Community Health Needs Assessment

Implementation Strategy

2022-2025

TEMPLE UNIVERSITY HOSPITAL

Advancing equity in healthcare delivery, medical education and research

TEMPLE HEALTH
TEMPLE UNIVERSITY HOSPITAL

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OVERVIEW OF COMMUNITY HEALTH NEEDS

TEMPLE UNIVERSITY HOSPITAL COMMUNITY COMMITMENT

As the chief clinical training site for the Lewis Katz School of Medicine at Temple University, Temple University Hospital (TUH) is an 879-bed non-profit acute care hospital and academic medical center that trains the next generation of healthcare professionals. We are an indispensable provider of healthcare for America's largest city without a public hospital. We provide access to medical care across all specialties with the same high quality care regardless of economic status.

TUH's commitment to healthcare equity transcends every aspect of our business model. This includes decisions around access points, care delivery, operations, employment and workforce training from the entry level throughout the spectrum of health professions education.

In recognition of our commitment to health equity, **Temple University Hospital has been ranked #1 in Pennsylvania and Top 10 in the Nation for "Health Equity"** by the Lown Institute, a non-partisan think tank that examined over 3,750 hospitals to assess their investment in community health and success serving people of color and individuals with lower incomes and education levels living in their surrounding communities.

TUH is a critical access point for vital public health services. Each year we serve thousands in our Emergency Departments, Crisis Response Center, and labor and delivery unit. We have one of the most active trauma units in our state. Among Pennsylvania's full-service safety-net providers, TUH serves the greatest volume and highest percentage of patients covered by Medicaid.

As a major teaching hospital, TUH has 46 accredited medical specialty residency programs training over 670 medical residents and fellows each year. Residents enhance their clinical education by engaging in service projects benefiting our communities. We also provide clinical rotations to thousands of nursing, social work, physician assistant and behavioral therapy students annually.

Our Episcopal Campus, which is home to TUH's behavioral health services, offers a wide range of adult psychiatric services. Episcopal' s Behavioral Health program is recovery treatment oriented, offering a welcoming approach and hope for those living with mental illness and co-occurring substance use disorders. Episcopal also manages a variety of outpatient services at our Northeastern Campus.

Our Jeanes Campus, located in Northeast Philadelphia, is the nation's only Quaker-founded hospital. Jeanes combines the services of a community hospital with the advanced capabilities of an academic medical center.

Along with other members of the Temple Health family, we are committed to providing our community access to the highest quality care.

Temple Physicians, Inc. is a network of community-based healthcare providers that deliver primary care in over 40 practice sites. **Temple Faculty Practice Plan** represents about 20 academic departments providing specialty care, including emergency medicine, oncology, gastroenterology, obstetrics, orthopedics, neurosurgery, neurology, general and specialty surgery and psychiatry. The **Temple Transport Team** conducts medical ground and air transportation for critically ill patients across our region.

Fox Chase Cancer Center, a *National Cancer Institute Comprehensive Cancer Center*, conducts cutting-edge cancer treatment, research, prevention, education, and outreach. The **Temple Center for Population Health** advances our health equity efforts though its comprehensive community health worker and chronic disease management programs for at-risk populations.

MISSION STATEMENT

Temple University Hospital's mission is to provide access to the **highest quality** of health care in both community and academic settings. The hospital supports Temple University and its Health Sciences Center's academic programs by providing the clinical environment and service to support the **highest quality teaching, training** and **research programs** for health care students and professionals. **We embrace our values of Respect, Service and Quality.**

TEMPLE PROGRAMS TO ADVANCE HEALTH EQUITY

Below we describe several of our initiatives to advance health equity in the communities we serve.

Providing Critical Resources. We connect thousands of people each year with free social supports, including transportation, legal services, and clothing. For our most vulnerable patients, we assist with co-pays and medical supplies to ease their transition home after treatment.

Connecting Patients with Financial Resources. Our Financial Counselors are dedicated to helping un- and under-insured patients obtain medical coverage.

Promoting Multi-Cultural Services. Our nearly 400 bilingual language proficient staff perform thousands of interpretations each year for non-English speaking patients and families.

Reaching Out to Communities. We engage with our neighbors through targeted outreach, support groups, and education programs on topics such as substance use disorders, behavioral health, cancer, diabetes care, childbirth and burn prevention. Our ***Community Health Worker*** Team conducts home visits, schedules and attends doctor appointments, coordinates transportation and connects the community with other social supports.

Responding to Community Behavioral Health Needs. We offer free support groups for patients and family members affected by mental health and substance use. Our behavioral health experts provide free community-based training and education on crisis response, depression, suicidal behavior and other issues. We offer specialized virtual resources for those struggling with anxiety, burn-out, social isolation and other mental health issues.

Addressing the Opioid Epidemic. In partnership with the Commonwealth, we are leading our region's ***Pennsylvania Coordinated Medication-Assisted Treatment*** program by expanding treatment for opioid use disorder to community sites. With lived experience and specialized training, our ***Certified Peer Recovery Specialists*** link overdose patients with needed services. Our ***Begin the Turn*** street side mobile unit is staffed by a behavioral health professional, case manager, medical practitioner and social workers. This team provides medication-assisted treatment and acute care services with a bridge to primary care and social supports.

Advancing Maternal Health Equity. We counsel expectant mothers on pre-natal care and offer classes on childbirth, breastfeeding, nutrition, post-natal recovery and newborn needs. Our free yoga classes promote stress reduction, fitness, breathing and wellness. As a ***Baby-Friendly USA*** designated birth facility, we provide evidence-based lactation education to improve infant health. Our ***Sleep Awareness Family Education*** at Temple initiative teaches families about safe infant sleep.

We are designated as a ***Center of Excellence*** by the Commonwealth for our care of pregnant and others with Opioid Use Disorder. Patients receive trauma-informed pre-natal care, maternal fetal consultation, primary care, behavioral health services and medication-assisted treatment.

Prevailing Over Cancer. To promote early cancer detection and increased survivorship, we offer free breast, prostate and other screenings on-site and in neighborhood settings. We partner with ***Fox Chase Mobile Screening Unit*** to bring cancer screenings to residents of North Philadelphia and the region. We conduct community-based education on cancer risk factors, symptoms, screening, detection, diagnosis and treatment for at-risk populations.

Re-Imagining Patient Care. Our ***Multi-Visit Patient Clinic*** provides a full continuum of care for patients with high emergency department use and frequent inpatient admissions. Upon discharge, we link patients with follow-up healthcare and provide meals, transportation, home visits and other social supports.

Addressing Public Health Impact of Violence. Our comprehensive approach to this public health crisis includes several prevention and intervention programs. In partnership with the Pennsylvania Commission on Crime and Delinquency and Philadelphia Works, our ***Healing Through Work*** program connects victims of gun violence with gainful employment to disrupt the cycle of interpersonal violence, open pathways, and bring stability to lives. ***Cradle to Grave*** is our collaborative program with the Juvenile Justice Department and local schools that works with at-risk youth to break the cycle of gun violence. ***Fighting Chance*** teaches community members how to provide basic first aid to gunshot wound victims.

Our ***Trauma Victim Advocate Program*** team provides social and emotional support to trauma patients and families from hospital entry through discharge. Our Advocates connect victims with services that assist with relocation, lost wages recovery, unpaid medical bills, mental health and other needs to support post-traumatic recovery and community re-integration.

Developing Tomorrow's Frontline Workforce. We are leading several initiatives that build a diverse workforce at all levels of healthcare. Our investment in the 1199c Training and Upgrade Fund ***Community Health Workforce Program*** provides community members with training in nursing, behavioral health, childcare, health IT and other areas. In partnership with the Philadelphia Housing Authority (PHA), Temple University and others, our ***PHA CARES*** program hires and trains public housing residents to work as on-site Community Health Workers at PHA locations.

Engaging Patients & Families. Our ***Patient Family Advisory Councils*** focus on family medicine, trauma, and cardiovascular medicine. They engage and encourage the participation of patients, families, and community members in evaluating patient satisfaction across different clinical areas.

Responding to Food Insecurity. Our ***Farm to Families*** initiative brings fresh, low-cost produce to North Philadelphia families through home delivery and neighborhood distribution to address obesity, food insecurity, cardiovascular disease, and diabetes. Families can use SNAP benefits and a "prescription" from a Temple doctor to purchase local fruits and vegetables. Our Jeanes Campus offers a seasonal fresh farm market, and community access to its walking trail.

Preparing for Emergencies. Our ***Emergency Preparedness*** program works on many levels to educate our communities and staff about the importance of personal preparedness. We are a critical link in federal, state, and local disaster response plans through our active participation and leadership in the regional healthcare preparedness coalition.

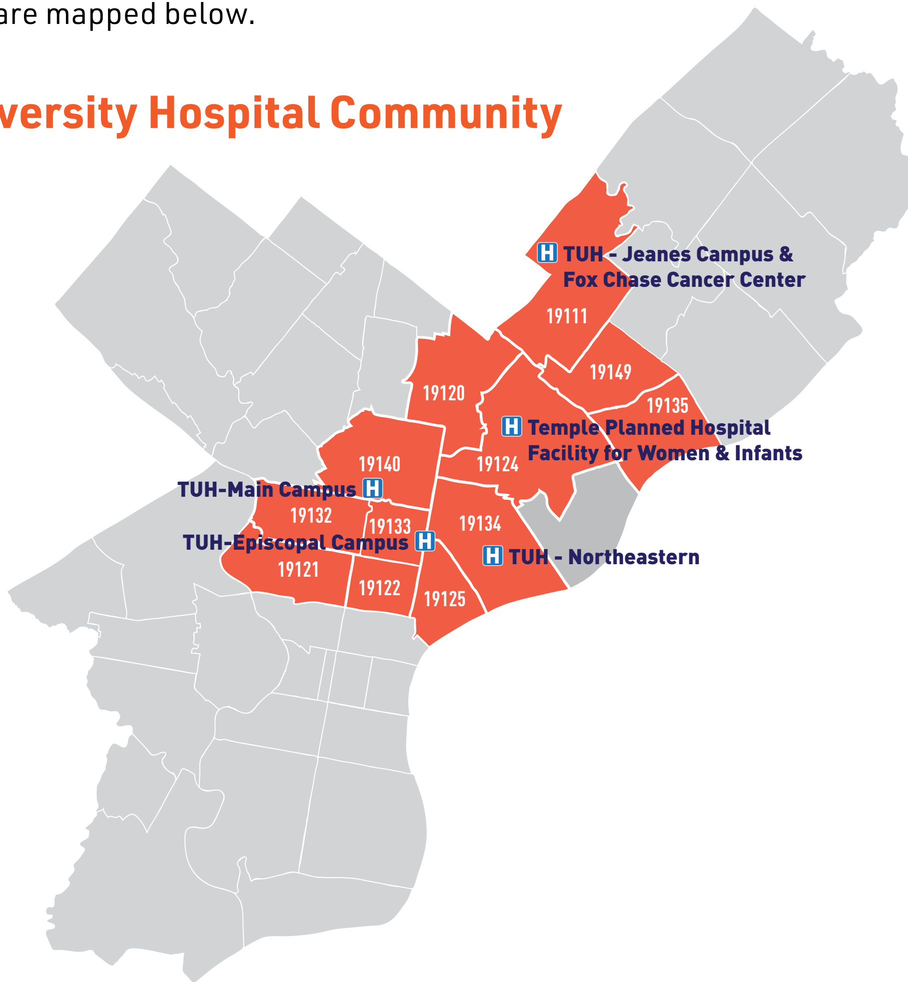
See Temple University Hospital's Community Health page for more information on our programs.

COMMUNITY HEALTH NEEDS ASSESSMENT SUMMARY

Community Definition

For the purpose of our 2022 Community Health Needs Assessment (CHNA), Temple University Hospital defined its community as comprised of 12 zip codes: 19111; 19120; 19121; 19122; 19124; 19125; 19132; 19133; 19134; 19135; 19140 and 19149. These are the zip codes from which about 70% of our patients seen on an inpatient and observation basis reside. These zip codes largely overlay with the *North Philadelphia-East, North Philadelphia-West, River Wards* and *Lower Northeast service areas identified* in the 2022 Southeastern Pennsylvania Regional CHNA done in collaboration with the Philadelphia Department of Public Health and the Health Care Improvement Foundation. Those zip codes are mapped below.

Temple University Hospital Community



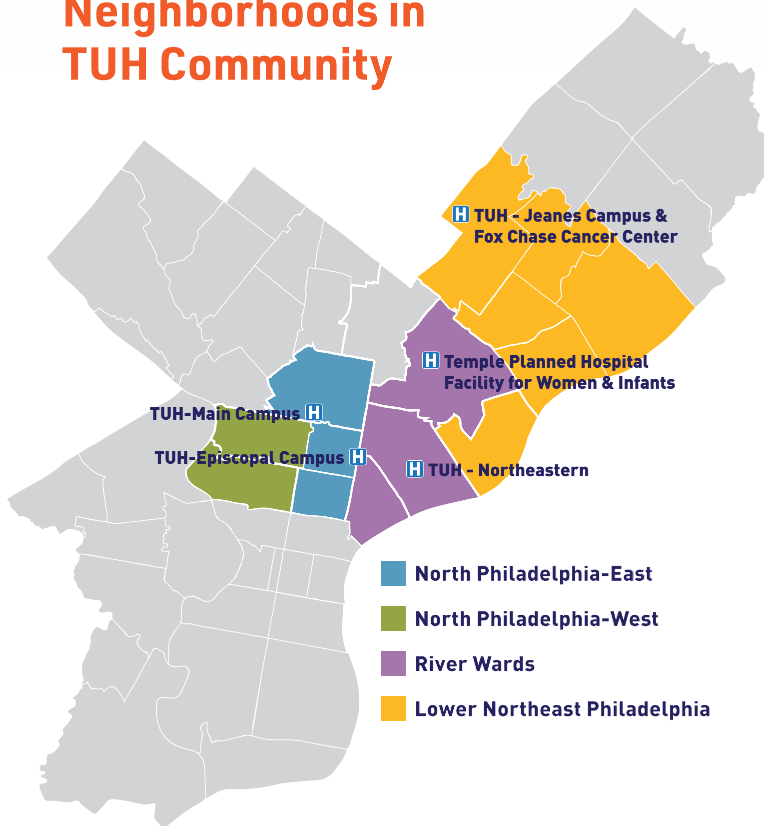
Community Health Needs Assessment Process

In assessing community health needs, we compared residents of our community's health status, access to care, health behaviors, and utilization of services to data from our region. Five focus groups were held to gather residents input living in our immediate community's 12 zip codes. We also incorporated feedback from over 20 topic specific discussions held with community organization and local government agency representatives on behavioral health, chronic disease, food insecurity, housing, substance use, violence and other topics. Additionally, we evaluated primary and secondary data focused on unmet health needs associated with conditions requiring specialized care. We also considered data on the needs of historically underrepresented communities such as immigrants, refugees, youth and LGBTQ+ individuals.

COMMUNITY HEALTH NEEDS ASSESSMENT FINDINGS & COMMUNITY FEEDBACK

Below are the major findings of Temple University Hospital's (TUH) 2022 Community Health Needs Assessment (CHNA). As defined by the CHNA, our community is predominantly divided into four service areas: *North Philadelphia-East, North Philadelphia-West, River Wards* and *Lower Northeast.* These service areas are depicted in the map below.

Southeastern PA CHNA Neighborhoods in TUH Community



Mental Health Conditions

Significant mental health needs were identified based on high rates of depression, frequent mental distress, and suicide with trends exacerbated by the pandemic. Over 20% of residents living in *North Philadelphia-East, West* and *River Wards* communities report poor mental health, the highest in Philadelphia. The *River Wards* have among the highest suicide mortality rates in the City.

▸ ***Community Request:*** Improve behavioral health integration, coordination and access for at risk groups across all care levels.

Access to Care

Community residents identified healthcare provider acceptance of Medicaid patients, affordability, language barriers, cultural bias, limited appointment availability and lack of primary care coordination as barriers to healthcare access. Over 10% of residents in *North Philadelphia-East* and *Lower Northeast* do not have health insurance, the highest in Philadelphia. Over 45% of residents overall and 83% of children in *North Philadelphia-East* are covered by Medicaid, also the City's highest. *North Philadelphia-East* and *West* service areas have the highest emergency department utilization rates in Philadelphia.

▸ ***Community Request:*** Increase healthcare provider acceptance of Medicaid. Embed social services into clinical care.

Chronic Disease Prevention & Management

Heart disease, cancer, stroke, and chronic respiratory diseases continue as leading causes of death in Philadelphia, which disproportionately affect communities of color. TUH's *North Philadelphia-East, West* and *River Wards* service areas have among the highest rates of obesity, diabetes, hypertension, cancer incidence and mortality, and premature cardiovascular disease in Philadelphia.

▸ ***Community Request:*** Increase health screenings and public education on chronic disease prevention and management.

Racism & Discrimination in Health Care

Racism was recognized as a public health crisis in need of collective attention. Higher rates of COVID-19 infection, hospitalization, and mortality experienced by Black communities were identified as stemming from structural racism.

▸ ***Community Request:*** Hire and train additional healthcare workers with lived experience to work in historically underserved communities. Increase diversity, equity, and inclusion within healthcare delivery system.

Substance Use & Related Disorders

Co-occurrence of substance use disorders and other mental health conditions was commonly raised and as associated with homelessness, community violence and other social and health disparities. The *North Philadelphia-West* service area has the highest drug overdose mortality rate in Philadelphia. The *River Wards* have the highest opioid-related hospitalization rate.

▸ ***Community Request:*** Increase number of certified peer recovery specialists and other resources to support warm handoffs to the next level of care.

Healthcare & Health Resources Navigation

Community members widely viewed navigating healthcare services as a challenge due to lack of awareness, cultural barriers, fragmented systems and resource constraints.

▸ ***Community Request:*** Increase availability of healthcare navigators. Raise public awareness of local community resources.

Food Access

Financial challenges brought by the pandemic have led to greater food insecurity. Over 47% of households in the *North Philadelphia-East* service area receive supplemental assistance for needy families (SNAP), the highest in Philadelphia.

▸ ***Community Request:*** Expand food distribution to those with limited healthy food access. Connect food and nutritional insecure patients to food and nutritional assistance.

Culturally & Linguistic Appropriate Services

The need for culturally concordant providers and resources to address language barriers was raised in over 50% of focus group meetings.

▸ ***Community Request:*** Develop hospital language access plans that outline protocols for identifying and responding to language needs.

Community Violence

Violent crime and homicide rates are 8-10 times higher in Philadelphia compared to suburban counties with this public health crisis disproportionately impacting *North Philadelphia* communities. The *North Philadelphia-West* community has the highest homicide rate in Philadelphia.

▸ ***Community Request:*** Expand access to youth education programs focused on violence prevention, athletic activities, arts programs and other recreational activities.

Housing

Community residents identified safe, stable housing as critical for physical and mental health and well-being.

▸ ***Community Request:*** Increase investments by hospitals, managed care organizations, and others in supportive housing programs to reduce housing insecurity and prevent homelessness.

Socioeconomic Disadvantage

Over 40% of families in *North Philadelphia-East* and *West* communities live in poverty, the highest in Philadelphia. Inadequate education, limited opportunities, and unemployment were identified as key drivers of poverty. Communities with higher poverty rates were found to have lower life expectancy, limited resource access and higher rates of adverse health outcomes.

▸ ***Community Request:*** Screen for social determinants of health and connect community members with social supports.

Neighborhood Conditions

Abandoned homes, vacant lots, trash and others forms of neighborhood blight are associated with increased community violence. Youth expressed avoiding going outside to exercise due to fears of violence, which negatively impacts physical health.

▸ ***Community Request:*** Strengthen investment in transit infrastructure near hospitals and improve vacant lots with green space to encourage socialization and physical activity.

CHNA Health Disparities Snapshot

- **43.5%** of residents in *North Philadelphia-West* & **40.8%** in the *North Philadelphia-East* live in poverty.
- **10.7%** of residents in *North Philadelphia-East* do not have health insurance.
- **22.8%** of residents in *North Philadelphia-East*, **22.3%** in *North Philadelphia-West* and **21.6%** in the *River Wards* report poor mental health.
- **47.5%** of households in *North Philadelphia-East* receive SNAP assistance.
- *North Philadelphia-West's* drug overdose mortality rate is Philadelphia's highest.
- *North Philadelphia-West's* homicide rate is Philadelphia's highest.

IMPLEMENTATION STRATEGY PROCESS

Upon completion of our 2022 Community Health Needs Assessment (CHNA), Temple University Hospital's (TUH) leadership formed an Implementation Strategy Team (Team) to guide development of our 2022-2025 CHNA Implementation Strategy. The Team began by reviewing needs identified by the 2022 CHNA. Using a consensus building process, the Team identified health priorities based on the following factors:

ROOT CAUSE	INTERNAL CAPACITY	STRATEGIC ALIGNMENT	COMMUNITY CAPACITY	COMMUNITY IMPORTANCE
Root cause of priority issue	TUH capacity to respond, including Temple Lewis Katz School of Medicine academic resources	Alignment with TUH mission and strategic priorities to improve healthcare access and outcomes	External resources of TUH community and capacity to respond	Importance to community and public health consequences of not responding

The Team worked with internal and external partners to collaboratively develop implementation plans that outlined specific goals, objectives, and action plans and resources TUH would contribute in response to each priority need.

In collaboration with Temple's Center for Population Health and Lewis Katz School of Medicine, we will work over the next three years to achieve mutual public health goals. Our efforts will align with the United States Department of Health and Human Services' Equity Action Plan to address health and other disparities in undeserved communities. This plan seeks to advance health equity by building data capacity, expanding stakeholder engagement and responding to root causes of inequity. We will closely monitor our progress, evaluate results, adjust or supplement as needed and develop annual progress updates.

HEALTH PRIORITIES

Our Implementation Strategy focuses on the 6 below priority areas that are interrelated with the health needs identified in our 2022 Community Health Needs Assessment. Our latest CHNA builds upon previously identified health needs using more recent data and community input. Our priorities were selected through our aforementioned implementation strategy process. Over the next three years, we will continue to review and expand programs and interventions based on the needs identified in our CHNA.

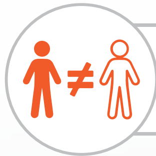
Interrelated Priority Areas

We will advance health equity by focusing on the following interrelated areas:

Behavioral Health Conditions

Substance Use & Related Disorders

Chronic Disease Prevention, Management & Access to Care



Racial, Ethnic & Other Healthcare Disparities

Social Determinants of Health

Community Violence

IMPLEMENTATION PLANS ADDRESSING HEALTH PRIORITIES

Increase Behavioral Healthcare Access & Education

Community members identified behavioral health as a top need exacerbated by the pandemic during the 2022 Community Health Needs Assessment (CHNA). Over 20% of adults in Temple University Hospital's community report poor mental health, the highest in Philadelphia. Twenty percent of youth and adults in Southeastern Pennsylvania report diagnosed depression with many more suffering from similar symptoms without a diagnosis. Fifteen percent report frequent mental distress. In response, CHNA focus groups recommended evidence-based integrated behavioral health care within primary care and increased access to other community behavioral health services.

Health Equity Goals

1. Increase community's behavioral health care access across other healthcare areas.
2. Strengthen patients' behavioral health services coordination following hospital treatment to next most appropriate community healthcare provider for best outcomes.
3. Improve healthcare professional and community's knowledge of behavioral health treatment importance, options and how to access care.

Executive Sponsors

Executive Director, TUH – Episcopal Campus, John Robison

Director of Behavioral Health Services, TUH – Episcopal Campus, Luciano Rasi

Internal Team

Episcopal Campus Senior Leadership Team

Crisis Response Center Team

Psychiatry Department

Case Management Departments

Community & Government Partners

Community Behavioral Health

Philadelphia Department of Behavioral Health & Intellectual disAbilities

Wedge Medical Center

Local behavioral health outpatient & partial hospitalization providers

Community organizations addressing social determinants of health

Healthcare Improvement Foundation

Collaborative Opportunities to Advance Community Health Collaborative

Metrics

1. Number of patients receiving behavioral health services across health system.
2. Number of same day patient after care appointment "warm handoff" made to other community behavioral healthcare providers.
3. Patient behavioral health appointment adherence post-hospital discharge.
4. Behavioral health hospital inpatient and Crisis Response Center (CRC) readmission rates.

Objectives

1. Increase patients receiving behavioral health services within both behavioral health specific and non-specific medical settings (i.e. primary care).
2. Increase warm handoffs to next community behavioral healthcare provider.
3. Improve patient behavioral health appointment adherence post-hospital discharge.
4. Reduce behavioral health hospital inpatient and CRC 30-day readmission rates.

Action Plans

1. Expand Crisis Response Center to serve additional patients and community members experiencing psychiatric emergencies.
2. Build and integrate increased behavioral health supports into primary care offices and other healthcare services within health system.
3. Train staff on community behavioral health services and techniques to improve care delivery.
4. Utilize behavioral health social workers to provide transitionary therapeutic interventions to patients in hospital settings. Coordinate timely follow-up for needs best addressed by other healthcare and social service providers.
5. Provide behavioral health resources to patients and families at various hospital locations and throughout community.
6. Enhance collaboration with community behavioral healthcare providers to address gaps in healthcare access.
7. Participate in community behavioral health screening and other events.

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Increase Behavioral Healthcare Access & Education

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Communication Plan

- Use flyers, posters, social media posts, patient portal and community outreach events to educate on behavioral health services.
- Announce staff behavioral health training opportunities at department meetings, through email and on staff webpages and portals.

Resources Committed

Crisis Response Center departmental budget. We will also seek and leverage any private, federal, state and local grant funding available to support this effort.

Expand Substance Use Disorder Recovery Opportunities

Temple University Hospital's community has the highest drug overdose mortality rate in Philadelphia. Substance use and related disorders (SUD) were identified as a high priority issue by focus groups during the 2022 Community Health Needs Assessment, which are exacerbated by the opioid epidemic and COVID-19 pandemic. SUD's association with co-occurring mental health conditions, community violence, homelessness, infectious diseases and social isolation were also raised. Stigma related to pursuing SUD care based on cultural beliefs and negative public perceptions were identified as barriers to accessing care resulting in poorer outcomes. In response, community members requested expanded access to SUD healthcare, education and peer services.

Health Equity Goals

1. Increase community's access to best practice SUD treatment and other interventions to prevent drug overdose and advance recovery.
2. Improve SUD patient coordination to the most appropriate next level of care at all healthcare levels to support best outcomes.
3. Improve healthcare professionals' and community's knowledge of SUD treatment importance, options and how to access treatment.

Executive Sponsors

Executive Director, TUH - Episcopal Campus, John Robison

Director Program Services, TUH - Episcopal Campus, Patrick Vulgamore

Internal Team

SUD Navigation Team

Program Services Team, Episcopal Campus

Addiction Medicine Team, Temple University Health System

Community & Government Partners

Pennsylvania Department of Drug & Alcohol Programs

Philadelphia Department of Behavioral Health & Intellectual disAbilities

Philadelphia Office of Homeless Services

Warm Handoff Collaborative for Addiction Treatment

Metrics

1. Number of patient encounters by the SUD treatment navigation team.
2. Number of successful same day patient appointment "warm handoffs" made by the SUD navigation team after treatment at Temple.
3. Number of educational outreach events Temple Health addiction professionals attend.

Objectives

1. Increase number of patient encounters made by SUD navigation team.
2. Increase number of successful same day patient appointment "warm handoffs" made by SUD navigation team.
3. Increase number of healthcare professional best practice SUD treatment presentations and community events attended.

Action Plans

1. Expand SUD navigation team services availability, which includes certified recovery specialists and drug/alcohol assessors.
2. Strengthen partnerships with SUD care referral destinations at all healthcare levels by increasing information exchange on how to best connect patients to services.
3. Share quality data with hospital departments that utilize the SUD navigation team, such as emergency departments, inpatient and outpatient sites to improve care delivery.
4. Present addiction-related topics aimed at decreasing stigma of pursuing recovery to healthcare professionals and community members.

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Expand Substance Use Disorder Recovery Opportunities

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Communication Plan

1. Announce how to access SUD navigation team and best practice treatment trainings at staff department meetings, through email and on employee webpages.
2. Disseminate SUD treatment educational materials at health fairs and other community events.
3. Use external SUD treatment professional list serves and other communications channels to announce SUD treatment trainings and care coordination opportunities.

Resources Committed

Episcopal Campus Program Services Department and Addiction Medicine Service Line departmental budgets. We will also seek and leverage any private, federal, state and local grant funding available to support this effort.

Prevent & Manage Chronic Disease by Improving Access to Care

The 2022 Community Health Needs Assessment revealed that heart disease, stroke, and respiratory diseases are among the top 5 leading causes of death in Philadelphia. These conditions disproportionally affect communities of color. Temple University Hospital's North Philadelphia community has among the highest rates of obesity, diabetes, hypertension, cancer, and premature cardiovascular disease in Philadelphia. In response, focus groups identified the need for increased health screenings, chronic disease prevention programs, and active care management for high-risk populations.

Health Equity Goals

1. Identify and address health outcome disparities in the community.
2. Decrease percent of preventable hospitalizations among Black and Hispanic individuals.
3. Provide Temple community equitable access to proactive health screenings and disease specific education and management to attain health and wellness.

Executive Sponsors

Senior Vice President, Chief Clinical Officer, TUHS - Daniel Del Portal, MD, MBA

Chief Medical Officer, Temple Center for Population Health (TCPH) – Nina O'Connor, MD

President & CEO, TCPH - Steven Carson, MHA, BSN, RN

Director Population Health, TCPH - Meaghan Kim, MHA, BSN, RN

Internal Team

Diabetes Education & Diabetes Prevention Programs Staff

Nurse Navigators & Community Health Workers

Community Relations Team

Health Together Mobile Outreach Van Staff

Temple Physician Inc. Primary Care Practices

Temple Faculty Physicians Family & Community Medicine Practice

Financial Services Department

Community Partners

Temple Care Integrated Network

Local health insurance plans

Local community coalitions & other partners

Metrics

1. Number of community members enrolled in disease management programs.
2. Number of patients served by Temple Multi-Visit Clinic.
3. Temple Multi-Visit Clinic patient emergency department and inpatient utilization rates.
4. Outpatient follow-up office visits within 7 days of hospital discharge.

Objectives

1. Increase number of community members enrolled in disease management programs.
2. Increase number of patients served by Multi-Visit Clinic.
3. Decrease Multi-Visit patient acute care hospital utilization.
4. Increase rate of outpatient office visits within 7 days of hospital discharge.

Action Plans

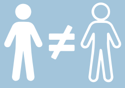
1. Use accurate and timely data to initiate activities that address areas and populations at risk for poor health outcomes.
2. Connect uninsured and underinsured patients with financial resources needed to access care.
3. Expand TUH Multi-Visit Clinic for the high-risk, high hospital utilizer population to provide the right care in the right setting at the right time.
4. Expand culturally appropriate disease management programs to include faith-based institutions and venues where community shops, congregates and works.
5. Improve access and doctor appointment show rate for appropriate patients needing a 7-day post discharge appointment.

Communication Plan

- Use social media, flyers, posters and the patient portal to heighten awareness of existing care management team availability to community members and patients.
- Attend community events to educate on care management services.

Resources Committed

Temple Center for Population Health, Community Relations, Temple Physicians Inc. and other Temple Health departmental budgets.



Address Racial, Ethnic & Other Healthcare Disparities

Temple University Hospital (TUH) is surrounded by one of the most diverse populations in the nation. Over 70% of TUH's community identify as a racial or ethnic minority - 38% Black, 30% Hispanic and 6% Asian. TUH serves a growing number of LBGTQ+ patients. During the 2022 Community Health Needs Assessment, racism was identified as a public health crisis in need of collective attention. Communities of color expressed mistrust of healthcare providers arising from the health disparities and discriminatory treatment they experience in healthcare settings. Fear of violence following anti-Asian hate crimes during the pandemic led to adverse mental and physical health outcomes among Asian communities. In response, a more diverse healthcare workforce with lived experience and increased diversity, equity, and inclusion training programs in healthcare institutions was requested.

Health Equity Goals

1. Strengthen healthcare providers, trainee and other staff training on structural racism, implicit bias, diversity and trauma-informed care to improve culturally appropriate care delivery.
2. Foster a diverse, equitable, and inclusive environment for patients, healthcare providers and other staff from historically marginalized backgrounds.
3. Expand community partnerships to build trust and collaboratively improve healthcare quality, outcomes and value for populations with greatest needs served by the hospital.

Executive Sponsors

Interim Senior Associate Dean, Office of Diversity, Equity, & Inclusion, Lewis Katz School of Medicine at Temple University; *President Medical Staff,* TUH - Abiona Berkeley, MD, JD

President & CEO, Temple Center for Population Health - Steven Carson, MHA, BSN, RN

Chief Medical Officer, TUH – Jeanes Campus; *Patient Safety Officer,* TUH - Rebecca Armbruster, DO, MS

Internal Team

Office of Health Equity, Diversity, & Inclusion

Office of Linguistic & Cultural Services

Temple Center for Population Health

Office of Human Resources

Office of Patient Experience

Graduate Medical Education Committee

Community Relations Team

Community Partners

Temple Health Transgender Advisory Board

North Philadelphia Community Collective

Community Advisory Committee & Patient Family Advisory Councils

Local organizations representing minority groups

Metrics

1. Number of faculty, trainees and staff completing cultural competency training.
2. Number of staff representing diverse and inclusive backgrounds.
3. Number of TUH community members participating in diversity workforce pathway programs.

Objectives

1. Increase number of faculty, trainees and staff completing cultural competency training.
2. Increase number of staff from diverse and inclusive backgrounds.
3. Increase community members participating in diversity workforce pathway programs.

Action Plans

1. Educate employees on health disparities and their impact through symposiums, trainings, and continuing education on cultural humility, trauma-informed practices, and anti-bias communication.
2. Strengthen diversity, equity, and inclusion (DEI) practices within health system's policies, procedures, and quality measures.
3. Partner with local organizations to increase community's access to workforce diversity pathway programs.
4. Collaborate with community relations team to develop culturally relevant educational materials for patients, community partners, providers, trainees, students and staff.

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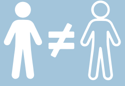

Address Racial, Ethnic & Other Healthcare Disparities

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5. Develop process to quantify patient dissatisfaction related to gender, race/ethnicity, sexual orientation, gender identity, disability status and other cultural competency indictors.
6. Strengthen collection of patient self-reported demographic information "REal Data" on race, ethnicity, gender identity, veteran status and other areas to improve disparities identification and response.

Communication Plan

1. Distribute diversity workforce program flyers and other information at local schools, community events and locations; and through social media.
2. Promote DEI initiatives through Temple Health broadcasting system, list serves, employee webpage and department-level social media accounts.

Resources Committed

Office of Diversity, Equity and Inclusion, Human Resources, Patient Experience, Graduate Medical Education and other Temple Health departmental budgets. We will also seek and leverage any private, federal, state and local grant funding available to support this effort.

Address Social Determinants of Health

Over 40% of families in Temple University Hospital's (TUH) North Philadelphia community live in poverty. Violence, substance use, homelessness, food insecurity and other social determinants of health (SDOH) were identified as influences of poverty by focus groups during the 2022 Community Health Needs Assessment, which disproportionally affect communities of color. Social norms and attitudes result in racial and gender discrimination that lead to lack of trust in healthcare systems. These influences negatively impact many communities' health status and safety. Research shows that addressing SDOH is a transformative approach to decrease health disparities and advance health equity.

Health Equity Goals

1. Strategically position TUH to accurately identify SDOH causing health disparities and implement strategies to deliver equitable healthcare.
2. Expand and improve staff continuing education on trauma informed approaches to assessing SDOH that address the impact of structural racism and implicit bias on healthcare access.
3. Build the confidence of staff to increase collection of race, ethnicity, language and other SDOH data.
4. Identify and address non-medical barriers to achieving health.

Executive Sponsors

Chief Medical Officer, Temple Center for Population Health (TCPH) – Nina O'Connor, MD

President & CEO, TCPH - Steven Carson, MHA, BSN, RN

Director, Community Care Management, TCPH - Lakisha R. Sturgis, MPH, BSN, RN

Internal Team

Temple Center for Population Health

Community Relations Team

Clinical Resource Team

Emergency Department

Temple Physician Inc.

Temple Faculty Practice Plan

Community Partners

Temple Community Integrated Network

Regional health insurance plans

Resource for Human Development

North Philadelphia Collective

Local social service & other community organizations

Metrics

1. Number of staff attending continuing education sessions on trauma informed approaches to assessing SDOH.
2. Number of completed SDOH screenings.
3. Percent of patients referred to a community health worker (CHW) connected with resources to address the identified SDOH.

Objectives

1. Increase number of staff participating in continuing education sessions on trauma informed approaches to assessing SDOH.
2. Increase number of patients screened for SDOH.
3. Increase number of CHW referrals that result in a patient connected with resources to address identified SDOH.

Action Plans

1. Participate in interdisciplinary workgroups to review SDOH data and develop strategies for data collection and response improvement.
2. Promote staff continuing education on assessing patients for SDOH using a trauma informed approach.
3. Consult trusted community advisors on how nurse navigation and community health worker services can be designed and implemented to maximize community participation and benefit.
4. Partner with other trusted local health systems, managed care organizations, social service providers and other organizations that provide housing, food, transportation, internet access and other SDOH resources. Engage in shared learning to advance health equity.

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Address Social Determinants of Health

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5. Collaborate with community relations team to develop educational materials to increase staff and community partners' participation in SDOH training and other efforts.
6. Promote the use of Temple Community Health Connect resource directory (Findhelp) among internal and external stakeholders.
7. Lead and participate in culturally-appropriate community events that connect community members with needed resources.

Communication Plan

- Distribute flyers and other educational materials on SDOH resources to community at health fairs and other local events.
- Announce SDOH staff training opportunities at department meetings and through employee webpages, portals and other communication channels.

Resources Committed

Temple Center for Population Health, Emergency Department, Clinical Resource Management and other Temple Health departmental budgets. We will seek and leverage any private, federal, state and local grant funding available to support this effort.

Address Public Health Crisis of Gun Violence

The gun violence public health crisis continues to place considerable strain on Philadelphia residents and health systems treating victims. Homicides in Philadelphia increased 58% between 2019 and 2021, with significant growth since the pandemic's onset. TUH's community has the highest homicide rate in Philadelphia. During the 2022 Community Health Needs Assessment, community members identified the need for integrated social and mental health services and other programs addressing poverty and other social determinants contributing to violence.

Health Equity Goals

1. Establish a behavioral health program for violently injured patients and families entering the hospital to support trauma recovery.
2. Strengthen underserved populations' access to crime victim services to address social determinants of health.
3. Increase job readiness among violently injured patients living in communities with high chronic unemployment rates to break the cycle of violence.

Executive Sponsors

Medical Director, Trauma Program, TUH*; Chief of Trauma & Surgical Critical Care, Department of Surgery,* Lewis Katz School of Medicine at Temple University - Lars Ola I. Sjoholm, MD

Director, Trauma and Burn Operations, TUH – Jill Volgraf, MSN, RN

Internal Team

Trauma Victim Advocates Team

Trauma Behavioral Health Team

Trauma Social Support Team

Community & Government Partners

U.S. Department of Justice

PA Commission on Crime & Delinquency Violence

City of Philadelphia

Local victim service agencies

Non-profit employment organizations

Community-based behavioral health organizations

Metrics

1. Number of violently injured patients receiving crime victim services.
2. Hours of counseling provided to violently injured patients.
3. Number of violence survivors engaging in work readiness programs.

Objectives

1. Improve Temple Victim Advocates collaboration with victim service agencies and increase the number of patients served.
2. Increase number of violently injured patients receiving behavioral health counseling pre- and post-discharge.
3. Improve violence survivors' access to job training and employment opportunities.

Action Plans

1. Hire and train a new workforce development specialist, licensed clinical social worker, case manager, and a trauma psychologist to work in Trauma Unit.
2. Establish workflow processes that integrate newly established staff and supports.
3. Implement case management software to track service delivery and patient progress.
4. Enroll patients in workforce development and behavioral health programs.
5. Evaluate service delivery improvement resulting from program expansion.

Communication Plan

- Use social media, brochures, and TUH SafetyNet website to inform community members about Trauma Unit's expanded behavioral health and social services.
- Attend community health fairs and other events to share information on programs.

Resources Committed

Trauma Program and Surgery Division departmental budget. We will also seek and leverage any private, federal, state and local grant funding available to support this effort.

APPROACH TO OTHER NEEDS

Our 2022 Community Health Needs Assessment revealed needs that are are beyond a hospital's traditional mission. Nevertheless, we routinely address these in our day to day operations or through innovative collaborations with private and public partners. Additional needs such as dental care are addressed through the comprehensive programs of our academic partner, Temple University. We discuss a few below.

Access to Health Insurance. Our financial counselors screen all uninsured and underinsured patients such as those with high deductibles and co-pays to determine eligibility for Medicaid, the Children's Health Insurance Program and other government funded medical insurance. If eligible, we connect patients with resources to help them attain coverage. We provide free or discounted care to patients who cannot afford to pay for their care under our *Emergency Care, Charity Care, Financial Assistance, and Uninsured Discount Policy*. Our financial counselors are also trained and certified in Federal and Pennsylvania health insurance marketplace enrollment under the *Affordable Care Act*. They assist uninsured patients that do not qualify for Medicaid or Medicare during open and special enrollment periods throughout the year. We sponsor open enrollment events on-site and also partner with government offices and other organizations on enrollment community outreach. Additionally, we assist Medicare recipients with assessing Medicare Advantage options.

Access to Primary and Preventative Care. Virtually all physicians in the Temple Health family accept patients covered by Medicaid and Medicare for both primary, preventative and specialty care. As reflected throughout this Implementation Strategy, we educate our communities on how to access to care though routine community education and outreach. Our ***Temple Care Integrated Network*** also includes independent community primary care providers in North Philadelphia that partner with Temple Health to provide their patients access to our services. Additionally, we collaborate with the Philadelphia Corporation for Aging, Pennsylvania Department of Health, United States Department of Health and Human Services, other hospitals and community stakeholders to strengthen primary and preventative care access.

Access to Dental Care. The Temple University Kornberg School of Dentistry (KSOD) in collaboration with Community Health Centers, is a major dental care provider for Philadelphia's underserved residents. It operates separate clinics for adults and children, including emergency dental services.

Improving Neighborhood Conditions. Temple University Health System has strong partnerships with a variety of community-based-organizations focused on improving the safety, cleanliness and quality of life in our neighborhood. These include members of the North Philadelphia Collective, Kensington Community Resilience Fund and Anna T. Jeanes Foundation. We also work with a variety of city agencies including the Department of Education, Department of Recreation and Office of Homeless Services. To improve public transit, pedestrian and traffic safety, we work with neighborhood coalitions, the Philadelphia Streets Department, and the Southeast Pennsylvania Transportation Authority.

Building Housing Supports. We collaborate with City of Philadelphia, HACE Community Development Corporation and Prevention Point on an opioid respite center on our Episcopal Campus. The center provides shelter and critical services for those suffering from homelessness and substance use disorder (SUD). Additionally, we are collaborating with Project Home and the Philadelphia Housing Authority on long-term recovery residences on our Episcopal Campus to serve those who are homeless, at risk of homelessness or recovering from SUD.

In collaboration with Health Partners Plan, Keystone First and Resources for Human Development, we also launched a two-year ***Housing Smart*** program to help homeless patients who frequently use hospital emergency departments. Patients are provided free housing and caseworkers to connect them with health and social services.

We also support a number of public and subsidized housing projects through rental space for physician offices and community outreach programs, enabling these organizations to fill funding gaps and leverage services to their residents

PLANNING FOR A HEALTHIER POPULATION

Temple Center for Population Health (TCPH) includes a robust care management infrastructure that identifies at risk patients for recurrent health care issues and intervenes with medical and social supports. Our programs help patients and caregivers manage medical conditions at home to enhance care coordination and reduce hospital readmissions. We collaborate with Federally Qualified Health Centers, City Health District Clinics, community primary care practices and other healthcare providers to deliver high value care to those most in need. We work with local, state, and federal government agencies on the implementation of grant-funded programs for high need populations. We are leaders in unique partnerships to address health disparities and advance health equity. Below are a few of TCPH's programs to address community needs and improve health outcomes.

Temple Care Integrated Network. This clinically integrated network of independent community primary care providers in North Philadelphia was established with Health Partners Plans to improve care quality and outcomes for our mutual patients. Independent practices are invited into a formal partnership with TCPH to collaboratively coordinate care and address significant health and wellness challenges facing our patients.

Long-term Care Resiliency Infrastructure Supports & Empowerment (LTC-RISE) Program. Through an innovative partnership with Penn Medicine, TCPH was selected to participate in the Pennsylvania Department of Health's LTC-RISE Program, a regional response health collaborative to improve COVID-19 care in long-term residential care facilities in Philadelphia, Bucks, Chester and Lancaster counties. We cover over 300 assisted living, personal care homes and skilled nursing facilities by providing consulting services on COVID care, PPE use and sourcing, testing, infection control and palliative care.

Skilled Nursing Home & Home Health Collaborative. This independent group of 22 skilled nursing home and rehabilitation facilities and 7 home health agencies provide collaborative care management for Temple Health patients from post-acute settings. These facilities and TCPH have developed and implemented a shared clinical communication strategy, care standards, patient education practices and other interventions that address care barriers to reduce hospital readmissions for mutual patients.

Transition of Care Program. This program provides post-acute support for patients discharged from TUH. After clinical staff identify inpatients with complex social and medical health issues, they are connected with CHWs and Nurse Navigators who assist with scheduling appointments, coordinating transportation, obtaining home support, and educating patients on how they can manage health issues and avoid future hospitalization.

Community Health Worker (CHW) Programs. In partnership with Temple University College of Public Health's Center for Social Policy and Community Development and the District 1199C Training and Upgrading Fund, we train community members to serve as CHWs for many populations and healthcare specialties. Many graduates transition into employment at TUH. Our CHWs assist with patient care management, connect with social supports and conduct home visits and other community outreach to serve our most vulnerable community members.

CMS ACO Realizing Equity, Access & Community (REACH) Health Model Implementation. Beginning in 2023, TCPH's affiliated network of Temple Physician Inc. and Temple Faculty Practice plan primary care and family medicine practices will participate in this Center for Medicare and Medicaid Services (CMS) Innovative Alternative Payment model. The model advances health equity by bringing accountable care's benefits to traditional Medicare Fee-For-Service beneficiaries in underserved communities while managing healthcare cost. We are developing a robust health equity plan to identify underserved communities and implement initiatives to reduce health disparities within our patient beneficiary populations.

Chronic Disease Prevention & Education. Our ***Diabetes Education Program*** provides those with diabetes personalized Spanish and English counseling on diabetes self-management, blood sugar levels monitoring, insulin pump use, meal planning and more. The ***Diabetes Prevention Program*** serves adults diagnosed with pre-diabetes, gestational diabetes and those at risk for type 2 diabetes through education on weight loss, exercise, stress management, food label reading and other topics to prevent diabetes onset. TCPH also provides significant education on stroke prevention and hypertension management.

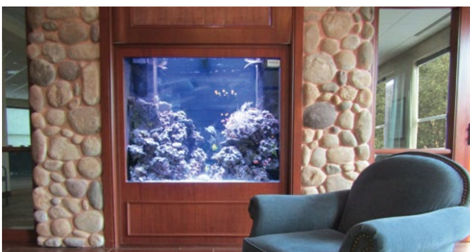
PLANNING TO ADVANCE MATERNAL HEALTH EQUITY

Temple University Hospital (TUH) is planning a major investment to convert the former Cancer Treatment Centers of America facility into a hospital facility for women and infants. Care will be provided by the same outstanding physicians on which our community already depends.

Pending approval of the Pennsylvania Department of Health, this specialty campus will offer women and families a safe, welcoming environment, complete with modern, spacious patient areas and outdoor landscaped walking trails. Exceptional services are being designed to ensure that our patients have access to the highest quality care in a patient-centered environment, and are able to achieve the best outcomes regardless of their social and economic circumstances.

While TUH already offers a comprehensive and coordinated approach to pre- and post-natal care and education, our new facility will allow us to expand and enhance these services with private rooms for mothers and babies, clinical space for 13 labor & delivery/ high risk antepartum beds, 32 post-partum beds, 41 neonatal intensive care beds, 8 adult intensive care beds, triage and stabilization area, over 75 exam rooms, plus radiology, mammography, diagnostic imaging and behavioral health services.

We expect to begin offering these services at the new campus in 2023. In the meantime, we are engaging a diverse groups of nurses, physicians, and support staff to develop the final plan. As demand for Temple's excellent clinical services and exceptional outcomes reaches new highs, the opening of this hospital will expand access for our community.



TEMPLE HEALTH
TEMPLE UNIVERSITY HOSPITAL