71.9</td>
</tr>
<tr>
<td>Provo-Orem, UT</td>
<td>71.2</td>
</tr>
<tr>
<td>Boulder, CO</td>
<td>71.1</td>
</tr>
<tr>
<td>Honolulu, HI</td>
<td>70.7</td>
</tr>
<tr>
<td>Santa Barbara-Santa Maria-Goleta, CA</td>
<td>70.6</td>
</tr>
<tr>
<td>San Jose-Sunnyvale-Santa Clara, CA</td>
<td>70.6</td>
</tr>
<tr>
<td>Fort Collins-Loveland, CO</td>
<td>70.5</td>
</tr>
<tr>
<td>Appleton, WI</td>
<td>70.4</td>
</tr>
</tbody>
</table>

2011 Gallup-Healthways Index Survey
Well Being of People

Life Satisfaction Index

Lancaster’s rankings out of 190 Metropolitan Statistical Areas on the Well-Being Index and its individual components are shown in this table.

In comparison, the overall ranks for other Pennsylvania MSAs included in the study were York/Hanover – 120, Reading – 56, and Harrisburg/Carlisle – 49.

Real Income

Increases in household income only tell part of the story of economic well being. Each year, the cost of goods and services changes due to inflation or deflation. With inflation, the same cart of groceries purchased last year costs more to buy this year. Unless income keeps pace with inflation, a household can find itself slipping in buying power.

This graph shows the percentage change in median household income from year to year going back to 2005. It also presents the Consumer Price Index (CPI) for each of the years. For a household to prosper, the percentage increase in household income should be the same or greater than the CPI. As seen, that occurred in two of the six years examined in the graph. Household income was, on average, keeping up with inflation until 2010. The 7.1 percent decrease in median household income in 2010 had a significant negative effect on households’ economic well being.

This, of course, is a consequence of the economy over the past several years. Future studies will track this to see if real income improves as the economy begins to recover.
Well Being of People

Relative Affluence

Part of our definition of well being is having the financial resources to meet basic needs. Living below the poverty level creates a situation in which persons have a difficult time meeting their needs. In 2010, the federal government defined poverty as having a household income of $22,050 for a family of four. Nationwide, the poverty rate in 2010 was 15.1 percent. This is the highest since 1993.

Since the emphasis is on prosperity, the graph shows the percentage of residents whose income is above the poverty level. The effects of the most recent recession are seen in the decrease in this percentage between 2000 and 2010. Even with this decrease, the percentage is still higher than the state.

Of the six counties being compared, Lancaster County has the third highest percentage of Residents above poverty.

Housing Affordability

When housing costs become excessive, there is a strain on funds for other nondiscretionary spending. The Census Bureau reports that housing expenditures exceeding 30 percent of household income are an indicator of a housing affordability problem.

In 2010, a third of homeowners with mortgages (34.3%) were spending this much on housing. Among renters, the percentage is even higher. Over half of all renters in the county (51.5%) were spending 30 percent or more of their household incomes on rent. Housing costs in 2010 are similar to Pennsylvania. Looking across the years, the increase in housing costs as a percentage of income is quite visible. Only one county has higher costs for both owners and renters than Lancaster County.
Well Being of People

Teen Pregnancy

It is difficult to think of anything that can limit the future opportunities of a young person more than a teenage pregnancy. Not only is the teen mother at a handicap, so is the child. The social and economic costs for the teen parents and their children are substantial. While the pregnancy rate has been dropping in the United States over the past 20 years, there is no clear pattern for the teen pregnancy rate in the county. It varies from one year to the next. The percentage for 2011 is the lowest it has been over the seven years presented in the graph.

Our teen pregnancy rate is lower than Pennsylvania’s. It is worth noting the state percentage also decreased from 2010 (3.0%) to 2011 (2.7%).

Of the six counties being ranked, Lancaster County has the second lowest teen birth rate.
Education
Education

School Readiness

Having children be prepared for school increases their likelihood of succeeding in their early years. Research has found that children not reading at their grade level by the time they reach third grade are at greater risk of dropping out of school later in life.

Quality pre-Kindergarten programs benefit both the children and their families by increasing the children’s readiness for school.

Looking at the percentage of 3 to 4 year olds enrolled in a public funded pre-K program, Lancaster County has a lower percentage than the state as a whole. Compared to its neighboring counties, it ranks fourth out of six for 2010-2011.

Over the past five years, the percentage of children in pre-K programs in the County has been relatively steady.

School Readiness at District Level

The state measure of school readiness presented above only shows children in publicly funded pre-K programs. Another measure of school readiness is the percentage of children deemed to be ready for school as determined by their school district. In Lancaster County, each district develops its own standards for readiness.

The table shows school readiness for ten of our county’s districts. On the average, 74 percent of our children across these districts are ready for school.
**Education**

**Academic Achievement Levels – Math**

It is predicted that the jobs of the future will require more education than ever before. This, of course, makes an educated workforce more important than ever. Young persons without an adequate education will be severely limited in their job opportunities. The state No Child Left Behind standards call for 78 percent of our students to be proficient or advanced in math in 2011-2012. All but three school districts have achieved this goal.

All districts have improved achievement levels since 2006-2007. For comparison purposes, the average performance of all students in the state is presented. The majority of our school districts exceed the state achievement levels.

<table>
<thead>
<tr>
<th>PA</th>
<th>Coocalico</th>
<th>Columbia Borough</th>
<th>Conestoga Valley</th>
<th>Donegal</th>
<th>Eastern Lancaster Co</th>
<th>Elizabethtown</th>
<th>Ephrata</th>
<th>Hempfield</th>
<th>Lampeter-Strasburg</th>
<th>Lancaster</th>
<th>Manheim Central</th>
<th>Manheim Township</th>
<th>Penn Manor</th>
<th>Pequea Valley</th>
<th>Solanco</th>
<th>Warwick</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2011-12</strong></td>
<td>75.6</td>
<td>83.6</td>
<td>67.5</td>
<td>85.7</td>
<td>78.5</td>
<td>80.3</td>
<td>80.4</td>
<td>85.1</td>
<td>87.1</td>
<td>89.2</td>
<td>56.7</td>
<td>83.6</td>
<td>86.8</td>
<td>83.7</td>
<td>75.6</td>
<td>83.4</td>
</tr>
<tr>
<td><strong>2010-11</strong></td>
<td>77.1</td>
<td>84.5</td>
<td>66.9</td>
<td>84.0</td>
<td>73.4</td>
<td>79.5</td>
<td>80.8</td>
<td>82.7</td>
<td>86.0</td>
<td>89.4</td>
<td>56.2</td>
<td>81.0</td>
<td>87.0</td>
<td>79.0</td>
<td>73.1</td>
<td>83.2</td>
</tr>
<tr>
<td><strong>2009-10</strong></td>
<td>76.3</td>
<td>84.9</td>
<td>66.3</td>
<td>83.2</td>
<td>75.5</td>
<td>80.7</td>
<td>81.6</td>
<td>84.9</td>
<td>89.0</td>
<td>54.8</td>
<td>81.6</td>
<td>86.7</td>
<td>77.8</td>
<td>74.1</td>
<td>81.3</td>
<td>82.5</td>
</tr>
<tr>
<td><strong>2008-09</strong></td>
<td>73.4</td>
<td>82.7</td>
<td>67.2</td>
<td>79.7</td>
<td>74.1</td>
<td>80.0</td>
<td>80.6</td>
<td>83.1</td>
<td>86.1</td>
<td>53.0</td>
<td>79.4</td>
<td>85.2</td>
<td>75.9</td>
<td>73.6</td>
<td>78.8</td>
<td>79.6</td>
</tr>
<tr>
<td><strong>2007-08</strong></td>
<td>71.5</td>
<td>81.5</td>
<td>69.3</td>
<td>79.2</td>
<td>67.7</td>
<td>80.2</td>
<td>78.7</td>
<td>79.3</td>
<td>82.9</td>
<td>54.5</td>
<td>76.0</td>
<td>85.2</td>
<td>78.9</td>
<td>73.9</td>
<td>78.3</td>
<td>79.8</td>
</tr>
<tr>
<td><strong>2006-07</strong></td>
<td>46.4</td>
<td>77.3</td>
<td>61.7</td>
<td>79.5</td>
<td>65.2</td>
<td>79.3</td>
<td>78.4</td>
<td>81.7</td>
<td>83.3</td>
<td>52.4</td>
<td>76.5</td>
<td>84.9</td>
<td>78.9</td>
<td>73.6</td>
<td>75.3</td>
<td>79.2</td>
</tr>
</tbody>
</table>

Pennsylvania Department of Education

**Academic Achievement Levels – Reading**

The state goal for reading under No Child Left Behind is to have 81 percent of students at the proficient level or higher in 2011-2012. On this measure, six districts reached this goal. Another one almost achieved it.

Twelve of the 16 districts have improved scores since 2006-2007. The remaining districts have had steady scores over the past five years.

Again, for comparison purposes, the state average is included. Most of our districts either come close to or do better than the statewide average. See Appendix for breakdown of scores for 3rd, 8th and 11th grades.
Education

High School Graduation Rate

A high school diploma is a prerequisite to any chance for a good job and a comfortable standard of living. According to the Editorial Projects in Education Research Center, only 69 percent of high school students nationwide graduate in four years. The Pennsylvania Department of Education for the first time in 2009-2010 calculated high school graduation using the 4 year cohort method recommended by No Child Left Behind. This method takes into account students who enter and leave the county during their high school years. At this time, findings are limited to the 2009-2010 and 2010-2011 school years. Comparisons with previous years would not be valid since the calculation of graduation rate changed.

As seen in the table, graduation rates vary notably across high schools. We have some high schools in which nearly all students graduate in four years. There are a few in which high school graduation is the exception. Fourteen of the 19 county high schools have graduation rates that exceed those for the state in 2010-2011.

With one exception, graduation rates have remained steady or increased across the two years. The exception only had 26 students in the cohort of potential graduates.

<table>
<thead>
<tr>
<th>PA</th>
<th>Cocalico</th>
<th>Columbia Borough</th>
<th>Conestoga Valley</th>
<th>Donegal</th>
<th>Eastern Lancaster Co</th>
<th>Elizabethtown Area</th>
<th>Ephrata Area</th>
<th>Hempfield SD</th>
<th>Lampeter-Strasburg SD</th>
<th>Lancaster SD</th>
<th>Manheim Central</th>
<th>Manheim Township</th>
<th>Penn Manor</th>
<th>Pequea Valley</th>
<th>Solanco</th>
<th>Warwick</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010-11</td>
<td>82.6%</td>
<td>94.7%</td>
<td>74.7%</td>
<td>88.9%</td>
<td>93.6%</td>
<td>92.2%</td>
<td>95.2%</td>
<td>95.7%</td>
<td>38.5%</td>
<td>94.7%</td>
<td>93.5%</td>
<td>20.7%</td>
<td>74.7%</td>
<td>63.0%</td>
<td>94.0%</td>
<td>93.0%</td>
</tr>
<tr>
<td></td>
<td>2009-10</td>
<td>78.2%</td>
<td>96.0%</td>
<td>82.8%</td>
<td>86.9%</td>
<td>83.8%</td>
<td>95.8%</td>
<td>94.1%</td>
<td>87.0%</td>
<td>92.3%</td>
<td>91.9%</td>
<td>6.8%</td>
<td>77.0%</td>
<td>93.0%</td>
<td>94.2%</td>
<td>92.9%</td>
</tr>
</tbody>
</table>

Pennsylvania Department of Education:
High school grads - 4 yr. cohort grad. rate 2009-2010
Education

Postsecondary Education Plans

For many jobs, a high school diploma is not enough. Hence, obtaining a high school diploma is only a first step in ensuring someone has enough education to be able to compete in the job market. Attracting new businesses to the county will be dependent to some degree on having a workforce that is qualified to meet the demands of jobs in the 21st century.

The table shows the percentage of graduates who have plans to continue their education beyond high school. Their plans could include college or technical school. As found with high school graduation, the school districts have varied percentages of students planning to further their educations. Looking at the individual districts, there are no clear patterns over time. Five of the sixteen districts have percentages that are near or exceed the percentage for the state in 2010-2011.

<table>
<thead>
<tr>
<th>PA</th>
<th>Cocalico</th>
<th>Columbia Borough</th>
<th>Conestoga Valley</th>
<th>Donegal</th>
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<th>Elizabethtown</th>
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<th>Hempfield</th>
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<th>Pequea Valley</th>
<th>Solanco</th>
<th>Warwick</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010-11</td>
<td>76.5%</td>
<td>57.1%</td>
<td>51.4%</td>
<td>68.6%</td>
<td>67.1%</td>
<td>60.7%</td>
<td>72.3%</td>
<td>69.3%</td>
<td>81.1%</td>
<td>79.3%</td>
<td>67.4%</td>
<td>86.3%</td>
<td>77.2%</td>
<td>73.5%</td>
<td>71.4%</td>
<td>56.7%</td>
</tr>
<tr>
<td>2009-10</td>
<td>75.2%</td>
<td>67.3%</td>
<td>64.9%</td>
<td>73.3%</td>
<td>63.7%</td>
<td>60.7%</td>
<td>72.0%</td>
<td>66.8%</td>
<td>81.7%</td>
<td>75.1%</td>
<td>61.7%</td>
<td>69.4%</td>
<td>85.2%</td>
<td>73.0%</td>
<td>63.4%</td>
<td>70.2%</td>
</tr>
<tr>
<td>2008-09</td>
<td>76.1%</td>
<td>55.5%</td>
<td>62.4%</td>
<td>84.1%</td>
<td>62.1%</td>
<td>57.2%</td>
<td>70.3%</td>
<td>65.9%</td>
<td>84.2%</td>
<td>77.6%</td>
<td>71.9%</td>
<td>58.0%</td>
<td>86.7%</td>
<td>70.3%</td>
<td>69.5%</td>
<td>71.7%</td>
</tr>
<tr>
<td>2007-08</td>
<td>75.0%</td>
<td>67.3%</td>
<td>64.5%</td>
<td>77.1%</td>
<td>61.5%</td>
<td>60.8%</td>
<td>72.2%</td>
<td>64.5%</td>
<td>78.9%</td>
<td>75.6%</td>
<td>65.9%</td>
<td>53.6%</td>
<td>87.2%</td>
<td>71.2%</td>
<td>64.3%</td>
<td>57.9%</td>
</tr>
<tr>
<td>2006-007</td>
<td>76.1%</td>
<td>63.4%</td>
<td>51.1%</td>
<td>76.9%</td>
<td>65.8%</td>
<td>62.1%</td>
<td>84.6%</td>
<td>48.2%</td>
<td>78.9%</td>
<td>76.9%</td>
<td>53.5%</td>
<td>56.9%</td>
<td>88.1%</td>
<td>74.7%</td>
<td>68.1%</td>
<td>66.9%</td>
</tr>
</tbody>
</table>

Pennsylvania Department of Education
## Education

### Educational Attainment

To be fully competitive in the marketplace, higher education is becoming increasingly necessary. Education levels the playing field for everyone. The Census Bureau has reported that education levels had more effect on earnings during 40 years in the workforce than any other demographic factor, such as gender or race.

Usually, educational attainment refers to persons 25 and older since they are mostly finished with their education by that time. Nationwide, 29.6 percent of women and 30.3 percent of men 25 and older have at least a bachelor’s degree. In Pennsylvania, that percentage is 27.1 percent for both sexes combined.

From 2000 to 2010, the percentage of Lancaster County residents 25 and older with a bachelor’s degree or a graduate or professional degree increased. Despite this, the county’s percentages are slightly lower than the state’s.

The county ranks third out of six for the percentage of residents with higher education degrees.

A unique characteristic in Lancaster County is the population of Amish and Mennonites. Their formal education stops at eighth grade. It is estimated that there are 35,000 persons who are Amish or Old Order Mennonites in the county. Of that number, probably half are under the age of 18. To produce a more accurate measure of higher education attainment, an adjustment was made that removed half of the 35,000 from the base number used to calculate the percentages with higher education. The adjustments presented in the graph are most likely conservative since they use under 18 rather than under 25.

### Educational Attainment Table

<table>
<thead>
<tr>
<th>Year</th>
<th>Bachelor Degree or Higher 25+</th>
<th>Graduate &amp; Professional Degrees 25+</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>20.5%</td>
<td>6.7%</td>
</tr>
<tr>
<td>2010</td>
<td>24.1%</td>
<td>8.6%</td>
</tr>
<tr>
<td>2010 Adjusted</td>
<td>25.4%</td>
<td>9.1%</td>
</tr>
<tr>
<td>PA 2010</td>
<td>27.1%</td>
<td>10.4%</td>
</tr>
</tbody>
</table>

### Educational Attainment Diagram

![% of Population with Bachelor's Degrees or Higher](image)

### Educational Attainment Notes

- 2010 American Community Survey; 2000 Census
- 2010 Adjusted takes into account the Old Order population of 35,000 with 50% being under 18 years of age.
- 17,500 was subtracted from the population number for 25+ and percentages were recalculated (Younger Center for Anabaptist & Pietist Studies, Elizabethtown College)
Economic Engine
Economic Engine

Unemployment Rate

Employing the maximum number of persons who want to work is core to a prosperous community. The recession definitely had an impact on the unemployment rate in Lancaster County. During the past six years, the unemployment rate reached a high of 7.7 percent from a low of 3.5 percent in 2006 and 2007. By September 2011, it decreased to 7.0 percent. This still represents 18,608 county residents who would like to work but cannot find a job.

The county’s unemployment rate is below Pennsylvania’s 8.3 percent and the United State’s 9.1 percent.

Lancaster County has the third Highest unemployment rate of the six counties.

% Labor Force Unemployed

<table>
<thead>
<tr>
<th>Year</th>
<th>Unemployment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>3.5%</td>
</tr>
<tr>
<td>2007</td>
<td>3.5%</td>
</tr>
<tr>
<td>2008</td>
<td>4.6%</td>
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<tr>
<td>2009</td>
<td>7.7%</td>
</tr>
<tr>
<td>2010</td>
<td>7.4%</td>
</tr>
<tr>
<td>2011</td>
<td>7.0%</td>
</tr>
<tr>
<td>PA 2011</td>
<td>8.3%</td>
</tr>
</tbody>
</table>

Bureau of Labor Statistics:
Local area unemployment statistics civilian labor force & unemployment by metropolitan area, seasonally adjusted – September (18,608 out of 264,372)
Economic Engine

Industry Mix and Number of Businesses (Non-Farm)

Economic cycles and their effects tend to vary by industry. Some industries are less affected by a bad economy than others. Due to this, having a mix of industries becomes important to a community’s economic health. This table shows the total number of businesses, the number in each industry, and the percentage this represents of all businesses that have employees. The Census Bureau conducts separate research for non-employer businesses.

Looking at the industry mix, little has changed over the four year time period shown. Retail (16.2%), construction (12.9%), and businesses classified as “other services” (13.0%) have the greatest number of businesses. As would be expected, the number of businesses in construction declined each year. In the opposite direction, the number of businesses classified as accommodation and food services and other services have been slowly increasing.

After decreasing from 2007 to 2009, the number of businesses in the county increased from 2009 to 2010.

The number of farms is presented in the Census of Agriculture conducted every five years by the United States Department of Agriculture. The number of farms in Lancaster County has been steadily growing as seen by these numbers: 1992 – 3,997; 1997 – 4,034; 2002 – 5,293, and 2007 – 5,462.

Industry Mix by Number and Percent (Non-Farm)

<table>
<thead>
<tr>
<th>Total</th>
<th>Forestry, Fishing, &amp; Hunting, &amp; Agriculture Support</th>
<th>Mining, Quarrying, &amp; Oil &amp; Gas Extraction</th>
<th>Utilities</th>
<th>Construction</th>
<th>Manufacturing</th>
<th>Wholesale Trade</th>
<th>Retail Trade</th>
<th>Transportation &amp; Warehousing</th>
<th>Information</th>
<th>Finance &amp; Insurance</th>
<th>Real Estate, Rental &amp; Leasing</th>
<th>Professional, Scientific, &amp; Technical Svs</th>
<th>Management of Companies &amp; Enterprises</th>
<th>Admin, Support, Waste Mgmt, &amp; Remediation Svcs</th>
<th>Educational Svcs</th>
<th>Health Care &amp; Social Assistance</th>
<th>Arts, Entertainment &amp; Recreation</th>
<th>Accommodation &amp; Food Svcs</th>
<th>(except public administration)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>12,029</td>
<td>42</td>
<td>12</td>
<td>22</td>
<td>1,546</td>
<td>856</td>
<td>669</td>
<td>1,953</td>
<td>366</td>
<td>137</td>
<td>641</td>
<td>340</td>
<td>961</td>
<td>66</td>
<td>553</td>
<td>106</td>
<td>1,065</td>
<td>160</td>
<td>964</td>
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<tr>
<td></td>
<td>0.3%</td>
<td>0.1%</td>
<td>0.2%</td>
<td>12.9%</td>
<td>7.1%</td>
<td>5.6%</td>
<td>16.2%</td>
<td>3.0%</td>
<td>1.1%</td>
<td>5.3%</td>
<td>2.8%</td>
<td>8.0%</td>
<td>0.5%</td>
<td>4.6%</td>
<td>0.9%</td>
<td>8.9%</td>
<td>1.3%</td>
<td>8.0%</td>
<td>13.0%</td>
</tr>
<tr>
<td>2009</td>
<td>11,975</td>
<td>40</td>
<td>14</td>
<td>28</td>
<td>1,558</td>
<td>873</td>
<td>664</td>
<td>1,942</td>
<td>372</td>
<td>133</td>
<td>667</td>
<td>349</td>
<td>948</td>
<td>62</td>
<td>546</td>
<td>103</td>
<td>1,030</td>
<td>162</td>
<td>932</td>
</tr>
<tr>
<td></td>
<td>0.3%</td>
<td>0.1%</td>
<td>0.2%</td>
<td>13.0%</td>
<td>7.3%</td>
<td>5.5%</td>
<td>16.2%</td>
<td>3.1%</td>
<td>1.1%</td>
<td>5.6%</td>
<td>2.9%</td>
<td>7.9%</td>
<td>0.5%</td>
<td>4.6%</td>
<td>0.9%</td>
<td>8.6%</td>
<td>1.4%</td>
<td>7.8%</td>
<td>13.0%</td>
</tr>
<tr>
<td>2008</td>
<td>12,171</td>
<td>38</td>
<td>14</td>
<td>26</td>
<td>1,593</td>
<td>926</td>
<td>670</td>
<td>1,978</td>
<td>375</td>
<td>136</td>
<td>679</td>
<td>345</td>
<td>939</td>
<td>72</td>
<td>562</td>
<td>106</td>
<td>1,046</td>
<td>168</td>
<td>937</td>
</tr>
<tr>
<td></td>
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<td>0.1%</td>
<td>0.2%</td>
<td>13.1%</td>
<td>7.6%</td>
<td>5.5%</td>
<td>16.2%</td>
<td>3.1%</td>
<td>1.1%</td>
<td>5.6%</td>
<td>2.8%</td>
<td>7.7%</td>
<td>0.6%</td>
<td>4.6%</td>
<td>0.9%</td>
<td>8.6%</td>
<td>1.4%</td>
<td>7.7%</td>
<td>12.8%</td>
</tr>
<tr>
<td>2007</td>
<td>12,275</td>
<td>44</td>
<td>14</td>
<td>16</td>
<td>1,621</td>
<td>930</td>
<td>682</td>
<td>1,999</td>
<td>392</td>
<td>137</td>
<td>669</td>
<td>354</td>
<td>966</td>
<td>71</td>
<td>547</td>
<td>107</td>
<td>1,070</td>
<td>169</td>
<td>932</td>
</tr>
<tr>
<td></td>
<td>0.4%</td>
<td>0.1%</td>
<td>0.1%</td>
<td>13.2%</td>
<td>7.6%</td>
<td>5.6%</td>
<td>16.3%</td>
<td>3.2%</td>
<td>1.1%</td>
<td>5.5%</td>
<td>2.9%</td>
<td>7.9%</td>
<td>0.6%</td>
<td>4.5%</td>
<td>0.9%</td>
<td>8.7%</td>
<td>1.4%</td>
<td>7.6%</td>
<td>12.7%</td>
</tr>
</tbody>
</table>
Economic Engine

Patents

Having a creative and inventive workforce is an asset to the company fortunate enough to have these employees and to the entire community’s economy. One measure of creativity is the granting of a patent for someone’s invention. The United States Patents and Trademark Office reports the number of patents granted to persons residing in a county. In 2010, the number of patents granted to county residents was at a high for the five years being examined. There has been steady growth in the number of patents granted since 2008.

Only one other county had more patents granted in 2010 than Lancaster County.

Minority Owned Businesses

In a prosperous community, everyone should have the opportunity to own a business. The number of minority businesses is a measure of the opportunities that exist for all. In the Census Bureau’s Economic Census, a distinction is made between all businesses and employer firms. All businesses include both single person enterprises and establishments that have employees other than the owner.

The Economic Census is conducted every five years. This is why data is presented for 2002 and 2007.

With the exception of all businesses owned by women, the percentage of businesses that are minority owned increased from 2002 to 2007.
Economic Engine

Residential Building Permits

A sign of a growing economy is new building starts. This graph presents data on the number of building permits for new residential housing. The bursting of the housing bubble is apparent in this graph. From 2006 to 2007, the number of building permits for new housing decreased by 26.5 percent. After a small rebound from 2009 to 2010, the number of residential housing building permits dropped from 1,184 in 2010 to 707 in 2011.

The Lancaster Association of Realtors did report that pending home sales increased by 28.9 percent in April, 2012 compared to a year ago. Sales of existing homes could positively affect housing starts.

The county ranks number one of the six counties for residential housing building permits.
Health & Safety
Health & Safety

Access to Health Care

Given the cost of health care, it is easy to imagine persons foregoing needed care when they are lacking health insurance. This can lead to persons resorting to the use of an emergency department when their health problems become acute. This drives up the cost of health care for all of us.

After a steady decline from 2006 to 2009, the percentage of county residents with health insurance coverage increased from 2009 to 2010. The 2010 percentage is slightly below the state.

Of the six counties being compared, Lancaster County has the lowest percentage of residents under 65 with health insurance coverage.

Health Status

Starting in 2010, the University of Wisconsin’s Population Health Institute began comparing counties within each state on health outcomes. These outcomes include measures of mortality (premature deaths) and morbidity (poor or fair health, poor physical health days, poor mental health days, low birth weight).

Out of the 67 Pennsylvania counties, Lancaster County is among the top 10 for the three years the program has been in existence.

Its rank of ninth in 2012 is a slight decrease from its seventh place position in 2011.

Compared to the other five surrounding Pennsylvania counties, Lancaster County has the second best health outcomes for 2012.
Health & Safety

Obesity in Adults

In terms of weight, the world is getting larger. Consequential to this is a worldwide increase in diabetes. The increase in obesity applies to Lancaster County residents as well. From 2005 to 2008, the percentage of adults in the county whose Body Mass Index defines them as being obese has increased steadily.

The county is comparable to Pennsylvania and still behind the nation.

Of the six counties, Lancaster County has the second highest percentage of obese adults.

Obesity in Children

Obesity is not limited to the adults in our population. Starting in the 2005-2006 school year, BMI screenings were mandatory for all students in K-4. This was expanded to K-8 in 2006-2007. In 2007-2008, all students in K-12 were included in the BMI screening.

The percentage of children in the county in K-6 and 7-12 who are classified as obese has been about 15% since the screenings began. However, this percentage has been inching upward over the past three years.

In the 2009-2010 school year, the percentage of obese children in the county was lower than in the state.

Lancaster County has the third highest percentage of children classified as obese in our six county region.
Health & Safety

Low Birth Weight

Low birth weight can be the result of several factors. Premature delivery or undernourishment of the mother during pregnancy are common causes of this. The lack of proper nourishment could be related to not receiving adequate prenatal care. Whatever the cause, low birth weight puts the child at risk.

The percentage of low birth weights out of all births in the county has fluctuated in the range of 6 to 7 percent over the past seven years. In 2011, the percentage returned to a high level of 6.9 percent.

This is lower than the percentage for the state.

Lancaster County has the second highest percentage of low weight births of the six counties being ranked.

% of all births 6.3% 6.2% 6.9% 6.9% 6.8% 6.4% 6.9% 8.4%

County Health Profiles, PA Dept. of Health
Health & Safety

Violent Crime Rate

In the ideal community, all residents should be able to live without fear of being victimized by a violent crime. Nationwide, the violent crime rate has been trending downward. Lancaster County has had the same experience as the nation and the state. Until 2010, there has been a steady decrease in the violent crime rate over the time periods shown in the graph. This includes the offenses of homicide, forcible rape, aggravated assault, and robbery.

The increase from 2009 to 2010 may be due to the low rate in 2009 being an anomaly.

The county’s violent crime rate is half of state’s.

Lancaster County ranks fourth on violent crime. Since the rankings are based on positive outcomes, this means three other counties have lower violent crime rates.

Property Crime Rate

In addition to feeling safe, all residents should not have to worry about losing property as a result of a criminal act. Property crimes include larceny, automobile theft, burglary, and arson. The county has seen a decrease in the property crime rate during the past five years. With the recession, this is an interesting finding. The state did have an increase in this crime rate in 2008.

Like violent crime, Lancaster County’s property crime rate is lower than the state’s. However, the gap between the county and the state is not as great as it is for violent crime.

The rank of sixth indicates that the county has the highest property crime rate of the six counties being compared.
Community & Culture
Community & Culture

Voting

Within a democracy, voting is a privilege. Through voting, citizens make their voices heard. Of course, to vote, one must be registered. In 2010, 81.1 percent of county residents 18 and older were registered to vote. This is lower than the percentage of registered voters in the state (88.6%).

Being registered does not necessarily mean you exercise your right to vote. The graph shows the percentage of registered voters who voted in the last four general elections. Lancaster County has a slightly higher voter turnout rate than the state.

The county is fourth in the percentage of voters in the 2010 general election when compared to the other five counties.

Volunteerism

A key component of social capital is persons volunteering in the community. Volunteering demonstrates a commitment to the greater good of the community without any material reward. The Volunteer Center of the United Way reports that the average annual volunteer rate of our county is 32.0 percent. We are a civically engaged community.

The county’s average is greater than the state’s or the nation’s. It is estimated that Lancaster’s volunteers make an annual economic contribution of $341.6 million.

Only one other county has a greater percentage of residents volunteering.
Community & Culture

Charitable Giving

Another component of social capital is charitable giving within a community. In 2008, county residents contributed 2.5 percent of their adjusted gross incomes to charities.

This percentage shows little variation over time.

Residents are considerably more generous than the state in their charitable giving.

Lancaster County ranks number one out of six in charitable contributions as a percentage of income.

![Charitable Contributions As Percentage of Income](image)

Cultural/Arts Participation

Residents participating in cultural activities can be seen as a sign of a healthy community. The measure presented here takes this a step further by examining the percentage of residents who visited Lancaster City for any arts, cultural, or historical activity. Having persons take advantage of these types of venues in the city contributes to having a vibrant Lancaster City.

Since 2009, the percentage of adult Lancaster County residents engaging in one of these activities in the city has increased. In fact, the percentage for 2011 is also the target established by The Lancaster County Community Foundation for 2012.

![% Residents Visited Lancaster City for Arts, Cultural, or Historical Activity](image)
Community & Culture

Cultural/Arts Affordability

Being able to afford arts and cultural activities can be a major influence on participation. Since 2009, the percentage of county residents who rate these activities as being affordable has decreased. This is measured by ratings of 9 or 10 on a 10 point scale where 10 is outstanding.

Population Diversity

Diversity in a population has the potential to create a rich, vibrant community. Research has found that a diverse population and a healthy economy go together.

Since 2000, the county population has become more diverse.

Percentages do not equal 100 since Hispanic and foreign born can be any race.
Community & Culture

Creative Class Index

Richard Florida in The Rise of the Creative Class posits that there are occupations that are instrumental to economic development in a region. Communities need to attract engineers, architects, artists, and people in other creative occupations to complete in today’s economy. These occupations are related to creative outcomes in the form of new ideas, new high tech businesses, and regional growth. In response to the creative class idea, the Economic Research Service in the United States Department of Agriculture defined the occupations that require “thinking creatively.”

In 2010, a total of 13.8% of the occupations in Lancaster County belong in the Creative Class.

This is a decrease from the nearly 20 percent of occupations that were in the Creative Class in 1990 and 2000.

Of the six counties being compared, Lancaster County had the third highest percentage of occupations belonging to the creative class in 2010.

% Employment in Creative Occupations

<table>
<thead>
<tr>
<th>Year</th>
<th>% of Creative Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>19.8%</td>
</tr>
<tr>
<td>2000</td>
<td>19.4%</td>
</tr>
<tr>
<td>2010</td>
<td>13.8%</td>
</tr>
</tbody>
</table>

Department of Labor, Bureau of Labor Statistics
Physical Environment
Physical Environment

Air Quality

Reflecting our increased sensitivity to the impact we all have on our environment, sustainability has become a focus of many communities. A major component of a clean environment is healthy air quality. The U.S. Environmental Protection Agency reports the percentage of days each year the air quality is either unhealthy for groups especially sensitive to poor quality air or unhealthy for all residents.

The percentage of days classified as good have been decreasing since 2008. However, it is positive that there have been no days classified as unhealthy for all residents since 2005.

Comparisons with other geographical areas is not recommended by the EPA since the location of air quality monitors varies.

Water Quality

Of the county’s 1,400 miles of streams, 47 percent (nearly 700 miles) are listed on Pennsylvania’s polluted list. These streams have some sort of pollution issue and warrant attention.

The Chesapeake Bay Foundation reports that Lancaster County produces more nitrogen from manure than any other county in the Chesapeake Bay watershed.

There are 300 miles of streams (20%) rated as being either High Quality or Exceptional Value.

The remaining 500 miles of streams are not polluted but also are not excellent in terms of water quality.
Physical Environment

Open Space and Parks

Among the many unique features of Lancaster County is the beautiful countryside that we enjoy. As development occurs, there may be concern that we are losing our open space.

The Lancaster County Conservancy is actively engaged in preserving our natural lands. Since 2000, the Conservancy has preserved 2,718 acres of natural land.

The county has nine parks and recreational trails totaling over 1,860 acres. Plus, the Susquehannock State Park over 224 acres.

The National Parks and Recreation Association has a standard of 15 acres per 1000 residents of county and local government owned parkland. Given our population growth and limited public funding, this has yet to be achieved.

Time Spent Commuting

A common complaint heard in the community is the amount of traffic congestion that exists. As the population grows, our transportation infrastructure does not necessarily grow at the same pace. One measure of congestion is time spent commuting. Of course, other factors such as the location of one’s job have an impact on commuting time. In fact, the percentage of employees who either work outside the county or the state increased from 14.4 percent in 2000 to 17.1 percent in 2010.

Despite the growth that occurred in Lancaster County and the increase in out-of-county workers from 2000 to 2010, the time required for commuting has only increased by 30 seconds. Residents throughout the state take longer to get to work than we do in Lancaster County.

Residents have the second shortest commute time of the six counties.
Physical Environment

Recycling

One way to reduce our impact on the environment is to recycle. In 2011, county residents recycled 202,113 tons of material. This is a notable increase over recycling efforts in previous years.

The Lancaster County Solid Waste Management Authority reports that a 40 percent recycling rate was achieved in 2011.

The county ranks fifth of the six counties being compared. Ranking is done per capita using 2010 population data.
Summary


**Summary**

The end goal of the indicators project is to provide information on the state of Lancaster County. As we work towards being a model of a prosperous community in the 21st century, we will want to examine the indicators and, where possible, draw conclusions about our progress. As mentioned in the introduction, this report presents information on where we are presently. When the data was available, it also provides a perspective over time and a comparison with surrounding counties.

Presented below is our assessment of the state of the Lancaster County based on the indicators. The dashboard indicator that we use has three levels – improving (green arrow), getting worse (red arrow), and no change or insufficient data to draw a conclusion (a black horizontal arrow). The dashboard indicators are primarily based on trends within the county. When there is insufficient data to create a trend, a comparison is made to the most appropriate measure.

<table>
<thead>
<tr>
<th>Indicators of Well Being of People</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeal of Lancaster County as a place to live</td>
<td>• Population growth exceeds state</td>
</tr>
<tr>
<td>Life Satisfaction Index</td>
<td>• Number 1 rank in the nation</td>
</tr>
<tr>
<td>Real income</td>
<td>• Loss of real income past two years</td>
</tr>
<tr>
<td>Relative affluence</td>
<td>• Decrease since 2000</td>
</tr>
<tr>
<td>Housing affordability</td>
<td>• Insufficient Data</td>
</tr>
<tr>
<td>Teen pregnancy</td>
<td>• Lowest level since 2005</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education Indicators</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>School readiness</td>
<td>• Percentage enrolled in public funded pre-K steady since 2006-2007; insufficient data on local school readiness</td>
</tr>
<tr>
<td>Academic achievement- math</td>
<td>• All 16 districts improved since 2006-2007</td>
</tr>
<tr>
<td>Academic achievement - reading</td>
<td>• 12 of 16 districts improved since 2006-2007</td>
</tr>
<tr>
<td>High school graduation rate</td>
<td>• 12 of 19 high schools with rates 90% or higher</td>
</tr>
<tr>
<td>Postsecondary school plans</td>
<td>• No clear pattern over time in individual districts</td>
</tr>
<tr>
<td>Educational attainment</td>
<td>• Increase in percentage with bachelor degree or higher since 2000</td>
</tr>
</tbody>
</table>
# Summary

<table>
<thead>
<tr>
<th>Economic Indicators</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployment rate</td>
<td>• While still historically high, rate has gone down from 2010 to 2011</td>
</tr>
<tr>
<td>Business growth</td>
<td>• Number of businesses decreased from 2007 to 2009; increased from 2009 to 2010</td>
</tr>
<tr>
<td>Industry mix</td>
<td>• Mix of industries continues to be diverse</td>
</tr>
<tr>
<td>Patents</td>
<td>• Number of patents increased from 2008 to 2010</td>
</tr>
<tr>
<td>Minority owned businesses</td>
<td>• Increase in minority owned businesses</td>
</tr>
<tr>
<td>Building permits</td>
<td>• Downward trend since 2005</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health &amp; Safety Indicators</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to health care</td>
<td>• Percentage with health insurance coverage steady since 2005</td>
</tr>
<tr>
<td>Health status</td>
<td>• Slight decrease in rank since 2011</td>
</tr>
<tr>
<td>Obesity</td>
<td>• Trending upward for children and adults</td>
</tr>
<tr>
<td>Low birth weight</td>
<td>• Percentage has not decreased since 2005</td>
</tr>
<tr>
<td>Crime rates</td>
<td>• Steady decrease since 2006</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Community &amp; Culture Indicators</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voting</td>
<td>• Lower percentage of registered voters than in state; voting turnout comparable to state</td>
</tr>
<tr>
<td>Volunteering</td>
<td>• While higher than state and nation, not enough data for a county trend</td>
</tr>
<tr>
<td>Charitable giving</td>
<td>• Remained flat for previous 5 years reported; higher than state and adjacent counties</td>
</tr>
<tr>
<td>Cultural/arts participation</td>
<td>• Percentage increased since 2009</td>
</tr>
<tr>
<td>Cultural/arts affordability</td>
<td>• Decreased since 2009</td>
</tr>
<tr>
<td>Population diversity</td>
<td>• Increase in diversity since 2000</td>
</tr>
<tr>
<td>Creative Class Index</td>
<td>• Decrease in creative class occupations since 2000</td>
</tr>
</tbody>
</table>
## Summary

<table>
<thead>
<tr>
<th>Physical Environment Indicators</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Air quality</td>
<td>• Percentage of days with good air quality has decreased since 2008</td>
</tr>
<tr>
<td>Water quality</td>
<td>• Not enough data to discuss trend</td>
</tr>
<tr>
<td>Open space and parks</td>
<td>• Preserved natural lands increased since 2000</td>
</tr>
<tr>
<td>Time spent commuting</td>
<td>• Small increase since 2000; shorter commuting time than statewide;</td>
</tr>
<tr>
<td>Recycling</td>
<td>• Increased recycling since 2008</td>
</tr>
</tbody>
</table>
Appendix
# Education

## Academic Achievement Levels – 3rd Grade (Math)

<table>
<thead>
<tr>
<th></th>
<th>PA</th>
<th>Cocalico</th>
<th>Columbia Borough</th>
<th>Conestoga Valley</th>
<th>Donegal</th>
<th>Eastern Lancaster Co</th>
<th>Elizabethtown</th>
<th>Ephrata</th>
<th>Hempfield</th>
<th>Lampeter-Strasburg</th>
<th>Lancaster</th>
<th>Manheim Central</th>
<th>Manheim Township</th>
<th>Penn Manor</th>
<th>Pequea Valley</th>
<th>Solanco</th>
<th>Warwick</th>
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</thead>
<tbody>
<tr>
<td>2011-2012</td>
<td>80.0</td>
<td>84.2</td>
<td>71.4</td>
<td>82.2</td>
<td>84.0</td>
<td>78.9</td>
<td>82.3</td>
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Pennsylvania Department of Education:
Percents of students scoring advanced and proficient on statewide standardized test

## Academic Achievement Levels – 3rd Grade (Reading)

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Pennsylvania Department of Education:
Percents of students scoring advanced and proficient on statewide standardized test
### Education

**Academic Achievement Levels – 8th Grade (Math)**

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*Pennsylvania Department of Education:*

*Percentages of students scoring advanced and proficient on statewide standardized test*

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**Academic Achievement Levels – 8th Grade (Reading)**

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*Pennsylvania Department of Education:*

*Percentages of students scoring advanced and proficient on statewide standardized test*
## Education

### Academic Achievement Levels – 11th Grade (Math)

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*Pennsylvania Department of Education: Percentages of students scoring advanced and proficient on statewide standardized test.*

### Academic Achievement Levels – 11th Grade (Reading)

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*Pennsylvania Department of Education: Percentages of students scoring advanced and proficient on statewide standardized test.*
### Addendum N: Healthy Communities Institute Legend

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<td><img src="image1.png" alt="Green-Grey-Red Gauge" /></td>
<td>The colored gauge gives a visual representation of how your community is doing in comparison to other communities. The three-colored dial represents the distribution of values from the reporting regions (e.g. counties in the state) ordered from those doing the best to those doing the worst (sometimes lower values are better and in other cases higher values are better). From that distribution, the green represents the top 50th percentile, the yellow represents the 25th to 50th percentile, and the red represents the &quot;worst&quot; quartile.</td>
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<tr>
<td><img src="image2.png" alt="Blue-White Gauge" /></td>
<td>This gauge shows how the County: Lancaster value compares with the median or mean value for all counties in the state (or all US counties). The gauge is blue and white when being higher (or lower) is not necessarily good or bad and is multi-colored when being higher (or lower) is good or bad.</td>
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<tr>
<td><img src="image3.png" alt="Green-Up Arrow" /></td>
<td>This gauge shows whether the County: Lancaster value is increasing or decreasing over time. A green arrow means the value is improving and a red arrow means the value is getting worse. The = (equal) sign means that there is not a significant increase or decrease since the last measurement.</td>
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Trauma/Safety

- Comprehensive care clinic for HIV and AIDS patients
- Child sexual assault center
- Child Death Review Team
- Drinking, Drugs, and Driving: an evening program with group discussion and a tour of the trauma areas
- Falls prevention program
- Farm Safety Day
- Harm reduction coalition
- Lead coalition
- Program that provides smoke detectors installed with education on fire safety
- SafeKids Car Seat Safety Checks
- School-based health clinics
- Think First, a national evidence-based program aimed to help people learn to reduce their risk for injury.
September 28, 2007

To: Funders Group
   Reach Out Lancaster

From: Pixie Berman
   Director, Success By 6

RE: Disposition of Remaining Reach Out Lancaster Funds

Background:
Reach Out Lancaster (ROL) was intended to reduce the number of uninsured children in Lancaster County by enrolling them in health insurance plans through a variety of venues. It was thought that if the parents of uninsured children were assisted with the enrollment process at the time the uninsured issue was determined, more children would have health insurance and by default, improved health outcomes.

The original funding partners at $30,000 each were the ALCOA Foundation, Lancaster General Hospital, Lancaster Osteopathic Health Foundation, St Joseph Health Ministries and The Oxford Foundation.

In its first iteration, one of the funding partners developed a training module for health care and other human service providers who were likely to make contact with uninsured children in their normal work setting. These Trained Application Assistants (TAA’s) or their organizations were reimbursed based on a successful enrollment as reported by the County Assistance Office. Eligible families were enrolled in either Medical Assistance or CHIP, depending on the family’s qualifications. After an initial flurry of activity over the first year, effort and interest on the part of the TAA’s dwindled to virtually nothing. It should be noted that two factors may have contributed to the decline - low reimbursement for the amount of time and effort required for a successful enrollment and TAA’s having more pressing work responsibilities.

Another funding partner developed a second plan to enroll uninsured children using their well-established access to at risk children. While there was significant effort to boost enrollment through their contact with children and families through the delivery of other health care activities, few enrollments resulted through this process.

A final effort, based on statistics and information about uninsured populations, led to the recommendation of developing a tightly focused awareness campaign targeting families in Lancaster County who would qualify for CHIP. Lengthy discussions over many months with the
Department of Insurance finally led to the conclusion that while statistics and national norms would indicate a high number of uninsured children with working parents, in fact the number of uninsured children in Lancaster County is low.

Recommendation:
In order to maintain the original intent of the ROL contributions to improve the health and well-being of children in the Lancaster Community, the following recommendations are offered:

**Medical-Legal Partnership for Children** – Based on a model developed in Boston in 1993, the Medical-Legal Partnership for Children combines the resources of pediatric clinicians with lawyers “to ensure that families can meet their children’s basic needs. MLPC combines the strengths of law and medicine to address non-biologic factors (food, housing, education, and safety) known to influence child health.”

The Medical-Legal Partnership for Children addresses non-biologic issues such food, housing, education and safety needs that impact children’s health.

The Medical-Legal Partnership for Children program model is being explored in Lancaster County by South East Lancaster Health Services and Mid Penn Legal Services.

**Funding Recommendation:** $50,000

http://www.mlpforchildren.org/

**Cribs for Kids** – Cribs for Kids is a national initiative to provide safe sleeping environments for newborns and infants. Its aim is to prevent infant deaths due to SIDS, suffocation caused by inappropriate sleeping situations and roll over deaths caused by co-sleeping. Cribs for Kids was initiated locally in February of this year by the Healthy Mother, Healthy Baby coalition. It operates out of Healthy Beginnings Plus (LGH). To date, almost 50 cribs have been distributed from the HBP site and South East Lancaster Health Services site. There is a referral process from targeted community human service organizations as a pre-screening process and a training component at the time of the receipt of the crib. The Cribs for Kids package includes a Pack and Play portable crib, suitable for an infant / child up to age 2, an appropriate crib sheet / mattress cover with instructions on safe sleep practices (“Back to Sleep”), a sleeper sack, lightweight top covering and pacifier. Recipients are required to review safe sleeping conditions and practices for infants and to evaluate their home environment for a safe sleep environment for the infant.

Crib packages cost @ $70 each. Funding for current crib stock came from a $3000 grant from PA DoH and $3000 from Ronald McDonald. (There is an application with LOHF for $2000.) HBP anticipates receiving referrals for at least 100 cribs per year.
Funding Recommendation: $25,000 (3 Years + Funding)

http://www.cribsforkids.org/

**Safe Haven** - Safe Haven is PA’s program for implementation of the Newborn Protection Act. Since 2003, parents of infants up to 28 days old are able to leave their newborn at any Pennsylvania hospital without fear of criminal charges, unless the infant has been neglected or harmed. Intended to prevent the deaths of unwanted newborns, Safe Haven has had sporadic publicity and community outreach on a state-wide basis.

Many materials are available from the state at no charge, so no funding would be needed for message development. Funds are needed for local distribution, outreach and a community awareness campaign. The local Safe Haven task force (part of HMHB) would develop a spring and fall education campaign including bus boards, outreach to school nurses and school counselors, and agency education.

Funding Recommendation: $25,000

Conclusions:
Outcome measurements in prevention programs are difficult at best. And while the original intent of the funding was to cut a broad swath through an identified population, individual children can and do need safe environments and families do need assistance in providing safe environments for their children.

Each of these programs reduces the risk for targeted children on an individual basis. There is no accurate way to measure the number of children who don’t die from SIDS or from co-sleeping, nor is there a way to accurately determine how many children will live in a safer environment if just a few properties institute lead abatement efforts as a result of a Medical Legal Partnership action. But many may be impacted by the ripple effect of targeted lead abatement programs or the re-use of cribs. If only one child is relinquished to a local hospital rather than a dumpster behind a convenience store, the investment is worthwhile.
Healthy Weight Management Habit Inventory

Name________________________ Date________

Would you like a clearer picture of the actions and feelings that affect your weight? Just fill out this Habit Inventory. It is not difficult and there are no “right” or “wrong” answers. Just answer each question based on what you did during the last week.

Directions:
Complete all 12 sections by circling your response and record your totals for each section. There are no “right” or “wrong” answers.

<table>
<thead>
<tr>
<th>I exercised with an increased exertion for an hour or more daily.</th>
<th>Often 3</th>
<th>I am frequently bored.</th>
<th>Often 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sometimes 2</td>
<td></td>
<td>Sometimes 2</td>
<td></td>
</tr>
<tr>
<td>Rarely 1</td>
<td></td>
<td>Rarely 3</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I spent free time sitting down.</th>
<th>Often 1</th>
<th>I watched 2 or more hours of TV a day</th>
<th>Often 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sometimes 2</td>
<td></td>
<td>Sometimes 2</td>
<td></td>
</tr>
<tr>
<td>Rarely 1</td>
<td></td>
<td>Rarely 3</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I exercised hard for an hour or more on weekend days.</th>
<th>Often 3</th>
<th>I was busy on the weekend.</th>
<th>Often 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sometimes 2</td>
<td></td>
<td>Sometimes 2</td>
<td></td>
</tr>
<tr>
<td>Rarely 1</td>
<td></td>
<td>Rarely 3</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I spent my weekend time sitting down.</th>
<th>Often 1</th>
<th>I often have nothing to do.</th>
<th>Often 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sometimes 2</td>
<td></td>
<td>Sometimes 2</td>
<td></td>
</tr>
<tr>
<td>Rarely 3</td>
<td></td>
<td>Rarely 3</td>
<td></td>
</tr>
</tbody>
</table>

1. HOW MUCH I EXERCISE TOTAL 1.____

<table>
<thead>
<tr>
<th>I had butter, margarine, mayonnaise or oil on my food.</th>
<th>Often 1</th>
<th>I ate breakfast.</th>
<th>Often 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sometimes 2</td>
<td></td>
<td>Sometimes 2</td>
<td></td>
</tr>
<tr>
<td>Rarely 3</td>
<td></td>
<td>Rarely 1</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I ate vegetables (like lettuce, carrots, broccoli, celery or tomatoes).</th>
<th>Often 3</th>
<th>I skipped lunch.</th>
<th>Often 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sometimes 2</td>
<td></td>
<td>Sometimes 2</td>
<td></td>
</tr>
<tr>
<td>Rarely 1</td>
<td></td>
<td>Rarely 3</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I ate sweets (like ice cream, cookies, pies, cakes or candy)</th>
<th>Often 1</th>
<th>I ate at least 4 times a day.</th>
<th>Often 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sometimes 2</td>
<td></td>
<td>Sometimes 2</td>
<td></td>
</tr>
<tr>
<td>Rarely 3</td>
<td></td>
<td>Rarely 1</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I ate fried or oily foods (like chips, fried chicken, bacon or salami)</th>
<th>Often 1</th>
<th>I ate dinner.</th>
<th>Often 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sometimes 2</td>
<td></td>
<td>Sometimes 2</td>
<td></td>
</tr>
<tr>
<td>Rarely 3</td>
<td></td>
<td>Rarely 1</td>
<td></td>
</tr>
</tbody>
</table>

3. THE TYPES OF FOOD I EAT TOTAL 3.____

| 2. HOW ACTIVE I AM TOTAL 2.____
<table>
<thead>
<tr>
<th>I ate breakfast.</th>
<th>Often 3</th>
<th>I ate breakfast.</th>
<th>Often 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sometimes 2</td>
<td></td>
<td>Sometimes 2</td>
<td></td>
</tr>
<tr>
<td>Rarely 1</td>
<td></td>
<td>Rarely 1</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I ate lunch.</th>
<th>Often 3</th>
<th>I ate lunch.</th>
<th>Often 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sometimes 2</td>
<td></td>
<td>Sometimes 2</td>
<td></td>
</tr>
<tr>
<td>Rarely 1</td>
<td></td>
<td>Rarely 1</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I ate dinner.</th>
<th>Often 3</th>
<th>I ate dinner.</th>
<th>Often 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sometimes 2</td>
<td></td>
<td>Sometimes 2</td>
<td></td>
</tr>
<tr>
<td>Rarely 1</td>
<td></td>
<td>Rarely 1</td>
<td></td>
</tr>
</tbody>
</table>
Addendum S: LGH Healthy Weight Management Operational Plan

Overview
2012-2013

Increase the number of adults and children who are at a healthy weight in Lancaster County.

Increase the number of individuals in Lancaster County who are physically active and make healthy food choices.

Lancaster County School Community Workplace School Community Workplace Adults

Increase likelihood of Lancaster City and County AMB the BPC application completion.
Increase Student Health Related Activities AMB the number of hits on the website.
Increase workplace awareness of Lighten Up Lancaster County Coalition and importance of physical activity and making healthy food choices.
Increase LULC awareness in community related activities AMB the number of hits to the website.
Increase the number of childcare centers utilizing the Color Me Healthy curriculum AMB state guidelines.
Increase LULC educational presentations at school boards and administration AMB the number of schools involved with LULC.
Increase LULC participation with Community gardens AMB the CDC best practices.
Increase comprehensive wellness programs AMB the number of companies implementing these programs.

Increase walkability of Lancaster City and County AMB the community walkability audit.
Increase awareness of Lighten Up Lancaster County Coalition and importance of physical activity and making healthy food choices.
Increase workplace awareness of LULC AMB the number of hits to the website.
Increase the number of hits to the website.
Increase the number of Safe Routes to School AMB the number of children walking to school.
Increase Buddy Up Participation AMB the number of individuals completing the program.

Increase the number of restaurants that offer healthy food choices AMB the CDC guidelines.
Create and implement policies around healthy food options for targeted populations AMB best practice guidelines.

Engage decision makers to impact policy related to increasing physical activity and policies that encourage healthy food choices.
Educate individuals about the importance of physical activity and making healthy food choices.
Engage in activities and programs that provide opportunities for physical activity and making healthy food choices, which will provide measurable behavior changes.
# Engage decision makers to impact **POLICY** related to increasing physical activity and policies that encourage healthy food choices

## Lancaster County

<table>
<thead>
<tr>
<th>Increase bikability of Lancaster City and County AMB the BFC application completion</th>
<th>Increase walkability of Lancaster City and County AMB the community walkability audit</th>
<th>Increase the number of restaurants that offer healthy food choices AMB the CDC guidelines</th>
<th>Implement policies around healthy food options for targeted populations AMB best practice guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Coalition members will attend 50% more planning commission meetings by 12/12 from 8 to 12</td>
<td>1. Coalition members will attend 50% more planning commission meetings by 12/12 from 8 to 12</td>
<td>1. Develop LULC criteria for healthy restaurants by 2013</td>
<td>1. Identify partnership opportunities with BFBL, Hunger Coalition, and Food Bank by 12/12</td>
</tr>
<tr>
<td>2. Convane stakeholders to discuss shared vision of bikability in the city by 4/12</td>
<td>2. Update the Lancaster Co trail map by 12/12 highlighting connectivity</td>
<td>2. Engage the Restaurant Association by reaching out to 3 contacts to obtain commitment to advancing initiatives</td>
<td>2. Secure 1 vendor for mobile market for the summer of 2012</td>
</tr>
<tr>
<td>3. Develop white paper in best practices to promote bikability in the community by 4/12</td>
<td>3. Develop white paper in best practices to promote walkability in the community by 4/12</td>
<td>3. Stamp 2 LULC approved restaurants by the end of 2013</td>
<td>3. Work with BFBL to identify retail and farmers market EBT machines in Lancaster County</td>
</tr>
<tr>
<td>4. Present BFC application process to LMC by 12/12</td>
<td>4. Identify mutual goals with Smart Growth Coalition by 12/12</td>
<td>4. Distribute 500 “Eat Here More” wallet cards by 12/12</td>
<td>4. Provide TA to school food service directors and wellness councils regarding policy implementation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. Two restaurants will implement healthy childrens menus by the end of 2013</td>
<td>5. Establish baseline data for school non-cafeteria food policies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6. Establish baseline data related to workplace policies</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>7. Conduct a County food system assessment by 12/12</td>
<td></td>
</tr>
</tbody>
</table>
### Increase AWARENESS of Lighten Up Lancaster

#### Schools
- Increase LULC awareness in school related activities AMB the number of hits on the school webpage and requests for LULC presence
  1. Attend a school event in 8 school districts where LULC materials are distributed by 12/12
  2. 4/16 school districts will apply for the Apple Award by May 2012
  3. Present to 8 Wellness Councils by the end of 12/12
  4. Present to 8 PTO’s by the end of 2013
  5. Identify LULC representation gaps on Wellness Councils by 12/12
  6. Secure LULC membership on 16/16 school wellness councils by 12/12

#### Community
- Increase awareness of LULC in community related activities AMB the number of hits to the website
  1. Attend 5 community events as defined by target audience by 12/12
  2. Identify 4 races that are strategically located to target all 4 areas of the county
  3. LULC speakers will present 20% more formal presentations by 12/12 from 10 to 12
  4. Crunch will appear at 20% more community events by 12/12 from 30 to 35
  5. LULC material distribution will increase by 10% by 12/12
  6. The # of landing webpage site impressions will increase by 15% for 12/12 from 3,000 to 3,500 per quarter
  7. Social media followers (Twitter 57 to 68, Facebook 339 to 375, LinkedIn (30 to 35)) will increase by 10% by 12/12
  8. On-line membership will increase by 10% by 12/12 from 40 to 44 per quarter
  9. Meeting attendance will increase by 10% by 12/12

#### Workplace
- Increase workplace awareness of LULC AMB the number of hits to the workplace website
  1. Increase number of well workplace applicants by 10% or 10 applicants by 11/12 from 30 to 33
  2. Increase number of workplaces that use LULC resources (e. workplace toolkits) by 15% by 12/12 from 50 to 55
**EDUCATE** individuals about the importance of physical activity and making healthy food choices.

**Schools**
- Increase the number of childcare centers utilizing the Color Me Healthy curriculum AMB state guidelines.
  - 1. Establish baseline number of people trained for CMH by 12/12
  - 2. Distribute newsletter electronically to 5 more centers by 12/12

**Community**
- Increase LULC educational presentations/outreach AMB the number of participants involved in LULC events.
  - 1. Present to 3 Community Organizations and School Boards by 4/12
  - 2. Increase number of participants who attend shopping tours by 10% by 12/12 from 25 to 28
  - 3. Add 2 additional grocery store locations for shopping tours by 12/12
  - 4. Present to African American, Latino, and Amish population twice, by 12/12

**Workplace**
- Increase LULC participation with Community gardens AMB the CDC best practices.
  - 1. Establish 2 community gardens by 12/12
  - 2. Establish 2 school gardens by 12/12
  - 3. Train workplace action team on best practices of comprehensive wellness programs
2012-2013

Engage in activities and programs that provide **BEHAVIOR CHANGE** opportunities for physical activity and making healthy food choices.

**Children**
- Increase the number of Safe Routes to School AMB the number of children walking to school
  - 1. Pilot walking to school day in 3 schools by 12/12
  - 2. Pilot biking to school day in 1 school by 12/12

**Adults**
- Increase Buddy Up Participation AMB the number of individuals completing the program
  - 1. Increase number of people who participate in events by 10% from 100 to 110
- Expand the reach of Maintain Your Weight program AMB the number of participants completing the program
  - 1. Increase MYW participation by 5% by 12/12 from 334 to 350
- Increase comprehensive wellness programs AMB the number of companies implementing these programs
  - 1. Establish baseline number of companies implementing comprehensive wellness programs by 5% by 12/12
Policy Scan Results: Clinical & Preventive Services

### Workplace:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>98%</td>
<td>2%</td>
<td>Does your business provide insurance coverage to employees for preventive services?</td>
</tr>
<tr>
<td>80%</td>
<td>20%</td>
<td>Does your business provide employee access to chronic disease self-management programs?</td>
</tr>
<tr>
<td>74%</td>
<td>26%</td>
<td>Does your business provide routine screening, follow-up counseling, and education to employees to help address chronic diseases and related risk factors?</td>
</tr>
<tr>
<td>54%</td>
<td>20%</td>
<td>Does your medical insurance company cover pharmacotherapy? (27% responded with not applicable)</td>
</tr>
</tbody>
</table>
### Policy Scan Results:
#### Clinical & Preventive Services

**Workplace (con’t):**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>14%</td>
<td>86%</td>
<td>Is your business a member of a collective prescription medical contracts purchasing consortium?</td>
</tr>
<tr>
<td>9%</td>
<td>91%</td>
<td>Is your business a member of a collective procurement of medications purchasing consortium?</td>
</tr>
<tr>
<td>9%</td>
<td>91%</td>
<td>Is your business a member of a collective procurement of food purchasing consortium?</td>
</tr>
<tr>
<td>26%</td>
<td>74%</td>
<td>Is your business a member of a collective health insurance purchasing consortium?</td>
</tr>
</tbody>
</table>
### Workplace (con’t):

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>52%</td>
<td>48%</td>
<td>Does your business offer a comprehensive employee wellness program?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(To qualify as a comprehensive employee wellness program, the program</td>
</tr>
<tr>
<td></td>
<td></td>
<td>must include: a) Senior Level Support, b) Functional Wellness Team, c)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Data Collection, d) Development of an Operating Plan, e) Selection of</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Appropriate Interventions, f) A Supportive Environment, and g)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Measurement and Evaluation of Outcomes.)</td>
</tr>
<tr>
<td>59%</td>
<td>41%</td>
<td>Does your business have a formalized wellness council/committee?</td>
</tr>
<tr>
<td>50%</td>
<td>50%</td>
<td>Has your business adopted and formalized an obesity prevention program</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(e.g. LEAN Works!, Weight Watchers, Biggest Loser)?</td>
</tr>
<tr>
<td>36%</td>
<td>64%</td>
<td>Does your business have written policies supporting wellness council</td>
</tr>
<tr>
<td></td>
<td></td>
<td>committees?</td>
</tr>
</tbody>
</table>
Policy Scan Results: Clinical & Preventive Services

Workplace (con’t):

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>46%</td>
<td>54%</td>
<td>Has your business adopted and formalized * other* health promotion program(s)?</td>
</tr>
<tr>
<td>54%</td>
<td>47%</td>
<td>Does your business have written policies supporting employee wellness services offered?</td>
</tr>
<tr>
<td>29%</td>
<td>71%</td>
<td>Does your business have written policies supporting alternative work schedules?</td>
</tr>
<tr>
<td>10%</td>
<td>90%</td>
<td>Does your business have other written policies?</td>
</tr>
<tr>
<td>16%</td>
<td>84%</td>
<td>Has your business been recognized locally or nationally for your workplace health promotion activities?</td>
</tr>
</tbody>
</table>

* Other teams indicated: 10,000 step, Eat Well for Life, Nutritional counseling, biometric testing, BRAVO, Café Well, Fitness challenges, health fairs, wellness incentives, onsite health coaching, exercise classes, personal trainers, walking challenges, weight loss challenges, healthy lifestyle financial incentive program.
## Policy Scan Results: Clinical & Preventive Services

**Physicians:**

<table>
<thead>
<tr>
<th>All</th>
<th>Most</th>
<th>Some</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>47%</td>
<td>29%</td>
<td>12%</td>
<td>12%</td>
</tr>
</tbody>
</table>

How many of your physicians ensure that they follow a protocol for hypertension and hyperlipidemia treatment and control?

| 44%  | 38%  | 6%   | 13%   |

How many of your physicians ensure that Hypertension and cholesterol control are tracked?

| 20%  | 33%  | 40%  | 7%    |

How many of your physicians ensure that at least two blood pressure measurements for hypertensive patients are taken during each visit?

| 41%  | 24%  | 29%  | 6%    |

How many of your physicians ensure that patients are referred to local programs for healthy weight management?
Policy Scan Results: Clinical & Preventive Services

Physicians (con’t):

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>94%</td>
<td>6%</td>
<td>Does your practice use electronic medical health records?</td>
</tr>
</tbody>
</table>
Policy Scan Results: Healthy Eating

Workplace:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>64%</td>
<td>36%</td>
<td>Does your business provide an onsite venue where employees can purchase food?</td>
</tr>
<tr>
<td>67%</td>
<td>33%</td>
<td>Does your business purchase or use foods grown in Lancaster County?</td>
</tr>
<tr>
<td>59%</td>
<td>41%</td>
<td>Does your business require healthy food preparation practices in on-site food venues?</td>
</tr>
<tr>
<td>100%</td>
<td>0%</td>
<td>Does your business offer healthy food and beverage options in on-site food venues?</td>
</tr>
<tr>
<td>89%</td>
<td>11%</td>
<td>Does your business offer healthy food and beverage options at company-sponsored meetings and events?</td>
</tr>
</tbody>
</table>
### Policy Scan Results: Healthy Eating

**Workplace (con’t):**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>33%</td>
<td>67%</td>
<td>Has your business instituted pricing strategies that encourage the purchase of healthy food and beverage options in onsite food venues?</td>
</tr>
<tr>
<td>20%</td>
<td>80%</td>
<td>Has your business banned marketing (e.g. counter advertisements, posters, other print materials) of less than healthy foods and beverages onsite?</td>
</tr>
<tr>
<td>80%</td>
<td>20%</td>
<td>Does your business provide vending machines in the workplace?</td>
</tr>
<tr>
<td>27%</td>
<td>74%</td>
<td>Are at least 50% of food and drink options in your workplace vending machines healthy?</td>
</tr>
</tbody>
</table>
## Policy Scan Results: Healthy Eating

### Workplace (con’t):

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>21%</td>
<td>80%</td>
<td></td>
<td>Has your business adopted and formalized Farm-to-Institution practices</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(e.g. purchasing food from local farmers, farm stand available for employees</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>to purchase fresh fruits/vegetables)?</td>
</tr>
<tr>
<td>56%</td>
<td>44%</td>
<td></td>
<td>Has your business adopted and formalized a breastfeeding/lactation support</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>program/practice at your worksite(s)?</td>
</tr>
<tr>
<td>50%</td>
<td>50%</td>
<td></td>
<td>Has your hospital adopted Baby Friendly Hospital Initiative components in</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>their entirety?</td>
</tr>
<tr>
<td>21%</td>
<td>79%</td>
<td></td>
<td>Does your business have written policies supporting healthy vending?</td>
</tr>
<tr>
<td>41%</td>
<td>60%</td>
<td></td>
<td>Does your business have written policies supporting breastfeeding?</td>
</tr>
</tbody>
</table>
### Policy Scan Results: Healthy Eating

**Physicians:**

<table>
<thead>
<tr>
<th>All</th>
<th>Most</th>
<th>Some</th>
<th>None</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6%</td>
<td>0%</td>
<td>53%</td>
<td>41%</td>
<td>Prescriptions are written for fresh fruits and vegetables?</td>
</tr>
<tr>
<td>63%</td>
<td>13%</td>
<td>19%</td>
<td>6%</td>
<td>Weight and height are taken and the appropriate BMI is calculated for every patient at each visit?</td>
</tr>
<tr>
<td>41%</td>
<td>29%</td>
<td>29%</td>
<td>0%</td>
<td>Counseling is provided to patients with elevated BMI?</td>
</tr>
<tr>
<td>41%</td>
<td>24%</td>
<td>29%</td>
<td>6%</td>
<td>Patients are referred to local programs for healthy weight management?</td>
</tr>
</tbody>
</table>
### Policy Scan Results: Healthy Eating

#### Schools:

<table>
<thead>
<tr>
<th>All</th>
<th>Most</th>
<th>Some</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>92%</td>
<td>0%</td>
<td>8%</td>
<td>0%</td>
</tr>
<tr>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>54%</td>
<td>39%</td>
<td>8%</td>
<td>0%</td>
</tr>
</tbody>
</table>

**How many of the districts schools have breakfast and lunch programs that meet the U.S. Department of Agriculture school mean nutrition standards?**

- **All:** 92%
- **Most:** 0%
- **Some:** 8%
- **None:** 0%

**How many of the districts schools require healthy food preparation practices (e.g., steaming, low fat, low salt, limited frying) are always used in the school cafeteria or onsite food services?**

- **All:** 100%
- **Most:** 0%
- **Some:** 0%
- **None:** 0%

**How many of the districts schools ensure that students are provided only healthy food and beverage options beyond the school food services (e.g., vending machines, school stores, and food brought for celebrations)?**

- **All:** 54%
- **Most:** 39%
- **Some:** 8%
- **None:** 0%
### Policy Scan Results: Healthy Eating

**Schools (con’t):**

<table>
<thead>
<tr>
<th>All</th>
<th>Most</th>
<th>Some</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>8%</td>
<td>23%</td>
<td>31%</td>
<td>39%</td>
</tr>
<tr>
<td>39%</td>
<td>23%</td>
<td>0%</td>
<td>39%</td>
</tr>
<tr>
<td>85%</td>
<td>15%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>39%</td>
<td>31%</td>
<td>15%</td>
<td>15%</td>
</tr>
</tbody>
</table>

- **How many of the districts schools have a school garden (e.g., access to land, container gardens, or raised beds)?**
  - 8% (23% Most, 31% Some, 39% None)

- **How many of the districts schools have banned marketing (e.g., counter advertisements, posters, other print materials) of less than healthy foods and beverages onsite?**
  - 39% (23% Most, 0% Some, 39% None)

- **How many of the districts schools provide adequate time to eat school meals (10 minutes for breakfast/20 minutes for lunch, from the time students are seated)?**
  - 85% (15% Most, 0% Some, 0% None)

- **How many of the districts schools prohibit the sale of sugar-sweetened beverages (excluding flavored, fat-free milk) during the school day?**
  - 39% (31% Most, 15% Some, 15% None)
Policy Scan Results: Healthy Eating

Schools (con’t):

<table>
<thead>
<tr>
<th>All</th>
<th>Most</th>
<th>Some</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>85%</td>
<td>8%</td>
<td>0%</td>
<td>8%</td>
</tr>
</tbody>
</table>

How many of the districts schools require fruits and vegetables to be available wherever foods and beverages are offered?

| 77%  | 0%   | 0%   | 23%  |

How many of the districts schools institute pricing strategies that encourage the purchase of healthy food and beverage options?

| 77%  | 15%  | 8%   | 0%   |

How many of the districts schools have a nutrition education curriculum for all students in grades pre-K to grade 12 as part of a sequential health education course of study, consistent with state or National Health Education Standards?
### Policy Scan Results: Healthy Eating

**Schools (con’t):**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th></th>
</tr>
</thead>
</table>
| 0%  | 100%    | Has the district implemented a formal Farm-to-School initiative?
Policy Scan Results: Healthy Eating

Municipalities:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>100%</td>
<td>Does your local government have a policy that prohibits the sale of less healthy foods and beverages in local government facilities?</td>
</tr>
<tr>
<td>3%</td>
<td>97%</td>
<td>Is the municipality directly involved in food procurement in any municipality-funded residential or detention programs or cafeterias?</td>
</tr>
<tr>
<td>0%</td>
<td>100%</td>
<td>Require the purchase or use of foods grown in Lancaster County (e.g., farm to institution program)?</td>
</tr>
<tr>
<td>100%</td>
<td>0%</td>
<td>Does the municipal government require healthy food preparation practices?</td>
</tr>
<tr>
<td>0%</td>
<td>100%</td>
<td>Does the municipal government provide funding to support community garden (or similar) programs?</td>
</tr>
</tbody>
</table>
### Policy Scan Results: Healthy Eating

#### Municipalities (con’t):

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>6%</td>
<td>94%</td>
<td>Does the municipality provide nutrition education as a component of their parks/recreation/enrichment initiatives?</td>
</tr>
<tr>
<td>0%</td>
<td>100%</td>
<td>Does the municipality provide dedicated funding to support nutrition programs for all people across the lifespan?</td>
</tr>
<tr>
<td>0%</td>
<td>100%</td>
<td>Does the municipality offer at least one incentive (financial or nonfinancial) to new and/or existing food retailers to offer healthier food and beverage choices in underserved areas?</td>
</tr>
</tbody>
</table>
## Policy Scan Results: Healthy & Safe Physical Environments

### Workplace:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>63%</td>
<td>37%</td>
<td>Does your business have bike racks?</td>
</tr>
<tr>
<td>7%</td>
<td>93%</td>
<td>Did your business complete the Bicycle Friendly Business application prior to July 1, 2012?</td>
</tr>
<tr>
<td>64%</td>
<td>36%</td>
<td>Does your business have designated walking paths?</td>
</tr>
</tbody>
</table>
Policy Scan Results: Healthy & Safe Physical Environments

Municipalities:

<table>
<thead>
<tr>
<th>Mean</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.6</td>
<td>Miles of paved sidewalks in the municipality</td>
</tr>
<tr>
<td>1.4</td>
<td>Number of walking/biking trails in the municipality</td>
</tr>
<tr>
<td>0.4</td>
<td>Miles of designated bike lanes in the municipality</td>
</tr>
</tbody>
</table>

Note: The mean total mileage of paved streets managed and paid for by the municipalities (excluding limited access highways) is 58.2 miles.
### Policy Scan Results: Healthy & Safe Physical Environments

**Municipalities (con’t):**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>6%</td>
<td>94%</td>
<td>Has the municipality conducted a walkability audit?</td>
</tr>
<tr>
<td>3%</td>
<td>97%</td>
<td>Has the municipality conducted a bikeability audit?</td>
</tr>
<tr>
<td>0%</td>
<td>100%</td>
<td>Has the municipality conducted a Health Impact Assessment?</td>
</tr>
<tr>
<td>85%</td>
<td>15%</td>
<td>Does the municipality’s Planning Committee (or similar organization) include a resident representative?</td>
</tr>
<tr>
<td>3%</td>
<td>97%</td>
<td>Does the municipality’s Planning Committee (or similar organization) include representation from the healthcare or public health community?</td>
</tr>
</tbody>
</table>
Policy Scan Results: Healthy & Safe Physical Environments

Municipalities:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>63%</td>
<td>38%</td>
<td>Comprehensive Plan includes goals for walkability?</td>
</tr>
<tr>
<td>47%</td>
<td>53%</td>
<td>Comprehensive Plan includes goals for bikability?</td>
</tr>
<tr>
<td>80%</td>
<td>20%</td>
<td>Does the municipality’s Comprehensive Plan require developers to include paved sidewalks in all new residential and commercial developments?</td>
</tr>
<tr>
<td>18%</td>
<td>82%</td>
<td>Comprehensive Plan include a goal to adopt at least one Complete Streets design element?</td>
</tr>
</tbody>
</table>
| 0%   | 100%| Has the municipality adopted a Complete Streets policy?
## Policy Scan Results: Active Living

### Workplace:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>5%</td>
<td>96%</td>
<td>Do you offer incentives for employees who walk or bike to work regularly?</td>
</tr>
<tr>
<td>59%</td>
<td>41%</td>
<td>Does your business provide employee access to a fitness center, a gymnasium, or physical activity classes onsite?</td>
</tr>
<tr>
<td>57%</td>
<td>43%</td>
<td>Does your business provide discounts to employees for offsite fitness center memberships?</td>
</tr>
<tr>
<td>37%</td>
<td>63%</td>
<td>Has your business adopted and formalized a program that promotes stair use by employees (e.g. Stair Well)?</td>
</tr>
<tr>
<td>34%</td>
<td>66%</td>
<td>Does your business allow flexibility in employee schedules to accommodate physical activity during the work day?</td>
</tr>
</tbody>
</table>
Policy Scan Results: Active Living

Workplace (con’t):

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Does your business have a company-sponsored volleyball team for employees?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>0%</td>
<td>100%</td>
<td>Does your business have a company-sponsored basketball team for employees?</td>
</tr>
<tr>
<td>7%</td>
<td>93%</td>
<td>Does your business have a company-sponsored softball/baseball team for employees?</td>
</tr>
<tr>
<td>6%</td>
<td>94%</td>
<td>Does your business have any other* company-sponsored teams for employees?</td>
</tr>
</tbody>
</table>

* Other teams indicated: games after work building drive incentives, soccer, and walking/hiking clubs)
## Policy Scan Results: Active Living

### Physicians:

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Most</th>
<th>Some</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Physicians</td>
<td>6%</td>
<td>0%</td>
<td>53%</td>
<td>41%</td>
</tr>
<tr>
<td>Question</td>
<td>How many of your physicians ensure that prescriptions are written for exercise?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of Physicians</td>
<td>63%</td>
<td>13%</td>
<td>19%</td>
<td>6%</td>
</tr>
<tr>
<td>Question</td>
<td>How many of your physicians ensure that weight and height are taken and the appropriate BMI is calculated for every patient at each visit?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of Physicians</td>
<td>41%</td>
<td>29%</td>
<td>29%</td>
<td>0%</td>
</tr>
<tr>
<td>Question</td>
<td>How many of your physicians ensure that counseling is provided to patients with elevated BMI?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of Physicians</td>
<td>31%</td>
<td>25%</td>
<td>44%</td>
<td>0%</td>
</tr>
<tr>
<td>Question</td>
<td>How many of your physicians ensure that patients’ physical activity is included as part of a written checklist or screening in all routine office visits?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Policy Scan Results: Active Living

Physicians (con’t):

<table>
<thead>
<tr>
<th>All</th>
<th>Most</th>
<th>Some</th>
<th>None</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>33%</td>
<td>40%</td>
<td>47%</td>
<td>0%</td>
<td>How many of your physicians ensure that regular counseling about the health value of physical activity is provided during all routine office visits?</td>
</tr>
<tr>
<td>20%</td>
<td>27%</td>
<td>20%</td>
<td>13%</td>
<td>How many of your physicians ensure that a standardized referral system is used to help patients access community-based resources or services for physical activity?</td>
</tr>
</tbody>
</table>
## Policy Scan Results: Active Living

### Schools:

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Most</th>
<th>Some</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>15%</td>
<td>23%</td>
<td>62%</td>
<td></td>
</tr>
<tr>
<td>54%</td>
<td>39%</td>
<td>8%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>92%</td>
<td>8%</td>
<td>0%</td>
<td>0%</td>
<td></td>
</tr>
</tbody>
</table>

- **How many of the district’s schools have a walk or bike to school initiative?**
  - 0% of schools have none, 15% have a few, 23% have many, and 62% have a large number.

- **How many of the district’s schools allow the use of their athletic facilities by the public or for non-school-related extracurricular physical activity programs during non-school hours (e.g., joint use agreements)?**
  - 54% of schools allow none, 39% allow some, 8% allow many, and 0% allow a large number.

- **How many elementary schools require at least 20 minutes of recess daily for students?**
  - 92% of schools have none, 8% have a few, 0% have many, and 0% have a large number.
## Policy Scan Results: Active Living

### Schools (con’t):

<table>
<thead>
<tr>
<th>All</th>
<th>Most</th>
<th>Some</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>85%</td>
<td>15%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

How many of the district’s schools have implemented a physical education curriculum for all students in grades pre-K to grade 12, as part of a sequential physical education course of study, consistent with state or national physical education standards?

| 62%  | 31%  | 0%   | 8%   |

How many of the district’s schools do not provide waivers or exemptions from participation in physical education for other school and community activities (e.g., band, chorus, sports, community volunteering)?
## Policy Scan Results: Active Living

### Schools (con’t):

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8%</td>
<td>92%</td>
<td>Does the district have a policy that requires at least 150 minutes per week of physical education for all elementary school students throughout the school year?</td>
</tr>
<tr>
<td>17%</td>
<td>83%</td>
<td>Does the district have a policy that requires at least 225 minutes per week of physical education for all middle school and high school students throughout the school year?</td>
</tr>
<tr>
<td>33%</td>
<td>67%</td>
<td>Does the district have a policy that requires students in K-12 to be physically active for at least 50% of the time spent in physical education classes?</td>
</tr>
</tbody>
</table>
## Policy Scan Results: Active Living

**Municipalities:**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>47%</td>
<td>53%</td>
<td>Does the municipality offer physical fitness opportunities for people of all ages as a component of its parks/recreation/enrichment initiatives?</td>
</tr>
<tr>
<td>3%</td>
<td>97%</td>
<td>Has the municipality completed the Bicycle Friendly Community application?</td>
</tr>
<tr>
<td>16%</td>
<td>84%</td>
<td>Has the municipality applied for federal Safe Routes to School funding in the past five years?</td>
</tr>
<tr>
<td>55%</td>
<td>45%</td>
<td>Besides Safe Routes to School funding, has the municipality applied for local, state, or federal funds in the past five years for transportation improvements that increase walkability and bikeability in the municipality?</td>
</tr>
<tr>
<td>9%</td>
<td>91%</td>
<td>Does your municipality participate in at least one coalition or partnership that addresses healthy eating and/or active living?</td>
</tr>
</tbody>
</table>
## Policy Scan Results: Active Living

### Municipalities (cont.):

<table>
<thead>
<tr>
<th></th>
<th>None</th>
<th>Some</th>
<th>Most</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>55%</td>
<td>36%</td>
<td>3%</td>
<td>6%</td>
</tr>
</tbody>
</table>

How many public buildings have bike racks?
# Policy Scan Results: Tobacco-Free Living

## Workplace:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>73%</td>
<td>27%</td>
<td>Has your business banned tobacco on or in company-owned property?</td>
</tr>
<tr>
<td>79%</td>
<td>21%</td>
<td>Does your business provide access to a referral system for tobacco cessation resources and services?</td>
</tr>
<tr>
<td>57%</td>
<td>43%</td>
<td>Has your business adopted and formalized tobacco cessation programs at your worksite(s)?</td>
</tr>
<tr>
<td>74%</td>
<td>26%</td>
<td>Does your business have written policies supporting tobacco prohibition on or in company-owned property?</td>
</tr>
</tbody>
</table>
## Policy Scan Results: Tobacco-Free Living

**Physicians:**

<table>
<thead>
<tr>
<th>All</th>
<th>Most</th>
<th>Some</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>59%</td>
<td>35%</td>
<td>6%</td>
<td>0%</td>
</tr>
<tr>
<td>69%</td>
<td>25%</td>
<td>6%</td>
<td>0%</td>
</tr>
<tr>
<td>63%</td>
<td>25%</td>
<td>13%</td>
<td>0%</td>
</tr>
<tr>
<td>56%</td>
<td>31%</td>
<td>13%</td>
<td>0%</td>
</tr>
<tr>
<td>56%</td>
<td>25%</td>
<td>19%</td>
<td>0%</td>
</tr>
</tbody>
</table>

- **How many of your physicians ensure that all tobacco users are systematically identified at every visit? (ASK)**
  - 59%
  - 35%
  - 6%
  - 0%

- **How many of your physicians ensure that all tobacco users are strongly urged to quit? (ADVISE)**
  - 69%
  - 25%
  - 6%
  - 0%

- **How many of your physicians ensure that willingness to make a quit attempt is determined? (ASSESS)**
  - 63%
  - 25%
  - 13%
  - 0%

- **How many of your physicians ensure that the patient is aided in quitting (i.e. brief counseling and medication)? (ASSIST)**
  - 56%
  - 31%
  - 13%
  - 0%

- **How many of your physicians ensure that patients are referred to cessation programs such as a quit line or local program? (ARRANGE)**
  - 56%
  - 25%
  - 19%
  - 0%
<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>88%</td>
<td>12%</td>
</tr>
</tbody>
</table>

Does your facility/grounds have a tobacco-free policy?

88% 12%

Is the Policy enforced?
## Policy Scan Results: Tobacco-Free Living

### Schools:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>0%</td>
<td>Does the district have a tobacco-free policy?</td>
</tr>
<tr>
<td>77%</td>
<td>23%</td>
<td>Does the district have a tobacco-use prevention curriculum for all students in grades pre-K to grade 12 as part of a sequential health education course of study, consistent with state or National Health Education Standards?</td>
</tr>
<tr>
<td>69%</td>
<td>31%</td>
<td>Does the district refer students to cessation programs when they violate school smoking policies?</td>
</tr>
</tbody>
</table>
## Policy Scan Results: Tobacco-Free Living

### Municipalities:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>65%</td>
<td>35%</td>
<td>Do you have a written policy prohibiting tobacco use on or in municipal property?</td>
</tr>
<tr>
<td>27%</td>
<td>74%</td>
<td>Has the municipality adopted a tobacco-free parks and playgrounds initiative (e.g., Young Lungs at Play)?</td>
</tr>
</tbody>
</table>

### Mean N=15

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.4</td>
<td>Number of exempt venues in Pennsylvania’s Clean Air Act</td>
</tr>
</tbody>
</table>
For more information, contact:

Alice Yoder, MSN RN  
Principal Investigator  
717-544-3283  
amyoder@lghealth.org

Eboni Bryant, MS MBA  
Grant Manager  
717-544-3808  
ebryant2@lghealth.org

Alyssa Landen  
Secretary  
717-544-3779  
alanden2@lghealth.org
## Lancaster General Health
### Community Health Improvement Scorecard
#### 2nd Quarter FY 2013

### Key Strategic Measures

<table>
<thead>
<tr>
<th></th>
<th>FY 12</th>
<th>9</th>
<th>8</th>
<th>7</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Raw Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Healthy Weight Management</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td># of Healthy Weight Management Impressions per quarter (thousand)</td>
<td>875,587</td>
<td>917</td>
<td>857</td>
<td>801</td>
<td>749</td>
<td>700</td>
<td>651</td>
<td>605</td>
<td>563</td>
<td>514</td>
<td>inc &amp; dec by 7%</td>
</tr>
<tr>
<td>% of participants who show a positive change in 2 habit inventory scores after completing Healthy Weight Management programs</td>
<td>91%</td>
<td>100</td>
<td>98</td>
<td>96</td>
<td>94</td>
<td>92</td>
<td>90</td>
<td>88</td>
<td>86</td>
<td>84</td>
<td>inc &amp; dec by 2%</td>
</tr>
<tr>
<td># of participants in Healthy Weight Management programs</td>
<td>379</td>
<td>563</td>
<td>512</td>
<td>465</td>
<td>423</td>
<td>385</td>
<td>347</td>
<td>312</td>
<td>281</td>
<td>253</td>
<td>inc &amp; dec by 10%</td>
</tr>
<tr>
<td><strong>Tobacco Use</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>% of adults in tobacco dependence treatment services that quit 30 days post intervention.</td>
<td>38%</td>
<td>43</td>
<td>42</td>
<td>41</td>
<td>40</td>
<td>39</td>
<td>38</td>
<td>37</td>
<td>36</td>
<td>35</td>
<td>inc &amp; dec by 1%</td>
</tr>
<tr>
<td># of participants completing tobacco dependence treatment services. (quarterly)</td>
<td>332</td>
<td>364</td>
<td>357</td>
<td>350</td>
<td>343</td>
<td>336</td>
<td>329</td>
<td>323</td>
<td>317</td>
<td>311</td>
<td>inc. &amp; dec. by 2%</td>
</tr>
<tr>
<td>% of children participating in school based prevention program who showed increase knowledge</td>
<td>79%</td>
<td>84</td>
<td>83</td>
<td>82</td>
<td>81</td>
<td>80</td>
<td>79</td>
<td>78</td>
<td>77</td>
<td>76</td>
<td>inc. &amp; dec. by 1%</td>
</tr>
</tbody>
</table>

### Quarterly Index

<table>
<thead>
<tr>
<th>Quarterly Index</th>
<th>YTD</th>
<th>Total</th>
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<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
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<tr>
<td>2</td>
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<td>3</td>
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<tr>
<td>4</td>
<td></td>
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<tr>
<td>YTD</td>
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</tr>
</tbody>
</table>

**Note:** Overall score of 1.0 indicates achievement of goal

**INDEX:** #DIV/0!
Figure 1. Lifetime Use of smokeless tobacco, 12th grade. 
Sources: Monitoring the Future and Compass Mark Youth Tobacco Survey, Lancaster County & PA

Figure 2. Lifetime use of smokeless tobacco, 8th grade. 
Sources: Monitoring the Future and Compass Mark Youth Tobacco Survey, Lancaster County & PA
Addendum V: Additional Youth Tobacco Trends

**Figure 3.** Smokeless 30 day use, 8th grade.
Sources: Monitoring the Future and Compass Mark Youth Tobacco Survey, Lancaster County & PA

**Figure 4.** Lifetime use of cigarettes, 12th grade.
Sources: Monitoring the Future and Compass Mark Youth Tobacco Survey, Lancaster County & PA
Figure 5. Lifetime use of cigarettes, 10th grade.
Sources: Monitoring the Future and Compass Mark Youth Tobacco Survey, Lancaster County & PA

Figure 6. Lifetime use of cigarettes, 8th grade.
Sources: Monitoring the Future and Compass Mark Youth Tobacco Survey, Lancaster County & PA
Tobacco Overview 2012-2013

Increase the number of adults and children who are tobacco-free in Lancaster County

Reduce tobacco use among residents of Lancaster County

- **Policy**
  - Communities: Increase the number of municipalities in Lancaster County that have adopted Young Lungs at Play (or similar) initiatives.
  - Workplaces: Increase the number of workplaces in Lancaster County that have adopted tobacco-free campus policies.
  - Schools/Colleges: Increase the number of public school districts with comprehensive tobacco prevention programs.
  - Healthcare: Increase the number of practices implementing Ask, Advise and Refer (AAR) initiatives.
  - Lancaster County: Develop a social media campaign.

- **Awareness**
  - Develop a mobile application with tobacco links.
  - Develop a county wide initiative for participation in nationally recognized tobacco events.

- **Education**
  - Increase number of practices implementing Ask, Advise and Refer (AAR) initiatives.
  - Increase number of practices implementing Ask, Advise and Refer (AAR) initiatives.
  - Increase number of practices implementing Ask, Advise and Refer (AAR) initiatives.
  - Increase number of practices implementing Ask, Advise and Refer (AAR) initiatives.
  - Increase number of practices implementing Ask, Advise and Refer (AAR) initiatives.

- **Behavioral Changes**
  - Adults: Increase participation in tobacco-cessation programs.
  - Children: Increase percent of students showing increase in knowledge upon completion of evidence-based tobacco prevention programs.

- **Communities**
  - Increase the number of municipalities in Lancaster County that have adopted Young Lungs at Play (or similar) initiatives.
  - Increase the number of workplaces in Lancaster County that have adopted tobacco-free campus policies.

- **Schools/Colleges**
  - Increase the number of public school districts with comprehensive tobacco prevention programs.

- **Healthcare**
  - Increase the number of practices implementing Ask, Advise and Refer (AAR) initiatives.

- **Lancaster County**
  - Develop a social media campaign.

- **Government**
  - Increase number of legislative visits.

- **Healthcare**
  - Increase number of practices implementing Ask, Advise and Refer (AAR) initiatives.

- **Schools**
  - Increase number of students receiving tobacco prevention education.

- **Community**
  - Increase number of practices implementing Ask, Advise and Refer (AAR) initiatives.

- **Government**
  - Increase number of legislative visits.

- **Children**
  - Increase percent of students showing increase in knowledge upon completion of evidence-based tobacco prevention programs.
Addendum W: Tobacco-Free Coalition of Lancaster County Operational Plan

**Policy**

**Communities**
- Increase the number of municipalities in Lancaster County that adopt Young Lungs at Play (or similar) initiatives
- Present to 20 municipalities by 1/2014

**Workplaces**
- Increase the number of housing authorities in the county that have adopted smoke-free multi-unit public housing policies
- Partner with LiveWell Lancaster to develop and implement a tobacco-free policy for multi-unit housing
- Partner with corporate wellness and Lighten Up Lancaster County (LULC) to identify ten interested companies by 2014

**Schools/Colleges**
- Increase the number of workplaces in Lancaster County that have adopted tobacco-free campus policies
- Develop baseline to identify the number of districts with prevention goals in their wellness policy
- Partner with LiveWell Lancaster to increase percent of top 150 businesses in Lancaster that have comprehensive tobacco-free policies

**Healthcare**
- Increase the number of public school districts with comprehensive tobacco policies included in their wellness policy including resources and how tobacco related offenses are addressed
- Increase the number of practices implementing AAR
- Collaborate with LGMG Quality team to monitor referral rates and provide technical assistance as needed
- Educate 5 non-LGMG practices regarding the implementation of AAR
Awareness

Lancaster County

**Develop a social media campaign**

- Facilitate an advocacy program and present to 20 youth by 2014
- Provide media with 4 tobacco-related stories by 2014
- Increase to 50 'likes' on Facebook for the Tobacco-Free Coalition of Lancaster County by 2014 and promote tobacco cessations services and educational resources

**Partner with LiveWell Lancaster to develop a mobile application with tobacco links**

- Identify 8 links for use on mobile application

**Develop a county wide initiative for participation in nationally recognized tobacco events**

- Partner with community organizations to develop an activity for promotion of Kick Butts Day, World No Tobacco Day and Great American Smoke Out
Education

**Community**
- Increase cessation resources and services provided to community partners who work with targeted populations
- Provide 2 trainings by 12/13 for community partners who work with targeted populations

**Schools**
- Maintain number of students receiving tobacco prevention education
- Continue to implement evidence-based prevention programs in schools, reaching 6,200 students/year
- Increase by 2% the number of classroom teachers facilitating evidence-based tobacco prevention curricula

**Health Care**
- Provide trainings and educational resources for health care providers and community partners regarding cessation medication
- Offer 4 trainings by 12/13 to LGMG practices on cessation medication
- Distribute TDT cessation medication fact sheets to 6 Mental Health agencies in Lancaster County
- Facilitate 15 educational tobacco groups on mental health unit of Lancaster General Hospital

**Government**
- Increase number of legislative visits
- Meet with 10 legislators to discuss tobacco funding, closing tax loopholes and Clean Indoor Air
<table>
<thead>
<tr>
<th>Adults</th>
<th></th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic Initiative</strong></td>
<td><strong>Sector</strong></td>
<td><strong>Objective</strong></td>
</tr>
<tr>
<td>Behavioral Changes</td>
<td>Adults</td>
<td>Children</td>
</tr>
<tr>
<td>Increase participation in tobacco-cessation programs</td>
<td>Increase number of people quit</td>
<td>Increase percent of students showing increase in knowledge upon completion of evidence-based tobacco prevention programs</td>
</tr>
<tr>
<td>Offer two Spanish-speaking Freedom from Smoking classes by 12/31/13</td>
<td>Develop baseline for pharmacotherapy usage</td>
<td>Increase to 80% number of students who score 75% or higher AMB post-survey</td>
</tr>
<tr>
<td>Offer four off-site Freedom from Smoking classes</td>
<td>Increase by 1% by 12/13 the number of people quit at 1 month AMB scorecard</td>
<td></td>
</tr>
<tr>
<td>Increase from 80 to 85 individuals seen in inpatient setting</td>
<td>Offer 2 motivational interview trainings for TDT counselors to standardize coaching guidelines</td>
<td></td>
</tr>
<tr>
<td>Offer individual counseling at one off-site location</td>
<td>Increase LGMG patients participating in TDT by 10%</td>
<td></td>
</tr>
<tr>
<td>Evaluate the feasibility of fax to quit at discharge for inpatient hospitalization</td>
<td></td>
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</tr>
</tbody>
</table>
### Mental Health Services in Lancaster County

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Arch Street Center</strong>&lt;br&gt;• Social club&lt;br&gt;• A psychologist focuses on the evaluation, prevention, diagnosis, and treatment of mental health issues.&lt;br&gt;• Psychologists are concerned with the different aspects of behavior and mental processes.&lt;br&gt;• A clinical psychologist uses psychotherapy and other counseling skills to improve emotional and mental health.</td>
<td>223 West Orange St.&lt;br&gt;Lancaster, PA 17601</td>
</tr>
<tr>
<td><strong>Catholic Charities</strong>&lt;br&gt;• In-Home Intensive Program&lt;br&gt;• Intensive Day Treatment Program&lt;br&gt;• Latino Division&lt;br&gt;• Outpatient Program</td>
<td>925 North Duke St.&lt;br&gt;Lancaster, PA 17602</td>
</tr>
<tr>
<td><strong>Center for Autism &amp; Developmental Disabilities</strong>&lt;br&gt;• Multidisciplinary evaluations&lt;br&gt;• Autism diagnostic service for toddlers – children through age 3&lt;br&gt;• Psychiatric services&lt;br&gt;• Individual and family therapy&lt;br&gt;• Behavioral consultations by a board certified behavior analyst&lt;br&gt;• Psychological testing&lt;br&gt;• Social skills groups&lt;br&gt;• Resources</td>
<td>Philhaven&lt;br&gt;283 South Butler Rd.&lt;br&gt;P.O. Box 550&lt;br&gt;Mount Gretna, PA 17064</td>
</tr>
<tr>
<td><strong>Child/Adolescent Service System Program</strong>&lt;br&gt;• Provide comprehensive mental health care for children, adolescents and their families.</td>
<td>Lancaster Co. MH/MR Program&lt;br&gt;1120 Frances Ave.&lt;br&gt;Lancaster, PA 17601&lt;br&gt;717-393-0421</td>
</tr>
<tr>
<td><strong>Community Services Group</strong>&lt;br&gt;• Community Residential Rehabilitation (CRR)&lt;br&gt;• Enhanced Personal Care Home (EPCH)&lt;br&gt;• Supported Housing and Long Term Structured Residence (LTSR)&lt;br&gt;• Enhanced Treatment for Children&lt;br&gt;• Family Based Services&lt;br&gt;• Group Homes&lt;br&gt;• Intensive Case Management&lt;br&gt;• Partial Hospitalization&lt;br&gt;• Psychiatric rehabilitation</td>
<td>790 New Holland Ave.&lt;br&gt;Lancaster, PA 17602&lt;br&gt;(717) 390-0353</td>
</tr>
<tr>
<td><strong>Outpatient Treatment</strong></td>
<td><strong>Peer support</strong></td>
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<tr>
<td>--------------------------</td>
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<tr>
<td><strong>Vocational services</strong></td>
<td><strong>Mental health first aid training</strong></td>
</tr>
<tr>
<td><strong>Targeted case management</strong></td>
<td><strong>Mobile Psychiatric Rehabilitation</strong></td>
</tr>
<tr>
<td><strong>Supported housing</strong></td>
<td><strong>Psychiatric assessments and medication monitoring</strong></td>
</tr>
<tr>
<td><strong>Psychological evaluations</strong></td>
<td><strong>Individuals, couples, family and group therapy</strong></td>
</tr>
<tr>
<td><strong>Employee assistance programs (EAP)</strong></td>
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</tbody>
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<table>
<thead>
<tr>
<th><strong>Compeer Lancaster</strong></th>
<th><strong>630 Janet Ave.</strong></th>
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<tbody>
<tr>
<td><strong>Friendship matching between volunteers and an adult who is in mental health recovery</strong></td>
<td><strong>Suite B-107</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Lancaster, PA 17601</strong></td>
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<table>
<thead>
<tr>
<th><strong>Concepts</strong></th>
<th><strong>790 New Holland Ave.</strong></th>
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<tbody>
<tr>
<td><strong>Partial hospitalization</strong></td>
<td><strong>Lancaster, PA 17602</strong></td>
</tr>
<tr>
<td><strong>Outpatient care</strong></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Crisis Intervention Unit, Division of Lancaster County MH/MR/EI</strong></th>
<th><strong>1120 Frances Ave.</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>Suicide</strong></td>
<td><strong>Lancaster, PA 17601</strong></td>
</tr>
<tr>
<td><strong>Acute emotional</strong></td>
<td><strong>(717) 394-2631</strong></td>
</tr>
<tr>
<td><strong>Drug &amp; alcohol programs</strong></td>
<td></td>
</tr>
<tr>
<td><strong>MH Case Management</strong></td>
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<table>
<thead>
<tr>
<th><strong>Keystone Human Services of Lancaster</strong></th>
<th><strong>211 Granite Run Dr.</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>Adult Community Autism Program</strong></td>
<td><strong>Lancaster, PA 17601</strong></td>
</tr>
<tr>
<td><strong>Adult Day Services</strong></td>
<td></td>
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<tr>
<td><strong>Autism Services</strong></td>
<td></td>
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<tr>
<td><strong>Autism Waiver Program</strong></td>
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<tr>
<td><strong>Community Homes</strong></td>
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<tr>
<td><strong>Comprehensive Autism Evaluations</strong></td>
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<tr>
<td><strong>Education and Training in Autism Spectrum Disorders</strong></td>
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<tr>
<td><strong>Independent Living Services</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Individual and Family Support Services</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Individualized Day Support</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Individualized Home Supports</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Nursing Services</strong></td>
<td></td>
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<tr>
<td><strong>Psychological Evaluation Services</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Family Preservation and Reunification Services</strong></td>
<td></td>
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<tr>
<td><strong>Head Start Program</strong></td>
<td></td>
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<tr>
<td><strong>High Fidelity Wraparound</strong></td>
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<tr>
<td><strong>Psychiatric Rehabilitation Program for Children</strong></td>
<td></td>
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<tr>
<td><strong>Psychological Evaluation Services</strong></td>
<td></td>
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<tr>
<td><strong>Service Dogs</strong></td>
<td></td>
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<tr>
<td><strong>Student Assistance Program</strong></td>
<td></td>
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<tr>
<td><strong>Summer Therapeutic Activities Program</strong></td>
<td></td>
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<tr>
<td><strong>Therapeutic Foster Care</strong></td>
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<tr>
<td><strong>Adult Day Services</strong></td>
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<tr>
<td><strong>Community Training Homes</strong></td>
<td></td>
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<tr>
<td><strong>Nursing Services</strong></td>
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<tr>
<td>Services</td>
<td>Address</td>
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<td>-------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Respite Services, Service Dogs, Summer Therapeutic Activities Program,</td>
<td>144 Orlan Rd. New Holland, PA 17557</td>
</tr>
<tr>
<td>Supported Employment, Supported Living, Assistive Technology Library,</td>
<td></td>
</tr>
<tr>
<td>Behavioral Aid Program, Behavioral Health Rehabilitation Services (BHRS)</td>
<td></td>
</tr>
<tr>
<td>Birth to Three, Comprehensive Autism Evaluations, Early Head Start</td>
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<tr>
<td>Program, Early Intervention Evaluations, Early Intervention, Family</td>
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<tr>
<td>Based Mental Health Services, Structured Residential Services,</td>
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<tr>
<td>Supported Employment</td>
<td></td>
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<tr>
<td>Supportive Living, Behavioral Aid Program, Behavioral Health Rehabilitation Services (BHRS), Community Residential Rehabilitation Services, Early Intervention Evaluations, Family Based Mental Health Services, High Fidelity Wraparound, Intensive Case Management, Lifesharing Thru Family Living, Mobile Psychiatric Rehabilitation, Peer Support, Psychiatric Rehabilitation Program, Psychiatric Rehabilitation Program for Children, Specialized Community Residences</td>
<td>315 West James St. Suite 106 Lancaster, PA 17603</td>
</tr>
<tr>
<td>Lighthouse Vocational Services</td>
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<tr>
<td>• Development services &amp; supported employment</td>
<td></td>
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<tr>
<td>The Lodge Supported Housing Program</td>
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<tr>
<td>• Supported housing program</td>
<td></td>
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<tr>
<td>Mental Health America of Lancaster County</td>
<td></td>
</tr>
<tr>
<td>• Information and Referral, Client Family Advocacy, Community Education</td>
<td></td>
</tr>
<tr>
<td>• Peer Education, Alpha Clubs (social clubs for persons who have or are</td>
<td></td>
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<tr>
<td>receiving professional help with mental/emotional problems.)</td>
<td></td>
</tr>
<tr>
<td>• Compeer Lancaster (see Compeer Lancaster in list for complete services)</td>
<td></td>
</tr>
<tr>
<td>• Public Policy advocacy, Lending Library of books, brochures and videos</td>
<td></td>
</tr>
<tr>
<td>NAMI Pennsylvania, Lancaster County Affiliate</td>
<td></td>
</tr>
<tr>
<td>• Family-to-Family (Free, 12-week course for family)</td>
<td>790 New Holland Ave. Lancaster, PA 17602</td>
</tr>
<tr>
<td><strong>Caregivers of individuals with severe mental illnesses</strong></td>
<td></td>
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<td>----------------------------------------------------------</td>
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<tr>
<td>• In Our Own Voice (Trained consumer speakers share compelling personal stories about living with mental illness and achieving recovery)</td>
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</tr>
<tr>
<td>• NAMI Connection (Weekly recovery support group for people living with mental illness)</td>
<td></td>
</tr>
<tr>
<td>• Peer-to-Peer (experiential learning program for people with any serious mental illness)</td>
<td></td>
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<tr>
<td>• NAMIWalks</td>
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<table>
<thead>
<tr>
<th><strong>No Longer Alone Ministries</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• R.E.A.C.H. (Mobile Psychiatric Rehabilitation Program)</td>
</tr>
<tr>
<td>• WRAP (Wellness Recovery Action Planning) self-management recovery system</td>
</tr>
<tr>
<td>• Family counseling</td>
</tr>
<tr>
<td>• Family Support Group</td>
</tr>
<tr>
<td>• Paths to Discovery - Consumer Support Group</td>
</tr>
<tr>
<td>• WRAP (Wellness Recovery Action Planning) Reunion Support Group</td>
</tr>
<tr>
<td>• Speaker's Bureau (speakers are available to speak to churches or civic groups on a variety of subjects related to mental illness)</td>
</tr>
<tr>
<td>• Circles of Care (teaches individuals and families in congregations how to be supportive of persons struggling with mental illness.)</td>
</tr>
<tr>
<td>• Lending Library</td>
</tr>
<tr>
<td><strong>630 Janet Ave.</strong></td>
</tr>
<tr>
<td><strong>Lancaster, PA 17601</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Nuestra Clinica</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Outpatient mental health services</td>
</tr>
<tr>
<td>• Bilingual team of licensed therapists, a psychiatrist, counselors and case managers.</td>
</tr>
<tr>
<td><strong>545 Pershing Ave</strong></td>
</tr>
<tr>
<td><strong>Lancaster, PA 17602</strong></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Nuestra Clinica Residencial</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Drug and alcohol non-hospital residential for latino men</td>
</tr>
<tr>
<td>• Professional Bilingual Services</td>
</tr>
<tr>
<td>• Residential Drug and Alcohol Treatment</td>
</tr>
<tr>
<td>• Dual Diagnosis</td>
</tr>
<tr>
<td>• Counseling</td>
</tr>
<tr>
<td>• Referrals for Vocation and Employment Development</td>
</tr>
<tr>
<td>• Transportation to and from Nuestra Clinica</td>
</tr>
<tr>
<td>• Family Therapy</td>
</tr>
<tr>
<td>• Physical Examinations and Follow Up</td>
</tr>
<tr>
<td>• Evaluations</td>
</tr>
<tr>
<td>• Aftercare Planning</td>
</tr>
<tr>
<td><strong>50 East New St.</strong></td>
</tr>
<tr>
<td><strong>Lancaster, PA 17602</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Parent Involved Network</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Parents involved network support group</td>
</tr>
<tr>
<td>• Advocacy group</td>
</tr>
<tr>
<td>• Group is for parents of children with emotional disturbances</td>
</tr>
<tr>
<td><strong>Mary Price</strong></td>
</tr>
<tr>
<td><strong>717-397-6728</strong></td>
</tr>
<tr>
<td><strong>717-397-7461</strong></td>
</tr>
<tr>
<td><strong><a href="mailto:woodseyldy@hotmail.com">woodseyldy@hotmail.com</a></strong></td>
</tr>
<tr>
<td>Philhaven Behavioral Healthcare</td>
</tr>
<tr>
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<tr>
<td>• Inpatient services</td>
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<tr>
<td>• Diversion program</td>
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<tr>
<td>• Assertive community treatment</td>
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<tr>
<td>• Day hospital/intensive outpatient</td>
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<tr>
<td>• Partners for process</td>
</tr>
<tr>
<td>• Lancaster Area Psychiatric Services (LAPS)</td>
</tr>
<tr>
<td>• Supported housing</td>
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<tr>
<td>• Peer support</td>
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<tr>
<td>• Outpatient services</td>
</tr>
<tr>
<td>• Residential</td>
</tr>
<tr>
<td>• Inpatient services</td>
</tr>
<tr>
<td>• Day hospital/intensive outpatient</td>
</tr>
<tr>
<td>• Family based mental health</td>
</tr>
<tr>
<td>• Behavioral rehabilitation services</td>
</tr>
<tr>
<td>• After school</td>
</tr>
<tr>
<td>• Summer Therapeutic Activities Program (STAP)</td>
</tr>
<tr>
<td>• Outpatient services</td>
</tr>
<tr>
<td>• Autism spectrum disorders</td>
</tr>
<tr>
<td>• Intellectual disorders</td>
</tr>
<tr>
<td>• Autism life care model</td>
</tr>
<tr>
<td>• Autism resource center</td>
</tr>
<tr>
<td>• The Voice of Autism</td>
</tr>
<tr>
<td>• Services at CADD</td>
</tr>
<tr>
<td>• Family Relationship services</td>
</tr>
<tr>
<td>• Emotionally Focused Therapy (EFT) Training</td>
</tr>
<tr>
<td>• Relationship Therapy</td>
</tr>
<tr>
<td>• Psychological testing</td>
</tr>
<tr>
<td>• Employee Assistance Program</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Special Offenders Services</th>
<th>Outpatient - Child &amp; Adolescent</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Operating under Lancaster County Adult Probation &amp; Parole Services and serving the Lancaster County Court of Common Pleas</td>
<td>50 North Duke St.</td>
</tr>
<tr>
<td>• Mental health and mental retardation program for probation/parole clients</td>
<td>P. O. Box 83480</td>
</tr>
<tr>
<td>• Each client works toward the goals of maintaining functional stability and achieving his/her maximum potential in life, given individual capacity and ability</td>
<td>Lancaster, PA 17608-3480</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tempo Clubhouse</th>
<th>Youth Advocate Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Job training/placement</td>
<td>• Advocacy</td>
</tr>
<tr>
<td></td>
<td>• Behavioral Health</td>
</tr>
<tr>
<td></td>
<td>• Community Reintegration Initiative (CRI)</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Counseling Services in Lancaster County</th>
<th>721 North Duke St.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lancaster, PA 17602</td>
</tr>
<tr>
<td>Name</td>
<td>Address</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>----------------------------------------------</td>
</tr>
<tr>
<td><strong>Abundant Living Ministries</strong></td>
<td>541 W 28th Division Hwy. Lititz, PA 17543</td>
</tr>
<tr>
<td>• Counseling</td>
<td></td>
</tr>
<tr>
<td>• Seminars/Classes</td>
<td></td>
</tr>
<tr>
<td>• Guest Speaking</td>
<td></td>
</tr>
<tr>
<td>• Seasonal Events</td>
<td></td>
</tr>
<tr>
<td>• Bi-Monthly Newsletter</td>
<td></td>
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<tr>
<td>• Family Style Bulletin Inserts</td>
<td></td>
</tr>
<tr>
<td><strong>Breath of Life Ministries</strong></td>
<td>1865 Lincoln Hwy. East Lancaster, PA 17602</td>
</tr>
<tr>
<td>• Ephrata and Lancaster prayer counseling ministries</td>
<td></td>
</tr>
<tr>
<td><strong>Catholic Charities</strong></td>
<td>47 S. Mulberry St. Lancaster, PA 17603</td>
</tr>
<tr>
<td>• Counseling Services</td>
<td></td>
</tr>
<tr>
<td>• Latino Division</td>
<td>417 Poplar St. Lancaster, PA 17603</td>
</tr>
<tr>
<td>• Advocacy</td>
<td></td>
</tr>
<tr>
<td>• Adoption</td>
<td>925 North Duke Street Lancaster, PA 17602</td>
</tr>
<tr>
<td>• Family Strengthening</td>
<td></td>
</tr>
<tr>
<td>• Housing Counseling</td>
<td></td>
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<tr>
<td>• Day treatment program</td>
<td></td>
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<tr>
<td>• In-home intensive program</td>
<td></td>
</tr>
<tr>
<td><strong>COBYS Family Services</strong></td>
<td>1417 Oregon Rd. Leola, PA 17540</td>
</tr>
<tr>
<td>• Individual and family counseling</td>
<td></td>
</tr>
<tr>
<td>• Adoption</td>
<td></td>
</tr>
<tr>
<td>• Family life education</td>
<td></td>
</tr>
<tr>
<td><strong>Family Resource and Counseling Centers</strong></td>
<td>1615 Stony Battery Rd. Lancaster, PA 17601</td>
</tr>
<tr>
<td>• Counseling</td>
<td>835 Houston Run Dr. Suite 230 Gap, PA 17527</td>
</tr>
<tr>
<td>• Understanding anger group</td>
<td></td>
</tr>
<tr>
<td><strong>Jewish Family Services</strong></td>
<td>1120 Columbia Ave. Lancaster, PA 17603</td>
</tr>
<tr>
<td>• Counseling - JFS licensed clinical social workers are here to help you navigate life’s ups and downs.</td>
<td></td>
</tr>
<tr>
<td>• Senior Services - Programs designed to help older adults maintain their dignity and independence.</td>
<td></td>
</tr>
<tr>
<td>• AdoptionLinks - Open your arms to welcome a deserving child into your family through adoption or foster care.</td>
<td></td>
</tr>
<tr>
<td>• Mynd Works - Specialized services for autism spectrum disorders, sensory/auditory processing, learning and emotional challenges</td>
<td></td>
</tr>
<tr>
<td><strong>Lancaster Clinical Counseling Associates</strong></td>
<td>131 East Orange St. Lancaster, PA 17602</td>
</tr>
<tr>
<td>• Outpatient treatment</td>
<td></td>
</tr>
<tr>
<td>• Drug &amp; alcohol evaluations, consultations, and referrals for both public and private sectors for individuals, groups, families, couples, women, sexual abuse, deaf and mentally retarded</td>
<td></td>
</tr>
<tr>
<td><strong>New Hope Community Life Ministry</strong></td>
<td>248-A Maple Ave. Quarryville, PA 17566</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>-----------------------------------------</td>
</tr>
<tr>
<td>- Counseling</td>
<td></td>
</tr>
<tr>
<td>- Support groups</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Pennsylvania Counseling Services</strong></th>
<th>40 Pearl St. Lancaster, PA 17603</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Outpatient services (mental health treatment-all ages, psychiatric treatment-all ages, specialized treatments, drug and alcohol treatment, and assessment services)</td>
<td>302 W. Orange St. Lancaster, PA 17603</td>
</tr>
<tr>
<td>- Children’s/Adolescents’ services (student assistance services, truancy prevention, behavioral health rehabilitation services, family based services, multisystemic therapy services, outpatient services, school based outpatient services, and psychological and psychiatric services)</td>
<td></td>
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<tr>
<td>- School-based services</td>
<td></td>
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</tbody>
</table>

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<thead>
<tr>
<th><strong>Pressley Ridge</strong></th>
<th>630 Janet Ave. Lancaster, PA 17601</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Deb’s House (a crisis and respite service for children and youth who reside in Lancaster County.)</td>
<td>516 North Duke St. Lancaster, PA 17601</td>
</tr>
<tr>
<td>- Outpatient Treatment Program</td>
<td></td>
</tr>
<tr>
<td>- Adoption Services</td>
<td></td>
</tr>
<tr>
<td>- Teen Pregnancy and Parenting Program</td>
<td>Focus On Children</td>
</tr>
<tr>
<td>- The Pathways Program (program dedicated to provide specialized treatment, intensive supervision and aftercare services to adolescents who commit sexual offenses and their families.)</td>
<td>Lancaster Health Campus (2nd Floor/Wellness Library)</td>
</tr>
<tr>
<td>- Counseling</td>
<td>2100 Harrisburg Pk. Lancaster, PA 17601</td>
</tr>
<tr>
<td>- Evaluation</td>
<td></td>
</tr>
<tr>
<td>- Employee assistance program</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Samaritan Counseling Center</strong></th>
<th>1803 Oregon Pk. Lancaster, PA 17601</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Counseling (individual, child, relationship, family, organization/workplace, faith community)</td>
<td></td>
</tr>
<tr>
<td>- Walking Together (Support for survivors of family violence)</td>
<td></td>
</tr>
<tr>
<td>- Family Violence Resources Network (FVRN)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>SHARE</strong></th>
<th>Share Late Loss Support Group, Share Early Loss Support Group, PALS (Pregnancy After Loss) Support Group meet at: Lancaster General Health Campus 2100 Harrisburg Pk. Lancaster, PA 17601</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Pregnancy and infant loss support groups</td>
<td>Grandparents support groups meet at: PATHways Center for Grief and Loss 4075 Old Harrisburg Pk. Mount Joy, PA 17552</td>
</tr>
</tbody>
</table>

| **Upward Call Counseling Services Inc. (Also operated as Shepherd’s Touch Campus)** | |
|---------------------------------------------------------------------------------||
## Shepherd’s Touch Counseling Ministry
- Counseling Services

<table>
<thead>
<tr>
<th>(Main Office)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2394 New Holland Pk.</td>
</tr>
<tr>
<td>Lancaster, PA 17601</td>
</tr>
</tbody>
</table>

**Cornerstone Campus**
- 6 West Newport Rd.
- Lititz, PA 17543

**Upward Call Campus**
- 441 South Kinzer Ave.
- New Holland, PA 17557

## YWCA Sexual Assault Prevention & Counseling Center
- Counseling services
- Empowerment center

| 110 North Lime St. |
| Lancaster, PA 17602 |

## Hospital Services in Lancaster County

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lancaster General Health</strong></td>
<td>555 N. Duke St.</td>
</tr>
<tr>
<td>Inpatient</td>
<td>Lancaster, PA 17602</td>
</tr>
<tr>
<td>Consult psych services to residential beds at Lancaster Rehabilitation Hospital and Women and Babies Hospital</td>
<td></td>
</tr>
<tr>
<td>Psych emergency service pod</td>
<td></td>
</tr>
<tr>
<td>Medical management</td>
<td></td>
</tr>
<tr>
<td>Counseling at women outpatient locations</td>
<td></td>
</tr>
<tr>
<td>Psychiatry contracts with the three major colleges in Lancaster County</td>
<td></td>
</tr>
<tr>
<td>Genetic testing at outpatient centers</td>
<td></td>
</tr>
<tr>
<td>Alzheimer’s and Memory Care Program – diagnostic and treatment program for individuals with suspected Alzheimer's or other dementia.</td>
<td></td>
</tr>
<tr>
<td>Neurological Day Treatment Program – provide a psychotherapeutic/psychoeducational group for patients and their families are dissipating in the Neurological Day Treatment Program</td>
<td></td>
</tr>
<tr>
<td>Neuropsychological Assessment Program - evaluation and treatment of cognitive/behavioral manifestations of brain disorders.</td>
<td></td>
</tr>
<tr>
<td>Bariatric Surgery Program - provide psychological treatment services to individuals with obesity and those individuals pre- post weight loss surgery to assist in maintaining dietary compliance and proper eating</td>
<td></td>
</tr>
<tr>
<td>Mindfulness Based Stress Reduction - for individuals with chronic insomnia</td>
<td></td>
</tr>
</tbody>
</table>

| **Ephrata Community Hospital** | 169 Martin Ave. |
| Inpatient | Ephrata, PA 17522 |
| Psychiatric evaluation | |
- Psychiatric nursing assessment
- Activities assessment/intervention
- Individual/group therapy
- Medication management
- Family support/education
- Social services/assessment/intervention
- Ephrata Community Hospital Medical and Surgical Staff consults when needed

<table>
<thead>
<tr>
<th>Lancaster Regional Medical Center</th>
<th>250 College Ave.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>Lancaster, PA 17603</td>
</tr>
<tr>
<td>Group therapy</td>
<td></td>
</tr>
<tr>
<td>Family therapy</td>
<td></td>
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<tr>
<td>Individual therapy</td>
<td></td>
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<tr>
<td>Discharge planning</td>
<td></td>
</tr>
<tr>
<td>24 hour care accessibility</td>
<td></td>
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<tr>
<td>Alcohol and drug abuse</td>
<td></td>
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<tr>
<td>Anxiety</td>
<td></td>
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<tr>
<td>Bi-polar disorder</td>
<td></td>
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<tr>
<td>Depression</td>
<td></td>
</tr>
<tr>
<td>Impulsive behaviors</td>
<td></td>
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<tr>
<td>Mood or thought disturbances</td>
<td></td>
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<tr>
<td>Panic disorders</td>
<td></td>
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<tr>
<td>Suicidal thoughts</td>
<td></td>
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<tr>
<td>Schizophrenia</td>
<td></td>
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<table>
<thead>
<tr>
<th>Heart of Lancaster Regional Medical Center</th>
<th>1500 Highlands Dr.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutritional services – weight loss and diet counseling</td>
<td>Lititz, PA 17543</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Support Groups Supported by Mental Health America in Lancaster County</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name</strong></td>
</tr>
<tr>
<td><strong>Bipolar Support Group</strong></td>
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<td></td>
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<tr>
<td><strong>Bipolar Mutual Help Support Group (Educational group)</strong></td>
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<td></td>
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<tr>
<td><strong>Bipolar Support Group</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>DAWN (Depression Awareness and Women’s Needs)</strong></td>
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</tr>
<tr>
<td><strong>Anxiety and Panic Support Group</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>Obsessive Compulsive Disorder</strong></td>
</tr>
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<td></td>
</tr>
</tbody>
</table>
| Support Group | 630 Janet Ave.  
Lancaster, PA 17601 |
|----------------|----------------------------------|
| Men's Depression Support Group | Community Service Building  
630 Janet Ave.  
Lancaster, PA 17601 |
| Sibling Support Group- Arc of Lancaster | Arc of Lancaster  
Community Service Building  
630 Janet Ave.  
Lancaster, PA 17601 |
| **Alcohol & Drug Abuse Services** | |
| **Al-Anon/Alateen** | **Lancaster Red Rose Al-Anon**  
Bethany Presbyterian Church  
25 N West End Ave.  
Lancaster, PA 17603 |
| • Al-Anon (support group for women, men, and children who have been impacted by alcoholism. By learning to help themselves, they can help their loved ones.) | **Serenity Seekers Al-Anon**  
Lancaster YWCA  
110 North Lime St.  
Lancaster, PA 17602 |
| • Alateen (Support group meeting for younger members who have an alcoholic parent or close relative or friend.) | **Al-Anon 11th Step**  
St. Thomas Episcopal Church  
301 St. Thomas Rd.  
Lancaster, PA 17601 |
| | **Lancaster Central Monday Night Al-Anon**  
Otterbien Methodist Church  
20 East Clay St.  
Lancaster, PA 17602 |
| | **Circle AFG**  
Emmanel Lutheran Church  
540 W. Walnut St.  
Lancaster, PA 17603 |
| **Alcoholics Anonymous of Lancaster County** | **Lancaster Central Service Office of Alcoholics Anonymous**  
630 Janet Ave.  
Lancaster, Pa 17601 |
| | Meetings Listed on:  
http://www.lancasteraa.org/index.php |
| **Drug & Alcohol Commission, Lancaster County** | 150 N. Queen St.  
Lancaster, PA 17602 |
| • Treatment, prevention & education | **The Gate House for Men**  
• Counseling  
649 East Main St.  
Lititz, PA 17543 |
<table>
<thead>
<tr>
<th>Service Description</th>
<th>Locations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structured living and on-going treatment of addiction</td>
<td></td>
</tr>
<tr>
<td><strong>The Gate House for Women</strong></td>
<td>649 East Main St.</td>
</tr>
<tr>
<td>Counseling</td>
<td>Lititz, PA 17543</td>
</tr>
<tr>
<td>Structured living</td>
<td></td>
</tr>
<tr>
<td>On-going treatment of addiction</td>
<td></td>
</tr>
<tr>
<td><strong>Lancaster Hogar CREA</strong></td>
<td>26 Green St.</td>
</tr>
<tr>
<td>Residential re-education program</td>
<td>Lancaster, PA 17602</td>
</tr>
<tr>
<td><strong>Manos House</strong></td>
<td>1290 Prospect Rd.</td>
</tr>
<tr>
<td>Long term residential, drug and alcohol, treatment program for young men</td>
<td>Columbia, PA 17512</td>
</tr>
<tr>
<td>Counseling and supportive services</td>
<td></td>
</tr>
<tr>
<td><strong>Salvation Army</strong></td>
<td>131 South Queen St.</td>
</tr>
<tr>
<td>Drug &amp; alcohol rehabilitation program</td>
<td>Lancaster, PA 17603</td>
</tr>
<tr>
<td>For men only</td>
<td></td>
</tr>
<tr>
<td><strong>Vantage</strong></td>
<td>208 East King St.</td>
</tr>
<tr>
<td>Adult Residential Services</td>
<td>Lancaster, PA 17602</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td></td>
</tr>
<tr>
<td>Adolescent Services (teens seeking recovery from chemical dependency)</td>
<td></td>
</tr>
<tr>
<td>Mental Health Residential Services</td>
<td></td>
</tr>
<tr>
<td>Prison Services</td>
<td></td>
</tr>
<tr>
<td>Transitional and Permanent Housing</td>
<td></td>
</tr>
<tr>
<td><strong>Water Street Mission</strong></td>
<td>210 South Prince St.</td>
</tr>
<tr>
<td>Supportive Services Program (For men who are unable to sustain independent living situations due to severely diminished mental capacities, we offer supportive housing under the care of a qualified social worker, until permanent housing can be found.)</td>
<td>Lancaster, PA 17603</td>
</tr>
<tr>
<td>LifeRecovery Program (For men whose homelessness involves addiction or other similar issues, we offer the tools to end the cycle and move out of homelessness.)</td>
<td></td>
</tr>
<tr>
<td>Women’s program (discussion groups, counseling)</td>
<td></td>
</tr>
<tr>
<td><strong>White Deer Run of Lancaster</strong></td>
<td>53 North West End Ave.</td>
</tr>
<tr>
<td>Inpatient Non-Hospital Detoxification</td>
<td>Lancaster, PA 17603</td>
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<tr>
<td>Inpatient Residential CD Rehabilitation</td>
<td></td>
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<tr>
<td>Partial Hospitalization</td>
<td></td>
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<tr>
<td>Halfway House</td>
<td></td>
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<tr>
<td>Intensive Outpatient Program</td>
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<tr>
<td>Outpatient Individual, Group and Family Therapy</td>
<td></td>
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<tr>
<td>CD Assessment</td>
<td></td>
</tr>
<tr>
<td>Adults and adolescents</td>
<td></td>
</tr>
<tr>
<td><strong>Addiction Recovery Systems (ARS) of Lancaster</strong></td>
<td>2192 Embassy Dr.</td>
</tr>
<tr>
<td>Outpatient addiction treatment and recovery</td>
<td>Lancaster, PA 17603</td>
</tr>
<tr>
<td>Programs</td>
<td>Address</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Elsie Shenk Outpatient Center</strong></td>
<td>211 E. Mifflin St.</td>
</tr>
<tr>
<td>- Outpatient substance abuse services to women, pregnant and parenting</td>
<td>Lancaster, PA 17602</td>
</tr>
<tr>
<td>women and their children</td>
<td></td>
</tr>
<tr>
<td>- Evaluations</td>
<td></td>
</tr>
<tr>
<td>- Intensive outpatient</td>
<td></td>
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<tr>
<td>- Individual and group counseling</td>
<td></td>
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<tr>
<td>- Relapse prevention</td>
<td></td>
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<tr>
<td>- Problem gambling treatment</td>
<td></td>
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<tr>
<td>- Education</td>
<td></td>
</tr>
<tr>
<td>- Prevention services</td>
<td></td>
</tr>
<tr>
<td>- Psychiatric, psychological, and vocational referrals</td>
<td></td>
</tr>
<tr>
<td><strong>HSA Counseling, Inc</strong></td>
<td>321 North Market St.</td>
</tr>
<tr>
<td>- Outpatient, intensive outpatient and partial hospitalization for</td>
<td>Lancaster, PA 17603</td>
</tr>
<tr>
<td>individuals, couples, adolescents, adults</td>
<td>107 East Locust St.</td>
</tr>
<tr>
<td>- Specialized groups, women's groups, sexual abuse/survivor, family</td>
<td>Ephrata, PA 17522</td>
</tr>
<tr>
<td>intervention, chronic relapse program</td>
<td></td>
</tr>
<tr>
<td>- EAP and consultation services problem</td>
<td></td>
</tr>
<tr>
<td>- Gambling treatment</td>
<td></td>
</tr>
<tr>
<td><strong>Lancaster Clinical Counseling Associates</strong></td>
<td>131 East Orange St.</td>
</tr>
<tr>
<td>- Drug &amp; alcohol evaluations, consultations, and referrals for both</td>
<td>Lancaster, PA 17602</td>
</tr>
<tr>
<td>public and private sectors for individuals, groups, families,</td>
<td></td>
</tr>
<tr>
<td>couples, women, sexual abuse, deaf and mentally retarded</td>
<td></td>
</tr>
<tr>
<td><strong>Lancaster Freedom Center, Inc</strong></td>
<td>436 North Lime St.</td>
</tr>
<tr>
<td>- Intensive (22 weeks) outpatient program for substance abuse and</td>
<td>Lancaster, PA 17602</td>
</tr>
<tr>
<td>10-week family and spouse program</td>
<td></td>
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<tr>
<td>- Drug and alcohol evaluations</td>
<td></td>
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<tr>
<td>- Early recovery groups</td>
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<tr>
<td>- Outpatient counseling for individuals, couples, and family</td>
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<tr>
<td>- Adolescent, individual, and group evaluations</td>
<td></td>
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<tr>
<td>- Adolescent track for partial hospital and IOP</td>
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<tr>
<td>- Suboxone maintenance program</td>
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<td>- EAP services</td>
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<tr>
<td>- Problem gambling treatment</td>
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<tr>
<td><strong>Naaman Center</strong></td>
<td>4600 East Harrisburg Pk.</td>
</tr>
<tr>
<td>- Christian-oriented, 12-step approach</td>
<td>Elizabethtown, PA 17022</td>
</tr>
<tr>
<td>- Intensive outpatient programs for alcohol and drug addictions</td>
<td>835 Houston Run Dr.</td>
</tr>
<tr>
<td>- Family programs</td>
<td>Suite 230</td>
</tr>
<tr>
<td>- Alcohol and drug evaluations</td>
<td>Gap, PA 17527</td>
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<tr>
<td>- Interventions</td>
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<tr>
<td>- Outpatient and individual counseling</td>
<td>39 West Vine St.</td>
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<tr>
<td>Service Provided</td>
<td>Address</td>
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<td>------------------------------------------------------</td>
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<tr>
<td>Problem gambling treatment</td>
<td>Lancaster, PA 17603</td>
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<tr>
<td></td>
<td>248-A Maple Ave. Quarryville, PA 17566</td>
</tr>
<tr>
<td>Nuestra Clinica- SACA Drug &amp; Alcohol Program</td>
<td>545 Pershing Ave. Lancaster, PA 17602</td>
</tr>
<tr>
<td>- Triple diagnosis clinic: drug &amp; alcohol, mental health and HIV services</td>
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<tr>
<td>- Individual, family and group therapy</td>
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<tr>
<td>- Dual diagnosis</td>
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<tr>
<td>- Evaluations, consultations and referrals</td>
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<td>- HIV testing</td>
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<td>- Support groups.</td>
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<td>- Women's groups</td>
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<tr>
<td>- Adolescents</td>
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<td>- Problem gambling treatment</td>
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<td>- Mental health evaluations</td>
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<tr>
<td>- Treatment therapy outreach service</td>
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<tr>
<td>Pennsylvania Counseling Services</td>
<td>40 Pearl St. Lancaster, PA 17603</td>
</tr>
<tr>
<td>- Drug &amp; alcohol and mental health</td>
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<tr>
<td>- Sex offenders</td>
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<td>- Evaluations</td>
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<td>- Groups</td>
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<td>- Teen recovery group</td>
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<td>- Individual and family counseling</td>
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<tr>
<td>- Problem gambling treatment</td>
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<tr>
<td>T.W. Ponessa &amp; Associates Counseling Services, Inc</td>
<td>2141 Oregon Pk. Lancaster, PA 17601</td>
</tr>
<tr>
<td>- Outpatient counseling for families, couples, individuals, and adolescent</td>
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<tr>
<td>- DUI and drug and alcohol evaluations</td>
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<tr>
<td>- Act 122 (DUI) groups</td>
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<td>- Family intervention</td>
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<td>- Problem gambling treatment</td>
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<td>- Consultations</td>
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<td>- Referrals</td>
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<tr>
<td>Wellness Counseling Associates</td>
<td>439 North Duke St. Lancaster, PA 17602</td>
</tr>
<tr>
<td>- Outpatient substance abuse and behavioral health services for adolescents and adults</td>
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<tr>
<td>- Anger management, substance abuse assessments</td>
<td></td>
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<tr>
<td>- DUI evaluations</td>
<td></td>
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<tr>
<td>Addiction Recovery Systems of Lancaster (ARS)</td>
<td>2192 Embassy Dr. Lancaster, PA 17603</td>
</tr>
<tr>
<td>- Methadone maintenance</td>
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<tr>
<td>- Suboxone maintenance</td>
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<tr>
<td>- Long-term methadone or Suboxone detoxification</td>
<td></td>
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<tr>
<td>- Outpatient counseling services for adults</td>
<td></td>
</tr>
<tr>
<td>RASE in Lancaster</td>
<td>130 East Chestnut St. Lancaster, PA 17602</td>
</tr>
<tr>
<td>- RASE in Lancaster is RECOVERY-ADVOCACY-SERVICE-</td>
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<tr>
<td>EMPOWERMENT</td>
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<tr>
<td>• Provide recovery support services</td>
<td></td>
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<tr>
<td>• Recovery 101 groups</td>
<td></td>
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<tr>
<td>• Buprenorphine/Suboxone care coordination</td>
<td></td>
</tr>
<tr>
<td>• All day drop-in services.</td>
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</tr>
</tbody>
</table>

Source: United Way and Compass Mark, Inc.
On May 30, 2008 approximately 250 people participated in the Lancaster County Mental Health Summit: Creating a Vision for Our Preferred Future. Participants included mental healthcare and human services professionals, local government representatives, law enforcement, patient advocates, and consumers.

Using Appreciative Inquiry as a group process tool, participants in the summit were involved in five different activities that each produced feedback for the event’s planning committee. These activities included:

1. Paired Interviews
2. Sharing Stories
3. Energy Diagram
4. SOAR
5. Strategies, Gifts, Commitments and Requests

The products of these activities, which were recorded on flip chart paper by the participants themselves throughout the summit, are presented below. It is important to note that this document is, as faithfully as possible, a transcription of the feedback recorded on the participants’ flip chart pages. It may include misspelled words, partial thoughts/phrases, and unusual punctuation. In an effort to simplify this final report for the benefit of the planning committee, words/phrases/ideas that were duplicated by participants are sometimes listed only once, with a reference to the number of times they actually appeared.

The intent of this report is to provide the Summit planning committee, and subsequent groups that might form to address the needs expressed at the Summit, guidance for their work based on participants’ feedback. These are the voices of Lancaster as they express their vision of a preferred future for mental health in the community…

### Energy Diagram

Participants in the Summit began with paired interviews in which they asked each other questions about successful experiences with mental health services, personal and community values, and visions for a preferred future. After the interviews, they met in small groups of 6-8 people and shared the stories they heard their partners tell. From this sharing of stories, each table initially generated a brainstormed list of common and important themes/ideas they heard from each other. Next, they selected the “Top 3” themes/ideas that they felt provided them with the most energy, excitement, and sense of possibility.
These “Top 3” themes were posted on the wall, and participants were then asked to use three dot stickers to indicate which themes/ideas around the room they personally felt were most energizing and exciting, and were most likely to lead to their vision of a preferred future for mental health in Lancaster County.

The following is the list of “Top 3” themes, with an indication of how many dots each received

[NOTE: When items were clearly duplicative, such as “Education” and “Education” or “Collaboration” and “Collaboration/Teamwork,” they were combined. When items are related but not necessarily duplicative, they were clustered together. If it is not clear whether an item belonged in a particular category, it was left under “Miscellaneous.” No words or phrases were changed.]

**Education**
- Education 11
- Access to educational opportunities 7
- Education for families and communities 8
- Education and Training (Para professional networking) 5
- Public Awareness/Public Education 27
- Reduces stigma by increasing education 5
- Increase consumer awareness of resources and access to resources 2
- Education/Compassion (needs to increase) 3
- Training for “lay” people (churches, professional, mentors, agency service workers etc) 24
- Education/Sigma reductions 5
- Dissemination of info in community 2

**Collaboration**
- Collaboration/Teamwork/Partnerships 30
- Increased collaboration between systems/funding sources/and providers 10
- Collaboration between agencies and programs 5
- Integration /Collaboration of services continuity of care 4
- Collaboration (improved) between social services and faith community 4
- Collaborative services to create better networking for Para-professionals 4
- Partnering between the secular and spiritual resources 20

**Resources**
- Funding 10
- Increase resources/funding and accessibilities 7
- Creative and collaborative use of existing resources 9
- Funding for services/human service providers 7

**Access**
- Access 2
- Quicker access to more providers for adults and children 6
- Reduce waiting list for services 7
- The need for breaking down barriers 1
- Systemic collaboration for access of services for all 5
- Removing economical barriers to services 4
- Access to resource in response to a presented need rather than a diagnosis 27
Access to treatment/Affordable services 14

**Recovery**
- Reduce “gap” between receiving services and being self sufficient 9
- Early intervention 18
- Recovery recognized as the norm (value the person) 14
- Transition to life 3

**Miscellaneous**
- Development of housing options 21
- Development of MH court
- HIPPA 1
- Hope 2
- Pro-active approach to treatment 1
- Improved services for children and adolescents 10
- Listening to others, Meeting them where they are 2
- Relationship between good physical and mental health 9
- Dealing with trauma, violence and bullying 4
- Creativity and thinking outside the box 9
- Holistic Approach (body, mind, spirit) 6
- Change culture from independence/entitlement to interdependence/community 1
- Stable neighborhoods involved/connecting neighborhoods 4
- Openness to talk about MH 2
- Coordination of services-informed commo.
- Proactive leadership vision 7
- Advocacy-personal recovery and system change 2
- Service emphasize importance of personal relationship 3
- Peer mentoring community 4
- Eliminate stigma 4
- Challenging the system 1
- People are valuable 7
- Advocacy
- Support for clinically-based research to better demonstrate efficiency of services 4
- Resource/networking 1
- Employer/Employee Relationship 7
- Housing 17
- Central Referral source 5
- Non competitive collaboration/Holistic 2
- Non violent environment 10
- Parity in funding-rapid response and introduction of services 5
- Reduction of barriers 1
- Open more honest discussion on diversity 5
- Increase medical& dental training & services to this population including tobacco cessation 6
- Holistic vs. fragmented (partial) treatment 6
- Information sharing-universal intake form 21
- Respect for individual 3
- Public/private sector/Gov’t/community education
- Increased compassion 2
• Healing effect of positive communication
• Person focused
• Respect/hope/dignity
• Independence
• Holistic approach
• Choice
• Enthusiasm
• Quality/compassion/professionalism of staff
• Variety of services
• Innovation/outside the box thinking

SOAR (Strengths, Opportunities, Aspirations and Results)

Once the “Energy Diagram” of the group’s “Top 3” themes was complete, four members of the planning committee and the event facilitator selected four topics that seemed to emerge with the greatest amount of energy and interest. These topics were:

1. Collaboration
2. Education
3. Access
4. Recovery

Participants were encouraged to select one of these topics and join a new small group of 6-8 people. In this new group, they conducted a “SOAR” analysis on their topic, brainstorming lists of their topic’s Strengths, Opportunities for growth and improvement, Aspirations for the future, and Results that would indicate they were reaching their preferred future for mental health in the county.

The groups were then asked to identify the “Top 3” in each area of their SOAR analysis and post their new, complete lists on the wall. The following is a combined list of all of the groups’ “Top 3” Strengths, Opportunities, Aspirations and Results for their selected topic. [NOTE: When items were clearly duplicative they were combined. Otherwise, they were left alone in the order in which they appeared on their respective list. No words or phrases were changed.]

1. Collaboration

Strengths

Dedicated providers
Dedicated faith-based community
Faith-based organizations
Focus on the individual
Talent/skill level
Good directories
Personal contacts
Mainstream resources MTG (LINC)
Case manager networking
Breadth of services
Dedication to client needs
Resources (rich foundation)
Collaboration between MHMR & CJ
Collaboration between MHMR & OFFICES OF AGING
Collaboration between Schools & PD & CJ
Willingness to collaborate
Coordination among varies to agencies/providers/services
Access to share database

Opportunities

Resource/database coordinator
Utilize technology
Coordinate grant writing
Tuition reimbursement
Enhance relationships with legis.
Internships to develop talent pool
Agency awareness
Collab. To advocate
New partnerships
Client-centered services
Service integration
MH and legal system integration/collab.
Information about agencies & resources available to all service providers employees through computerization and mixed media & Consumers
Collaboration between faith based and government agencies
Training and coordination between agencies
Access to collaborative ability to network across systems
Shift from program/system/agency to person centered plan
Continuity over life span

Aspirations

Person be treated holistically/reduce stigma
  Removal of stigma
Collaboration between mental health/faith based community for resources/holistic care
Different types of funding sources
Collaboration of funding
Less duplication of resources
Recruitment of quality emp.
Gov’t funded coordinator
Legislative involvement, support
More permanent housing
Behavioral health services integration into primary care
Equal access to services
XXXX Coordination of resources
Openness of community re: MHMR issues and how to get help
More dialogue between agencies
Develop stable community neighborhoods
Nonviolence/safety/security
Common information/database

**Results**

CST would measure results
Advocate for MH parity
Improved networking
Less turnover of employees
Track number of psych evals and police contacts
Meeting basic needs (3 HOT + A COT) by having smaller/non-existent waiting lists
Passage of C.O.L.A. for MHMR workers
Number of people without housing decreases
    More affordable housing
Collab. to create education
Equal access to services
Well-educated community about available services
Lower homeless population
Fewer MHMR in prison
More cross training
Decrease recidivism
Reported increased sense of well being
Speed of access to services

2. **Education**

**Strengths**

MHALC
LINC
Universities
Available agencies
Higher education facilities and faculty
Existing community networks
Discussion of parity
Diverse core group of concerned people
Start of public awareness
Church
Multi Agencies
Technology/communication
Opportunities

Media
Central data base
“411” promotion of info
Multi faceted education, libraries online etc
Marketing resources
Collaboration and integration between higher education and community providers
Encompass a greater understanding of wellness and wholeness
Legislative advoc./awareness
Promotion of holistic approach
Broad dissemination of info.
Service/Social Org.
Info systems: schools, research library, technology, Linc
Training volunteers (holistic)

Aspirations

MH Single Point for info
Educated $ decision makers
More resources
Recognizing mental health issues touch everyone
Incorporating mental health education into curriculum for related professionals
Community events focuses on education
Stigma reduced/real face on MH
Fair & accurate & balanced media attention
Prevention /early intervention
Cross Training
Community education “who do I call?”
Advocates

Results

Establishment of central data base
More positive media coverage
Winfo earlier access to MH services
Fewer MH ER visits
Less stigma/access to resources and utilization of resources
Change in behavior ie: less violence more compliance, less incarceration in schools/community,
Increase healthy life style
Evidence or participatory approach i.e.: education
Passing Parity legislation
Acceptance of diverse approach/holistic
Cultural acceptance
Side by side services-consumer surveys outcomes research
Training programs
LINC, expanded and more readily available
3. Access

**Strengths**

Quality/Compassionate staff
Variety of services
Innovative thinking
Energy towards networking
Abundance of resources here
More people invested in MH issues
Passionate, committed active, visionaries and participants
Variety of service that work well together now
Early intervention children (now in school) as a start
Talk/communication within systems has allowed for creation of new programs
Good mix of service providers more options (faith based, public and private services)
Access to different levels of support
Partnerships
Commitment to action
Concept of choc
LINC book-ID providers #, Type of services
Diversity of services
Thinking outside the box/creativity
Evidence based services

**Opportunities**

Bring services to schools
Access regardless of ability to pay
Mental health resources center
Unified communication/database
Education to de-stigmatize (provide curriculum)
More mental health maintenance programs
Transportation
Education
Build services (transport etc)
Centralized intake system so people don’t have to tell their story multiple times
Education for educators (schools & others churches, police etc)
Promote & use LINC more
Evaluate faster to access services
Decrease wait time for benefits
Housing
Achieve goals/outcomes-action
Early intervention
Stream line access
Better management of current resources
Mental health ER
Housing respite
Aspirations

Eliminate fear/stigma allowing everyone access to services (including family support people)
Services based on need rather than diagnosis alone
Creation of MH resource center
Consolidated consent process
Coordinated database
Empower rather than enable
Access services from any point/participant in the systems (community)
No gaps in services (system-self sufficient)
Immediate/quicker access to services
Access to services based n need, not diagnosis
Really listening to what people need
A certain quality of life exists for all Lancaster Counties
Triage within 24 hrs.
Culturally sensitive & appropriate (bilingual)
Mobile services
Equal access
Quality services
For under/uninsured and in school to also include learning differences.
Database that stores and shares medical/MH info with collaborating agencies
People in need of services receive them in a timely manner
MH parity legislation advocacy

Results

Measure individual client success
Track # served
Track by type of service
All of this to be done through the resource center
Establish qualitative and quantitative baseline
Reduce wait time 50%, increase access by 50%
Standardize curriculum for mental health in schools
Fewer inappropriate incarcerations, hospital stays etc
Appropriate treatment for all individuals needs (transport etc)
No barriers! Insurance Funding, wait list, transport. Language
Education/common knowledge of resources
Utilize centralized in take idea to track timely receipt of services
Survey of community members to address needs and perceptions.
Decrease # of people waiting & wait time
Creation of non ER triage
Increase consumer satisfaction
100% access
Seamless transition-community of care
Measurable increase in evidence based TX. Programs
Clinical outcomes
Interagency surveys
Length of time from intake to treatment
4. Recovery

**Strengths**

Support Groups/Family Support  
Education  
Counselors, crisis intervention, 911, NAMI  
Recovery task force ([www.lancasterrecovery.com](http://www.lancasterrecovery.com))  
Trainings  
Crisis @ Police Station  
Recovery training for professional  
Community Education  
Step-down housing  
Support Group  
Recovery task force  
Compeer (relational program)

**Opportunities**

Workshops, seminars, to educate family members, consumers or victims of suicide attempts or Witnesses of such attempts  
Proper diagnosis & Meds  
Generalized education for all age groups  
Education (Universities, Docs, Consumers, Individuals, Community)  
Empowering  
Publicity  
Team Approach: Faith based, community, employers  
Training in education  
Consumer run services and options  
Certified peer support  
Need PR (arts & including stories of recovery)  
Choice (spiritual vs. scientific, mentoring Rel.)

**Aspirations**

Independence  
Replace stigma with compassion  
Die naturally not suicide  
Stigma free world  
Holistic/Spirituality  
Collaboration  
Medical model incorporated into recovery  
Every organization is recovery oriented/collaborative  
Individuals-self functioning vs. “warehousing”  
Transitional housing  
Value and honor our uniqueness and diff.  
Putting no labels on people  
Networking (cultural competency)
Results

Improve quality of life with independence
Increased compassion/sensitivity for mental illnesses
Saving lives and families
Measure quality of life instead of symptoms
Individuality
People understand “people can do recovery.”
Less people institutionalized/homeless/needing services
More consumer choices/involvement
Accountability brings success!
Satisfaction survey
Self evaluation of service provider
Utilization outcomes by provider

Strategies

Next, participants were asked in their small groups to select one opportunity from those posted on the wall, and develop a strategy that would move the community toward accomplishing that opportunity. These are the strategies developed by the small groups:

1. Collaboration

Collaboration with higher education resources:
- Create a forum to brainstorm/set goals for opportunities
- Notify institutions: colleges, universities, nursing schools, trade schools, etc.
- Involve mental health providers/community agencies

2. Education

Collaboration in education and training:
- Create a web site where all agencies list training and educational opportunities.
- Offer key training on a regular basis.
- Write a grant to request to fund the hiring of the a person to oversee coordination and the hiring of webmaster.
- Begin a web site that would list training opportunities for providers, educational opportunities for providers and public.
- Contact all social services, government and faith-based agencies to make them aware of web site and how to list their training there as well.
- Some educational features can be web-based for the public (webinars).
- Have a schedule of training education by date, topic, etc.
- Assess effectiveness by number of hits on web site as well as number of organizations listing events.
- Give certificates/CEUs where possible.
3. Access

Opportunity: Ability to access mental health services based on need, not on diagnosis
- Centralized intake/point of information
- Well-trained staff trained in assessments and with excellent knowledge of resources
- Independent of current system

Opportunity: Improve/expand LINC and expand its ability
- Call for additional resources (collect)
- Update current listings
- Print new book
- Place copies in
  - Churches
  - Stores (all types)
  - Doctors’ offices
  - MH/MR, CSG, etc. (mental health agencies)
  - Bus, train stations
  - ER’s
  - CAO
  - Domestic relations office
- Mass mailing?

Opportunity: MH Gateway—“411” info “Database” (like a Mental Health “Easy” button)
- Create a work group
- What agencies/resources exist in county (listing and support)
- Research if there are similar ideas in other places
- Determine what is covered! (Public, prvt, therapists, orgs, housing)
- Updating of info
- Liability issues
- Format—Internet, print, phone, in-person
- Forms—intake tracking
- Promotion of service
- Funding—resources

4. Recovery

Opportunity: Community awareness.
- Elect a leader to go out in the community to educate families, consumers, police officers, authority figures, etc. about mental illness and personal experiences. [Deb Gontarz, P.O. Box 7993, Lancaster, PA 17604, (717) 285-7534]

Opportunity: Broad dissemination of information
- To expand the reach of the Recovery Task Force:
  - PSA’s
  - Video documentary
  - Personal stories
  - Legislative subcommittee

Opportunity: Database for sharing info (to empower clients)
- Find/develop product/software (minimal cost)
- Promote to all agencies
Gifts, Commitments and Requests

Finally, participants were encouraged to write a personal Gift, Commitment, or Request that would help them, as an individual in the community, move toward their vision of a preferred future for mental health in Lancaster County. [NOTE: This activity was shortened due to time constraints.]

- **Commitment:** I will work to assure that the Philhaven (sp?) organization seeks to improve our collaboration with the other providers in Lancaster County. –Phil Hess (sp?)
- **I will contact psychological assoc. – mental health assoc. and see how to collaborate better together.** –Beverly Stark, Lane City & Co. Medical Society
- **Request:** PALCO need mental health providers. –Beverly Stark, Lane City & Co. Medical Society
- **Gift/Resource:** Medical society has list of members/non-members—all licensed physicians for the county. We will provide local provider to patients who request them. –Beverly Stark, Lane City & Co. Medical Society
- **Energy and Optimism**
  - **Gift:** Consider funding a project initiative. –Sharon Greelish Cody
  - **Commitment:** Help facilitate a group project/initiative by providing staff support, meeting space, etc. –Sharon Greelish Cody
  - **Good at procuring ifno. Experience in education. Speak at elementary school—students and/or teachers.** –Linda Gutshall
  - **Request:** Identify what “Good” Mental Health means to general population and ways to “build it and make stronger” in particular-personal/family disaster preparedness. –Brenda Pittman
  - **Request:** Create an ongoing working group of MH organization leadership to do problem solving and program development. –Brenda Pittman
  - **Gift:** volunteer with an organization that raises awareness about trauma, abuse and healing. –Greta Kernicky (digs_giraffes@hotmail.com)
  - **Commitment:** starting a trauma/mental health library. –Greta Kernicky (digs_giraffes@hotmail.com)
  - **Request:** How to establish a non-profit organization (business/legal aspects) for a trauma/mental health library. –Greta Kernicky (digs_giraffes@hotmail.com)
  - **We need more info for couples of whom are in the mental health program (how non related people) support one another?** --Shellie Berge
  - **Organizational ability. Experience in education. Willingness to do public speaking/training. Volunteer experience (I’m retired!)** --Marcia Snyderr
• Look into provider group.
• More cooperation/collab.
• Put more energy into having contact with other providers (collab.)
• Easier access to information
• I am concerned about needs of mentally ill offenders returning to community, and I would be happy to work on this. –Lance Canturier (sp?)
• Forensics was not mentioned much. – Lance Canturier (sp?)
## Addendum Z: LGH Community Health and Wellness Support Groups

<table>
<thead>
<tr>
<th>Service Line</th>
<th>Support Groups</th>
</tr>
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</table>
| Cardiology     | • Healthy Hearts Support Group  
|                | • Pulmonary Hypertension Support Group                                         |
| Musculoskeletal| • Multiple Sclerosis Support Group  
|                | • Fibromyalgia Awareness and Education Group                                  |
| Oncology       | • Breast Cancer Groups  
|                | • Survivorship: Life After Cancer  
|                | • Journaling for Healing  
|                | • Leukemia, Lymphoma Support Group  
|                | • The Iris Connection Support Group for Women with Breast Cancer  
|                | • Us Too! Prostate Cancer Community Network  
|                | • Us Too! Women Only for wives of Prostate Cancer Survivors  
|                | • Women’s Cancer Courage of Lancaster, PA is a support program run by and for women with metastatic cancers |
| Women’s Health | • Bedrest Buddies Support Group  
|                | • Pregnancy After Loss Support Group  
|                | • Postpartum Depression Support  
|                | • Share PALs (pregnancy after loss) Support Group  
|                | • Share Early Loss Support Group for those lives who are touched by the death of a baby (less than 16 weeks)  
|                | • Share Late Loss Support Group for those who are touched by the death of a baby (16 weeks or later)  
|                | • Type 1 Diabetes Women’s Community Group                                       |
| Neuroscience   | • Brain Tumor Community Support Group  
|                | • Epilepsy Community Group  
|                | • Memory Loss Support Group  
|                | • Stroke Survivorship Support Group  
|                | • Neuropathy Resource Group                                                     |
| Others         | • Amputee Support Team  
|                | • Autism Support Group in Spanish  
|                | • Surgical Weight Loss Support Group  
|                | • Lupus support Group  
|                | • Adult Type 2 Diabetes Support Group  
|                | • American Lung Association Better Breathers Club is a support groups for people with chronic lung disease and their love ones |
Check Out These Websites for More Helpful Information
www.postpartum.net
www.MedEdPPD.org
www.nmha.org/go/postpartum
www.DepressionStealsTheRealYou.org
www.ppdsupportpage.com

My Healthy Beginnings Social Worker’s Name and Number:
______________________________________________________________________
______________________________________________________________________

My Healthy Beginnings Nurse’s Name and Number:
______________________________________________________________________
______________________________________________________________________
What is Depression During & After Pregnancy?

Any big life change can cause stress. Pregnancy and having a new baby are major changes. Many pregnant and new mothers experience symptoms of depression or anxiety during this period of their lives. This can also be called perinatal or postpartum depression. This can occur during pregnancy or up to one year after you have your baby.

Common Symptoms of Depression
- Crying a lot
- Not enjoying things you used to enjoy
- Being tired all the time
- Feeling alone
- Staying to yourself
- Sleeping too much or too little
- Eating too much or too little
- Feeling hopeless and/or helpless
- Trouble making decisions
- Trouble paying attention
- Using drugs or alcohol to feel better
- Feeling more irritable
- Feeling disconnected from life
- Feeling more angry
- Feeling overwhelmed or immobilized
- Feeling guilty
- Thoughts of wanting to harm yourself or someone else

What Can I Do If I Am Feeling Depressed?
Speak to your doctor or midwife about how you are feeling. Your social worker can assist you in scheduling an appointment for mental health treatment.

You could also try some of the following activities:
- Watch a funny movie
- Take a warm bath with bubbles
- Listen to music that makes you feel good
- Exercise or take a walk
- Journal or write a letter to a friend
- Try a deep breathing exercise
- Call a friend who is positive and helpful
- Do creative activities with your hands
- Smell something that makes you feel good
- Pet your animal
- Hug your child
- Enjoy your favorite food
- Enjoy your favorite non alcoholic drink

How Can I Feel Better?
It may be helpful for you to create your own personal plan of activities you can do if you are feeling depressed. They include activities from the “ways I can handle my feelings” list or you can think of your own.

If you are at risk for having thoughts to harm yourself, you should include your therapist’s phone number or the phone number of a close friend or family member.

Things I Can Do To Feel Better:

1. ______________________________________________
   ______________________________________________

2. ______________________________________________
   ______________________________________________

3. ______________________________________________
   ______________________________________________

4. ______________________________________________
   ______________________________________________

5. ______________________________________________
   ______________________________________________

If you are feeling like hurting yourself or someone else, go to the emergency room or call Crisis Intervention at 717-394-2631 24 hours a day/7 days a week.

If you need help with your children during this emergency, ask your social worker for resources.