



Chestnut Hill Hospital

# **COMMUNITY HEALTH NEEDS ASSESSMENT IMPLEMENTATION PLAN**

FY23 PROGRESS REPORT

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## CHNA PROGRESS REPORT

### Plan Title: Access to Equitable Care

COVID-19, helped the hospital to realize the even wider gaps that resulted as related to accessing care, such as a lack of education and awareness of available health services and programs, an even greater digital divide and lack of access to technology, an increased demand for behavioral health services, and a limited capacity to provide quality and appropriate care because of limited communication services.

### Executive Sponsors:

Community Relations, Temple Health-Chestnut Hill Hospital, Catherine Brzozowski  
Informatics, Temple Health-Chestnut Hill Hospital, Kathleen Morrione  
Physician Practices, Temple Health-Chestnut Hill Hospital, Theresa Ward

### Health Equity Goal:

Increase access to equitable care by community members, particularly those considered vulnerable and/or living in underserved areas.

### Objectives:

1. Promote patient portal to encourage patients to more proactively manage health care and access timely reports and communication
2. Utilize Ride Health and Cab Voucher processes to coordinate free transportation to and from appointments for eligible patients
3. Expand communication services to include hearing impaired patients and those in need of translators with in-person, video and audio options.

### Metrics Data Dashboard:

Metric	FY 2022 Baseline	FY 2023	% Change
# of Portal Users	27,789 (44%)	24,337 (48%)	+4%
#of Transportation Assistance	555	964	+73%
# Using translation services	No tracking	104 translations; 7 deaf hearing encounters	--

### Metric Progress Summary:

- While we surpassed our goal to increase users by 3% annually, we lost overall users.
- Due to changes in our ride support process more than 400 more patients rides were provided to patients in need. each year
- Translation/hearing services are serving more than 110 patients annually

### Action Plans Implementation Summary:

Little promotion was done for patient portal awareness and access due to pending sale of the hospital and lack of direction regarding the continued use of the portal.

With the elimination of ineffective transportation services and increased awareness of the new service options among staff, case management and the ER departments experienced a significant increase (409) in patient ride support.

A new language services provider and employee education lead to increases in translation services encounters (104) that provided translations in 18 different languages. 60% of the translation service requests were for Spanish. Deaf hearing encounters often occurred in-person allowing for continuous translation during patient appointments especially significant in physical therapy sessions. All communication services offer audio, video and in-person options.

**Next Steps:**

Use of the new MyTempleHealth patient portal is being actively promoted at all patient encounters at the hospital and at physician offices. The tool provides easier access for patients to see reports, communicate with physicians. In the next year we hope to increase use of online scheduling for appointments.

Transportation services will continue to be evaluated to provide the best support to patients.

We will continue to track use of communication tools for our patients and promote the ease use of the resources to staff for better patient communication. With Spanish translation requests at 60%, we adjust printed and online resources to include Spanish versions.

## CHNA PROGRESS REPORT

**Plan Title:** Increase Behavioral Healthcare Access

Improving access and adequacy of behavioral health services and programs has become a high priority for Chestnut Hill Hospital’s communities in recent years. More than 48% of community survey respondents noted behavioral health as having the greatest impact on overall community health. The COVID-19 pandemic, social distancing policies, mandatory lockdowns, isolation, and the fear of getting sick made the need for access to behavioral health services even more evident.

### Executive Sponsors:

Wellbeing Engagement, Human Capital Services, Melissa Spinosa  
Medical Director, Senior Behavioral Health Unit, Jacqueline Arenz, MD  
Community Relations, Temple Health-Chestnut Hill Hospital, Catherine Brzozowski

### Health Equity Goal:

Improve access to screening, assessment, treatment, and support for behavioral health.

### Objectives:

1. Introduce Telepsychiatry
2. Support Senior Behavioral Health Unit
3. Introduce Employee Wellness Support

### Metrics Data Dashboard:

Metric	FY 2022 Baseline	FY 2023
# Patient encounters	--	Pivoted to transfer patients to Episcopal Hospital for care.
# Secure Staff	--	Added an NP
# of Employee Communications and encounters	--	Monthly emails and web presence. Used EAP counseling – 8 or 3% (CHH) of 263 (TUHS) 34 employees signed up for Ginger 32 employees signed up for Headspace

### Metric Progress Summary:

Telepsychiatry was not implemented due to changes related to ownership transition. Additional staff was hired to support care in the Senior Behavioral Health Unit. Mental health resources for employees are readily available on the HUB and communicated via monthly emails.

### Action Plans Implementation Explanation:

Telepsychiatry was a solution through Tower to get patients in need immediate treatment. Through our new alliance with Temple, we have resolved this challenge by transferring mental health patients to Episcopal Hospital for proper care.

An NP with 30 years of geriatric psych experience was added to our staffing complement in the SBHU. The NP supports unit-based care and consults patients in the ER and on med surg. Marketing for the SBHU continues to encourage community to call directly to refer family members for care and outreach to physicians in ongoing through the KAMS team.

Temple Health is committed to providing resources to help prioritize mental health. That includes tools like Ginger, Headspace, and Carebridge, which are available to all employees and family members within the health system.

**Next Steps:**

TH-CHH will continue to explore opportunities to provide access to treatment for our behavioral health patients and partner with organizations who can support people in need.

Our social workers will provide information on community resources to patients with mental health issues.

Collaboration between Temple and CHH will continue to transfer patients who require a higher level of behavioral health management to the facility best able to provide their care.

We will also focus on our employee's mental health by communicating more diligently about the opportunities for care that are available to them.

## CHNA PROGRESS REPORT

**Plan Title:** Strengthen Health Education and Prevention

Health education programs help people better understand how to manage an existing health condition and prevent further illness, which is paramount to good health. Health education and health literacy empowers individuals to make informed health decisions and helps them effectively navigate today's complex health care delivery system.

### Executive Sponsors:

Community Relations, Temple Health-Chestnut Hill Hospital, Catherine Brzowski  
Temple Health-Chestnut Hill Family Medicine Residency Program, Andrew Berta, MD, family medicine, program director  
Temple Health-Chestnut Hill Northwest Family Medicine Residency Program, Janet Cruz, MD, family medicine, program director

### Health Equity Goal:

Implement chronic disease education and prevention programs in the primary service area, specifically targeting vulnerable populations.

### Objectives:

4. Launch Healthy Lifestyle Support Group to encourage maintenance of healthy lifestyle
5. Increase health education programming
6. Increase number of at-risk individuals reached with health screening/assessments
7. Partner with Philadelphia Public School system to provide health education to at-risk youth and families

### Metrics Data Dashboard

Data Element	Baseline	FY23	% Change
# Healthy Lifestyle Sessions	0	12	--
# Community Health Ed. Programs	20	24	+20%
# Individuals Reached with Screenings	200	300	+50%
# Public School Ed. Sessions	0	8	--

### Metric Progress Summary:

- Implemented a Healthy Lifestyle Support Group. The free, in-person, monthly session has 10-14 attendees on average. Certified educators focus on a different aspect of wellness each month.
- Virtual, community education programs have increased 20% enabling clinical staff to reach more people. Programs focus on various topics from Hip and Knee Pain to Care and Protection for Black and Brown Skin. In addition, the staff has provided 4 lectures at a local nursing home.

- Residents provided free health clinics to 200 at-risk individuals through Face-to-Face Germantown and to 100 at-risk individuals at the Rock, a health clinic in Kensington.
- Through a new partnership with the Philadelphia Public School Dept, residents have provided 8 classroom sessions for 250 children at the Jenks Academy.

#### **Action Plans Implementation Explanation:**

TH-CHH Dietitian and Health Educator meets weekly with community members interested in healthy lifestyles. The group was formed to address general wellness including obesity and related health concerns to empower participants to gain control of their health before problems arise. The group has grown in popularity from 6-8 participants to an average of 12.

Educational outreach continues with the support of hospital clinical staff. Topics are selected based on issues that patients most commonly ask about at physician visits.

Our family medicine residents provide extensive clinical encounters with at-risk populations. Weekly sessions are held at the Salvation Army Rehab Center (Rox), Eliza Shirley House (transitional Homeless shelter for women and children in Center City), St Raymond's (shelter for individuals over the age of 55 with chronic illness in Wyndmoor) and monthly visits to Dornsife Community Wellness HUB (West Phila).

Health screenings including BP and Vaccination Clinics were provided at Whosoever Gospel Mission (Germantown), New Covenant Church of Philadelphia (Mt Airy) and Nationalities Services Center (Norristown) among others. A sensory-friendly COVID vaccination clinic for 15 children with autism was provided at the Academy of Natural Sciences.

A new partnership with Jenks Academy in our Chestnut Hill neighborhood has enabled our family medicine resident to engage with elementary and middle school students to provide education on wellness topics from proper sleep to healthy food choices. The Rotary of Chestnut Hill supported this program with funding for outdoor recreational equipment and healthy snacks.

#### **Next Steps:**

Community health education continues to be the foundation of Chestnut Hill Hospital's outreach. Our clinical staff is engaged and voluntarily serves the community with special focus on our most at-risk neighbors.

CHH will partner with Temple's Center for Population Health to host a Pre-Diabetes Workshop at the hospital. This program will be promoted through the Healthy Woman newsletter and KAMs visits to physicians whose patients may benefit from attending.

CHH will reestablish a relationship with a local senior center, Center in the Park, to offer education and screenings to older adults in need.



## CHNA PROGRESS REPORT

**Plan Title:** Advance Health Equity

Social determinants of health (SDOH) have a major impact on people’s health, well-being, and quality of life. Temple Health-Chestnut Hill Hospital has taken steps to address some of the conditions in our local environments that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

### Executive Sponsors:

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Temple Health-Chestnut Hill Family Medicine Residency Program, Andrew Berta, MD, family medicine, program director  
Temple Health-Chestnut Hill Northwest Family Medicine Residency Program, Janet Cruz, MD, family medicine, program director

### Health Equity Goal:

Increase health equity by addressing Social Determinants of Health and providing culturally competent care.

### Objectives:

1. Establish and convene DEI Council
2. Provide DEI programming and mandatory education for employees.
3. Support local organizations that address SDOH
4. Increase Warm Handoff (WHO) encounters
5. Increase employee awareness of non-punitive reporting for workplace violence concerns

### Metrics Data Dashboard:

Metric	FY 2022 Baseline	FY 2023	% Change
Council convened	Council Established	Council on hold	--
DEI education and programming	100% Mandatory Ed 12 programs	100% Mandatory Ed 0 programs	-- -100%
Organization funding	\$6,000	\$13,000	+116%
WHO encounters	New program	173 patients (CY22)	--
Workplace violence Reporting	(not tracked)	174 reports	--

### Metric Progress Summary:

- Mandatory DEI courses including sensitivity training remained in place for all employees
- Engaged with 173 patients to educate on addiction and refer to drug and alcohol programs.
- Funding of local organizations increased by \$7,000 with focus on SDOH

- Workplace Violence Committee was established and encourages reporting through staff engagement and resolution of issues.

### **Action Plans Implementation Explanation:**

CHH's DEI Council was closely tied to the systemwide DEI Council at Tower Health. The transition along with DEI leadership changes have created a void in this area.

In addition our reliance on the system for monthly lunch and learn DEI-related sessions ended.

(insert Warm Handoff Information) CHH's emergency department social worker partners with the City of Philadelphia on the warm handoff program to help get people with non-fatal overdose from the hospital to a treatment provider for immediate and ongoing care.

In addition, our family medicine residents distributed 100 care packages to the homeless in Philadelphia. They also supported city youth training to become lifeguards in the City Rec. program by providing physical exams. Two times a month, residents provided health counseling to participants at the Healing Hurt People program in Center City.

CHH find one of the best ways to address SDOH is to support our local organizations that specifically address these issues. In FY 2023 funding was increased to include support for food insecurity (Meals on Wheels), housing needs (Mt Airy CDC), drug addiction (Face-to-Face), and literacy (Mt Airy Schools Coalition).

A proactive effort to engage staff in reporting issues of violence has resulted in increased reporting and regularly scheduled meetings to address issues.

### **Next Steps:**

Explore opportunities among its new owner group to partner on DEI initiatives.

Continue to implement warm handoff and identify and provide resources to those identified with SDOH need.

Partner with local non-profit organizations that have resources to address SDOH among our community members. We will identify areas of need and work to find resources to provide appropriate services.

The Workplace Violence Committee will continue to encourage reporting and address issues both collectively and individually as needed.

Partner with Temple's Center for Population Health to implement an inpatient screening process in September 2023 and in January 2024 patient screening for SDOH will be implemented at the physician practices. Nursing staff is completing training for this program and case managers will provide resources to all appropriate patients identified by the nurse assessment.

