Aligning Forces for Quality | Improving Health & Health Care in Communities Across South Central Pennsylvania


Aligning4Health: Summer 2014
Message from Aligning Forces for Quality – South Central PA’s Project Director

Ralph Waldo Emerson once wrote, “Do not go where the path may lead, go instead where there is no path and leave a trail.” To me, that is what the Aligning Forces for Quality project has done in south central Pennsylvania.

When we began in early 2007, we didn’t have a charted course to follow or a well-marked roadmap that outlined all of the hills, valleys, skyline, turns or bumps. Instead, we had to trust each other and remain transparent about our goals and challenges, celebrating accomplishments with each step forward.

It is not enough for patients to visit the doctor when they are sick. We must help them become prepared, empowered partners in their own care.

Where has the trail taken us? To start, we came to grips with the fact that the current health care system cannot operate as it has in the past if we want to achieve the Triple Aim – better care, better health and lower costs. It is not enough for patients to visit the doctor when they are sick. We must help them become prepared, empowered partners in their own care.

This is especially important for our patients, as many of them are facing our country’s biggest epidemic: chronic disease. Diabetes, heart disease and other conditions require a lifelong commitment to healthy living every single day. But, through our work we’ve also uncovered that in many instances patients face barriers (language, transportation, time and cost), which can keep them from achieving their goals and staying healthy. To directly help patients achieve health goals, we have developed programs such as I Can! Challenge and It’s Your Health... Take Charge! that improve patient engagement and health literacy gaps.

Additionally, we have helped patients by improving processes within providers of care; integrating community resources into health care teams; developing a strong hub of care through the Patient-Centered Medical Home Collaborative; and testing new models of paying for health care.

Continuing to reflect on our progress, I feel that one of our greatest accomplishments is the relationships we have built with patients, not just as advisors, but as true partners. Was it a move into uncharted territory and at times uncomfortable for everyone? Yes! However, some of the highest peaks take a bit of effort, and the success and impact of our Patient Partner Program has proven that partnering with patients is exactly what the system needs.

Today, 37 practices across central Pennsylvania open their doors and invite patients to go behind the scenes to offer honest, insightful feedback about what gets in the way of accessing the best care they can. Our Patient Partners help us to give warmer greetings, develop materials that will better resonate with patients, and remind us on a daily basis that our improvement work, together, is significant.

One of our greatest accomplishments is the relationships we have built with patients, not just as advisors, but as true partners.

While our efforts thus far have focused on building stronger relationships with primary care physicians, we could not be more excited for the adventure that lies ahead with the launch of the 2014-2015 LIFT Collaborative that incorporates specialty care practices with the goal of building a robust patient-centered medical neighborhood to achieve better population health.

You, a member of AF4Q-SCPA, are the reason I am most proud. As we look to the future with continued strategic intent, may we not lose our fearless attitudes and commitment to overcoming challenges together, leaving a visible trail for others to follow.

Christine Amy
Project Director of Aligning Forces for Quality – South Central PA (AF4Q-SCPA)
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Patient Partner Program Is Ready to Hit the Neighborhood Streets

195,000. That’s the number of patients positively impacted by AF4Q-SCPA’s booming Patient Partner Program.

In April of 2011, AF4Q-SCPA launched its Patient Partner Program to put patients’ voices at the forefront of the health care system. A first-of-its-kind initiative in the commonwealth, the program began with only eight patients and seven practices. Today, it is soaring to new heights; receiving national recognition; and collecting feedback from more than 60 Patient Partners in 37 practices.

While the progress is striking, Kathy Hutcheson, consumer engagement coordinator for AF4Q-SCPA and staff lead for the Patient Partner Program noted that ongoing direction and guidance from patients is vital to keep the program on-mission and growing successfully.

“It can be very scary for patients to give direct feedback and advice to their doctors because there is still a deeply held belief in our culture that the doctor and nurse are the experts,” she said.

To address these concerns and expedite the success of integrating patient feedback, AF4Q-SCPA launched the Patient Partner Steering Committee in March of 2013 with six veteran Patient Partners who are guiding their peers to bigger outcomes.

“They can take the view of the patient and their understanding of the practice and combine them to move the program forward,” said Kathy.

This help will be crucial as AF4Q-SCPA plans to grow the Patient Partner Program to 56 practices and more than 100 patients during the next six months.

In addition to helping new Patient Partners better integrate with their practice, the Patient Partner Steering Committee is working to solicit feedback about the program from both patients and providers by creating and implementing survey tools to gauge satisfaction. The group also has encouraged practice teams to provide agendas and discussion materials in advance of meetings to help Patient Partners be prepared to meaningfully contribute at quality improvement meetings and collaborative sessions.

“Members of the Patient Partner Steering Committee also recommend topics and speakers for Partner meetings,” said Kathy. And, by sprinkling themselves among the new Patient Partners at meetings, members can help answer questions and provide advice.

What’s next on the horizon for Patient Partners and the Steering Committee? Taking to the streets of the neighborhood – the Patient-Centered Medical Neighborhood – which includes specialty-care practices, pediatric practices and community agencies.

Why Patient Partners Work: A Practice Perspective

PCMH. PCMN. QIT. WHAT? With a rapidly changing health care system, Joyce Knisely, clinical nurse coordinator for WellSpan Health’s Stony Brook Family Medicine, admits that even medical professionals struggle to stay updated on new acronyms and measures.

“We wanted to achieve Level 3 Patient-Centered Medical Home Certification, but when we first started it was very overwhelming,” she said.

They had heard great reviews about the Patient Partner Program but still questioned how a Patient Partner could help.

Now, two years into the program and achieving top-rated results, Joyce said, “It’s a whole different way of looking at the medical field. Instead of saying, ‘what can we do for patients,’ we now think, ‘how can we work together?’”

One example includes changing the way urine samples are collected. The practice previously gave patients a bag and container at the front desk to collect a sample in the waiting room’s public restroom. While the restroom is used by many patients, Stony Brook’s Patient Partner alerted the team that offering more privacy and the use of the restroom in the back of the office would be preferred.

She admits that they were surprised since so many patients use the restroom, but “you start thinking like a patient and putting yourself in the patient’s shoes.”

Their Patient Partner self-selected another surprising role – cheerleader. “He pumps us up!” said Joyce. “He appreciates all of the work, and tells the team that they’re really making a difference.”

Together, the relationship with AF4Q and the Patient Partner is propelling Stony Brook Family Medicine forward. The practice has made significant strides in ensuring patients are seen within seven days of discharge from the hospital. In fiscal year 2013, 83 percent of patients achieved this measure, and as of May 2014 they earned a 91 percent success rate.
January 19, 2009 began like any other normal day for Doris King. She got up, drove to work and spent her morning investing in her students as a teaching assistant for youth with learning disabilities at Southeastern School District.

“It came out of nowhere,” she said. “I had been at work that day and turned yellow. In a matter of a few hours I ended up in the emergency room and they knew it was cancer.”

While this news would be devastating for anyone, for Doris, this wasn’t the first time she’d heard it. In 1989, as a young mother of two, she was first diagnosed with Hodgkin’s lymphoma.

This time around, however, she said, “I am definitely driving this bus. Cancer is only a passenger.”

It’s with this same gusto that Doris serves as a Patient Partner at WellSpan Health’s East York Family Medicine. While her new diagnosis, follicular lymphoma, is thought to be incurable by many, she has seen how being actively engaged in her health care has made a difference in keeping the disease at bay. She sees being involved in the Patient Partner Program as an opportunity to influence others to become actively engaged.

To date, her practice has incorporated new processes to improve efficiency, such as reorganizing supplies and office layout. Additionally, the team is working to improve measures among its patients with diabetes. Doris also is anxious for the opportunity to improve health education surrounding medications by having each label indicate why the patient should take it.

“We are pioneers,” she said. “We are all going to benefit from the work of Patient Partners and health care will improve.”

After all, why would you choose to be a passenger and not drive the bus?

How One Mother is Changing Health Care for Our Youth

Imagine having two children with health complications, two back surgeries and a hip replacement all before age 40.

It might leave you feeling a little exhausted or avoiding one more visit to the doctor’s office? Not Patient Partner Gwen Babcock! She’s ready and excited to spend time influencing health care for future generations.

“While I unfortunately had to repeat much of my health care journey, I could see things improving,” she said with a smile.

Gwen, a member of the Patient Partner Steering Committee, is one of the new Patient Partners at WellSpan Health’s Springdale Pediatric Medicine. She joined the program to understand health care from “the other side of the fence,” and positively shape her children’s perspective on medicine.

A few focus areas for pediatric practices include tracking asthma, obesity, BMI and vaccination metrics to gauge improvement and areas of concern.

“I’m watching them,” she said. “They aren’t just checking off numbers. They are really trying to do this and make a concerted effort. Before, I thought the team just came in, assessed my children and decided whether they had a virus or bacterial infection. They do so much more.”

While just a few months into the program, Gwen is already making great strides with her practice to implement friendlier greetings when patients arrive and much more.

“I’m putting my heart and soul into this because I want to see the benefits of the work that we are doing,” she said. “I think more parents should become involved because we are really just going to pump the line for better health care in the future. If we start today, imagine where our children will take our ideas 20 years from now.”
When AF4Q-SCPA began the Patient-Centered Medical Home (PCMH) Collaborative in April of 2010, known then as the Planned Care Collaborative, no one could predict the incredible transformation that would take place across York and Adams Counties.

On launch day, there were just eight practices staffed with compassionate, risk-taking leaders with a will to make a difference.

The Collaborative first focused on improving quality care by helping practices reduce waste; boosting morale; and implementing problem-solving techniques for patients with diabetes. But, as the health care landscape evolved, the Collaborative grew too. After completing their first year, the Enduring Learning Forum (ELF) was developed because first-year practices expressed the need for additional support on their journeys toward PCMH certification. In ELF, they also worked to reduce potentially avoidable hospitalizations and trips to the emergency department, as well as improve diabetes process and outcome composites and some preventative outcomes like depression and colorectal screenings.

While the work is sometimes challenging, practices report that the rewards outweigh the extra effort. Nowhere was this more evident than at the Year 4 celebration dinner on April 24, 2014.

“We’ve been doing the Collaborative for four years,” said Karen Jones, MD, FACP, vice president, chief medical officer for WellSpan Medical Group at WellSpan Health. “Thirty-seven practices have participated since the beginning...that’s 195,000 people we care for across York and Adams Counties!”

The emotions in the room oscillated from cheers of celebration to overwhelming inspiration, as attendees were treated to firsthand accounts from participating practices. In total, the Collaborative has improved the lives of more than 18,800 patients with diabetes, one of the leading chronic diseases facing our community and the country. It has also worked to gather and share impactful insights from 60 patients through its Patient Partner Program.

“They [Patient Partners] have allowed us to have a window into our patients,” said Whitney W. Almquist, business manager for White Rose Family Practice and Year 4 participant. Another leader noted that “they saw things we never see because we’re there every day.”

And, it’s working. Preventable diabetic admissions per 1,000 diabetic patients fell by 8.1 percent from February 2013 to January 2014, as compared to the same time period the prior year. Additionally, Collaborative participants prevented 18 cases of invasive pneumococcal disease.

Next on the horizon for AF4Q-SCPA, Collaborative graduates and 10 new specialty practices are working to achieve the Institute for Healthcare Improvement’s Triple Aim: improving population health; reducing costs; and improving patient experience through its new initiative, Learning and Innovating for Transformation (LIFT), a medical neighborhood collaboration.

Practices in Carlisle and Ephrata, Pa., also will launch a new PCMH Collaborative beginning in July of 2014.
Year 4 Bright Spot: White Rose Family Practice

What Are You Missing?

White Rose Family Practice in York, Pa., is no stranger to the world of health care innovation. The practice earned Level 3 PCMH certification from the National Committee for Quality Assurance in July of 2010 and again in July of 2013. But, as an independent practice, the team saw joining AF4Q-SCPA’s PCMH Collaborative as a great avenue for staying abreast of industry changes.

“Sometimes, you just don’t know what you don't know,” said Whitney W. Almquist, business manager for White Rose. “The tyranny of the urgent is what gets our attention, but this holds us accountable and offers us the opportunity to rub shoulders and exchange best practices.”

Peeking Inside the Closet

“I think there is always hesitation when you let people inside to see how you run things,” said Whitney as she explained how adding Patient Partners was like opening up the practice’s closets. “I think we didn’t initially see how they could fit in and help us, but now we wholeheartedly do.”

She points to Patient Partners for their success in identifying needed improvements for doctor-patient communication, educational materials on the website and brochure, as well as updates to the practice’s phone system. “I recorded the voice on the prescription refill for the phone system about 10 years ago. What is needed now is totally different – it was new technology then,” she said. “It really made me aware of how they use the phone system and how important it is to be quick and to the point.”

Outcomes with Impact

High blood pressure is the leading diagnosis among White Rose’s baby boomer population. For years, the practice felt stalled between 62-68 percent of patients with controlled high blood pressure (at less than 140/90). Today, they’ve changed their processes and reached 70 percent controlled.

New It’s Your Health…Take Charge! Program Turns Education into Action

Since its inception, AF4Q-SCPA has remained committed to keeping patients at the center of health care teams. To make care even more personal, AF4Q-SCPA launched It’s Your Health…Take Charge! (IYHTC) in the winter of 2013 with the guidance of its own Patient Partners.

“We asked Patient Partners, ‘If you attended a class about engaging in your health, what kind of topics do you think would be important to cover?’” said Kathy Hutcheson, consumer engagement coordinator for AF4Q-SCPA. “Then, we collected their direct input to create the series.”

Five areas rose to the forefront and became the IYHTC topics:

1. Create a Partnership for Your Health outlines all of the members of a health care team and how patients play a role in connecting, for example, physical therapists to primary care physicians.
2. Quality Healthcare: How to Find It & How to Get It assists patients in knowing how to identify if they are getting the right care for the right value.
3. The ABC’s of Health Insurance helps participants understand health insurance coverage, specific needs and responsibilities.
4. What to Do When You Need Care helps patients decide if the emergency department, urgent care center or primary care physician would be best suited for various medical situations.
5. Understanding Your Medications: Why It Matters addresses the issue that 50 percent of adults do not take medications as prescribed and works to increase safety and understanding.

“Instead of overwhelming patients with information, we keep the classes short and simple, and end the program by helping each participant outline two action steps that they can easily remember and do,” she said. Bring IYHTC to your organization by e-mailing Kathy at khutcheson4@wellspan.org.
Regional High Utilizer Team Takes Care Beyond

Picture a patient who suffers from hypertension, hypothyroidism, sleep apnea, Crohn's disease and has a history of blood clots.

He doesn’t come home to crisp, white sheets or even have enough food to calm his growling stomach. Instead, he spends many evenings alone in his 7-by-12 foot room, tossing and twisting anxious thoughts. On evenings when his fears prove too great, he calls 9-1-1 and the emergency department becomes his refuge.

While this is one man's story, these circumstances are far too common. Known as “high utilizers,” these patients have been diagnosed with a medical illness, but for many other reasons use a higher rate of medical services than would be expected. In fact, five percent of the population consumes approximately 49 percent of health care costs.

Launched in 2013, AF4Q-SCPA’s High Utilizer Learning Collaborative brings together PinnacleHealth, WellSpan Health, Lancaster General Health, Neighborhood Health Centers of the Lehigh Valley and Crozer-Keystone Health to uncover trending issues faced among high utilizers and provide the tools needed to deliver quality, efficient care.

By combining each system’s data, the team painted a more accurate regional picture and uncovered that their patients’ issues go far beyond medical diagnoses. Ninety percent of patients suffered from financial issues, 62 percent reported transportation difficulties and 61 percent noted food insecurity.

“We have to view our patients differently, not just looking at the diagnosis and treatment, but what support services and resources they need,” said Samantha Obeck, quality improvement coordinator for AF4Q-SCPA. “For example, patients cannot focus on their health if they are challenged with food or housing insecurities or require behavioral health support.”

A busy year, the group of pioneers achieved success. They launched the program with funding from two foundations; designed a health worker curriculum; and solidified core concepts of a high utilizer program to serve as a guide for others.

Q&A with High Utilizer Collaborative Leader John Wood, MD, FAAFP

About Dr. John Wood

Dr. Wood is Chairman of Family and Community Medicine at Lancaster General Health. He also serves as a family physician at Downtown Family Medicine in Lancaster’s urban center and works to improve care for high utilizer patients as Medical Director for Lancaster General Health’s Care Connections program.

What is Care Connections?

Care Connections was built to meet the needs of high utilizer patients in an interdisciplinary format. We have everyone on the team from nurses, physicians and case managers to social workers, paramedics and EMTs. Our secret sauce is our care navigator who helps patients navigate through what can feel like a maze of care.

Our patients have three or more medical problems plus behavioral health issues, and have been admitted to the hospital multiple times in the past year.

Why did you want to join AF4Q’s High Utilizer Collaborative?

There were a lot of different reasons for joining the Collaborative. First, we needed a professional network to really learn how to innovate together. We also needed to make sure we were marching to the same measures and outcomes to prove these models are working. It’s a great, safe place to network, where we can succeed together and fail together as we work towards clinical transformation. The Collaborative also has afforded us a unified voice to lobby and affect policymaking.

Are there any quantifiable results from Care Connections?

We’ve shown a 60 percent decrease in inpatient hospital stays, and a 55 percent decrease in emergency room stays. All of our patients with diabetes have gotten better and have better blood pressure control. We’re also marching along with our payers, as a small segment of our patients shows 19 percent cost savings.

What’s next on your list to accomplish with the Collaborative?

Care Connections is scaling to meet the number of patients. By July of 2016, we’re aiming for 400 patients.
New Collaborative Shines Light on Leaders at Federally Qualified Health Centers (FQHCs)

If you peeked through the doors of any FQHC, you’d find employees giving tirelessly of themselves to support many of our most vulnerable community members. They invest their time, expertise and compassionate spirits to ensure everyone has access to care. AF4Q-SCPA's FQHC Learning Collaborative ensures that these leaders have someone investing in them, too.

Launched in 2013, the Collaborative brings together Family First Health, Hamilton Health, Keystone Health, Southeast Lancaster Health and Welsh Mountain to help clinical and quality improvement staff become stronger leaders while improving processes around Pap tests and diabetes.

Each center selected a peer coach, or lead representative for that center, to receive one-on-one peer coaching support from experts in leadership, including Ann Fischer, consultant and educator at The Wharton School of the University of Pennsylvania and Edward O’Neil, MPA, PhD.

“So frequently, physicians and nurses assume leadership roles without support in transitioning from clinical expert to a leader within an organization. They may wonder which strategies will help them become effective leaders and how to use data to drive changes with their centers,” explained Samantha Obeck, quality improvement coordinator for AF4Q-SCPA. “Through the Collaborative, they now have one-on-one mentors who explain the purpose of leadership goals and work with them to develop action plans.”

The other key components to the FQHC Collaborative are understanding how to unpack data, effectively presenting it to others and working towards continuous improvement. While every center has its own nuances, the group is united through collaboration and invigorated to work together for better outcomes.

“Practice Spotlight: Family First Health

Every day, 33 women in the United States hear the chilling words, “you have cervical cancer.”

These women are mothers, daughters, aunts and grandmothers to families who need their leadership and love, but find themselves battling a disease that in many cases could have been prevented or detected before the cancer invaded.

In addition to measuring diabetic indicators, ensuring timely Pap tests is a key focus of AF4Q-SCPA's Federally Qualified Health Center Collaborative. Pap tests can find cervical pre-cancer before it progresses into cancer, saving the lives of women every day. This is especially true for minority women, as research indicates that African-American women are about 20 percent more likely to develop cervical cancer and almost twice as likely to die from the disease compared with non-Hispanic white women.¹

Jenny Englerth, CEO, Family First Health in York and participant in the Collaborative is determined to stamp out this trend by ensuring timely preventative screening and increasing human papillomavirus (HPV) vaccinations.

“If we combine both of these efforts, we really have every reason to believe that we can end cervical cancer for the future,” she said.

By concentrating efforts on Pap test screenings, the center uncovered barriers that women in their community faced and worked to reduce them with creative solutions. Family First Health improved its measures by nearly 10 percent and continues to incorporate patient feedback into its preventative care.

Jenny noted the Collaborative’s focus on developing leaders and change agents as integral to helping her team create this and other positive outcomes.

“Especially in the community health center world, we give a lot to people, but we aren’t always the best care takers of ourselves,” she said. “Having the new tools and ability to lead change and invigorate people to take on new change initiatives – it’s a big deal.”

While business professionals may be well aware of leadership development strategies, health care professionals aren’t always greeted with the same access. The peer coach on Jenny’s team even commented having a leadership coach is like nothing she’s ever experienced previously.

From developing leaders to ending cervical cancer, AF4Q-SCPA is committed to better outcomes for our communities.

¹. Duke University’s obstetrics and gynecology
LIFT-ing Health Care to a New Standard of Excellence

Having tackled the first meeting of patients and providers at home – Patient-Centered Medical Homes – AF4Q-SCPA is excited to take to the streets for its next challenge: the neighborhood!

“If you want to improve a community, it really takes all of the partners working together,” said Samantha Obeck, quality improvement coordinator for AF4Q-SCPA. “We need to have the ability to share information and communication with all of the people who touch the patient.”

A first-of-its-kind initiative in central Pennsylvania, Learning and Innovating for Transformation (LIFT) will join 10 specialty care practices with 37 primary care and endocrinology practices to focus on building strong medical neighborhoods. Through the Collaborative, participants will improve communications processes and develop shared care plans that patients and all providers can implement together.

“Many patients assume that communication is flowing between their primary care physicians and their specialists, but this is not necessarily the case,” said Kathy Hutcheson, consumer engagement coordinator for AF4Q-SCPA. “This can be particularly challenging for people who are taking multiple medications.”

To solve these challenges, AF4Q-SCPA leaders are creating a curriculum that explains how to:

• Develop coordinated care management for all involved participants
• Improve communications among providers, as well as between patients and their care teams
• Increase access and continuity across the care setting as patients transition from hospitals to their homes.

The pioneer specialty practices will include cardiology, obstetrics and gynecology, pediatrics, orthopedics and neurology. Todd F. Barron, M.D., medical director of WellSpan Neurosciences and his team will be among the first practices to participate.

“If I see a patient and notice that he hasn’t been immunized in two years, rather than just ignoring it, I can talk to the patient’s primary care physician,” said Dr. Barron. “At the same time, we can reconcile medication lists, reduce costs, reduce potential emergency room visits and have better safety, satisfaction and overall outcomes.”

Having spearheaded similar collaboratives in the past, AF4Q-SCPA leaders are excited for the challenges and opportunities that lie ahead.

“We’ve already heard that relationships with primary care physicians are getting better, but patients are still not sure what to do when they arrive at specialists,” said Samantha. “We provide a safe place to come together to have these important, necessary conversations.”

All LIFT practices will have Patient Partners to help drive dialogue and provide thoughtful, patient-centered feedback. The new specialty practices are currently recruiting from their patient lists.

As Dr. Barron explained it, “We’re all responsible for the patient at any given time. We want them to walk out feeling confident and hopeful and get them back to the life that interests them.”
A Closer Look at AF4Q-SCPA

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- Community Care Behavioral Health
- Community Progress Council, Inc.
- Cross Keys Village
- Crozer-Keystone Health System
- CUNA
- Ephrata Community Hospital
- Family First Health
- Gateway Health Plan
- Genesis Health
- Glatfelter
- Glatfelter Insurance Group
- Hamilton Health Center
- Hanover Family Practice
- Hanover Hospital
- HealthSouth Rehabilitation Hospital
- Healthy Adams County Coalition
- Healthy York County Coalition
- Healthy York Network
- Highmark
- Holy Spirit Hospital
- Hospice & Community Care
- Keystone Health
- Lancaster General Hospital
- Lehigh Valley Health Network
- Lutheran Social Services
- ManorCare
- Margaret E. Moul Home
- Memorial Hospital
- Merck
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- Orthopedic Institute of Pennsylvania
- PA Association of Community Health Centers
- PA Department of Health
- PA Department of Public Welfare
- PA SPREAD
- Partners in Family Health
- Penn State Milton S. Hershey Medical Center
- Pennsylvania Employees Benefit Trust Fund
- Pennsylvania Health Care Quality Alliance
- PinnacleHealth
- Quality Insights of Pennsylvania
- Rest Haven
- Sadler Health Center Corporation
- South Central Preferred
- SouthEast Lancaster Health Services
- Suasion
- Summit Health
- The Graham Health
- True North
- United Way of Adams County
- United Way of York County
- UnitedHealthcare
- UPMC
- Visiting Nurse Association of Hanover & Spring Grove
- WellSpan Health
- Welsh Mountain Medical Center
- White Rose Family Practice
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- WITF
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- York County Area Agency on Aging
- York County Assistance Office
- York County Literacy Council
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