TEMPLE UNIVERSITY HOSPITAL

Community Health Needs Implementation Strategy

FY14 Progress Report

TEMPLE HEALTH

Temple Health refers to the health, education and research activities carried out by the affiliates of Temple University Health System (TUHS) and by Temple University School of Medicine. TUHS neither provides nor controls the provision of health care. All health care is provided by its member organizations or independent health care providers affiliated with TUHS member organizations. Each TUHS member organization is owned and operated pursuant to its governing documents.

Community Benefit Implementation Plan – Progress Report
Temple University Hospital
July 1, 2013 – June 30, 2014

Priority Area #1: To improve health of moms and newborns. Reduce the incidence of infant mortality and improve access to community resources for mothers and newborns.			
Goal	**Action Item**	**Progress**	**Outcomes**
Improve the success of breastfeeding through both patient and nursing staff education programs. Create a hospital and community – partnership for the development of a breast feeding resource center, as well as a community support group offered at Temple University Hospital and Episcopal Hospital. Implement an obstetric based community health worker program within the Temple obstetric practice to focus on women who are at high risk for poor pregnancy **Objectives** ▪ Improve the number of prenatal visits by 20%. ▪ Achieve the Healthy People 2020 target of breast feeding initiation to a rate of 40%.	Implement an obstetric based community health worker program within the Temple obstetrics practice to focus on woman at high risk for delivering a high risk infant.	☐ Not started ☒ In progress ☐Completed	Community health worker (CHW) role established. Continued work on assessment of patient needs and role delineation with high risk maternity population. Awarded Planning grant by Kellogg Foundation to develop comprehensive program inclusive of increasing lactation, coordination of care, and post discharge planning/follow up
	Collaborate with community partners to improve access to healthy food and promote physical activity.	☐ Not started ☒ In progress ☐ Completed	Women & Infant's team established community database to gain understanding of nutritional options available. Working collaboratively with WIC Philadelphia and Health Centers on nutritional education. Farm to Families program established in TUH clinic for patients
	Improve communication on the health status of pregnant mothers though collaborative practice arrangements.	☐ Not started ☒ In progress ☐ Completed	Comprehensive review of all clinical practices and access points for TUH Women & Infants population. Established formal committee with representatives of each subdivision. Focused pediatrics sessions to better understand practice model and future integrations with newborn care
	Reduce smoking and alcohol consumption thought promoting smoking cessation and alcohol use awareness.	☐ Not started ☒ In progress ☐ Completed	Smoking cessation awareness and education in progress. Community resource access plan along with City of Philadelphia resources being explored.
	Establish a Doula program.	☐ Not started ☒ In progress ☐ Completed	In collaboration with Maternity Care Coalition and the Kellogg Foundation, a doula program established with community trained women. Early impact for pregnancy and labor support encouraging. Program will be ongoing.
	Continue our support of the City of Philadelphia's MOM program, which connects mothers and their babies from birth through age 5 are connected with social, educational, and healthcare supports.	☐ Not started ☒ In progress ☐ Completed	Ongoing collaboration with Maternity Care Coalition, City of Philadelphia, Health Centers to enhance prenatal education and post-partum/newborn wellness.
Priority Area #2: Address the dangers of obesity and overweight BMI. Improve general knowledge of healthy food choices, and identify resources to aid in nutrition education.			
Goal	**Action Item**	**Progress**	**Outcomes**
Meet the goal of Health People 2020 to reduce adult obesity to 30.6%. Collaborate with community efforts focused on nutrition and	Develop a hospital / community work group to identify methods to establish a healthy choice nutrition platform.	☐ Not started ☒ In progress ☐ Completed	Established Temple University Health System (TUHS) group representative of partners/programs in early phase
	Inventory community resources available to support nutritional education programs outside the hospital.	☐ Not started	Initiated a comprehensive list of nutritional resources and offerings for our community.

weight management. Integrate nutrition education into all patient classes and group session (for example: preoperative joint replacement classes, transplant support groups). Include an educational program on nutrition and weight management as part of the TIGR patient education programming available through the internal TV programming at TUH. Collaborate with human resource programs at TUH to address employee obesity and provide nutritional education opportunities **Objectives** ▪ Implement two community education programs related to nutrition ▪ Complete assessment of resources ▪ Establish two additional collaborative relationships to broad reach and effect community obesity rate		☒ In progress ☐ Completed	
	Establish healthy menu choices in the hospital cafeteria; identify healthy foods for both employees and visitors inside the hospital.	☐ Not started ☒ In progress ☐ Completed	TUH developed new menu choices and caloric intake of items added to cafeteria on select items. Plan to expand. Piloted a spoken menu with dietary education component for healthier choices post discharge.
	Implement 2 community based nutrition education programs.	☐ Not started ☒ In progress ☐ Completed	Current education programs offered with diabetes and heart healthy focus. Curriculum and additional opportunities are being explored.
	Implement nutrition chapters for current patient education programs.	☐ Not started ☒ In progress ☐ Completed	Plan initiated for new integrated television system linked to patient education.
	Implement a TIGR education program on nutrition for inpatients.	☐ Not started ☐ In progress ☒ Completed	See above. New program. Team is currently reviewing online patient education materials provided by Krames.

Priority Area #3: To improve heart and vascular health. To improve the heart and vascular health of our communities by strengthening access to hospital and community-based services and building patient navigation services.

Goal	Action Item	Progress	Outcomes
Maintain community support for patients discharged with congestive heart failure and improve access to medical follow-up post hospitalization. Expand navigation services to include patients who have a high risk of cardiovascular disease, such as hypertension, diabetes and renal disease; each influencing heart and vascular health.	***Based upon initial data analysis, the following programs are planned for Fiscal Year 2014:***		
	Community Health Worker (CHW)s will coordinate community based services, such as: o Medical Assistance Application o Meals on Wheels o Utility assistance o Food Assistance o Smoking Cessation programs o Mental health services o Transportation assistance	☐ Not started ☐ In progress ☒ Completed	1. Program staffing for community health workers was fully expanded to 7 CHW, focused on the care transitions for high risk and CHF patients discharged from Temple University Hospital. The program includes staff assigned to the Emergency Department, physician practices (TUP and TPI) and high risk obstetrical services. 2. TUH collaborated with treatment Research Institute and secured a $ 1.7 million PCORI grant to focus on CHF patients who have a history of substance abuse. The intervention will add social work and peer support to patients identified with CHF and substance abuse. The program includes the

Improve access to community resources that will enable patients to gain knowledge regarding nutrition, available transportation services, and medications to support their care requirements. Improve access to primary and specialty care, to provide longitudinal care, reducing the impact of chronic conditions. **Objectives** ▪ Reduce congestive heart failure readmissions by 10%from the existing base line of 10.8%. ▪ Capture 45%of patients eligible for program services. ▪ Improve compliance with scheduled appointments at community based primary care providers by 20%. Coordinate identified social service needs on 100%of patients enrolled in the program.			implementation of a community advisory group to collaborate on the program implementation and ongoing reporting of progress outcomes.
	Establish a home care program for patients with chronic diseases, organize nursing staff by zip code and link staff with a community health worker.	☐ Not started ☒ In progress ☐ Completed	1. Visiting Nurses Association (VNA) of Philadelphia has a chronic care program where staff is dedicated by specific zip codes, patients who meet eligibility requirements are enrolled directly or through the CCTP program. 2. TUHS is actively evaluating the expansion of home health services utilizing Jeanes Home Health to service the TUH community.
	Allocate the CHWs to highest risk utilizers of emergency and hospital services.	☐ Not started ☐ In progress ☒ Completed	See note above, program implemented.
	Expand the Transition Care Center staff by adding three community health workers, who will call patient after being seen in the ED, after being discharged from the observation unit, or after hospital discharge.	☐ Not started ☐ In progress ☒ Completed	1. Expansion of call center care transition services was initiated in August of 2013 and was fully implemented by January 2014. 2. Early program results have demonstrated a reduction of 7 and 14 day readmissions. The team needs to continue to focus on cardiovascular readmits.
	The Transition Care Center will also schedule all follow up appointments for physicians as well as diagnostic studies.	☐ Not started ☒ In progress ☐ Completed	1. With TUH, a process has been initiated for physicians to order follow-up appointments. Appointments are scheduled prior to discharge and imbedded into the patients discharge instructions. 2. TUH collaborating with Cigna Health Plan to assure appointment coordination between the Living Well Center, community based providers and TPI / TUP. 3. Program needs refinement and management of key metrics to improve performance.
Priority Area #4: Improve access to mental health resources.			
Goal	**Action Item**	**Progress**	**Outcomes**
Increase community Knowledge of mental health resources and access to mental health care. **Objectives** ▪ Provide information in user friendly formats via resource manuals, website links and participation in community health fairs. ▪ Partner with other community mental health providers in North Philadelphia area to distribute information about mental health resources and increasing access	Finalize members of the work group team by June 28, 2013. Responsible party – Director of Behavioral Health. Revised format to one to one meetings with each entity.	☐ Not started ☒ In progress ☐ completed	Meetings held with staff at local community mental health providers and hospitals to determine what mental health needs or resources they had, what types of community outreach services they provide, or are willing to provide, and identify crisis services and drop in access points for mental health treatment. Agreements were made with Community Behavioral Health, Comhar Community Mental Health Center, Warren E. Smith Community Mental Health Center, North Philadelphia Health system, Delaware Valley Community Health, Hall Mercer Crisis Service and the Social Work Department from Aria Health System and the Department of Behavioral Health and Intellectual Disabilities to work together to increase knowledge of and access to care for mental health care.
	Conduct first meeting of work group team by August 30, 2013. Responsible party – Director of Behavioral Health.	☐ Not started ☒ In progress ☐ Completed	Format changed to 1:1 on site visits for each group as many are competitors to one another. 1:1 meetings allowed for greater depth in ascertaining what each provider is doing and what mental health resources continue to be needed. New

to mental health care.			information was added to our comprehensive mental health resource manual.
	Participate in orientation program for Temple University Hospital - Community Health workers by August 2013, and each orientation thereafter- responsible party-Director of Social Work.	☐ Not started ☐ In progress ☒ Completed	The Director of Social Work and the Director of Utilization Management have provided 4 separate education offerings to the Community Health workers since August. They have been given orientation to mental health and drug and alcohol resources as well as training in Appropriate Response. This will continue throughout the year as new staff is hired and educational needs are identified. We also established a mechanism for Community Health Workers to receive consultation from the Director of Social Work via phone if situations arise where they need assistance.
	Initiate ongoing meeting of all Behavioral Health providers in the Temple Episcopal catchment area to discuss access to mental health care and facilitate creation of drop in appointments and welcome centers for those in immediate need. Starting August 30, 2013. *Responsible party- Director of Behavioral Health*.	☐ Not started ☒ In progress ☐ Completed	Twice a month, different Behavioral Health providers are being asked to meet with Episcopal social work and management staff to discuss their programs. Part of each discussion and presentation is what types of access points each program has with an emphasis on recovery based programs, including drop in appointments and peer lead groups. This strategy will continue to be implemented.
	Revise comprehensive manual of behavioral health resources in the Delaware Valley by October 30, 2013, and then update once a year. *Responsible party- Director of Social Work*.	☐ Not started ☐ In progress ☒ Completed	A user friendly, comprehensive manual of behavioral health resources was completed by the Director of Social Work in October and distributed to staff at Episcopal Hospital. Plans are to updated this in the fall.
	Place revised comprehensive resource manual on Temple Intranet and assure access to all Temple Health System employees by January 30, 2014 and update annually. *Responsible party – Director of Social Work*.	☐ Not started ☐ In progress ☒ Completed	The user friendly comprehensive resource manual was uploaded on the Temple Intranet for all Temple employees to be able to access in October of 2013. It will be updated in the fall. We will need to publicize its availability more to the Temple staff.
	Develop consumer version of behavioral health resource guide in English and Spanish by March 30, 2014 and update annually. *Responsible party- Director of Social Work*.	☐ Not started ☐ In progress ☒Completed	A user friendly consumer version of the resource guide was developed in English and Spanish and was published in January of 2014. It will be updated again next year. This resource manual is also distributed as a resource at local health fairs. We are also developing a user friendly one sheet resource guide to provide to patients and family. This resource will be developed in both English and Spanish to address the needs of our patient population as identified in the community health needs assessment.
	Make consumer version of behavioral health resource guide available for distribution to all TUHS Emergency Departments, and outpatient practices and clinics via IKON by July 30, 2014, update annually. *Responsible Party- Director of Social Work*.	☐ Not started ☒ In progress ☐ Completed	The consumer version is currently being used in the Episcopal Crisis Response Center and was made available to the Community Health Workers. The book was loaded into RICOH Trac to facilitate access and utilization. We will need to disseminate information about how to order through RICOH Trac to all TUHS Emergency Departments and outpatient clinics.
	Provide educational sessions on Behavioral Health Resources to all Temple University Health System Social Work Departments by July 30, 2014. *Responsible party- Director of Social Work and ETAL*.	☐ Not started ☒ In progress ☐ Completed	Educational sessions about behavioral health resources were made to the to the Temple Social Work Department staff in the Fall of 2013, other sessions need to be scheduled at Jeanes and Fox Chase Cancer Center.

	Provide educational sessions on Behavioral Health Resources to at least 3 Temple University Health System outpatient providers, office managers and departments per year, starting August 2014. *Responsible party - Director of Social Work and ETAL*.	☐ Not started ☒ In progress ☐ Completed	Educational sessions were presented to the Community Health Workers, the Temple University Residential Counselors and the Temple Department of Social Service in the fall of 2013.
	Work with community behavioral health providers to provide education on mental health resources and depression screenings during community health fairs, Senior Expo's, on Mental Health Resources at least 3 per year, starting October 2013. *Responsible party - Director of Behavioral Health and Director of Social Work*.	☐ Not started ☒ In progress ☐ Completed	Participated in Senator Vince Hughes's *Breaking the Silence* conference in May 2014. We reached over 400 participants; participated in the Spiritualty and Behavioral Health Resource Fair in May 2014 with the Department of Behavioral Health and Intellectual Disability. Served over 300 individuals. WE are scheduled to do a Mental Health Depression Screening day in June with the Office of Behavioral Health and Intellectual Disabilities.
Priority Area #5: Strengthen awareness of gun violence. To strengthen awareness of the dangers of gun violence in an effort to reduce hospitalizations, reduce barriers to preventative health care, and to improve quality of living in our underserved community.			
Goal	**Action Item**	**Progress**	**Outcomes**
Reduce the number of young people in the city generally, and in North Philadelphia specifically, who suffer gun-related injuries. Temple University Hospital has committed to a plan to strengthen awareness of gun violence. **Objectives** ▪ Between fall 2013 and summer 2014, educate at least 1,000 individuals using the programs education methods. ▪ Improve knowledge on the impact of gun violence as a result of participation in the program. (A pre-post/control design will be utilized to measure improvement in individuals' attitudes.)	The Cradle to Grave program will bring young people into the hospital as students – and ultimately improve their attitudes towards gun violence – in order to offer a countermeasure to the cultural influences that might bring them here as patients.	☐ Not started ☐ In progress ☒ Completed	In Philadelphia, gun homicide represents the leading cause of death for young black men between the ages of 14 and 24. More than 80% of the city's gun victims, however, will survive their shootings. Unfortunately, given the severity of their injuries, their recovery will generally be as costly as it is painful. Currently, TUH treats more gunshot victims than any other trauma center in the state of Pennsylvania. Recognizing that a significant number (75%) of city gun victims ages 18 to 24 had prior arrests at the time of their injury, the Cradle to Grave program made a concentrated effort this past year to establish relationships with various branches of the city's juvenile justice system in an effort to target those youth who are most likely to either perpetrate or fall victim to gun violence. As a result, Cradle to Grave is now offering its services to Philadelphia's Court of Common Pleas (Family Division), Juvenile Probation, District Attorney's Office (Juvenile Division), Defenders Association (Juvenile Unit), and The Juvenile Justice Service Center.
	During this interactive two-hour experience participants see representative images of violent injuries, as well as reflect on the value their lives hold for their friends and families.	☐ Not started ☐ In progress ☒Completed	Between September 30, 2013 and June 1, 2014, Temple University Hospital facilitated its Cradle to Grave program for 1,265 young people from Philadelphia and its surrounding communities. Participants came from more than 50 different organizations, with the majority of these organizations serving youth who live within Temple University Hospital's catchment area.
Priority Area #6: To strengthen practices for providing culturally competent care.			
Goal	**Action Item**	**Progress**	**Outcomes**
To educate staff and physicians about the diversity of the	Develop a Cultural Competency in Health Care Symposium to educate staff on the delivery of Cultural	☐ Not started ☐ In progress	Staff from all TUHS entities participated in weekly conference calls leading to the May 2, 2014 symposium.

clients/patients we serve. To provide high quality safe care to patients with language needs including the deaf and hard of hearing. **Objectives** ▪ To provide a comprehensive symposium on Cultural Competence. ▪ To provide Comprehensive training to all employees of TUHS, TUP, and TPI on language access service and resources. ▪ To provide an annual mandatory employee competency on Language Assistance Services and resources. ▪ To provide a training program for bilingual employees interested in becoming dual role medical interpreters. ▪ Continuing education for Dual Role Medical Interpreters. ▪ To add new communication equipment for hard of hearing patients.	Competent care to patients	☒ Completed	
	Identify opportunities for Temple university Hospital faculty to be involved in the development of topics for the symposium.	☐ Not started ☐ In progress ☒ Completed	Staff assisted with the development and implementation of a TUHS survey to assess learning needs for next symposium. Based on their feedback the following information was presented on May 2, 2014. Keynote speaker: Health Disparities, Cultural Competency and Implications for Quality Care Breakout sessions: 1- Impact of Language Standards on Quality Patient Care 2- Pillars of Resilience: Coping in a Cultural Context 3- Working with the Deaf and Hard of Hearing Patients from Other Countries. Health Disparities Among Underserved Asian Americans
	Educate staff within key areas of care on language access resources and processes.	☐ Not started ☐ In progress ☒ Completed	In-services were conducted in all patient registration areas, the emergency room, ancillary services, in-patient and out-patient settings, and intensive care units.
	Revise annual employee mandatory competencies to reflect the addition of services and the revision of language access policies.	☐ Not started ☐ In progress ☒ Completed	The annual employee mandatory competencies were revised to reflect changes to language access policy and the deployment of new resources and the process to access the equipment.
	Training for bilingual employees to become dual role medical interpreters.	☐ Not started ☐ In progress ☒ Completed	The Linguistic and Cultural Services team provided two Dual Role medical interpreter training sessions for FY14. There were 15 participants from all TUHS entities who successfully completed the process to acquire their credentials in this capacity.
	Addition of equipment to communicate with patients who are hard of hearing.	☐ Not started ☐ In progress ☒ Completed	New equipment was added in April 2014 to facilitate communication between hard of hearing patients and TUH, and TUP providers.