



JEANES HOSPITAL

COMMUNITY HEALTH NEEDS ASSESSMENT 2019-2022 IMPLEMENTATION PLAN

October 2019

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JEANES HOSPITAL COMMUNITY COMMITMENT

Jeanes Hospital (Jeanes) was founded in 1928 through a bequest of Philadelphia Quaker leader Anna T. Jeanes. Now over 90 years later, Jeanes is a member of the Temple University Health System (TUHS).

Jeanes' mission is to be the destination for all who need ambulatory, inpatient acute, surgical, and emergency care in Northeast Philadelphia and surrounding areas, by combining the compassionate nature of a Quaker-founded community hospital with the advanced capabilities of an academic medical center. Jeanes devotes manpower and budgetary resources to provide health screenings and health education opportunities to its community.

Jeanes has 146 licensed beds. Each year, we serve thousands in our Emergency Department and other inpatient and outpatients departments.

Jeanes surgical services include vascular, thoracic, joint replacement, spine, ENT, orthopedic, plastic, urologic, ophthalmologic, gynecologic, minimally-invasive general surgeries, weight-loss surgery, and neurosurgery. Jeanes medical services include emergency care, intensive care, cardiology, nephrology, pulmonary, neurology, endocrinology, rheumatology, gastroenterology and primary care. We provide outpatient services for cardiac rehabilitation, chemotherapy infusion services, and diagnostic imaging. Jeanes offers procedures/testing such as cardiac catheterization, electrophysiology, stress echocardiogram, MRI scan, CT scan, endoscopy, interventional radiology, digital mammography, pain management, sleep studies and more. We work in tandem with our colleagues at the Hospital of Fox Chase Cancer Center (FCCC) to provide on-site hematologic and oncologic services.

In addition to Jeanes, other member hospitals of TUHS include Temple University Hospital and FCCC.

MISSION STATEMENT

To maintain and enhance the quality of life for individuals in the communities we serve. The hospital emphasizes the Quaker belief that in each person there resides a spirit that creates a common bond among us all.

PROGRAMS TO IMPROVE COMMUNITY HEALTH

Jeanes Hospital (Jeanes) takes great pride in the broad array of community services we provide to our neighborhoods. Many of our programs address the social determinants of health impacting health outcomes. Below is a summary of some of our programs and activities that promote healthy living in the communities we serve.

- **Providing Critical Resources.** We connect hundreds of people with social services, including transportation services, legal services, and clothing to destitute patients upon discharge. For our most vulnerable patients, we also assist with pharmaceuticals, co-pays and medical supplies to connect them with resources they need to heal upon discharge.
- **Connecting Patients with Financial Resources.** Our Financial Counselors are on site and dedicated to helping un- and under-insured patients obtain medical coverage.
- **Reaching out to our Communities.** We reach thousands of people each year through outreach and community education programs. These efforts focus on cancer, heart disease, obesity, diabetes, stroke, COPD and other chronic diseases, mental health, wellness and disease prevention, smoking cessation, women's health, nutrition and many other topics. We also work with key community organizations to provide free health screenings.
- **Promoting Multi-Cultural Services.** We respond to the needs of our growing community of non-English-speaking patients by providing translated written materials and live and telephone-based interpretation services. We work closely with the Temple University Health System's (TUHS) linguistics team who educates us on our community's various cultures and their response to illness and health care. Our staff are invited to participate in conferences on cultural competence which is a system wide educational program designed to heighten awareness and increase cultural sensitivity. Our employees are also required annually to complete a series of cultural awareness competencies as part of their employment requirements.
- **Building a Healthy Community.** Our *Community Classroom* series presents numerous education seminars each year focused on health, wellness, and safety. Our physicians and healthcare professionals volunteer their time and expertise to present on our Hospital's campus and at several community and senior events throughout our surrounding neighborhood. Our chaplain also offers programs on loss, bereavement and other related topics. In addition, we hold many food, blood, clothing, and book donation drives to enhance our community's quality of life.
- **Substance Use Disorder & Behavioral Health Resources.** We are responding to the behavioral health needs of our community and increasing care coordination for those battling addiction by providing continuing education to our physicians on pain management and the opioid epidemic. We also conduct warm hand off to the next level of care for patients with opioid use disorder and provide community-based education on seeking help for depression, suicidal behavior and other mental health issues.

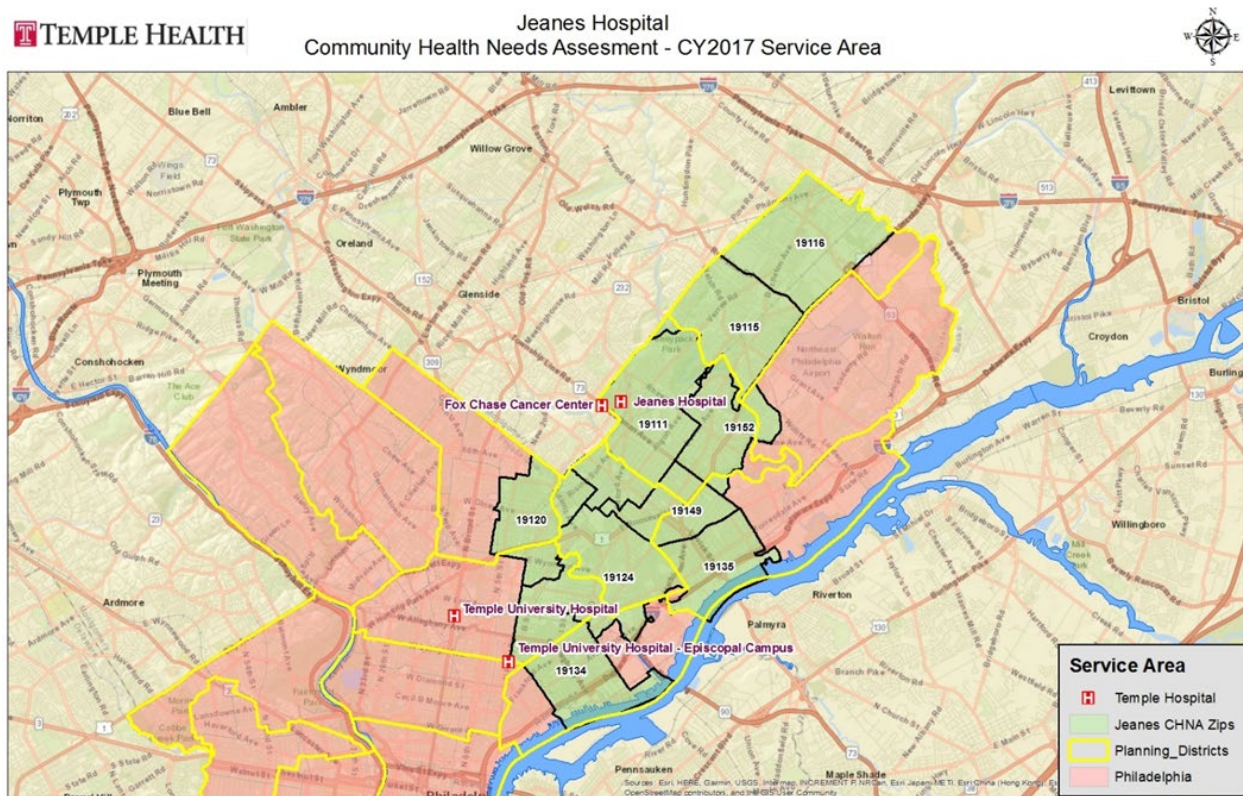
- **Encouraging Physical Activity.** We offer free walking trail and exercise equipment on our campus for employees and community members. We also sponsor activities throughout the year focused on increasing activity, disease prevention, health promotion and management. Our neighbors are encouraged to utilize the walking trail and equipment to increase their physical activity level.
- **Connecting with our Senior Communities.** Each fall, we conduct an annual Senior Health & Wellness Fair serving hundreds of seniors living in our surrounding neighborhoods. Physicians and healthcare professionals on site provide health education and screening activities. We have also partnered with local organizations serving senior members of our community.
- **Connections to Primary Care.** Our partnership with Temple Physicians Inc. (TPI) creates a unique opportunity for us to formally partner with local primary care physicians. These front-line practices are mainstays of our community and our alignment allows us to care for our community right in their own neighborhoods. When emergency or hospital care is needed, the Jeanes connection serves as a conduit to enhance continuity of care for patients when they need it most. Upon discharge, the transition of care to the primary care provider is seamless as patients are navigated back to their neighborhood physician.
- **Partnering with our local Emergency Medical Services (EMS).** Our EMS colleagues are an integral partner in caring for our shared community. We work in tandem with EMS realizing the important role they play in pre-hospital care and its effect on patient outcomes. Our EMS colleagues are part of our community outreach, healthcare events and participate on our multi-disciplinary committees.
- **Connections to Cancer Care.** Our collaboration with Fox Chase Cancer Center (FCCC) allows us to offer patients cutting-edge cancer care right in their community. The FCCC Connect program serves as a connection between primary care and oncologic specialty physicians. These providers work in tandem to meet the cancer care needs of our community sharing treatment plans and focusing on quality of life and survivorship.
- **Anna T. Jeanes Foundation.** The Anna T. Jeanes Foundation (ATJF) is a not-for-profit organization incorporated for the purpose of conducting exclusively charitable, scientific and educational activities in support of Jeanes Hospital and the community it serves. The majority of the members of the Foundation's Board are members of the Religious Society of Friends. Currently, the Foundation serves as a primary source of funding for community wellness education and the Jeanes Hospital Community Grants Program.
- **Community Advisory Board.** The purpose of the *Community Advisory Board* (CAB) of Jeanes is derived from our hospital's mission, vision and values statements. CAB exists primarily to provide a forum for communicating meaningful information between the Jeanes and the community it serves. Members come from the residential and business communities, the Jeanes Board of Directors, the Jeanes Hospital Auxiliary, and Volunteers, and includes the Chief Executive Officer of our hospital. Currently, an important function of the CAB is to solicit and review applications and select recipients for the *Jeanes Hospital Community Grants Program*. These grants are awarded to not for profit organizations in the service areas of Jeanes engaging in activities that support the health and wellness of the community.

COMMUNITY HEALTH NEEDS ASSESSMENT SUMMARY

COMMUNITY DEFINITION:

For the purpose of our 2019 Community Health Needs Assessment (CHNA), Jeanes Hospital (Jeanes) defined its immediate service area as nine (9) zip codes in Philadelphia County: 19111; 19115; 19116; 19120; 19124; 19134; 19135; 19149; and 19152. These are the zip codes from which about 70% of our patients seen on an inpatient and observation basis reside. These zip codes roughly correspond to the City of Philadelphia's Lower Northeast, Central Northeast and North Delaware Planning Districts as set forth in the City of Philadelphia Department of Public Health's [2017 Community Health Assessment for Philadelphia, PA](#). Figure 1 outlines our service area.

Figure 1: Jeanes Hospital Service Area



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

UNMET HEALTH NEEDS:

Unmet health needs for Jeanes' community were identified by comparing the health status, access to care, health behaviors, and utilization of services for residents of our service area to data for the county, state, and the Healthy People 2020 goals for the nation. In addition, a Key Informant Survey was sent to all Jeanes Staff as well as other social and health service providers throughout our service area to obtain their perspectives about the community's health needs. A Focus group was also held to collect input from community stakeholders on problems with access to care, and populations with special health needs.

HEALTH PRIORITIES:

With a focus on improving life for individuals in the communities it serves, Jeanes emphasizes the Quaker belief that in each person there resides a spirit that creates a common bond among us all. With this in mind, our 2019 CHNA building upon previously identified unmet health needs using more recent data, revealed the following health needs and priorities across our community:

Priority area #1: Chronic Disease

Priority area #2: Access to Healthcare

Priority area #3: Mental Health Access and Education

Priority area #4: Substance Use Disorder Treatment Integration

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

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

- [Jeanes Hospital](#)-Community Health

COMMUNITY FEEDBACK:

Below are the major findings of Jeanes 2019 CHNA.

Chronic Disease

Focus Group Participants identified the lack of widespread information on the impact of chronic diseases on the body as a key community issue for patients who are living with chronic diseases. They noted that lack of education on how to use the medical equipment associated with treating chronic diseases; lack of education on how to avoid hospitalizations; and lack of access to preventative information as key issues. Participants also identified health system navigation, limited providers and limited availability of services, as well as lack of income, high co-pays and lack of insurance coverage as barriers to chronic disease care.

Access to Quality Health Care

34% of Focus Group Participants rated the health status of the community as “fair” or “poor.” They explained that the population had barriers to care including access, limited financial resources, lack of insurance, out-of-pocket costs were also noted as a barrier to care. Survey Respondents indicated the following barriers to care: lack of insurance, scarcity of livable wages, language and cultural barriers, homelessness, transportation, gun violence, inability to pay out-of-pocket expenses and health system navigation as barriers to care.

Substance Use Disorder

67% of Focus Group Participants identified the need for resources to manage substance use as a top community need. They identified a lack of resources for managing substance use issues and addictive behaviors. More than half of Key Informant Survey Respondents indicate that Substance Use (Alcohol, Drugs) is a top community need. They noted that the community is failing to associate addiction struggles with substance use disorders, and that it lacks the appropriate number and range of substance use disorder resources needed to manage the epidemic locally.

Mental Health

Close to half (46.7%) of Focus Group Participants identified the need for more behavior health screenings and a third (33.6%) of Key Informant Survey Respondents identified mental health services as one of the community's top three needs. Almost a third of Key Informant Survey Respondents (30.0%) also indicated mental health services as a top needed resource to improve access to health care in the city. Barriers to mental health identified included lack of insurance, scarcity of livable wages, language barriers, stigma and inability to navigate the system.

Healthy Environment

Focus Group Participants indicated that there are numerous social determinants of health that play a role in overall health care including poverty, scarcity of living wages, housing, gun violence, homelessness, low graduation rates, lack of employment, lack of housing and transportation. More than 70% of Focus Group Participants indicated safer housing was a top community need. About 40% of Focus Group Participants also indicated gun violence education was also a major need.

Women and Children's Health

Public health data, survey results and Focus Group Participants similarly identified the following needs related to women, mothers, infants and children: affordable child care, assistance with Pennsylvania's Women, Infants and Children (WIC) assistance program and Medicaid benefits; low birth weight, smoking during pregnancy, lack of pre-natal care, teen pregnancy and infant mortality. Nearly half of Focus Group Participants identified the need for more screening and prevention programs for youth as a priority community need.

Physical Activity & Nutrition

67% of the Focus Group Participants identified better nutritional food options as a top community need. Participants noted that many food banks were often missing the key nutritional groups that are needed for a healthy diet. They also noted the need for safe spaces to exercise as well as green areas for gardening. More than half (60.0%) of the Focus Group Participants identified the need to have protein choices available at local food pantries. They stressed the need for dietitians and nutritionist in the community to help individuals with strict diets with meal planning. Education on how to access and cook vegetables was also stressed.

Infectious Disease

Focus Group Participants identified the HIV/AIDS population, especially those with mental health or substance use issues, as a medically vulnerable population because they often drop out of care and can become homeless.

Unmet Needs

Analysis of the quantitative and qualitative data collected shows that the unmet health care needs of the residents of our service area include the following prioritized needs:

- Access to comprehensive, quality health care .
- Access to patient education related to chronic disease management.
- Access of resources for managing substance use issues and addictive behaviors. Availability of preventive health care to support early detection.
- Access to healthy foods /nutrition/food insecurity.

Health Education Priorities

Priority unmet needs in Jeanes service area include increased educational programs to address:

- CPR and First Aid training;
- Early intervention training on warning signs of Chronic Diseases;
- Training on disease processes;
- Improve follow-up process to be more accessible through technology;
- Increased advocacy for preventative care.

IMPLEMENTATION PLAN PROCESS

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

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

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

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

PLAN TO ADDRESS CHRONIC DISEASE MANAGEMENT

Rationale:

Focus Group Participants identified the lack of widespread information on the impact of chronic diseases on the body as a key community issue for patients living with chronic diseases. They noted that lack of education on how to use the medical equipment associated with treating chronic diseases; lack of education on how to avoid hospitalizations; and lack of access to preventative information as key issues. Participants also identified health system navigation, limited providers and limited availability of services, as well as lack of income, high co-pays and lack of insurance coverage as barriers to chronic disease care.

Goals:

- Educate community on the prevention and management of chronic diseases.
- Partner with clinicians and staff to provide educational programs to help our community optimally manage their health conditions.
- Heighten community awareness on the importance of wellness and health screenings to prevent chronic disease.
- Expand the ability to continue treatment beyond hospitalization by increasing follow-up appointments to help ease barriers to access.

Metrics:

- Number of community outreach events and screening programs in which Jeanes Hospital participates and number of attendees.
- Number of patients who connect to follow up health services within 7 days of hospital discharge.
- Number of patients re-admitted to Jeanes Hospital.

Available Resources:

Jeanes Hospital (Jeanes) offers leadership, clinician support, staff support, manpower, meeting space, office and educational outreach opportunities. Jeanes has an engaged medical staff with clinical expertise that are willing to present free educational programs to the community. The hospital will make a difference in the community by promoting this expertise to engage community, build awareness and to begin to change behaviors in the management of chronic disease. Jeanes will enlist outreach assistance from its healthcare professionals and medical staff to appropriately provide health screenings for our community.

Implementation Team:

- Executive sponsors
 - *Chief Medical Officer, Jeanes Hospital* - Rebecca Armbruster, DO
 - *Chief Nursing Officer, Jeanes Hospital* - Denise Frasca

- Team members
 - *Team Leader, Director of Volunteer Services, Jeanes Hospital* - Rosemarie Schlegel
 - *Director of Rehabilitation Services, Jeanes Hospital* - Denise Nawalany
 - *Clinical Manager of Nutrition and Food Services, Jeanes Hospital* - Kara Stromberg
 - *Community Outreach Coordinator, Jeanes Hospital* - Barbara Buford
 - *Transitional Care Coordinator, Clinical Resource Management, Jeanes Hospital* - Cecelia McGinley
 - *Senior Director of Business Development, Jeanes Hospital* - Lisa Donnelly
 - Jeanes Hospital Executive Leadership
 - Jeanes Hospital Medical and Hospital Staff
 - Jeanes Hospital Clinical Service Lines
 - Anna T. Jeanes Foundation
 - Jeanes Hospital Community Advisory Board
- Health System Partners
 - *VP/ Operations, TUH - Episcopal Campus* - LuAnn Kline
 - *VP, Temple Physicians Incorporated* - Renee Reedman
 - *Marketing Manager, TUHS* - Amanda Snider

Community Participants:

- Community Organizations
 - Common Market Philadelphia
 - Burholme Emergency Medical Services

Action Plans:

- Provide healthcare educational and screening programs through the Jeanes Community Classroom, Temple Diabetes Program, Better Breathers, Bariatric Seminars and Joint Education Classes.
- Participate in local community outreach events to promote health and wellness.
- Encourage community participation in health promoting events and activities.

Objective:

Jeanes will provide health education and screening programs through a variety of venues to promote the optimal health and wellness of our local community.

Communication:

- Utilize multiple communication tools including web-based outlets, social media, email, traditional print advertisement, direct mail, newsletters, flyers, bulletins to invite and encourage community and employee participation.

Estimated Budget:

- Portion of hospital employee and physician salaries \$100,000
- Event participation costs \$30,000
- Resource materials \$9,000

PLAN TO ADDRESS ACCESS TO HEALTHCARE

Rationale:

34% of Focus Group Participants rated the health status of the community as “fair” or “poor.” They explained that the population had barriers to care including access, limited financial resources, lack of insurance, out-of-pocket costs were also noted as a barrier to care. Survey Respondents indicated the following barriers to care: lack of insurance, scarcity of livable wages, language and cultural barriers, homelessness, transportation, gun violence, inability to pay out-of-pocket expenses and health system navigation as barriers to care.

Goals:

- Partner with clinicians and staff to provide access to healthcare services to meet the needs of our community.
- Heighten community awareness of Temple University Health System (TUHS) clinical services and health screenings.
- Expand the ability to continue treatment beyond the hospital. Jeanes Hospital (Jeanes) will aim to increase follow up appointments to help ease barriers to access.
- Connect patients with financial counselors during hospitalization to discuss insurance and learn more about available options and resources.

Metrics:

- Measure number of patients who connect to follow up health services within 7 days of hospital discharge.
- Measure number of patients who go directly from Jeanes to other TUHS entities/programs for further treatment.
- Monitor appointment availability in clinical practices and departments.

Available Resources:

Jeanes offers leadership, clinician support, staff support, manpower, meeting space, office and screening opportunities. Jeanes has an engaged medical staff with clinical expertise that are actively involved in healthcare access and transitions of care. Jeanes’ Clinical Resource Management Team will work with patients and families in active discharge preparation and planning. The hospital will make a difference in the community by promoting this collaboration to engage community, build awareness and to begin to change behaviors in the navigation of the health care system. Jeanes will enlist outreach assistance from TUHS financial counselors to assist our community in connecting with available insurance options and resources.

Implementation Team:

- Executive sponsors
 - *Chief Medical Officer, Jeanes Hospital* - Rebecca Armbruster, DO
 - *Chief Nursing Officer, Jeanes Hospital* - Denise Frasca
- Team members
 - *Team Leader, Transitional Care Coordinator, Jeanes Hospital* - Cecelia McGinley

- *Senior Director of Business Development, Jeanes Hospital* - Lisa Donnelly
- Jeanes Hospital Executive Leadership
- Jeanes Hospital Medical and Hospital Staff
- Jeanes Hospital Clinical Service Lines
- Health System Partners
 - *VP, Temple Physicians Incorporated* - Renee Reedman
 - *VP, Temple Faculty Practice Plan* - Lisa Fino
 - *Director, Temple Access Center* - Joseph Alfonsi
 - Temple Financial Counselors

Community Participants:

- Community Organizations
 - Private Physician Practice Offices in Jeanes Service Area
 - District Health Center in Jeanes Service Area

Action Plans:

- Provide patient access to clinical appointments and services.
- Navigate and connect community to appropriate clinical providers and services.
- Participate in local community outreach events to promote health and wellness.

Objective:

Jeanes will provide and assist with navigation to access to a variety of primary care and clinical specialists to promote the optimal health and wellness of our local community.

Communication:

- Collaborate with TUHS and private practices to provide patient access to physicians, allied health clinical resources and emergency departments and urgent care centers.
- Collaborate with community partners to transition care appropriately.

Estimated Budget:

- Portion of hospital employee salaries: \$110,000
- Collateral materials: \$40,000

PLAN TO ADDRESS MENTAL HEALTH ACCESS & EDUCATION

Rationale:

Close to half (46.7%) of Focus Group Participants identified the need for behavior health increased screenings and a third (33.6%) of Key Informant Survey Respondents identified mental health services as one of the community's top three needs. Almost a third of Key Informant Survey Respondents (30.0%) indicated mental health services were the top key resource to improve access to health care in the city. Barriers to mental health identified by the community included lack of insurance; scarcity of livable wages, language barriers; stigma; and inability to navigate the system.

Goals:

- Enhance onsite capabilities to assess and care for patients experiencing mental health issues during hospitalization.
- Expand the ability to continue treatment beyond Jeanes Hospital (Jeanes). Jeanes will aim to increase its linkage rates to next levels of care with a warm handoff. These enhanced linkages will help ease barriers to access.

Metrics:

- Measure number of patients who connect to mental health services within 7 days of hospital discharge.
- Measure number of patients transferred from Jeanes to Temple University Hospital - Episcopal Campus's Crisis Response Center.

Available Resources:

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

Implementation Team:

- Executive sponsors
 - *Chief Medical Officer, Jeanes Hospital* - Rebecca Armbruster, D.O.
 - *Chief Nursing Officer, Jeanes Hospital* - Denise Frasca

- Team members
 - *Team Leader, Clinical Resource Manager, Jeanes Hospital* - Elizabeth Zachariah
 - *Attending Psychiatrist, Jeanes Hospital* - Kenneth Levy, M.D.
 - *Senior Director of Business Development, Jeanes Hospital* - Lisa Donnelly
 - Jeanes Hospital Executive Leadership
 - Jeanes Hospital Medical and Hospital Staff
- Health System Partners from Episcopal Campus
 - *Director of Behavioral Health, TUH - Episcopal Campus* - LJ Rasi
 - *Chair and Chief Medical Officer, TUH - Episcopal Campus*, - William R. Dubin, M.D.
 - *Vice President Chief Nursing Officer, TUH - Episcopal Campus* - Yasser Al-Khatib, RN, BSN

Community Participants:

- Community Organizations
 - CORA
 - Aldersgate

Action Plans:

- Collaborate with colleagues at Episcopal Campus to develop care pathways.
- Measure door-to-door linkages from Jeanes to Episcopal's Crisis Response Center.
- Review educational needs of physicians/staff and offer educational programs.

Objectives:

Jeanes will provide mental health assessment, treatment and direct referral to the next level of care via a dedicated network of health system and community providers. Care will be delivered by all providers in the network using evidenced based treatment.

Communication:

- Collaborate with Episcopal to provide educational programs to physicians, nursing, clinical resource management, allied health and emergency departments on available resources with the health system.
- Collaborate with community partners at CORA and Aldersgate.
- Provide training on the use of the Episcopal Crisis Response Center Resource Guide.

Estimated Budget

- Employee and physician resource: \$220,000
- Training costs: \$40,000
- Resource materials: \$20,000

PLAN TO ADDRESS SUBSTANCE USE DISORDER TREATMENT & EDUCATION

Rationale:

67% of Focus Group Participants identified the need for resources to manage substance use as a top community need. They identified a lack of resources for managing substance use issues and addictive behaviors. More than half of Key Informant Survey Respondents indicate that Substance Use is a top community need. They noted that the community is failing to associate addiction struggles with substance use disorders, and lacks the appropriate number and range of substance use disorder resources needed to manage the epidemic locally.

Goals:

- Establish multidisciplinary “Addiction Response Advisory Committee” to respond to the care, management and transition of our patients with Substance Use Disorder (SUD).
- Collaborate with Temple University Health System (TUHS) colleagues to enhance onsite capabilities to assess and care for patients with SUD.
- Work with TUHS to establish Certified Recovery Specialist support onsite at Jeanes.
- Expand the ability to enter/continue treatment beyond the hospital. Jeanes will aim to increase its linkage rates to next levels of care by being part of the “Temple Substance Use Disorder Warm Handoff Collaborative”.

Metrics:

- Measure number of providers who have undergone specific training for medication assisted therapies for SUD.
- Measure number of patients who connect to SUD treatment programs.

Available Resources:

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

Implementation Team:

- Executive sponsors
 - *Chief Medical Officer, Jeanes Hospital* - Rebecca Armbruster, D.O.
 - *Chief Nursing Officer, Jeanes Hospital* - Denise Frasca
- Team members
 - *Team Leader, Performance Improvement Manager, Jeanes Hospital* - Catherine Huck
 - *Jeanes IHP Hospitalists, Jeanes Hospital* - William Vemula, M.D.
 - *Senior Director of Business Development, Jeanes Hospital* - Lisa Donnelly
 - *Jeanes Hospital Executive Leadership*

- Jeanes Hospital Medical and Hospital Staff
- Jeanes Hospital Emergency Department
- Health System Partners from Temple University Hospital
 - *Project Manager, Temple Center for Population Health, TUHS* - Patrick Vulgamore
 - Temple Recovery Using Scientific Treatment (TRUST) Clinic Center Team

Community Participants:

- CORA Services (Counseling Or Referral Assistance)
- Aldersgate

Action Plans:

- Initial meeting of the Addiction Response Advisory Committee to assess current state, identify necessary support resources, and develop multidisciplinary plans of care to be used in tandem with our Temple University Hospital (TUH) colleagues.
- Collaborate with colleagues at TUH to continue implementation of TUHS clinical management pathways.
- Measure number of patients transferred from Jeanes to the Temple's Trust Center and SUD treatment programs.
- Review educational needs of physicians/staff and offer educational programs.

Objectives:

Jeanes will provide patients with SUD assessment, treatment, education and direct referral to the next level of care via a dedicated network of health system and community providers. Care will be delivered by all providers in the network using evidenced based treatment.

Communication:

- Collaborate with TUH partners to provide educational programs to physicians, nursing, clinical resource management, allied health and emergency departments on SUD.
- Communicate the available resources within TUHS and the local community.
- Collaborate with community partners at CORA and Aldersgate.

Estimated Budget:

- Employee and physician resources: \$200,000
- Training costs: \$100,000
- Resource materials: \$10,000

APPROACH TO UNMET NEEDS

Addressing Social Determinants of Health. In 2018, Temple University Hospital (TUH) in collaboration with the Temple Center for Population Health (TCHP), Temple Faculty Practice Plan (TFP) and Temple Physicians Inc. (TPI) developed a data collection tool for recording the assessment of the social determinants of health. This tool is imbedded into TUH's EPIC electronic medical record and administered to patients on a daily basis in TUH's Emergency Department, and inpatients and ambulatory clinics. Commencing in February 2020, Jeanes Hospital (Jeanes) will adopt the tool into its EPIC electronic medical record (EMR). As part of the implementation, Jeanes will begin to record and collect assessment data in their EMR.

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

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

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

Access to Primary and Preventative Care. As a community hospital, we have limited resources to address the comprehensive primary care needs in our community. However, as a member of the Temple University Health System family of hospitals and physicians, we will work with our affiliates to strengthen access to primary care and preventative services. Our affiliated network of community physicians, TPI, as well as TFP, provide our low-income community with access to primary and specialty services. Virtually all Temple physicians, whether community or faculty based, accept patients covered by Medicaid.

PLANNING FOR A HEALTHIER POPULATION

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

Temple Center for Population Health

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

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

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

Key Programs for High Value Care

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

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

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

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

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

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

Collaborative Programs on Local, State and National Levels

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

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

Collaboration with the Lewis Katz School of Medicine at Temple University

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