

TEMPLE UNIVERSITY HOSPITAL

# COMMUNITY HEALTH NEEDS ASSESSMENT 2019-2022 IMPLEMENTATION PLAN

October 2019



## **CONTENTS**

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<b>Temple University Hospital Community Commitment .....</b>	<b>2</b>
<b>Programs to Improve Community Health .....</b>	<b>3</b>
<b>Community Health Needs Assessment Summary .....</b>	<b>5</b>
<b>Implementation Plan Process.....</b>	<b>9</b>
<b>Plan to Address Diabetes &amp; Obesity .....</b>	<b>10</b>
<b>Plan to Improve Mental Health Resources &amp; Education .....</b>	<b>14</b>
<b>Plan to Improve Disease &amp; Care Management.....</b>	<b>17</b>
<b>Plan for Violence Reduction &amp; Intervention.....</b>	<b>20</b>
<b>Plan to Improve Substance Use Disorder Treatment Integration.....</b>	<b>21</b>
<b>Plan to Improve Health of Moms and Newborns.....</b>	<b>29</b>
<b>Approach to Unmet Needs .....</b>	<b>32</b>
<b>Planning for a Healthier Population .....</b>	<b>33</b>

## TEMPLE UNIVERSITY HOSPITAL COMMUNITY COMMITMENT

The Temple University Health System (TUHS) consists of Temple University Hospital (TUH), which is the chief clinical training site for the Lewis Katz School of Medicine at Temple University. It also includes Jeanes Hospital, and the American Oncologic Hospital, known as the Hospital of the Fox Chase Cancer Center. Additionally, the Temple family includes Temple Physicians, Inc., our network of over 100 community-based physicians, nurse practitioners, and physician assistants in over 40 practice sites, as well as our school of Medicine's faculty practice plan.

TUH was founded in 1892 as "Samaritan Hospital," with the mission of providing care to low-income residents of its surrounding North Philadelphia neighborhood. Today, TUH is a 732-bed non-profit acute care hospital that provides a comprehensive range of medical services to its low-income communities, and a broad spectrum of secondary, tertiary, and quaternary care to patients throughout Southeastern Pennsylvania and beyond. TUH is accredited as an Adult Level 1 Trauma Center by the Pennsylvania Trauma Systems Foundation.

In addition to its main campus in North Philadelphia, TUH includes its Episcopal and Northeastern campuses, both of which are in economically distressed areas within three miles of the TUH main and medical school campus. The Episcopal Campus (Episcopal) is home to TUH's behavioral health services, including a Crisis Response Center that handles thousands of psychiatric emergency visits each year. Episcopal also provides a wide range of long and short-term adult psychiatric services as well as a full-service emergency room and various outpatient services. Episcopal is a key provider of psychiatric care within Philadelphia County.

Located in the heart of North Philadelphia, TUH serves one of our nation's most economically challenged and diverse urban populations. More than 85% of the patients served by TUH are covered by government programs, including Medicare and Medicaid. Patients dually eligible for both Medicare and Medicaid comprise roughly half of our Medicare inpatient base. Over 40% of our total inpatient cases include a behavioral health diagnosis.

TUH is an indispensable provider of health care in the largest city in America without a public hospital. Among Pennsylvania's full-service safety-net providers, TUH serves the greatest volume and highest percentage of patients covered by Medicaid. Within our primary service area, over 30% of area residents live below the federal poverty level.

TUH is also a critical access point for vital public health services. Each year we serve thousands in our Emergency Department, inpatient Behavioral Health unit, labor and delivery unit and other departments. We also have one of the most active trauma units in the Commonwealth of Pennsylvania.

### MISSION STATEMENT

Temple University Hospital's mission is to provide access to the highest quality of health care in both community and academic settings. The hospital supports Temple University and its Health Sciences Center's academic programs by providing the clinical environment and services to support the highest quality teaching and training programs for health care students and professionals, and to support the highest quality research programs. The hospital's values are simple: Respect, Service and Quality.

## PROGRAMS TO IMPROVE COMMUNITY HEALTH

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Temple University Hospital (TUH) takes great pride in the broad array of community services and programs we provide to our diverse, economically challenged neighborhoods and the Southeastern Pennsylvania region. Many of our programs address the social determinants of health impacting health outcomes. Below is a summary of some of our programs and activities that promote healthy living in the communities we serve.

- **Providing Critical Resources.** We connect thousands of people each year with social services, including free transportation, legal services, and clothing. For our most vulnerable patients, we assist with pharmaceuticals, co-pays and medical supplies to ease their transition home after treatment.
- **Connecting Patients with Financial Resources.** Our Financial Counselors are dedicated to helping un- and under-insured patients obtain medical coverage.
- **Promoting Multi-Cultural Services.** Our nearly 400 language proficient bilingual staff perform thousands of interpretations each year for non-English speaking patients and families. We also assist other hospitals that call on us to adapt our linguistic services module to their patient populations.
- **Reaching out to our Communities.** We reach thousands of people each year through community outreach, support groups, and education programs. Our efforts focus on substance use disorders, behavioral health, cancer, diabetes care, childbirth, burn prevention, and other topics.
- **Responding to our Community's Behavioral Health Needs.** Behavioral health is a major concern in our service area. More than 25% of adults in our surrounding community and over 40% of our inpatients have a mental health diagnosis. In response, we provide programs that increase access to behavioral health supports and education. Our Episcopal Campus is home to free support groups for patients and family members affected by mental health issues and addiction. Our physicians and staff also provide free trainings to providers and non-profits on topics such as patient safety and crises response as well as community-based education on depression, suicidal behavior and other mental health issues.
- **Addressing the Opioid Epidemic.** We are working closely with the Commonwealth of Pennsylvania and City of Philadelphia to address Philadelphia's opioid epidemic. Our Episcopal Campus is located at the epicenter of the state's opioid crisis and has the highest number of opioid related deaths in Philadelphia. In response, we are expanding our medication-assisted treatment programs to several community-based sites throughout Philadelphia using multidisciplinary care teams and social supports. Our *Recovery Overdose Survivor Project* links overdose patients and their families with needed services after treatment in our Emergency Departments or Crisis Response Center. In addition, we are working with Philadelphia's Office of Homeless Services to provide respite services to address homelessness among opioid users.
- **Addressing Violence.** Our 360 degree approach to addressing violence in our community includes several programs. *Cradle to Grave* is our collaborative program with the Juvenile

Justice Department and local schools that works with at-risk youth to break the cycle of gun violence. *Turning Point* with a focus on survivors, helps change attitudes toward gun violence and encourages victims to alter their paths. *Fighting Chance* is one of the nation's few initiatives that teach community members how to provide basic first aid to gunshot wound victims.

- **Protecting Moms & Babies.** Our North Philadelphia community has one of the highest infant mortality rates in the nation. Many babies are born to young mothers living in poverty who lack resources to care for a newborn. In response, we developed several programs that provide a comprehensive and coordinated approach to pre- and post-natal care and education. All expectant mothers at TUH receive counseling on pre-natal nutrition and other topics to support healthy pregnancy. We also provide free childbirth classes on labor and delivery, breastfeeding, post-natal recovery and newborn needs. Our free yoga classes help expectant mothers with stress reduction, fitness, breathing and wellness.

Our *Safe-T Program* provides all mothers that deliver at TUH a Safe Sleeper Kit complete with a sleep-safe baby box, clothing, sheets, a blanket, a baby book (in English and Spanish), diapers, and other supplies and resource referrals. In partnership with Philadelphia's Department of Public Health's *Philadelphia MOM Program*, we also connect new mothers and their babies from birth through their sixth birthday with social, educational, and healthcare supports.

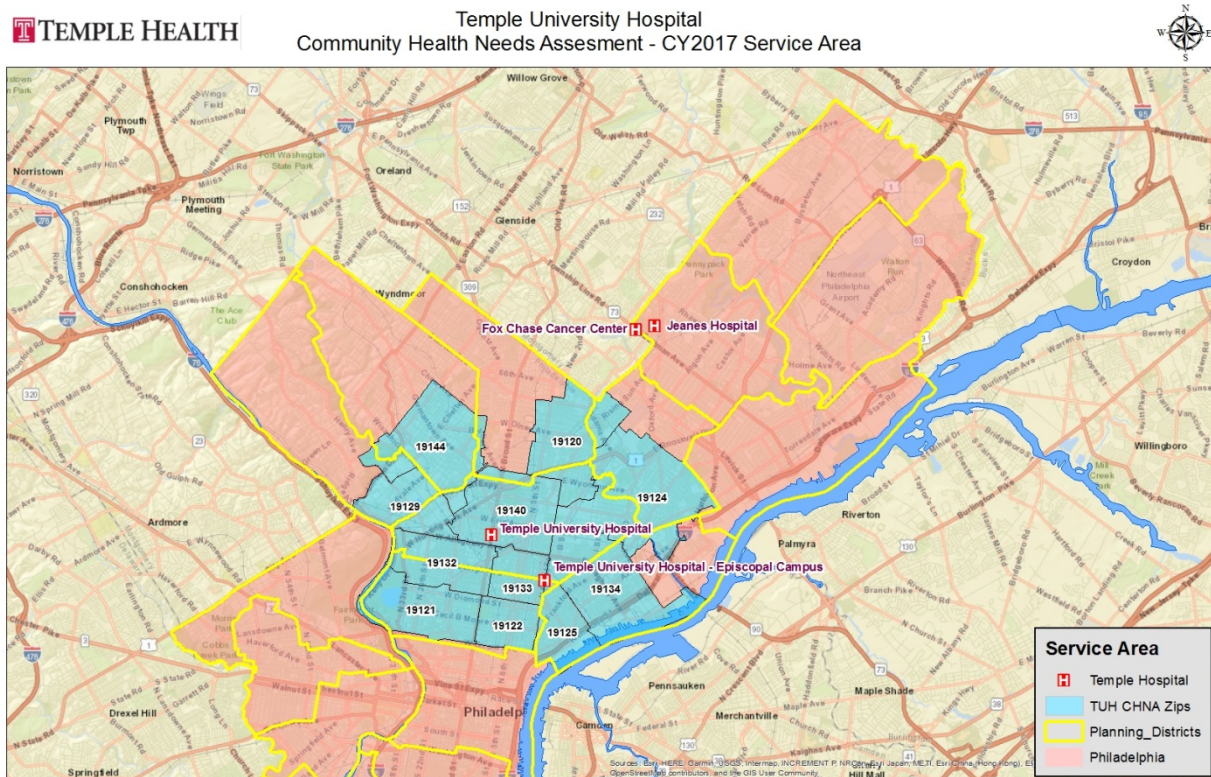
- **Developing Tomorrow's Frontline Workforce.** We are leading several initiatives that build a diverse workforce at all levels of healthcare. Our investment in 1199C's *Community Health Workforce Program* provides union and community members with training in nursing, behavioral health, childcare, health IT and other areas. This program reinforces valuable skills with confidence for participation in our ever-changing healthcare workforce. TUH is also the primary teaching site for the Lewis Katz School of Medicine at Temple University, where hundreds of physician residents and fellows come for specialized, postgraduate training.
- **Engaging our Patients & Families.** We created eight (8) Patient Family Advisory Councils focusing on family medicine, trauma, and cardiovascular medicine. The goal of these councils is to engage and encourage the participation of patients, families, and members of the community in evaluating patient satisfaction across different clinical areas.
- **Preparing for Emergencies:** Our *Emergency Preparedness* program helps ensure our staff and hospital facilities are prepared to provide safe, quality patient care even under the most austere conditions. We work on many levels to educate our communities and staff about the importance of personal preparedness. TUH's *Emergency Preparedness* is a critical link in federal, state, and local disaster response plans through our active participation and leadership in the regional healthcare preparedness coalition.
- **Supporting Smoking Cessation:** TUH maintains dedicated resources for addressing smoking cessation in North Philadelphia. Our programs consist of a support group, medical management, and pharmaceuticals to manage smoking withdrawal. TUH is also a smoke-free campus.

# COMMUNITY HEALTH NEEDS ASSESSMENT SUMMARY

## COMMUNITY DEFINITION:

For the purpose of our 2019 Community Health Needs Assessment (CHNA), Temple University Hospital (TUH) defined its community as comprised of 11 zip codes: 19120; 19121; 19122; 19124; 19125; 19129; 19132; 19133; 19134; 19140; and, 19144. These are the zip codes from which about 70% of our patients seen on an inpatient and observation basis reside. These zip codes largely overlay the City of Philadelphia’s Lower North, North and Riverward Planning Districts as set forth in the Philadelphia Department of Public Health’s [2017 Community Health Assessment for Philadelphia, PA](#). Figure 1 outlines TUH’s service area.

**Figure 1: TUH Service Area**



Source: Esri, HERE, USGS, Intermap, INCREMENT, P.NR

## UNMET HEALTH NEEDS:

Unmet health needs for our community were identified by comparing the health status, access to care, health behaviors, and utilization of services for residents of our service area to data for the county, state, and the *Healthy People 2020* goals for the nation. In addition, a Key Informant Survey was sent to social and health service providers to obtain their perspectives on the community’s health needs. Furthermore, *Temple University’s Institute for Survey Research (ISR)* conducted a Resident Survey using contact information from a sample of over 2,000 Philadelphia residents within their survey database living in the 11 zip codes representing TUH’s immediate service area.

Finally, input from community participants during two focus groups helped identify problems with access to care, and populations with special health needs.

## **HEALTH PRIORITIES:**

Mindful of our mission of providing access to the highest quality of health care in both community and academic settings, TUH's 2019 CHNA revealed the underlying health needs of its broad geographic area. The current CHNA builds upon previously identified health needs using more recent data and revealed the following health needs and priorities:

**Priority area #1:** Chronic Disease

**Priority area #2:** Access to Healthcare

**Priority area #3:** Mental Health Treatment Access and Education

**Priority area #4:** Substance Use Disorder Treatment Integration

**Priority area #5:** Violence Prevention and Intervention

**Priority area #6:** Programs for Moms and Newborns

These six priority areas are in line with the priority areas identified our 2016 CHNA and addressed in the implementation strategies and programs that have been implemented since then. Over the next three years, we will continue to review and expand programs and interventions based on the needs identified in our 2019 CHNA.

As outlined, TUH's latest Implementation Plan is based on the findings of our 2019 CHNA, which is available to the public on our website. See hyperlinks below:

- [Temple University Hospital – Community Health](#)

## **COMMUNITY FEEDBACK:**

Below are the major findings of TUH's 2019 CHNA.

### **CHRONIC DISEASE**

Public health data, Key Informant Survey and Resident Survey Respondents mentioned the following as issues related to chronic disease:

- Cancer;
- Cardiovascular disease and stroke;
- Diabetes;
- Overweight/obesity; and
- Dental health.

Focus Group Participants also identified lack of post-care planning and knowledge about medications and their use as issues related to chronic disease management.

### **ACCESS TO QUALITY HEALTHCARE SERVICES**

Public health, Focus Group, Key Informant Survey and Resident Survey data showed the following issues related to access:

- Health insurance issues due to high deductibles/copays/affordability of health care plans/uninsured and underinsured;
- Health care costs;
- Transportation;
- Availability of providers (number of providers, convenient hours, wait times to schedule an appointment);
- Knowing what services are available and how to access these services, including navigation;
- Financial resources;
- Safe and affordable housing; homelessness;
- Lack of trust in the health system; and
- Language and cultural accessibility.

When asked to rate the health status of the community, 69.0% of Focus Group Participants rated the community's health status of as fair or poor. When asked to explain the rating, participants noted that there are higher rates of asthma and other chronic conditions including diabetes and hypertension and that the Geriatric community is underserved and not familiar with the array of services available. Gun violence and poor housing conditions were also identified as a tremendous problem as well as drug use and lack of medication compliance because community members cannot afford their prescriptions.

## **MENTAL HEALTH**

Public health data, Focus Groups and Key Informant Survey and Resident Survey Respondents mentioned the following as needs and issues related to mental health:

- Lack of mental health providers;
- Suicide;
- Mental/behavioral health issues; and
- Inability to navigate the system.

About 37% of Key Informant Survey Respondents indicated mental health was an important community health issue and 59% identified mental health services as a top needed service. 91% of Focus Group Participants indicated that early intervention mental health services are a priority and 33% identified grief counseling for trauma patients as a top needed service. Focus Group Participants, Key Informant and Resident Survey Respondents also mentioned that there is a limited range of providers with accommodating hours. About 31% of Resident Survey Respondents identified suicide as major mental health issue facing the community.

## **SUBSTANCE USE**

Public health data, Focus Groups, Key Informant Survey and Resident Survey Respondents identified the following needs and issues related to substance use disorders:

- Substance use – adults and children;
- Alcohol use/deaths – adults and children;
- Smoking/vaping – adults and children; and
- Inability to navigate the system.



Needed substance use disorder services identified included early intervention and education services.

### **PHYSICAL ACTIVITY & NUTRITION**

Public health data and Focus Group Participants identified the following needs and issues related to physical activity and nutrition:

- Food insecurity/access to healthy foods/nutrition; and
- Lack of physical activity/leisure time/green space

About 70% of Focus Group Participants indicated food insecurity as an important community issue. They stressed that access to healthy food upon discharge from the hospital is an important priority. The need for safe exercise spaces and more green space were also identified by about 60% of Focus Group Participants.

### **WOMEN'S AND CHILDREN'S HEALTH**

Public health data and Focus Group Participants identified the following needs and issues related to healthy women, mothers, babies and children:

- Affordable child care;
- Medicaid assistance;
- Pennsylvania Department of Health Women, Infants and Children (WIC) Assistance Program;
- Low birth rate;
- Non-smoking pregnancy;
- No pre-natal care;
- Teen pregnancy; and
- Infant mortality.

Focus Group Participants also noted that a rise in teen pregnancies, particularly with second-time teen parents is a community issue and stressed the need for a holistic program for teen pregnancy that includes education on the role of a midwife, parenting classes and affordable childcare.

### **INFECTIOUS DISEASE**

About 38% of Focus Group Participants rated Hepatitis C treatment and screening as an important community need. About 14% identified access to HIV screening as important. County health data shows a higher rate of chlamydia and gonorrhea in North Philadelphia.

## IMPLEMENTATION PLAN PROCESS

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Following completion of Temple University Hospital's (TUH) 2019 Community Health Needs Assessment (CHNA), the hospital's leadership formed an Implementation Strategy Work Group ("Group") to guide development of the 2019-2022 Implementation Plan. The Group began its planning process by reviewing needs identified during the 2019 CHNA. Using a consensus building process, the Group created implementation plan for addressing each priority that considered the following factors:

- 1) **Root Cause:** The root cause of the priority issue;
- 2) **Internal Capacity:** The internal resources of TUH and capacity to respond, including constraints or limitations.
- 3) **University Resources:** The Academic Resources of Temple University, including the Lewis Katz School of Medicine.
- 4) **External Community Capacity:** The external resources of TUH's surrounding communities and capacity to respond to the priority need.
- 5) **Consequences:** The public health consequences of not responding to the need.

Thereafter, the Group met regularly and worked with stakeholders to collaboratively develop implementation plans that outlined specific goals, objectives, and action plans as well as the resources TUH would contribute in response to each priority need.

In collaboration with Temple's Center for Population Health (TCPH), TUH will work over the next three years to achieve mutual public health goals. We will align our efforts with the United States Department of Health and Human Services' three-part aim of improving patient care, better health for our communities and lowering costs through health care system improvement. In addition, we will closely monitor our progress in meeting goals, their impact and will develop annual progress updates.

## PLAN TO ADDRESS DIABETES & OBESITY

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### Rationale:

More than 100 million U.S. adults are living with pre-diabetes or diabetes according to the U.S. Center for Disease Control and Prevention (CDC). 1 in 3 American adults have pre-diabetes and nine out of ten individuals don't even know they have it. Without taking action, many people with pre-diabetes can develop type 2 diabetes within 5 years.

During our Community Health Needs Assessment (CHNA), Resident Survey Respondents identified Diabetes as a top community issue and chronic condition impacting Temple University Hospital's (TUH) surrounding communities. Lack of knowledge and the need for more education on managing chronic conditions was also identified. In response, TUH will deliver the following two (2) programs to address pre-diabetes and diabetes in the communities we serve.

### Program 1: *Diabetes Prevention Program (DPP)*

#### Goals:

1. Enhance access to Temple's Center for Population Health's (TCPH) DPP at various locations including community and health system location campuses.
2. Increase number of community members who receive information from the DPP curriculum and other resources which help them make healthy lifestyle changes that reduce their risk of developing type 2 diabetes and improve overall health.

#### Metrics:

- DPP class participant retention rate.
- Number of DPP locations as compared to the prior year(s).
- Volume of participants in DPP program that are patients from Temple Physicians Inc. (TPI), Temple Faculty Practice Plan Inc. (TFP) and TUH employees and community members.
- Average weight loss as compared to prior year(s) for DPP participants

#### Available Resources:

- *DPP Coordinator & Trainer, TCPH* - Eдорis Lomax
- *Director of Population Health, TCPH* - Ronni Whyte, MS, BSN, RN

#### Implementation Team:

- Executive sponsor(s)
  - *Director of Population Health, TCPH* - Ronni Whyte, MS, BSN, RN
  - *Vice President, Population Health, TCPH* - Steven R. Carson, MHA, BSN, RN
  - *CEO, TPI* - Marc Hurowitz, M.D.
  - *Director of Quality, TPI* - Alyssa Mullen
- Team members
  - *DPP Coordinator & Trainer, TPI* - Eдорis Lomax
  - *Project Manager, TPI* - Mitali Desai

**Other Participants:**

- Other TUHS hospitals/Temple entities
  - Jeanes Hospital
  - TPI
  - TFP Practices
- Community Organizations
  - Bright Hope Baptist Church
  - Jewish Federation of Greater Philadelphia
  - Kleinlife Community Center
  - Lutheran Settlement House
  - Zion Baptist Church

**Action Plans:**

- Identify TPI and TFP patients who meet DPP pre-diabetes criteria.
- Perform proactive outreach to patients identified as pre diabetic and enroll in DPP.
- Attend community and faith based organization health fairs and other events to communicate DPP offerings.
- Attain recognition as a Medicare DPP (MDPP) Supplier (set to occur by October 2019)

**Objectives:**

- Increase number of participants enrolled in DPP from communities across the TUHS catchment area.
- Increase DPP participant retention rate by 5%.
- Expand current DPP to 2 additional locations within catchment area.
- Increase volume of participants from health plans, TPI, TFP, TUH employees and community members by 5%.

**Communication:**

- Communication plans will be developed to include outreach to faith-based community organizations, physician practices and health system human resources to encourage attendance and outreach.

**Estimated Budget:**

- Resource Materials: \$3,000
- Staff resources: \$45,000

**Program 2: *Diabetes Education*****Goals:**

1. Expand access to Diabetes education classes (Diabetes class) and related initiatives at TUH's Main, Episcopal, and Northeastern campuses and Jeanes Hospital.

## Metrics:

- Number of students attending Diabetes classes
- A1C beginning and ending values among students that complete diabetes class series

## Available Resources:

- Diabetes educators who offer Diabetes classes and sessions at each TUH Campus.
- Collaboration with TPI and the TFP providing onsite Diabetes education.
- Partnership with Salus Eye Institute for Diabetes Education and Precaution.
- Existing nutritional programs and activities at TUH including Farm-to-families and cooking classes and demonstrations.

## Implementation Team:

- Executive Sponsors
  - *Executive Director, TUH – Episcopal Campus* - Kathleen Barron
  - *Section Chief, Endocrinology, Diabetes and Metabolism, TFP* - Jonathan Anolik, MD
- Team Members
  - *Manager, Diabetes Program, TUH* - Casey Dascher
  - *Educator, Diabetes Program, TUH* - Lindsey Verano
  - *Educator, Diabetes Program, TUH* - Christine Luby
  - *Educator, Diabetes Program, TUH* - Adrienne Licchetto
  - *Vice President, Operations, TUH – Episcopal Campus* - LuAnn Kline
  - *Administrator, Diabetes Center, TUH – Northeastern Campus* - Hernan Alvarado
- Diabetes Advisory Board
  - *Vice President, Chief Nursing Officer, TUH – Episcopal Campus* - Yasser Al-Khatib, RN
  - *Regional Manager, TPI* - Marilyn Velasquez
  - *Director, Laboratory, TUH – Episcopal Campus* - Patricia Spinosi
  - *Assistant Professor of Medicine, Section of Endocrinology, Diabetes and Metabolism, TFP* - Ajaykumar Rao, M.D.
  - *Nurse Practitioner, TFP* - Ann Varghese, CRNP
  - *Care Transition Navigator, TUH* - Sylvia Speller
  - *CHW Program Coordinator, TUH* - Edoris Lomax
  - *Clinical Nurse Specialist, TUH – Episcopal Campus* - Edgardo Jaminola
  - *Office Supervisor, TPI* - Minerva Belen
  - *Office Manager, TPI* - Debra Smith
  - Patient Representatives
    - Kenneth McFadden
    - Anna Roque

## Community Participants:

- Salus Eye Institute for Diabetes Education and Precaution
- Farm-to-Families Program

**Action Plans:**

- Adjust staffing schedule to allow for increased Diabetes classes.
- Expand reminders for Diabetes classes to include text messaging.
- Have front staff schedule patients for classes at the time of their medical appointment.
- Integrate scheduling into EMR allowing patient linkage to educator at time of doctor visit.
- Track A1C pre and post class series participation.
- Explore other educational opportunities with physician groups to improve patient compliance with care plans.
- Maintain accredited program from American Diabetes Association.
- Conduct community education at local health fairs/centers in the community.
- Coordinate efforts with existing Diabetes Prevention Program (DPP) and have Diabetes class participants participate in a DPP class.

**Objectives:**

- Increase Diabetes class attendance by 5-10%
- Demonstrate reduction of A1C by 1.5 among students that complete class series

**Communication:**

- Diabetes educators will participate in marketing / physician visit within the community and team up with government representatives for community engagement events.
- Provide diabetic education and resource guides in Spanish and English.

**Estimated Budget:**

- Resource material: \$5,000.00
- Diabetic Educator : \$43,680
- Scheduler for appointments: \$15,600

## **PLAN TO IMPROVE MENTAL HEALTH RESOURCES & EDUCATION**

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### **Rationale:**

Over half of Resident Survey Respondents indicated mental health care was a top needed service in Temple University's Hospital's (TUH) surrounding communities. Over 90% of Focus Group Participants cited the need for improved mental health early intervention. Almost half of Philadelphia County Residents indicated their mental health was not good on at least one day in the last month. Mental health services access was a priority in TUH's 2016 Community Health Needs Assessment (CHNA).

### **Goals:**

Expand ability to continue mental health treatment beyond the hospital while increasing access to treatment across all levels of care. This will involve increasing care transition linkages and the number of patients that go directly from TUH on a warm handoff to their next level of care. These enhanced linkages will help ease barriers to access.

### **Metrics:**

- Percentage of patients who connect to other services within 7 days of hospital discharge;
- Number of patients who go directly from TUH Episcopal Campus's Crisis Response Center or other inpatient units to a lower level of care for behavioral health services.

### **Available Resources:**

TUH's Episcopal Campus (Episcopal) is the primary location for behavioral health services within the Temple University Health System. Episcopal has 74 adult acute psychiatric and 44 adult extended acute psychiatric beds. In addition, a Crisis Response Center (CRC) that is open 24 hours per day, 7 days a week, with services to treat adults 18 years of age and older who are in a psychiatric emergency. Children and adolescents experiencing psychiatric emergencies are sent to the designated, city sponsored, child and adolescent crisis response center, which is located within 10 miles. Episcopal is also the site for the Lewis Katz School of Medicine at Temple University's Department of Psychiatry Outpatient Clinic. This clinic is primarily a teaching site for the department's residency program and provides care for adults, children and adolescents. In addition, Episcopal provides comprehensive inpatient services and refers patients for after care treatment to mental health outpatient and substance services through linkage agreements with more than 40 outpatient, rehabilitation and substance use disorder treatment facilities in the Delaware Valley. Each TUHS entity site also has consultation liaison psychiatrists who care for inpatients at each site.

### **Implementation Team:**

- Executive sponsor(s):
  - *Chair & Chief Medical Officer, TUH – Episcopal Campus, William R. Dubin, MD*
  - *Executive Director, TUH – Episcopal Campus - Kathleen Barron*
- Team members
  - *Team Leader, Director of Behavioral Health, TUH –Episcopal Campus, - LJ Rasi*

- *Vice President & Chief Nursing Officer, TUH –Episcopal Campus, Yasser Al-Khatib, RN, BSN*
- *Director of BHT and Utilization Management, TUH –Episcopal Campus, Kelly Kulp*
- *Drug and Alcohol Supervisor, TUH –Episcopal Campus, Danny Rivera*
- *Supervisor of Behavioral Health Care, TUH – Episcopal Campus, Tory Tuman*
- *Crisis Response Center Medical Director, TUH –Episcopal Campus, James Graham, MD*
- *Vice Chair, Research, Lewis Katz School of Medicine, Mary Morrison, MD*

**Community Participants:**

- *Program Director, Merakey - Jose Tirado*
- *Business Development Specialist, Ambrosia - Joe Harvey*
- *Executive Director, Northeast Treatment Center - Regan Kelly*
- *Executive Director, Prevention Point - Jose Benitez*
- *Comhar Community Mental Health Center*
- *Community Behavioral Health, and City of Philadelphia Department of Behavioral Health and Intellectual Disabilities*
- *Collaborative Opportunities to Advance Community Health Initiative (COACH)*

**Action Plans:**

- *The Episcopal Outpatient Psychiatry clinic will accommodate additional patients beginning in September 2019 as new Residents join the program. These additional slots are expected to yield 150 new patient visits a year.*
- *Continue to measure door-to-door care transition linkages as stated above from the CRC and acute inpatient units.*
- *Conduct an annual review of staff mental health services education needs each October. Provide classes to address these identified needs each spring.*
- *Add additional CRC attending physician coverage specializing in substance use beginning January 2020.*
- *Explore funding opportunities to support non-medical transportation for discharged patients to their next level of care by March 2020. The lack of transportation is the most significant barrier to care plan adherence.*
- *Identify gaps and needed services that network providers are not currently offering by June 2020.*
- *Complete affiliation agreements with at least three new service providers in FY 20. Provider types include outpatient mental health, and inpatient dual diagnosis programs.*
- *Expand use of warm handoffs from our acute inpatient units to the next level of care. The goal is to increase warm handoffs 5% from the 117 linkages stated above completed in FY19.*
- *Partner with Collaborative Opportunities to Advance Community Health Initiative (COACH) to develop collaborative approach to address City of Philadelphia’s behavioral health needs with other area health systems through community-based partnerships.*

**Objectives:** Episcopal will provide mental health and/or substance use disorder assessment, treatment and direct referral to the next level of care via a dedicated network of community providers for an additional 500 (FY20), 750 (FY21) and 1,000 (FY22) patients per year from the FY19 total. The extra 1,000 patients by FY22 would correspond to a 60% increase from FY19. Care will be delivered by all providers in the network using evidenced based treatment. In addition, our



goal is improve the number of care linkages from our CRC and other acute care inpatient units by 5% to the next appropriate level of behavioral health care as compared to the same period in the prior year.

**Communication:**

- Provide training on available behavioral health resources to social work and emergency department staff throughout TUHS.
- Place educational material on available behavioral health resources online for review at all times in English and Spanish.
- Facilitate placement of information about the availability of behavioral health and other services at Episcopal on city wide websites.
- Update Episcopal Crises Response Center’s Resource Guide and make it available for distribution by all within TUHS.
- Work with TUHS public relations to establish a communication plan that highlights our 5-star rating with Community Behavioral Health (CBH) and high scores from Press Ganey on patient satisfaction.

**Estimated Budget:**

- Additional Physician time for both the CRC and Outpatient Service: \$200,000-\$400,000
- Training Costs- \$20,000
- Resource materials and Communications- \$10,000

## PLAN TO IMPROVE DISEASE & CARE MANAGEMENT

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### Rationale:

Focus Groups and Key Informant and Resident Survey Respondents identified homelessness, transportation, limited providers and appointments, language and culture differences, healthcare cost and lack of trust and in the healthcare system as impacting access to care in Temple University Hospital's (TUH) surrounding communities. Over half of Resident Survey Respondents also identified the inability to navigate the health care system (52.7%) and more than a quarter (27.0%) stated that community members not having their basic needs met were barriers to care. In order to improve access, community health education on resources available and assistance navigating the system was recommended.

### Goals:

1. Heighten community awareness of Temple University Health Systems (TUHS) clinical services including primary care networks, disease specific programs and care management resources.
2. Increase number of patients who utilize the Care Transitions Team members of Community Health Workers, Nurse Navigators, and Social Workers at TUH.
3. Increase number of patients enrolled in longitudinal care management.
4. Screen patients for disparities in the social determinants of health and link to various community based organizations.
5. Improve appointment adherence post discharge.
6. Improve care transitions for patient discharged from inpatient hospitalization to their next site of care.

### Metrics:

- Post-hospital, discharge follow-up appointment adherence
- Medication adherence for patients discharged from hospital
- Hospital readmission rate for low acuity admissions

### Available Resources:

The Temple Center for Population Health (TCPH) has developed a cohesive and robust series of programs that address medical and social disparities and work to link patients to appropriate services. Programs include a strong primary care network of 27 NCQA-designated level three Patient Centered Medical Homes (PCMHs) in North Philadelphia, a network of high quality specialty physicians, a network of alliances and partnerships with community agencies and organizations that specialize in managing non-medical health-related social needs, a robust care management infrastructure as part of our *Temple Care Transition Program* using nurse navigators and community health workers, and Electronic Health Information Exchange (Health Share Exchange) to assure that electronic information is securely transferred and is available to healthcare providers across our region when needed.

### Implementation Team:

- Executive sponsor(s)
  - *Vice President, Population Health, TCPH* - Steven R. Carson MHA, BSN, RN

- *CEO, TPI* - Marc Hurowitz, M.D.
- *Chief Medical Officer, TUH* - Tony Reed, M.D.
- *Vice Dean and CEO, TFP* - Susan Wieggers, M.D.
- Team members
  - *Care Transitions Manager, TCPH* - Theresa David
  - *Project Manager, TPI* - Mitali Desai
  - *Director of Quality, TPI* - Alyssa Mullen,
  - *Director of Population Health, TCPH* - Ronni Whyte
  - TCPH Care Transitions Team
  - TUH Clinical Resource Management Team
  - TUHS Access Center Team

### **Other Participants:**

- TUHS & Other Temple Entity Partners
  - *VP, TPI* - Renee Reedman,
  - *VP, TFP* - Lisa Fino
  - *Director, Temple Access Center, TUHS* - Joseph Alfonsi
  - Temple Financial Counselors
  - Temple Care Integrated Network (TCIN)
- Community & Other External Participants
  - Private Physician Practice Offices in TUHS's service area
  - Local Health Insurance Plans
  - Community Based Organizations focused on addressing social disparities
  - Post-Acute Care providers, including local skilled nursing facilities and home health agencies.

### **Action Plans:**

- Connect with patients/families at the bedside while hospitalized.
- Enhance collaboration with preferred SNFs and HHAs to assure patients are appropriately transitioned from facility to home.
- Enroll patients into longitudinal care management program and establish care plans.
- Build upon existing relationships and develop new partnerships with various community based organizations to assure patients social needs are met that inhibit access to care (co-pays, transportation, etc.)
- Assist patients with navigating complex health system linking patients to high quality healthcare.
- Link patients back to primary and specialty care.

### **Objectives:**

- Increase post-hospital, discharge follow-up appointment adherence to primary care by 10%.
- Improve medication adherence by 5% for patients discharged from hospital.
- Reduce hospital readmission rate by 5% for low acuity admissions.

**Communication:**

- Use social media, flyers, posters and the patient portal to heighten awareness of existing care management team availability to community members and patients.
- Attend health fairs and other community events to increase knowledge available of care management and transition services.

**Estimated Budget:**

- Staffing: \$220,000
- Collateral Materials: \$10,000

## PLAN FOR VIOLENCE REDUCTION & INTERVENTION

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### Rationale:

In 2018, one out of 8 Philadelphia gunshot victims was age 18 or under. If history is any indication, roughly two dozen teenage shooting victims will die in Philadelphia this year alone. When young black Philadelphians between the ages of 15 and 24 die, gun homicide is the cause nearly 60% of the time. Nearly 1,400 people were shot in Philadelphia last year. No hospital in the city – nor the Commonwealth of Pennsylvania – treats as many patients suffering penetrating injuries as Temple University Hospital (TUH). However, for each person who dies from gun violence in the city, four more will survive – often with devastating injuries. Unfortunately, many young people are unaware about the long-term consequences of gun violence, which, we believe, contributes to their willingness to reach for firearms during disputes.

During TUH's 2019 Community Health Needs Assessment, Focus Group Participants and Key Informant Survey and Resident Survey Respondents identified violence as a major problem in the community. Nearly three fourths of Focus Group Participants (71.4%) also indicated that gun violence preventative services and education for youth is a top need. Violence prevention was also a priority in TUH's 2016 CHNA. In response, TUH will deliver the following four (4) programs to reduce violence and improve survivability.

**Program 1:** *Cradle to Grave* is our collaborative program with the Juvenile Justice Department and local schools that works with at-risk youth to break the cycle of gun violence.

### Goals:

1. Focus the *Cradle to Grave* program to specifically target the most at-risk youth in order to educate them about the clinical realities of firearm injury.
2. Increase the number of incarcerated and adjudicated youth who participate in *Cradle to Grave* program.
3. Measure changes in participants' attitudes towards guns and violence.

### Metrics:

- Number of incarcerated and adjudicated youth who participate in *Cradle to Grave*.
- Scores on pre- post-surveys measuring participants' attitudes towards guns and violence.

**Available Resources:** TUH's Trauma Outreach Coordinator will travel to the Juvenile Justice Services Center to facilitate the *Cradle to Grave* program for incarcerated youth and will host a series of *Cradle to Grave* programs for a variety of organizations serving adjudicated youth.

### Implementation Team

- Executive Sponsor
  - *Chief of Surgery, TUH* - Amy Goldberg, M.D.
- Team members:
  - *Trauma Outreach Coordinator, Trauma Program, TUH* – Scott Charles
  - Surgical residents

### **Community Participants:**

- Community Organizations: Northeast Treatment Centers
- Government Offices: Philadelphia Juvenile Justice Services Center, Philadelphia Department of Juvenile Probation, Boys Track Program (DHS)

### **Action Plans:**

- Arrange visits with partner organizations and agencies.
- Purchase Aggressive Response to Shame sub-scale of the Attitudes towards Guns and Violence Questionnaire (AGVQ Survey) for administration to *Cradle to Grave* youth participants to measure changed towards violence pre- and post-participation in the program. The AGVQ survey is a validated survey instrument that is used widely for measuring the effectiveness of violence prevention efforts.
- Administer AGVQ Pre-Survey to participating groups 2 weeks prior to *Cradle to Grave* presentation.
- Facilitate *Cradle to Grave* presentation for groups.
- Administer AGVQ Post-Survey to participating groups 4 weeks following *Cradle to Grave* presentation.
- Analyze results of surveys.

### **Objectives:**

- Reach 1,200 at-risk youth each year.
- Demonstrate 12% improvement in *Cradle to Grave* youth participants' attitudes towards violence as demonstrated by comparison of their AGVQ pre- and post-program participation survey scores.

**Estimated Budget:** \$110,000 for staffing and educational materials (*for Cradle to Grave, Fighting Chance & Safe Bet collectively*)

**Program 2:** *Fighting Chance* is one of the nation's few initiatives that teach community members how to provide basic first aid to victims of gunshot wounds.

### **Goals:**

1. Increase number of Philadelphia residents who receive the *Fighting Chance* training.
2. Offer *Fighting Chance* training to Philadelphia public schools.

### **Metrics:**

- Number of community members who participate in *Fighting Chance* trainings.
- Number of School District of Philadelphia staff who participate in *Fighting Chance* trainings
- Number of community members who report an increased willingness to assist people suffering from penetrating injuries.

### **Available Resources:**

- Volunteer team from TUH’s Trauma and Emergency Medicine departments willing to offer *Fighting Chance* trainings to school and community groups.

**Implementation Team:**

- Executive Sponsor
  - *Chief of Surgery, TUH - Amy Goldberg, M.D.*
- Team members
  - *Trauma Outreach Coordinator, Trauma Program, TUH – Scott Charles*
  - *Assistant Professor, Clinical Emergency Medicine, Lewis Katz School of Medicine at Temple University - Tim Bryan, M.D.*

**Community Participants:**

- Community Organizations: Local churches, recreation centers, and community-based agencies
- Government Offices: School District of Philadelphia, Philadelphia Police Department, Philadelphia Office of Emergency Management

**Action Plans:**

- The implementation team will utilize Philadelphia Police Department data to identify neighborhoods that suffer the highest rates of firearm injury and will offer the *Fighting Chance* training as a resource to groups in those communities.
- Conduct train-the-trainer sessions for new volunteer staff.
- Coordinate with school and neighborhood leaders to offer *Fighting Chance* trainings within their communities.
- Research options for conducting a study measuring community members that receive *Fighting Chance* training willingness to assist people suffering from penetrating injuries post-training.

**Objectives:**

- Provide *Fighting Chance* training to 1,000 community members each year.
- Provide *Fighting Chance* training to 500 Philadelphia School District Staff each year.
- Develop survey to assess community members’ willingness to provide first aid to people suffering from penetrating injuries post-training.

**Estimated Budget:** \$110,000 for staffing and educational materials (*for Cradle to Grave, Fighting Chance & Safe Bet collectively*)

**Program 3:** *Safe-Bet* provides gunlocks to families to reduce accidental shootings.

**Goals:**

1. Increase awareness about the importance of the safe storage of firearms among residents living in disadvantaged communities.
2. Provide free cable gun locks to residents living in disadvantaged communities impacted by gun violence.

**Metrics:**

- Number of gun locks distributed.
- Number of visitors to Temple Safety Net's how-to page for using cable gun locks.

**Available Resources:** TUH's Trauma Outreach Coordinator has an arrangement that allows for the purchase of cable gun locks from the manufacturer at cost. These devices are then regularly offered to Philadelphia residents during community events.

**Implementation Team**

- Executive Sponsor
  - *Chief of Surgery, TUH - Amy Goldberg, M.D.*
- Team members:
  - *Trauma Outreach Coordinator, Trauma Program, TUH - Scott Charles*

**Community Participants:**

- Community Organizations: Operation Save Our City, Father's Day Rally Committee.
- Government Offices: Philadelphia Police Department, SEPTA Police Department, Pennsylvania Attorney General's Office.

**Action Plans:**

- Purchase gunlocks.
- Coordinate with community partners to host gun lock giveaways.
- Distribute free gun locks at community events.
- Monitor traffic at Safe Bet's how-to page - webpage referenced on gun-lock packaging that provides instruction on using cable gun locks.

**Objectives:**

- Distribute 2,500 gun-locks per year
- Facilitate 500 visits (or 20% of community members provided gun locks) to Safe Bet's how to use gun locks instructional webpage.

**Communication:** Gunlock giveaways will be announced on the Temple's Safe Bet website, as well as on the social media platforms of various partner agencies.

**Estimated Budget:** \$110,000 for staffing and educational materials (*for Cradle to Grave, Fighting Chance & Safe Bet collectively*)

**Program 4:** *Trauma Support Advocates Program*

**Goals:**



1. Expand existing collaboration between TUH and the community-based agencies focused on violence prevention and intervention to enhance support provided to violently injured crime victims within the 22<sup>nd</sup>, 24<sup>th</sup>, 25<sup>th</sup>, 26<sup>th</sup>, 35<sup>th</sup>, and 39<sup>th</sup> Philadelphia Police Districts.
2. Develop hospital-based best practices for addressing the needs of a homicide victim's family in the immediate aftermath of their loved one's death and beyond.
3. Decrease response time from victim service agencies from 72 hours to 12 hours of initial victimization.
4. Increase number of crime victim compensation claims filed on behalf of violently-injured patients from the 22<sup>nd</sup>, 24<sup>th</sup>, 25<sup>th</sup>, 26<sup>th</sup>, 35<sup>th</sup>, and 39<sup>th</sup> Philadelphia Police Districts.
5. Increase number of assault victims who complete the Criminal Justice Preliminary Hearing process.
6. Establish volunteer chaplaincy program in collaboration with TUH's Office of Patient Experience and Injury Patient Family Advisory Council to provide spiritual and emotional support to patients and families in the hospital's trauma unit.

### **Metrics:**

- Average response time for service agencies to make initial contact with violently-injured patients.
- Number of patients who file crime victim compensation claims after being treated at TUH.

**Available Resources:** A team of 6 trauma support advocates (3 full-time; 2 part-time/weekend; and 1 pool) will be available in-house 24-7-365. They will round in the emergency department throughout the day, respond to every crime-related trauma alert, and offer emotional support to patients and their families as part of their everyday responsibilities.

### **Implementation Team:**

- Executive Sponsor
  - *Chief of Surgery, TUH - Amy Goldberg, M.D.*
- Team members
  - *Trauma Outreach Coordinator, Trauma Program, TUH - Scott Charles*
  - *Director, Trauma and Burn Operations, TUH - Jill Volgraf*
  - *Trauma Victim Advocate, Trauma Program, TUH - Ian Hirst-Hermans*
  - *Trauma Victim Advocate, Trauma Program, TUH - Leslie Ramirez*
- Other TUH Partners:
  - Office of Patient Experience
  - Injury Patient Family Advisory Council

### **Community Participants:**

- Community Organizations: Northwest Victim Services; Congreso; North Central Victims Services; Concilio.
- Government Offices: Pennsylvania Commission on Crime and Delinquency; Philadelphia Police Department; Philadelphia District Attorney's Office.

### **Action Plans:**

- Hire 6 new trauma support advocates.
- Have new hires complete trauma-informed training.
- Facilitate in-services for the departments with which advocates will have the most contact, including the emergency department and 9 West and 9 East in TUH.
- Host community outreach events to inform past and potential victims of crime about their rights and the services available to them through the *Trauma Support Advocates Program* initiative.
- On-board first class of 5-10 volunteer chaplains to serve in hospital's trauma unit.

**Objectives:**

- Decrease the time that it takes violently-injured patients treated at TUH to be connected with a victim agency from 72 hours to 12 hours;
- Connect 300 violently-injured patients to crime victim services.
- Provide ongoing emotional and spiritual support to trauma patients and families through volunteer chaplains.

**Communication:** A trauma support advocate will attend daily trauma morning reports and each advocate will attend emergency department huddles throughout the day.

**Estimated Budget:** \$730,000 for 30-month project funded through federal *Victims of Crime Act* grant.

# PLAN TO IMPROVE SUBSTANCE USE DISORDER TREATMENT INTEGRATION

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## Rationale:

Temple University Hospital's (TUH's) service area has the highest opioid mortality rate in the City of Philadelphia. During our CHNA, about three-quarters of Resident Survey (76.3%) and Key Informant Survey Respondents (73.7%) indicated that substance use was one of the top three issues facing the community. Needed substance use disorder services identified included early intervention and community education as well more behavioral health services and providers.

During the past year, Temple University Health System (TUHS) has expanded access to best practice substance use disorder (SUD) integrated treatment within its hospitals, including at TUH, and external to TUHS. There is still additional opportunity to place patients into the appropriate level of care for substance use disorders more efficiently.

## Goals/Objective:

1. Establish 24/7 Certified Recovery Specialist (CRS) coverage in all TUHS Emergency Departments (ED).
  - o Work with ED leadership to ensure effective patient flow.
2. Deploy the level of care pre-assessment (LOC) in the CRS workflow.
3. Engage the EPIC team to review the current SUD monitoring infrastructure and modify based on needs specified in the goals.
4. Launch the "SUD Warm Handoff Collaborative" to support the transition of SUD patients treated in TUHS's acute care units to the next appropriate level of behavioral health care.
5. Introduce Medication Assisted Treatment into TUH Episcopal Campus's CRC and utilize 23 hour observation status for the purpose of improving patient recovery.

## Metrics:

- Number of SUD patients seen by the CRS team as compared to prior year.
- Number of SUD patients in ED/Hospital vs. number of LOC completions.
- Number of Buprenorphine waived providers as compared to prior year
- Number of SUD patients that link successfully to an appropriate-level of care for further treatment and support necessary for managing SUD.

**Available Resources:** An internal team representing SUD treatment programs throughout TUHS, encompassing all settings, will collaborate to ensure the proper infrastructure is established to attain the goals. For the Warm Handoff Collaborative, representatives from both TUHS and external SUD treatment programs will be present to ensure SUD patients are tapped into the most appropriate resources based on individual needs. When the need and treatment site is targeted, the network will collaborate to ensure the referral process is as simple as possible.

## Implementation Team:

- Executive sponsor(s)
  - o *Vice President, Population Health, TCPH* - Steven R. Carson MHA, BSN, RN
  - o *Chief Information Officer, TUHS* - David Kamowski (EPIC)

- *Chief Medical Officer, TUH - Tony Reed, MD*
- *Chief Executive Officer, TUH – Episcopal Campus, Kathleen Barron*
- *Chief Medical Officer, Jeanes Hospital - Rebecca Armbruster, D.O.*
- **Team members**
  - *Project Manager, Population Health, TCPH - Patrick Vulgamore*
  - *Drug and Alcohol, Clinical Supervisor, TUH - Episcopal Campus - Danny Rivera*
  - *Executive Director, PRO-ACT - Jennifer King*
  - *Director of PI and Infection Prevention, Jeanes Hospital - Catherine Huck*
  - *PI – Informatics Manager, TUH - Kathleen Lux (EPIC)*

### **Community Participants:**

- **Community Organizations:** Team of self-selected outpatient practices, inpatient rehabs and PROACT.
- **Government Offices:**
  - **City:** Department of Health, Community Behavioral Health, Office of Addiction Services
  - **State:** Department of Human Services, Department of Drug and Alcohol Programs, Department of Health
- **Collaborative Opportunities to Advance Community Health Initiative (COACH)**

### **Action Plans:**

- Finalize contracts between TUHS and the City of Philadelphia’s Office of Addiction Services to secure enough support to sustain 24/7 CRS coverage for all of our EDs and coverage of our outpatient clinic, The TRUST Clinic.
- Deploy the LOC Assessment via EPIC.
  - Ensure CRS team has:
    - Appropriate EPIC access
    - Training on the LOC Assessment
    - Training on EPIC
- TUHS team to work with individual ED’s to ensure effective patient flow based on the addition of continuous CRS coverage and the deployment of the LOC assessment by the CRS prior to patient discharge.
- Convene the “Warm Handoff Taskforce”, establish hand-off pathways specific to each site with contingencies based on days/times the patient will be discharged.
  - Meet monthly to review data/effectiveness of the pathways.
- Partner with Collaborative Opportunities to Advance Community Health Initiative (COACH) to develop collaborative approach to address City of Philadelphia’s behavioral health needs, including for SUD patients, with other area health systems through community-based partnerships.

### **Objectives:**

- Increase number of SUD patients seen by the CRS team as compared to prior year.
- Increase number of waived providers as compared to prior year.
- Increase ratio of SUD patients that link successfully to an appropriate-level provider.

**Communication:**

- We will work in tandem with each of our ED's to deploy a new patient flow pattern and continuously train all staff.
- We will be in continuous contact with our referral sites to ensure effective pathways.
- We will work with TUHS public relations to establish a communications plan once the infrastructure is solidified.

**Estimated Budget:** \$1.1 million - includes \$1million contingent on awarding of combined grant funding from the Department of Human Services, Pennsylvania Drug and Alcohol Prevention Warm Handoff Initiative and U.S. Substance Abuse and Mental Health Services Administration & \$100,000 from internal TUHS resource allocations.

## PLAN TO IMPROVE HEALTH OF MOMS AND NEWBORNS

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### Rationale:

The well-being of mothers and their children determines the health of the next generation and can help predict future public health challenges for families, communities, and health care systems. Temple University Hospital's (TUH) North Philadelphia community has one of the highest infant mortality rates in the nation. Many babies are born to young mothers living in poverty who lack resources to care for a newborn.

During TUH's Community Health Needs Assessment (CHNA), Public health data and Focus Group Participants identified affordable childcare, pre-natal care and parenting classes as important needs for mothers, babies and families in the hospital's service area. Providing programs for mothers, babies and families was also a priority in TUH's 2016 CHNA.

### Goals:

1. Maintain TUH's *Sleep Awareness Family Education at Temple Program (SAFE-T)*, which provides education to mothers regarding safe infant sleep practices and free "Baby Boxes" - functioning bassinets that provide babies a safe place to sleep.
2. Promote breastfeeding through patient, family, peer support and nursing staff education programs.
3. Increase patients' compliance with pre-natal care.
4. Initiate a taskforce to explore delivery of care models to enhance the delivery of care in the prenatal practice with the goal of increasing compliance with prenatal visits. (i.e. "Centering" prenatal care, which involves development of groups of women of similar gestation to provide women with a support group).

### Metrics:

- Breast feeding initiation rate
- Breastfeeding exclusive rate
- Aggregate number of pre-natal days
- Number of *SAFE-T* baby boxes distributed

### Available Resources:

- Community resources for food and nutrition through Pennsylvania's Women's Infant and Children Assistance Program (WIC).
- Breastfeeding Resource Center lactation consultants for training nursing staff and assisting mothers in the hospital with breastfeeding education and support.
- TUH Breastfeeding Task Force
- Smoking Cessation Programs

### Implementation Team:

- Executive Sponsors
  - *Senior Nurse Manager Labor and Delivery and Maternity, TUH* - Kimberly Hanson, BSN, RN

- *Chair, Obstetrics and Gynecology, TFP* - Enrique Hernandez, MD
- *Medical Director of Postpartum and Lactation, TFP* - Gail Herrine, MD, IBCLC
- **Team Members**
  - *Medical Director, Labor and Deliver, Maternal Fetal Medicine, TFP* - Wadia Mulla, MD
  - *Medical Director, Well Baby Nursery, TFP* - Megan Heere, MD
  - *Medical Director, Infant Intensive Care Unit, TFP* - Heidi Taylor, DO
  - *Nurse Manager, Infant Intensive Care Unit, TUH* - Colleen Moran, BSN, MHA, RN, RNC-NIC
  - *BLS Provider, Infant Intensive Care Staff Nurse, TUH* - Sue Todd, RN
  - *Assistant Nurse Manager, Quality and Newborn Screening, TUH* - Cheryl Selden-Klein, MSN, RN, RNC-OB
  - *Assistant Nurse Manager, Maternity, TUH* - Kulwant Klair, MSN, RN
  - *Assistant Nurse Manager, TUH* - Diana Giampietro, MSN, RN
  - *Operations Manager, Performance Improvement, TUH* - Ashley Manual, MS
  - *Senior Director, Corporate and Foundation Relations, TUH* - Lindsay Farrington
  - *Social Worker, TUH* - Maria Sierra - Ortiz, MSW
  - *Senior Administrator, OB-GYN, TUH* - Nancy Fox

### **Community Participants:**

- Community Organizations – Breast Resource Center, MOM Mobile, United Way, March of Dimes
- Government Offices – City of Philadelphia, Pennsylvania’s Supplemental Nutrition Program for Women, Infants and Children (WIC) assistance program
- Other Temple University Health System (TUHS) ambulatory facilities

### **Action Plans:**

- Advance breast feeding education strategies at TUH to support improved breastfeeding initiation and exclusive rates to sustain hospital’s *Baby Friendly Hospital Designation*.
- Continue *SAFE-T Program* including ongoing research study measuring efficacy of program post discharge.
- Obtain additional funding for *SAFE-T Baby Boxes* with assistance from Institutional Advancement for grant support.
- Implement infant CPR education program for all newborns delivered at TUH.
- Maintain as a key strategy, improving compliance with pre-natal care and continued implementation of TUH’s comprehensive coordinated approach to pre-natal care & education.
- Expand hospital’s database for nutritional options in community in collaboration with USDA Women, Pennsylvania’s Women, Infants and Children (WIC) assistance program and City Health Centers, Common Market and Farm-to Families programs to improve access to and educate families on nutritional foods.
- Continue to support City of Philadelphia MOM program, which connects mothers and babies from birth through age 5 with social, educational and healthcare support.
- In partnership with City of Philadelphia, explore a community resource access plan for mothers and families.
- Reduce smoking and alcohol consumption among mothers through promoting smoking cessation and alcohol use awareness.

## Objectives

- Improve breast feeding initiation to rate of 75 % over course of next year.
- Increase breastfeeding exclusive to rate of 30 % over course of next year.
- Continue to provide baby boxes to all mothers who deliver and have their babies discharged from TUH.

## Communications:

- Collaborate with community partners to improve access to obstetrical care, pre-natal & lactation education, and healthy food consumption and physical activity among families.
- Expand obstetric and pediatric based community outreach programs within Temple's practices and surrounding community with a focus on women at high risk for delivering high risk infants.
- Provide pre-natal education materials in all pre-natal practices and inpatient settings.
- Explore options for grant funding to support advancing education related to comprehensive pre-natal care, newborn care, and post-partum follow up.

**Estimated Budget:** \$175,000 (\$75,000 in grant funding for *SAFE-T Program* from Snider Foundation as well as a financial grant from Temple University Owl Crowd Drive in addition to \$100,000 each year for staffing)



## APPROACH TO UNMET NEEDS

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**Addressing Social Determinants of Health.** In 2018 Temple University Hospital (TUH) in collaboration with the Temple Center for Population Health (TCPH), Temple Faculty Practice Plan (TFP) and Temple Physicians Inc. (TPI) developed a data collection tool for recording the assessment of the social determinants of health for patients. This tool is imbedded into TUH's EPIC electronic medical record and is administered to patients on a daily basis in the Emergency Department and inpatient and ambulatory clinics.

TUH, TCPH and our employed physician practices will continue to connect our vulnerable patients with community-based services responding to the social determinants of health, such as free transportation, clothing, housing assistance, free pharmaceuticals, medical supplies and assistance with co-pays that provide them with the resources they need to heal after discharge.

**Access to Health Insurance.** Our financial counselors screen all uninsured and underinsured patients (including those with high deductibles and co-pays) who are hospitalized or require elective outpatient hospital services to determine their eligibility for government funded medical insurance such as Medicaid and the Child Health Insurance Program. If eligible, we connect these patients with resources that can help them attain coverage.

While we are vigilant in our efforts to connect patients with insurance options, we do not have sufficient resources to conduct extensive community outreach related to health insurance access. This can be carried out by area health insurers, who are expected to conduct significant outreach efforts for the health insurance exchanges under the *Affordable Care Act*.

**Access to Primary and Preventative Care.** As a hospital, we have limited resources to address the comprehensive primary care needs in our community. However, as discussed in previous sections, we have developed many programs and services to reduce barriers to care, such as our *Cradle to Grave* program, social services, community outreach, and financial counseling. In addition, our affiliated network of community physicians, TPI, as well as TFP, provides our low-income community with access to primary and specialty services. Virtually all Temple physicians, whether community or faculty based, accept patients covered by Medicaid.

TUH is also a partner with the City of Philadelphia, the Philadelphia Corporation for Aging, and the United States Department of Health and Human Services, other hospitals and community stakeholders in efforts to strengthen access to primary and preventative care.

## PLANNING FOR A HEALTHIER POPULATION

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Temple University Hospital (TUH) is committed to improving the health of the communities we serve. While our Implementation Strategy provides a broad outline of our current plans, we will continue to develop and refine our approach moving forward. In so doing, we plan to work with the City of Philadelphia's Department of Public Health and Department of Behavioral Health and Intellectual Disabilities to integrate our community outreach and education initiatives with theirs to make more efficient and effective use of resources already available, and to align our efforts, as appropriate, with the City's public health priorities. In partnership with community organizations, other health providers, the City of Philadelphia, the Commonwealth of Pennsylvania and the Temple family of hospitals and physicians, we hope to improve the health of our population and the quality of living in the neighborhoods we serve.

### **Temple Center for Population Health**

As a member of Temple University Health System (TUHS), TUH will continue to align its efforts with the Temple Center for Population Health (TCPH) to support the clinical and financial objectives of TUHS in attaining a sustainable model of health care delivery through clinical and business integration, community engagement and the implementation of medical and nonmedical interventions to promote high value care, improved health outcomes and academic distinction.

Consistent with federal health priorities of providing better care, ensuring smarter spending and building healthier communities, TCPH is utilizing a series of population health building blocks to unite clinical and business models into a cohesive and robust series of programs. These include:

- Value-Based Contracting – TCPH works with TUHS hospitals and ambulatory practices in partnership with third party payers to share risk and provide high value care to our patients.
- A strong employed primary care model supported by a network of 27 NCQA-designated level three Patient Centered Medical Homes (PCMHs) in North Philadelphia.
- A Clinically Integrated Network of independent community primary care providers, focused on improving quality outcomes. A network of alliances and partnerships with community agencies and organizations, many of whom specialize in managing the non-medical health-related social needs of our patients that ultimately influence health outcomes.
- A robust care management infrastructure that identifies patients at risk for recurrent health care issues and intervenes to provide medical and non-medical support utilizing nurse navigators, social workers and community health workers.
- A connected and cohesive care delivery and transitions of care of care model implemented to assure a high level of communication and care when a patient is transferred to a different care setting or is discharged home.
- Community engagement focused on provider and community agency partnerships and community leaders.
- Electronic Health Information Exchange (Health Share Exchange) to assure that electronic information is securely transferred and is available to health care providers across our region as needed.

## **Key Programs for High Value Care**

The TCPH coordinates and supports patient and family care by focusing on quality indicators and assuring accurate and timely communication between providers and between providers and patients. This is achieved through a variety of inter-related programs including:

Nurse Navigation: The TCPH nurse navigators are registered nurses who work with and in physician practices to improve patient outcomes related to quality measures, including the Healthcare Effectiveness Data and Information Set (HEDIS) measures. These measures are focused on management of chronic diseases including hypertension and diabetes; appropriate cancer screening; immunizations; appropriate use of medications and smoking cessation. The nurse navigators also smooth the way for transitions of care from the inpatient to the outpatient setting, calling patients shortly after discharge to make sure they are managing at home, understand their medications and have access to and appointments for timely post-hospitalization follow-up. Nurse navigators play a vital role in population health management.

Community health workers (CHWs): Temple University is a national leader in training and utilizing CHWs as coaches and support for patients with chronic disease and high utilization of health services. These individuals live and work in our community and visit our patients in their homes to link the patients with the support they need to enhance their care and health outcomes. The CHWs serve as liaisons between the patients and their providers to improve compliance with the care plan and prevent unnecessary emergency department visits and readmissions.

Wellness programs and chronic disease management: TCPH provides chronic disease management services and calcium score screening for defined populations affiliated with organizations that are self-insured. These programs identify individuals at risk for health issues and intervene to prevent progression of disease.

The Skilled Nursing Home and Home Health Collaborative: Initiated by the TCPH, this group of 22 skilled nursing home facilities and 7 home health agencies caring for TUHS patients is working to reduce readmissions from the post-acute setting by establishing a clinical communication strategy, metric standardization and a care management competency inventory.

Transition of Care Program: In collaboration with the Temple Access Center, the TCPH *Transitions of Care Program* provides post-acute care contact for patients discharged from Temple University Hospital. The program schedules follow-up calls to assure that patients are compliant with scheduled appointments and helps resolve open issues. Complex problems are escalated to nurse navigators.

## **Collaborative Programs on Local, State and National Levels**

The TCPH collaborates with a number of health care providers external to TUHS to improve communication and transitions, and deliver high value care. These include Federally Qualified Health Centers, City Health District Clinics and community primary care practices. We also work with city, state and federal government agencies on the implementation of grant-funded programs to create resources for specific populations of patients. For example:

- The Diabetes Prevention Program (DPP) funded by the Center for Disease Control (CDC) through the Philadelphia Department of Health. At the core of this program, is the training of CHWs as peer coaches to target pre-diabetes, hypertension and obesity. The program includes patient education for newly diagnosed hypertension. The patients who have benefited from this grant are in TPI practices, the Bright Hope Baptist Church, or are part of the Law Enforcement Health Benefits program.
- The TCPH was invited to participate in a practice transformation network called the Transforming Clinical Practice Initiative (TCPI), a Center for Medicare and Medicaid Innovation (CMMI) grant, awarded to Vizient. The collaborative is designed to provide tools and data to support performance improvement. Metrics have been selected that support the clinical and business imperatives of TPI and TUP. The focus is on the patient experience, improvement in care coordination and a reduction of gaps in care. The collaborative is designed to prepare providers for alternative payment models being considered by CMS for implementation in the near future.

## **Collaboration with the Lewis Katz School of Medicine at Temple University**

As part of the academic mission of TUHS and the Lewis Katz School of Medicine, the TCPH contributes to the undergraduate and graduate curriculum for teaching population health in collaboration with the Temple Center for Bioethics, Urban Health and Policy. This collaboration includes conducting research to compare different models of care and interventions focused on enhancing the delivery of high value care.