TEMPLE UNIVERSITY HOSPITAL

Community Health Needs Implementation Strategy

FY18 Progress Report

TEMPLE HEALTH
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Community Health Needs Assessment

FY 2018 Progress Report

Temple University Hospital implemented a number of innovative programs to address community health, including the priorities identified in the Temple University Hospital (TUH) Community Health Needs Implementation Strategy. During FY 2018 homelessness, the growing opioid epidemic and the related epidemic of new infections with HIV and hepatitis C became major areas of focus. A Federally Qualified Health Center (FQHC) was opened at Temple University Hospital to meet the acute care health needs of patients coming to the TUH Emergency Department for minor illnesses. By May 2018, twenty five patients a day were being referred to the Health Center. Patients without a primary care physician are also offered appointments for ongoing care.

In order to address the opioid epidemic, TUH has established a task force organized at the health system level land and a physician run addiction medicine consult service that is staffed by two experts who also offer counseling and medical treatment with suboxone for patients who meet the criteria for use. Starting in the fall of 2017, HIV and hepatitis C testing were offered to patients in at-risk groups visiting the Temple and Episcopal Emergency Departments. By May 2018, 6986 patients had been tested for hepatitis C with 579 (8.3%) testing positive. All of the patients who tested positive were offered clinic appointments to discuss curative treatment. In addition, over 1000 HIV tests have been performed on high risk patients at the TUH-Episcopal Emergency Department, with 11 patients testing positive and offered appointments for follow-up care.

Plan to Strengthen Culturally Competent Care

Title: Provide staff and physicians with education and resources to deliver culturally competent care.

Strategy Team Lead: Sherry Mazer, Chief Regulatory Affairs Officer; Angel Pagan, Director of Linguistics and Cultural Services

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

Summary of Tactics Implemented and Outcomes:

- **Tactic**: Promote awareness of health disparities through the annual Cultural Competence and Awareness in Healthcare Symposium.
    - This year's Symposium focused on the LGBTQ Community. The presentations included:
        - Keynote address on Culture, Context, and Health in the LQBTQ Community Health Disparities in the LQBTQ Community;
        - Implications for Quality Care for the LGBTQ Community;
        - Temple University Health System's (TUHS) LGBTQ Alliance Task Force and the work they are doing in the community and partnership alignments.

    - **Outcome**: The 6th annual Cultural Competence and Awareness in Healthcare Symposium took place on April 27, 2018. There were over 170 TUHS's staff members and clinicians in attendance. The event provided information to participants on the importance of providing culturally competent care to our diverse patient populations.

- **Tactic**: Improve Interpretive Services

    - The following languages were added to the existing Video Remote Interpreter system:

        - Spanish
        - Arabic
        - Russian
        - Polish
        - Cantonese
        - Mandarin
        - Burmese
        - French
        - Haitian Creole

- Korean
- Nepali
- Portuguese
- Somali
- Vietnamese.
- The system already provided American Sign Language.

- **Outcome**: The pilot to provide additional language resources using the over video was implemented in the following TUH departments: Emergency Room, Labor and Delivery, Post-Partum, OB Triage, and the Operating Room. This pilot was successful. The next steps during fiscal year 2019 are to fully implement this service by providing access to these additional languages via the current video conference system across all Temple University Hospital departments and campuses. The system is going to provide live interpreter services via video conferencing to facilitate communication between our non-English speaking and deaf patients and clinicians. The languages selected are the highest volume languages for patients throughout TUHS facilities. This service will be in addition to our on-site interpreters and phone interpreters.

- **Tactic:** Mandatory Competency

  - A mandatory competency for Cultural Awareness was developed and initiated in FY 2018 competencies for all TUHS staff. Basic information regarding cultural awareness, TUHS policies on nondiscrimination, patient rights, the use of qualified language resources, and translation of documents was provided. A definition of what culture is was provided. Also, information was included on the Temple Health LGBTQ Alliance.

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

- **Conclusion and Next Steps:**

  - This year, the annual Cultural Competence and Awareness Symposium provided education to all Temple Health front end staff and clinicians on the importance of providing culturally competent care to the LGBTQ community and to strengthen our relationships with community organizations like the Mazzoni Center. The Mazzoni Center provides health care, counseling and recovery, education, HIV prevention and care, and legal services to the LGBTQ community.

  - Online webinars from this year's Cultural Competence and Awareness Symposium are being posted to the Intranet. The online webinars will provide continuing education on the provision of culturally competent care to our patient population.

The webinars will offer continuing education credits to staff at all Temple Health facilities, and it will be available for a span of three years.

- In addition, we rolled out enhanced technology for spoken languages in addition to American Sign Language through the use of our over video remote interpreter system. This has provided our patients and their families a better way to communicate their health care needs.

Plan to Address Hunger and Food Insecurity

Title: Collaborative Opportunities to Advance Community Health (COACH)

Strategy Team Lead: Veronica Whyte, Director Population Health

Goal: Identify food insecurity in TUHS discharged patient population and connect them to appropriate food resources or the Philadelphia Department of Health which will assist with 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:** The Health System's hospitals have joined the collaborative. Temple University Health System (TUHS), 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.

Conclusions and Next Steps: TUHS was the first to launch the food insecurity screening program in August 2017 and was among the first to report preliminary data. Following evidence-based best practices, community health workers in Temple's Access Center were trained to include two questions about food insecurity in post-discharge follow-up calls conducted with 48 hrs. after hospital inpatient stay findings over a 5-month period revealed that 27% of patients reported food insecurity, which is higher than the recent published food insecurity rate of 19% in the city of Philadelphia; 21% was reported in 2016 and additional findings revealed that 68% of patients who reported food insecurity also reported receiving food assistance such as food stamps, SNAP or WIC. 32% do not participate in these programs.

During the program evaluation, all patients who screened food insecure and consented to a follow up call were contacted. Between September 2017-January 2018, 297 follow up calls were made to patients, connecting to 123 patients. Of these patients, only 22% (n=27) reported connecting with a community resource; 24% refused food assistance, and 64% of patients did not connect to resources.

The following barriers were identified by individuals who did not connect to services:

1) Did not remember being screened
2) Were overwhelmed by competing priorities and other healthcare needs
3) Health Literacy
4) Multiple interacting social determinants
5) Disconnect between community agency and patient perceptions of food insecurity
6) Service organization system barriers.

The next phase will be focused on decreasing these barriers.

Plan to Address Diabetes

Title: Diabetes Prevention Program

Strategy Team Lead: Veronica Whyte, Director Population Health

Goal: Identify TUH patients, employees and community members within the TUHS catchment area who are pre-diabetic. Engage them in the Diabetes Prevention Program using the Centers for Disease Control and Prevention (CDC) 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 per week or 2 ½ hrs.

Summary of Tactics Implemented and Outcomes:

- **Tactic:**
  - Temple Center for Population Health (TCPH) is participating in a CDC-funded grant with the Philadelphia Department of Health to provide free Diabetes Prevention Program (DPP) classes at various locations in the TUHS catchment area and North Philadelphia.
  - TCHP was granted a fourth year of CDC grant funds in collaboration with the Philadelphia Department of Health. The core of the program is focused on training Community Health Workers (CHWs) to be lifestyle coaches for the purposes of managing pre-diabetes, hypertension and obesity. This year's funding was intended to expand DPP classes across the TUH catchment area and hypertension education in the physician practices for newly diagnosed hypertensive individuals. The grant provides an additional $95,000 to expand education services in two additional practices, commencing in October 2018.

- **Outcome:**
  - Year 1 Diabetes Prevention Program (DPP) graduates updated surveys which were in process for status of lifestyle changes to be current post-graduation.
  - Year 2 of the DPP ended in February 2017 with approximately 20 graduates.
  - Year 3 DPP sessions began October 2016 with 70 initial enrollees
  - Three additional DPP sites were added in year 3 of the Grant totaling 6 sites.
  - Year 4 of the DPP began in March 2017 with 2 additional sites supported by $145,000 of grant funding. Enrollment for year 4 will continue through February 2018.
  - Year 4 DPP sessions launched 3 classes in October 2017 with 45 enrollees. One of the three classes is delivered in Spanish. Two additional classes were added in March 2018 with one additional class delivered in Spanish.

- Current Locations for DPP sessions include North Philadelphia: TUH, Bright Hope Baptist Church, Zion Baptist Church, Mercy Neighborhood Ministries, Fortaleza Rehab & Fitness Center; N.E. Philadelphia: Jeanes Hospital & Klein Life Community Center; Center City: Law Enforcement Health Benefits (LEHB).
- The Self-Management Blood Pressure (SMBP) program activity of the 1422 Grant was implemented in a total of 4 practices. Preliminary findings show a reduction in systolic and diastolic blood pressures over a 6-month period.

Grant Year	classes	enrollees	currently enrolled	graduates	avg weight loss
Year 1	4	36		11	
Year 2	8	157		69	
Average Weight Loss Data Submitted to CDC for Years 1-3:					4.60%
Year 3	9	144		60	
Average Weight Loss Data Submitted to CDC for Years 1-3:					5.90%
Year 4	Currently Mid-Year				
	9	99	52	Scheduled to complete October 2018	

Conclusions and Next Steps:

- Based on Grant year 3 outcome data submitted to the CDC in June, the program was awarded CDC-Recognition as a DPP. This recognition is renewed annually.
- Grant year 4 began in September 20, 2017.
- Additional classes will be offered at various locations throughout Grant Year 4 which will end in September 2018.

Plan to Reduce Gun Violence

Title: To strengthen awareness of gun violence

Strategy Team Leads: Scott Charles, Trauma Outreach Coordinator, Temple University Hospital Trauma Program and Amy Goldberg, M.D., Chair of Surgery Lewis Katz School of Medicine at Temple University and Chief of Surgery Temple University Hospital

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 for this fiscal year were designed 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 the use of gun locks (Safe Bet) and to seize a teachable moment with education and resources for victims of gun violence within the first 48 hours of hospitalization (Turning Point).

- **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 being detained at the Philadelphia Juvenile Justice Center. These presentations were given to individuals through the facility's high school program.
  - Continued Project Fighting Chance, which uses volunteers from TUH's Trauma and Emergency Medicine departments to train community members to administer first aid in the wake of a shooting. To date, the project has trained more than 1,000 residents living in neighborhoods suffering high rates of gun violence.
  - Provided free gun locks to Philadelphia residents – most of who reside in North Philadelphia – as part of the TUH's Safe Bet Initiative. Working in collaboration with community organizations and local law enforcement agencies, this initiative has distributed nearly 7,000 gun locks to date.
  - Continued the Turning Point Program, which connects gunshot victims with personal and education counseling, employment placement, and housing assistance in an effort to reduce the chance of retaliation and re-injury.

Conclusions and Next Step: We conclude that the North Philadelphia community is receptive to efforts to educate the public about the effects of gun violence. These efforts will continue into the next fiscal year.

Women and Infants

Title: Reduce the incidence of infant mortality and improve access to better coordinated community resources for mothers and newborns.

Strategy Team Lead: Elizabeth Craig, DNP, RN, FACHE, Chief Nursing Officer, Enrique Hernandez, MD, Chair, OB/GYN, Gail Herrine, MD, Obstetrician

Goal: Improve the health of moms and newborns. Reduce the incidence of infant mortality and improve access to community resources for mothers and newborns. Continue the hospital and community partnership of a breast feeding resource center, as well as a community support group offered at Temple University Hospital and TUH-Episcopal Campus. Improve the compliance with prenatal visits. Increase breast feeding initiation to a rate of 25%.

Summary of Tactics Implemented and Outcomes:

- **Tactics:**
  - Expand the role of obstetric and pediatric based community outreach programs within the Temple practices and 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, prenatal & 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 age 5 with social, educational, and healthcare supports. Some additional tactics: focused breast feeding education for attending obstetricians and resident physicians, active engagement with Maternity Care Coalition, unit based staff meetings, community lactation meetings, and initiate Quarterly Health Center updates.

- **Outcomes:**
  - Achieved Baby Friendly Designation in March 2018.
  - Completed the Kellogg Foundation grant which supported a comprehensive program inclusive of lactation, care coordination and post-discharge follow-up.
  - Advanced Infant Safe Sleep Program including an ongoing research study post discharge, adopted a new patient and family education portal, and maintained distribution of the "Baby Box".

- Received additional funding for the Baby Box with assistance of Institutional Advancement for grant support received $75,000.00 grant for Baby Box – Safe Sleep Program from the Snider Foundation as well as financial grant from Temple University Owl Crowd Drive.
- Maintained as a key strategy in improving compliance with prenatal care, implemented a comprehensive coordinated approach to Prenatal Care & education CoFective Prenatal education materials in all prenatal practices and inpatient settings.
- Collaborated with the team through our “EMPower Grant -Enhancing Maternity Practices Breastfeeding” and Keystone 10 Initiative to support advancement of breast feeding education of patients, financial support for all phases of Baby Friendly Designation Application, and ongoing education of hospital personnel. Program completion December 2017.
- Continued to expand our database to understand nutrition options in our community. Working with USDA Women, Infants & Children Food & Nutrition Program (WIC) and City Health Centers, Common Market, Farm-to families to improve access to nutritional foods and to educate families.
- Continued smoking cessation awareness and education program. In partnership with City of Philadelphia, we are exploring a community resource access plan.
- Continued our support of the City of Philadelphia MOM program, which connects mothers and babies from birth through age 5 with social, educational and healthcare support.

Conclusions and Next Steps: The team continues to expand outreach and relationships in our community with local nonprofit agencies. Active participation in all City wide Department of Health initiatives has facilitated collaboration on care delivery for Women and Infants. This past year, the implementation of the Baby Box and associated research has expanded our relationships with various community partners. These strategies will continue for FY2019.

Obesity and Overweight

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

Strategy Team Lead: Adam Messer, AHD and Elizabeth Craig, DNP, RN, FACHE, Chief Nursing Officer

Goal: Improve general knowledge of healthy food choices and identify resources to aid in nutrition education. Meet the goal of Healthy People 2020 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 (for example: 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 the internal TV programming at TUH. Collaborate with human resource programs at TUH to address employee obesity and provide nutritional education opportunities. Promote 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 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 the FY2018 and FY2019 years. The Farm to Families program at TUH will continue to serve as an anchor program in providing access to healthy food options for Temple patient, employees, and the North Philadelphia community.

- **Tactic:** Improve awareness of poverty and the social programs available to improve social determinants of health amongst the multidisciplinary clinical teams at Temple University Hospital.

- **Outcome:** Hosted multidisciplinary Poverty Simulation in collaboration with the Coalition Against Hunger in September 2017. More than 40 TUHS department leaders, physicians, and employees participated in a poverty simulation to improve awareness of the complexities of social programs and the pros and cons of how they address various needs within the communities they are intended to serve. The Poverty Simulation facilitated a meaningful learning experience to allow members of the healthcare community to understand a variety of needs and programs to address social determinants of health.

Conclusions and Next Steps: Expand Farm to Families programs through collaboration with TUHS and Temple University (TU) Lewis Katz School of Medicine; specifically the pharmacy programs in Cardiology, General Internal Medicine, Maternity, and Endocrine specialties. Collaborate with TUHS, Temple University, and community benefit programs to advance health food security in the region and educate community, staff, and patient populations regarding the health benefits derived by healthy eating and the impact related to overweight and obesity. Using Collaborative Opportunities to Advance Community Health (COACH) program data through the office of Population Health strengthen existing tactics and develop new programs for addressing food security in North Philadelphia.

Plan to Address Access to Mental Health Resources

Title: Plan to Improve Access to Mental Health Resources-Expansion and Coordination of Substance Abuse Services

Strategy Team Lead: Doris Quiles, MSN, APRN, BC – Associate Hospital Director of Behavioral Health Services

Goal: Expand services within the 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:**
  - Architectural designs submitted to the state for approval for renovations to the CRC.
  - Furniture and equipment needs presented to designer, awaiting quotes for new furnishing.
  - Job Descriptions for Drug and Alcohol Supervisor, Therapists and Recovery Peer Specialists, developed and compensation range identified.
  - Warm Hand off Project involving 4 Recovery Peer Specialists from PRO-ACT and Department of Behavioral Health and Intellectual Disability Services (DBHIDS) oriented to work in the CRC with people who have overdosed form Opioids and who are risk for relapse.
  - Education for staff concerning drug and alcohol is ongoing, 75 slots for the American Society of Addictions Medicine (ASAM) training requested from DBHIDS for staff in the CRC. This training of ASAM replaces the current Pennsylvania Client Placement Criteria (PCPC) that is utilized to determine what level of care a patient requires upon discharge from the CRC. The training is sponsored by DBHIDS and will take place over the next 3-8 months.
  - Episcopal is working with different organizations in the community to address the needs of patients living in the encampment areas, under bridges on Lehigh Avenue, North Philadelphia. The CRC will provide services to patients who present through the outreach programs which are dedicated to clearing the areas in the next few months.

- **Outcome:**
  - Waiting for final approval from the Commonwealth for the CRC Renovations
  - Furniture and equipment to be ordered prior to the end of the fiscal year
  - Positions for Drug and Alcohol Supervisor, Therapists and Recovery Peer Specialists were created, funded and posted. The drug and alcohol counselor started work June 18, 2018. The drug and alcohol supervisor will start work July 23, 2018. Recruitment of a recovery specialist is in the final phases.

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

- **Outcome:**
  - The network of Community Providers continues to be developed and expanded.
  - The Director of Behavioral Health Care Management continues to invite community providers to sessions for staff to learn about outside resources.
  - The Warm Hand off project with the Office of Addictions and Department of Behavioral Health and Intellectual Disabilities, placing recovery specialists in the Crisis Center and the Emergency Department to work with patients who are using or have overdosed on opiates.
  - Doris Quiles, MSN. APRN, BC, AHD for Behavioral Health and Regina Ford, Recovery Peer Specialist Supervisor from PRO-ACT presented at the Warm Handoff Program to the DBHIDS Executive's meeting in April. The Peer Specialists continue to work with Temple Staff to provide warm hand offs to the next level of care.
  - We continue to work with Northwest Human Services, now called Mareky to provide onsite outpatient and intensive outpatient services for patients with substance abuse and mental health problems. The location has been identified, renovation drawings have been rendered. We are currently in negotiations with them regarding the lease agreements and hours of operation. We met with CBH in April to discuss the program and are also awaiting their support.
  - BSW Social Worker was hired in December 2017 to facilitate transitions from the inpatient service to outpatient substance abuse and mental health aftercare providers.

Conclusions and Next Steps: We continue to work with City officials related to substance abuse issues in the city and the state. There are discussions about the possibility of utilizing a building on campus as a new respite center for people with substance abuse issues. We also continue to need to expand substance abuse services and linkages to the next level of care. This includes exploring options for funding renovations for the drug and alcohol detox-rehab unit. Over the next few months we will focus on the successful renovations/expansion of the CRC, and the recruitment of staff to fill key positions so that effective substance abuse services can be rendered. We will also seek to finalize the agreement and implementation of the NHS Outpatient/Intensive Outpatient patient program so that we can have warm handoff from both the CRC and the Inpatient Service for a significant number of patients seeking care.

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