Community Health Needs Assessment (CHNA)

FY 2026-2028 Implementation Strategy

Robert Packer Hospital

One Guthrie Square, Sayre, PA 18840

FY 2026

General Information

Contact Person: Joseph Sawyer, President

Date of Written Plan: June 6th, 2025

Date Written Plan was Adopted by Organization's Authorized Governing Body: July 17th , 2025

Date Written Plan was Required to be Adopted: June 30th, 2025

Authorizing Governing Body that Adopted Written Plan: Robert Packer Hospital Board of Directors

Name and EIN of Hospital Organization Operating Hospital facility: Robert Packer Hospital 24-0795463

Address of Hospital Organization: One Guthrie Square, Sayre, PA 18840

I. Purpose of Implementation Strategy

This Implementation Strategy has been prepared to comply with federal tax law requirements set forth in Internal Revenue Code section 501(r) requiring hospital facilities owned and operated by an organization described in Code section 501(c)(3) to conduct a community health needs assessment at least once every three years and adopt an implementation strategy annually to meet the community health needs identified through the community health needs assessment. This Implementation Strategy is intended to satisfy each of the applicable requirements set forth in proposed regulations released April 2013.

II. List of Community Health Needs Identified in Written Report

- Mental Health Problems: increasing services for mental & behavioral health
- Aging Problems: increasing preventive health / chronic disease management services
- Diabetes: increasing preventive health / chronic disease management services
- Cancers: increasing cancer prevention screenings
- Heart Disease and Stroke: increasing preventive health / chronic disease management services

III. Health needs planned to be addressed by facility

- Heart Disease & Stroke
- Mental Health Problems

IV. Health needs facility does not plan to address

- Aging Problems
- Diabetes
- Cancers

FY2026-2028 Robert Packer Hospital Implementation Strategy

Priority: Chronic Disease Management
Focus Area: Heart Disease & Stroke
Goals: Reduce Readmission Rates
Objective: Reduce readmission rates for (Congestive Heart Failure) CHF and (Chronic Obstructive Pulmonary Disease) COPD patients

	Intervention Description	Population Description	Effect Measure	Evaluation of Intervention	Program Frequency
Intervention #1	Discharge Interventions Ensure patients are discharged on the correct medications and determine any barriers to compliance (medication reconciliation).	Patients admitted to the hospital and treated for COPD or CHF exacerbations.	Increase in % of patients discharged with successful medication reconciliation.	Determine success in reducing COPD and CHF readmissions by comparing readmission rates from current fiscal year to previous fiscal year utilizing reports in the electronic medical record EPIC Report.	Quarterly

Intervention #2	Discharge Interventions Utilize Care Pathways.	Patients admitted to the hospital and treated for COPD or CHF exacerbations.	Increase in % of patients enrolled in a care pathway.	Determine success in reducing COPD and CHF readmissions by comparing readmission rates from current fiscal year to previous fiscal year utilizing reports in the electronic medical record EPIC Report.	Quarterly
Intervention #3	Patients contacted within 2 business days post discharge by office nurse or care coordinator.	Patients admitted to the hospital and treated for COPD or CHF exacerbations.	Increased % of patients contacted within 2 business days post discharge by office nurse or care coordinator.	Determine success in reducing COPD and CHF readmissions by comparing readmission rates from current fiscal year to previous fiscal year utilizing reports in the electronic medical record EPIC Report.	Quarterly

Intervention #4	Increased follow-up/transitional care management (TCM) appts. scheduled for COPD/CHF patients within 7 days of discharge from the hospital.	Patients admitted to the hospital and treated for COPD or CHF exacerbations.	Increased % of patients scheduled for follow-up/TCM appointments within 7 days of discharge from the hospital.	Determine success in reducing COPD and CHF readmissions by comparing readmission rates from current fiscal year to previous fiscal year utilizing reports in the electronic medical record EPIC Report.	Quarterly

FY2026-2028 Robert Packer Hospital Implementation Strategy-

Priority: Increasing Services for Mental/Behavioral Health
Focus Area: Mental Health Problems
Goals: Increase Support for Patients with Mental Health Needs
Objective: Increase Access to Guthrie Mental Health Resources

	Intervention Description	Population Description	Effect Measure	Evaluation of Intervention	Program Frequency
Intervention #1	Increase the number of mental health medical providers (including telepsychiatry).	Inpatient: Providers in inpatient setting Outpatient: Providers in ambulatory setting	Increase in total number of mental health medical providers.	Determine success with an increased number of mental health medical providers by comparing the total number to the previous fiscal year.	Quarterly
Intervention #2	Partner with local and regional mental health resources.	Bradford County	Number of partnerships.	Relationships with local and regional mental health resources.	Quarterly

Intervention #3	Increase number of therapy providers, Master of Social Work (MSWs), and Licensed Clinical Social Worker (LCSWs).	Inpatient: Providers in inpatient setting Outpatient: Providers in ambulatory setting	Increase in total number of therapy providers, MSWs, & LCSWs	Determine success with an increased number of mental health medical providers by comparing the total number to the previous fiscal year.	Quarterly
Intervention #4	Increase number of inpatients served who require mental health services.	Inpatients requiring mental health services.	Increase in inpatients receiving mental health care.	Determine success with an increased number of inpatients requiring mental health services cared for.	Quarterly