TEMPLE UNIVERSITY HOSPITAL

Community Health Needs Assessment Implementation Plan

FY19 Progress Report

TEMPLE HEALTH
TEMPLE UNIVERSITY HOSPITAL

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FISCAL YEAR 2019 PROGRESS REPORT HIGHLIGHTS

During Fiscal Year 2019 (FY19), Temple University Hospital (TUH) launched several innovative initiatives to improve community health and address our 2016 Community Health Needs Assessment Implementation Plan priorities. In response to the opioid crisis, TUH and the Temple Center for Population Health (TCPH) with support from the Commonwealth of Pennsylvania, established a warm hand-off clinic, the TRUST (Temple Recovery Using Scientific Resources) clinic, which served over 326 patients with more than 2771 visits this year. The TRUST clinic provides hot meals, emergency shelter services, medication assisted treatment (MAT) and peer recovery specialist counseling to individuals with substance use disorder (SUD). With this clinic as a hub, we also expanded MAT programs to several community based sites throughout Philadelphia using multidisciplinary care teams and social supports. We are now coordinating SUD treatment services among our emergency departments, local health centers, physician offices and other outreach organizations.

In addition to the TRUST clinic, we created a community network of primary care providers in North Philadelphia to share best practices for treating individuals with SUD as well as joined Pennsylvania's Opioid Learning Network to implement SUD best practice clinical interventions in collaboration with other healthcare providers across the Commonwealth. To address the social determinants, TUH and Temple Physician Inc. (TPI) also developed an assessment tool that captures patient information on housing, food insecurity, transportation, health care literacy, safety and financial concerns. The tool is imbedded into our electronic medical record EPIC system and was launched in May 2019 within select hospital units and TPI clinics. To date, 86% percent of individuals asked to answer the tool's survey questions were willing to respond and of these 37 % have at least one social determinant that needs to be addressed. In FY20, use of this tool will expand to all TUH locations.

PLAN TO STRENGTHEN CULTURALLY COMPETENT CARE

Title: Provide Physicians and Other Staff Education and Resources to Deliver Culturally Competent Care

Strategy Team Leads:

- *Chief Regulatory Affairs Officer, TUHS* - Sherry Mazer
- *Director of Linguistics and Cultural Services, TUHS* - Angel Pagan

Goal: To improve health care outcomes by educating healthcare providers on how to provide culturally competent care.

Summary of Tactics Implemented and Outcomes:

- **Tactic**: Promote awareness of health disparities through Temple University Health System's (TUHS) annual Cultural Competence and Awareness in Healthcare Symposium.
    - This year's Symposium focused on the Russian Speaking Community. The presentations included:
        - Keynote address on *Culture, Context, and Health Disparities* in this community;
        - Presentation on *Implications for Quality Care* for this community.

- **Outcome**: The 7th annual Cultural Competence and Awareness in Healthcare Symposium took place April 2019. There were over 135 TUHS staff members and clinicians in attendance. The event provided information on the importance of providing culturally competent care to our diverse patient populations. In order to strengthen our relationships with the community we also had a presenter from The Center for Holistic Medicine discuss the importance of understanding Russian patients use of complementary medicine.

- **Tactic**: To improve interpretive services expand our video remote interpreter system (video system) to include the following languages:
    - American Sign Language
    - Spanish
    - Arabic
    - Russian
    - Polish
    - Cantonese
    - Mandarin
    - Burmese
    - French
    - Haitian Creole
    - Korean

- Nepali
- Portuguese
- Somali
- Vietnamese

- **Outcome**: The additional language resources provided over our video system have been successfully implemented in all inpatient areas of Temple University Hospital (TUH) and the following departments: TUH Emergency Room, TUH-Episcopal Campus Emergency Room, Jeanes Hospital Emergency Room, Labor and Delivery, Post-Partum, OB Triage, and the Operating Room. The languages selected are the highest volume languages for patients throughout TUHS facilities. This service is provided in addition to our on-site interpreters and phone interpreters.

- **Tactic:** Mandatory Competency
    - The mandatory competency for Cultural Awareness developed in FY 2018 for all TUHS staff continues to be required. Basic information regarding cultural awareness, health system policies on nondiscrimination, patient rights, the use of qualified language resources, and translation of documents is covered.

- **Outcome:** Every employee is required to take and pass this competency. Mandatory competencies are reviewed with staff during their annual performance evaluation conducted by their manager.

Conclusion and Next Steps:

- This year, the annual Cultural Competence and Awareness Symposium provided education to all TUHS front end staff and clinicians on the importance of providing culturally competent care to the Russian Speaking Community.

- Online webinars from this year's Cultural Competence and Awareness Symposium will be posted to the Intranet. The online webinars will provide continuing education for those who participate and will be available for a span of three years.

- During FY20 we will expand our video system language services to all TUH departments and campuses. This expansion will enhance our non-English speaking and hearing impaired patient and families' capacity to communicate health care needs.

PLAN TO ADDRESS HUNGER & FOOD INSECURITY

Title: Collaborative Opportunities to Advance Community Health (COACH)

Strategy Team Lead:

- *Director Population Health, TCPH* - Veronica Whyte

Goal: Identify food insecurity in Temple University Hospital's (TUH) discharged patient population and connect them to appropriate food resources or the Philadelphia Department of Public Health to assist with accessing financial resources.

Summary of Tactics Implemented and Outcomes:

- **Tactic:** Join Philadelphia city-wide collaborative to identify and address poor health outcomes related to food insecurity. Food insecurity is defined as the lack of consistent access to affordable, nutritious food.

- **Outcome:** During FY19 TUH collaborated with other Philadelphia base health system's hospitals. These include the Children's Hospital of Philadelphia, Einstein Healthcare Network, Holy Redeemer Health System, Jefferson Health (including Abington-Jefferson Health and Aria-Jefferson Health), Mercy Health System, and University of Pennsylvania Health System along with Benefits Data Trust, Drexel University's Center for Hunger-Free Communities, Coalition Against Hunger, Delaware Valley Regional Planning Commission, The Food Trust, Health Federation of Philadelphia, Health Partners Plans, Keystone First, Philabundance, Philadelphia Association of Community Development Corporations, SHARE Food program, and United Way of Greater Philadelphia and Southern New Jersey have begun a food access pilot designed to connect patients in need with appropriate resources and programs. The work of the pilot and results are too early to report.

Conclusions and Next Steps: In an effort to address social barriers causing health disparities in our surrounding communities, TUH and our network of primary care and specialty care physicians, Temple University Physicians (TPI), created an assessment tool that captures patient information related to the social determinants of health. The tool was developed by a multidisciplinary workgroup based on the CMS accountable care model recommendation and contains 10 questions on food insecurity, housing, transportation, utilities, finances, healthcare literacy, and safety. The tool also includes referral resources to address unmet needs identified. This tool was launched in May 2019 within select hospital units and TPI practices and is imbedded into our electronic medical record EPIC system. To date, 86% percent of individuals asked to answer the tool's survey questions were willing to respond and of these 37 % have at least one social determinant that needs to be addressed. Preliminary data findings are below:

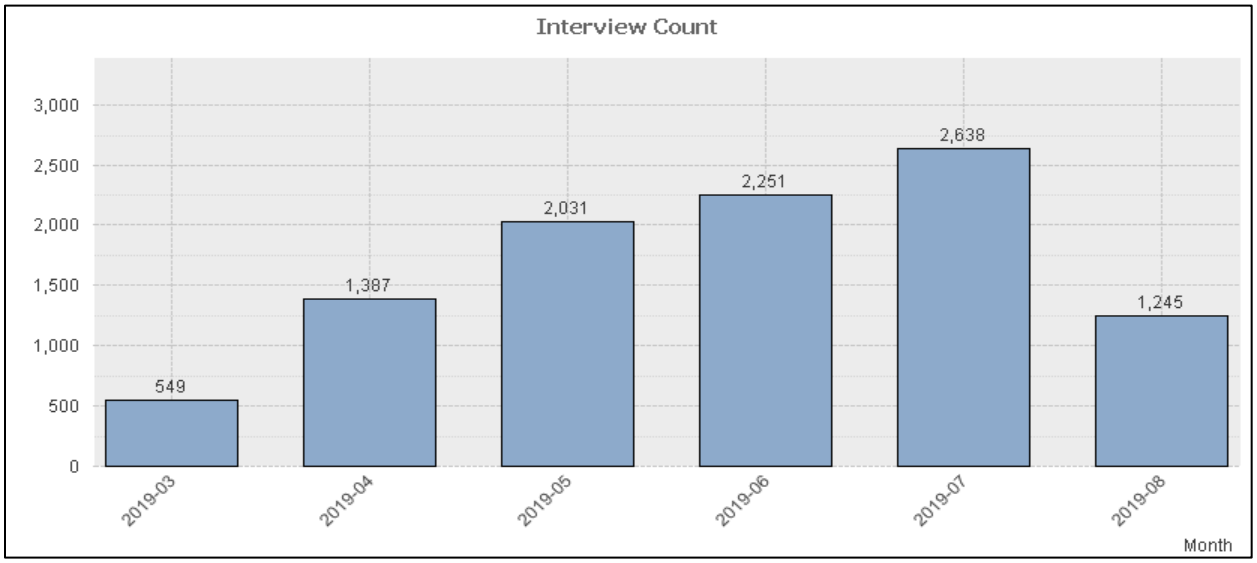
Interviews 3/19/2019 thru 8/15/19

Data as of 8/19/19

Participated Patients Overview:

Total Patients	3,786
Patients w/ Housing Instability	369
Patients w/ Food Insecurity	414
Patients w/Transportation Issues	246
Patients w/ Utility Needs	138
Patients w/ Safety Concerns	36
Patients w/ Health Related Fin Strain	205
Patients w/ Issues Understanding Healthcare	835
Patients w/ any SDOH	1,380

Housing Instability as % of all Patients	9.70%
Food Insecurity as % of all Patients	10.90%
Transportation Issues as % of all Patients	6.50%
Utility Needs as % of all Patients	3.60%
Safety Concerns as % of all Patients	1.00%
Health Related Fin Strain as % of all Patients	5.40%
Issues Understanding Healthcare as % of all Patients	22.10%
Any SDOH as % of all Patients	36.50%



In FY20, use of this tool will expand to all TUH locations. Additionally, we will also continue to develop processes to link patients in need with the appropriate services based on the tool's survey results. Through standardized use of this tool, we plan to conduct population-based analytics and to develop risk stratification models so we can better meet the needs of our patients.

PLAN TO ADDRESS DIABETES

Title: Diabetes Prevention Program (DPP)

Strategy Team Lead:

- *Director Population Health, TCPH* - Veronica Whyte

Goal: Identify Temple University Hospital (TUH) patients, employees and community members within our catchment area who are pre-diabetic. Enroll them in the Diabetes Prevention Program (DPP) using the Centers for Disease Control and Prevention (CDC) DPP curriculum. This includes education on how to incorporate exercise into their daily routine along with calorie and fat control to attain a 5-7% weight loss and increase their activity level to 150 minutes or 2 ½ hrs per week.

Summary of Tactics Implemented and Outcomes:

- **Tactic:**
  - With the Temple Center for Population Health (TCPH) in collaboration with the City of Philadelphia, participate in a CDC-funded grant to provide free DPP classes at various locations in our catchment area, including across North Philadelphia. The core of the program focuses on training Community Health Workers (CHWs) to be lifestyle coaches for the purposes of managing pre-diabetes, hypertension and obesity.

- **Outcome**
  - In FY19 the DPP program completed its fourth and final year of grant funding. DPP also applied for a Medicare provider number and once received can bill for the services it provides. The program has also partnered with Health Partner Plans and Keystone First to provide services for their member populations.

  - DPP sessions continue to be provided at TUH, Bright Hope Baptist Church, Zion Baptist Church, Mercy Neighborhood Ministries, Fortaleza Rehab & Fitness Center; in N.E. Philadelphia: Jeanes Hospital & Klein Life Community Center; and in Center City: Law Enforcement Health Benefits (LEHB).

  - DPP participants lost an average weight loss of 4.69% of their body weight as measured at the time of program completion as shown in Figure 1 below.

Figure 1: Average % Weight Loss, DPP Participants

CDC-Funded Grant with the Philadelphia Department of Health 10/1/2014 – 9/30/2018					
Grant Year	**Classes**	**Enrollees**	**Currently enrolled**	**Graduates**	**Avg. Weight Loss**
Year 1	4	36		11	
Year 2	8	157		69	
Avg. Weight Loss Data Submitted to the CDC for Years 1-2:					**4.60%**
Year 3	9	144		60	
Avg. Weight Loss Data Submitted to the CDC for Years 3:					**5.90%**
Year 4	9	99		44	
Avg. Weight Loss Data Submitted to the CDC for Years 4:					**6.90%**
Post Grant Reporting Start Date: 10/1/2018 – 9/31/2019					
Year 1 Currently Mid Year					
	8	220	110	Scheduled to Complete 2019	
Avg. Weight Loss based on current calculations:					**4.69%**

Conclusions and Next Steps: Over the past four years, DPP has proven a valuable resource for our patients and surroundings communities in the prevention of chronic disease. In FY20, we will continue to partner with the City of Philadelphia on a new CDC grant we were awarded to expand cholesterol and blood pressure management community education to 22 Temple Physician Inc. (TPI) clinic locations. To date, we have expanded this education to 6 TPI practices. Preliminary findings show a reduction in systolic and diastolic blood pressures over a 6-month period among participants.

PLAN TO REDUCE VIOLENCE

Title: To Strengthen Awareness of Gun Violence

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

Goal: Strengthen awareness of the dangers of gun violence to reduce hospitalizations, barriers to preventative health care, and to improve the quality of living in our underserved community.

Summary of Tactics Implemented and Outcomes:

- **Tactic:** The tactics and Temple University Hospital's (TUH) violence prevention and intervention programs for FY19 were designed to continue to educate the Philadelphia community's youth about the dangers of gun violence (*Cradle to Grave*), how to provide first aid to gunshot victims (*Fighting Chance*), promote use of gun locks (*Safe Bet*), and link victims of violent crime to resources that will assist them in meeting their social, emotional, and financial needs before they leave the hospital (*TUH Victims Services Collaborative*).

- **Outcome:**
  - Delivered our *Cradle to Grave* (C2G) program presentation to more than 1,000 Philadelphia residents, a significant number of whom were at-risk youth residing in North Philadelphia.
  - C2G delivered a series of presentations modified for young offenders detained at the Philadelphia Juvenile Justice Center (center). These presentations were given to individuals through the center's high school program.
  - Continued *Fighting Chance* program, which uses volunteers from TUH's Trauma and Emergency Medicine departments to train community members to administer first aid to gunshot victims.
  - As part of TUH's *Safe Bet* Initiative, provided 1,000 free gun locks to Philadelphia residents in collaboration with community organizations and local law enforcement agencies– most of who reside in North Philadelphia.
  - Referred more than 200 victims of violent crime to community-based victim advocacy programs serving North Philadelphia as part of the *TUH Victims Services Collaborative*.

Conclusions and Next Step: Our surrounding North Philadelphia communities continue to be receptive to our violence intervention initiatives. During FY20, we will expand our programs with the launch of a new 24-hour *Trauma Support Advocate Program* that will provide immediate assistance to violently-injured patients upon their arrival to the hospital.

PLAN TO IMPROVE HEALTH OF MOMS & NEWBORNS

Title: Reduce Infant Mortality and Improve Access to Coordinated Community Resources for Mothers and Newborns.

Strategy Team Lead:

- *Interim Director, Nursing for Women's and Infants* - Kim Hanson, MSN, RN
- *Interim Chief Nursing Officer* - Elizabeth Menschner, DNP, MSN, MAS, RN
- *Chair, OB/GYN* - Enrique Hernandez, MD
- *Obstetrician, OB/GYN* - Gail Herrine, M.D.

Goal: Improve the health of moms and newborns. Reduce infant mortality and improve access to community resources for mothers and newborns. Continue hospital breast feeding resource center in partnership with the community. Improve compliance with pre-natal visits. Increase breast feeding initiation to a rate of 25%.

Summary of Tactics Implemented and Outcomes:

- **Tactics:**
  - Expand role of obstetric and pediatric based community outreach programs within Temple practices and the surrounding community with a focus on women at high risk for delivering a high risk infant.
  - Maintain and advance strategies to enhance Safe Sleep in our newborns.
  - Collaborate with community partners to improve access to obstetrical care, pre-natal & lactation education, and healthy food and promote physical activity.
  - Improve communication on the health status of pregnant mothers through collaborative practice arrangements.
  - Reduce smoking and alcohol consumption through promoting smoking cessation and alcohol use awareness.
  - Continue our support of the City of Philadelphia's MOM program, which connects mothers and their babies from birth through their 6th birthday with social, educational, and healthcare supports.
  - Provide focused breast feeding education for attending obstetricians and resident physicians.
  - Actively engage with Maternity Care Coalition and provide updates on women and infant initiatives during obstetrics staff meetings, community lactation meetings, and initiate quarterly health center updates on initiatives.

- **Outcomes:**
  - Advanced our *Sleep Awareness Family Education at Temple Program* (SAFE-T), including an ongoing research study post discharge, adopted a new patient and family education portal, and maintained distribution of the "Baby Box".
  - Maintained commitment to improving compliance with pre-natal care, implemented a comprehensive coordinated approach to pre-natal care & education in all pre-natal practices and inpatient settings.
  - Expanded our nutrition database to capture additional nutritional programs and options in our community. Working with USDA Women, the Pennsylvania Women's Infant and Children Assistance Program (WIC), City Health Centers, Common Market and Farm to Families to improve access to nutritional foods and to educate families.

- In partnership with City of Philadelphia, continued to provide smoking cessation awareness and education.
- During FY19, in partnership with the Commonwealth, TUH's Department of Obstetrics as a Center of Excellence expanded its scope of services to provide care to all women of child bearing years suffering from substance use disorders. Our Obstetric Department also entered into a partnership with Temple's TRUST clinic to provide access to peer recovery specialists to support the coordination of care for substance use disorder treatment.

Conclusions and Next Steps: Over the last three years, active participation in all city-wide Department of Health initiatives has facilitated collaboration on care delivery for women and infants. During FY19, our *SAFE-T* program and associated research has expanded our relationships with various community partners. During FY20, we will continue on the success of our obstetrics clinics and Center of Excellence and expand access to treatment to reduce infant mortality and babies in the neo-natal ICU.

PLAN TO ADDRESS OBESITY

Title: Improve general knowledge of healthy food choices, and identify resources to aid in nutrition education.

Strategy Team Lead:

- *Vice President, Service Lines, Temple Heart and Vascular Institute* - Adam Messer, AHD
- *Interim Chief Nursing Officer* - Elizabeth Menschner, DNP, MSN, MAS, RN

Goal: Improve knowledge of healthy food choices and resources to aid in nutrition education. Meet Healthy People 2020 goal to reduce adult obesity to 30.6%. Collaborate with community efforts focused on nutrition and weight management. Integrate nutrition education into all patient classes and group sessions (i.e. preoperative joint replacement classes, transplant support groups). Include an educational program on nutrition and weight management as part of the patient education programming available through Temple University Hospital's (TUH) internal TV programming. Collaborate with Temple University Health System's human resources to address employee obesity and provide nutritional education opportunities. Support good cardiovascular health outcomes by addressing obesity and hyperlipidemia, major causes of cardiovascular morbidity and mortality.

Summary of Tactics Implemented and Outcomes:

- **Tactic:** Develop collaborative to assess and improve access to healthy food options for the community. Implement Food 'RX' to provide discounted or free food options for patients and community members with a validated clinical need or/and food security concern.

- **Outcome:** Expanded *Farm to Families* program to every Thursday at TUH and secured funding to sustain discounted meal boxes for Fresh RX program and other special needs populations using the program in FY2018 and FY2019. Our *Farm to Families* program will continue to serve as an anchor program in providing access to healthy food options for TUH patients, employees, and the greater North Philadelphia community.

- **Tactic:** Improve awareness of social and health disparities our surrounding communities are experiencing to better address the social determinants of health using multidisciplinary care teams.

- **Outcome:** TUH collaborated with the Temple Center for Population Health (TCPH) and Temple Physician Inc. (TPI) to establish social determinates of health evaluation tool imbedded in our electronic medical record EPIC system. This tool was launched in select TUH locations and TPI clinics during March 2019 and includes questions on food insecurity, homelessness, financial resources and other topics.

Conclusions and Next Steps: We will continue to collaborate with TUHS, Temple University, and other community partners to respond to food insecurity in the region and educate our community, staff, and patient populations on the health benefits derived from healthy eating and its impact on obesity. In FY20, we will also analyze data collected using our social determinants evaluation to develop a food insecurity response strategy for 2020.

PLAN TO IMPROVE ACCESS TO BEHAVIORAL HEALTH RESOURCES

Title: Plan to Improve Access to Behavioral Health Resources-Expansion and Coordination of Substance Use Disorder (SUD) Treatment Services

Strategy Team Lead:

- *Director of Behavioral Health Services, TUH – Episcopal Campus* - L.J. Rasi, LSW

Goal: Expand services within Temple University Hospital Episcopal Campus (Episcopal) Crisis Response Center (CRC) and Inpatient Behavioral Health Service to provide care for an additional 3600 patients per year.

Summary of Tactics Implemented and Outcomes:

- **Tactic:**
  - Renovations began in March 2019 and are scheduled within the 2019 calendar year.
  - Furniture has been ordered and will be delivered once the new area is ready for use.
  - A Drug and Alcohol Supervisor, Therapist and a Recovery Specialist were all hired between July and October 2018.
  - Warm Hand off Project involving Recovery Peer Specialists from PRO-ACT and Philadelphia Department of Behavioral Health and Intellectual Disability Services (DBHIDS) began at Episcopal and expanded to the main campus. The rolls of these peer specialists continues to be refined as we seek additional coverage for evening and weekends.
  - Education for staff concerning drug and alcohol is ongoing with both internal and external trainings. Many employees received American Society of Addictions Medicine (ASAM) training and Episcopal currently has two employees certified to serve as trainers on ASAM.
  - Episcopal worked with different community organizations and city agencies to address the behavioral health needs of patients living in local homeless encampment areas.

- **Outcome:**
  - Waiting for renovations to conclude and approval from the Commonwealth to open the new CRC area.
  - Currently recruiting a second Certified Recovery Specialist to join the Episcopal team.
  - Continuing to seek additional hours of coverage in the PRO-ACT/DBHIDS partnership.

- **Tactic:** Develop a network of community providers who will provide a continuum of care for 3600 patients per year with substance use disorder issues.

- **Outcome:**
  - The network of Community Providers continues to be developed and expanded.

- The Director of Utilization Management and BHT continues to invite community providers to sessions for staff to learn about outside resources.
- The new positions noted above have been particularly helpful at increasing the number of patients who get sent directly to another care provider after their treatment at both TUH campuses is completed. The number of such linkages has been tracked monthly beginning in September 2018. On April 3rd, several Episcopal employees presented this program and data at Community Behavioral Health's (CBH) Executive Director meeting.
- In June 2019, Merakey opened an office at Episcopal to provide onsite outpatient, intensive outpatient and medication assisted treatments for patients with substance use disorder and mental health problems.
- A discharge planner was hired in December 2017 to facilitate transitions from inpatient services to outpatient substance use disorder and mental health aftercare providers and to track the monthly volume of these warm handoffs. During 2019, several Episcopal employees were the keynote speakers at Community Behavioral Health's Annual Inpatient Provider Forum to discuss this initiative.

Conclusions and Next Steps: We will continue to work with the City to address substance use disorder issues in our city and state. Episcopal continues to negotiate with the City about the utilization of a building on campus to serve as an opioid respite center. We will also continue to expand substance use disorder services and linkages to the next level of care. This includes the induction of medication assisted treatment in our newly expanded CRC, which is slated to begin in October 2019. A plan is also developing to share a Psychiatrist specializing in substance use disorders between the CRC and Merakey to provide more seamless integration.