Temple University Hospital

COMMUNITY HEALTH NEEDS ASSESSMENT IMPLEMENTATION PLAN

FY23 PROGRESS REPORT

TEMPLE HEALTH
TEMPLE UNIVERSITY HOSPITAL

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CHNA Progress Report

Plan Title: Increase Behavioral Healthcare Access and Education

Executive Sponsors:
John Robison, Executive Director, TUH-Episcopal Campus
Luciano Rasi, Director of Behavioral Health, TUH-Episcopal Campus

Health Equity Goals:

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

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 Crisis Response Center [CRC] 30-day readmission rates.

Metrics Data Dashboard:

Data Element	Baseline	FY23
Number of patients receiving behavioral health services across health system.	67,152	66,699
Number of same-day patient after-care appointment "warm handoffs" made to other community behavioral healthcare providers following inpatient psychiatry admission.	145	127
Patient behavioral health appointment adherence post-hospital discharge.	38.5%	44.9%
Behavioral health hospital inpatient and CRC readmission rates	13.6%/12.2%	12.9%/10.3%

Metric Progress Summary:

1. This calculation includes CRC visits, 23-hour beds, inpatient behavioral health census days, outpatient psychiatry visits, psychiatric consults and progress notes. In the future, integrated care behavioral health visits will be included in this metric.

2. A newly-implemented program had warm handoffs on track for a total of 208 in FY23 after the first six months. However, staffing and regulatory issues caused this program to cease operation. Alternative options with community partners are being reviewed.
3. Due to data lag, the newly-implemented program was running for the bulk of our FY23 data. This rate shows a substantial improvement in adherence post-discharge.
4. Readmission rates continued to trend in the right direction. In the grid above, the first number in each block is inpatient readmission rate and the second is CRC readmission rate.

Action Plans Implementation Summary:

- Plans to expand the CRC are in progress. Drawings have been completed, funding secured and bidding to complete the work is to begin in the next few weeks.
- Integrated behavioral health supports continue to be added to locations in the health system.
- There have been over a dozen programs that have presented their services to staff this fiscal year while also learning about Temple resources.
- A newly-created position of a behavioral health social worker assigned to the Department of Medicine at the Main Campus has been approved and applicant selected. Start date for this new position is mid-September.
- Behavioral health services took part in several health fairs throughout the fiscal year as well as a large community event specifically focusing on the Crisis Response Center in May 2023.
- Behavioral health screening events have been conducted by the outpatient Psychiatry department.

Conclusion & Next Steps:

One of the main tactics used to impact objectives 2, 3 and 4 has had to cease operations due to a combination of external staffing and regulatory challenges. Several different strategies are currently under review that will target these objectives. Strengthening partnerships with community resources and fine-tuning internal hires to augment behavioral health in non-traditional settings and the CRC expansion are making positive progress, and may lead to the consideration of additional important metrics and goals in the coming months.

CHNA Progress Report

Plan Title: Expand Substance Use Disorder (SUD) Recovery Opportunities

Executive Sponsors:
John Robison — Executive Director, TUH Episcopal Campus
Patrick Vulgamore — Director of Program Services, TUH Episcopal Campus

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 the community's knowledge of SUD treatment importance and options, as well as how to access treatment.

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 bestpractice SUD treatment presentations and community events attended.

Metrics Data Dashboard:

Data is reported in averages per month.

Data Element	Baseline	FY23
Number of patient encounters by the SUD treatment navigation team.	**157.5**	**321.2**
Number of successful warm handoffs by the SUD treatment navigation team.	**28.5**	**147.2**
Number of educational outreach events Temple Health addiction professionals attend.	**0.41**	**1.17**

Metric Progress Summary:
The number of patient encounters by the SUD treatment navigation team increased 103.87%, from 157.5 to 321.2 average encounters per month, from FY22 to FY23.

The number of successful warm handoffs by the SUD treatment navigation team increased by 416.14%, from 28.5 to 147.2 successful handoffs per month, from FY22 to FY23.

The number of education outreach events that the SUD treatment navigation team attended increased by 184.88%, from 0.41 to 1.17, from FY22 to FY23.

Action Plans Implementation Summary:

- Objective 1:

    - Documentation was standardized and digitized to more efficiently measure progress.
    - The SUD treatment navigation team expanded to serve multiple campuses and levels of care.
    - Soft skills were refined to better integrate the care team and engage more effectively with our patients

- Objective 2:
    - The SUD treatment navigation team has expanded options for both inpatient and outpatient referrals by:
        - Actively engaging community-based programs.
        - Regularly meeting with referral sites to understand each referral destination's requirements and key personnel.
        - Episcopal leadership is pursuing an outpatient addiction clinic to provide more options for referral destinations.
        - Regularly meeting with community behavioral health to understand expectations placed on their network from a referral source and destination perspective.

- Objective 3:
    - The SUD treatment navigation team has actively pursued opportunities to attend community functions and health fairs.
    - Episcopal has started our own health fairs.

Conclusion & Next Steps:
By integrating best-practice SUD treatment into physical and behavioral healthcare settings, we will continue expanding recovery opportunities. At times, staffing the SUD treatment navigation team is difficult at times, given staff turnover levels, but when the team is fully staffed, it has enormous potential for making a population-level impact in the city of Philadelphia. As the team is fully grant-funded, another challenge we will face over the next 6 months will be establishing a financially-sustainable operating model.

CHNA Progress Report

Plan Title: Prevent & Manage Chronic Disease by Improving Access to Care

Executive Sponsors:
Daniel Del Portal, MD, MBA – *Senior Vice President, Chief Clinical Officer, TUHS*
Nina O'Connor, MD – *Chief Medical Officer, Temple Center for Population Health*
Steven Carson, MHA, BSN, RN – *President & CEO, Temple Center for Population Health*
Meaghan Kim, MHA, BSN, RN – *Assistant Vice President, Population Health, Temple Center for Population Health*

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.

Objectives:

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

Metrics Data Dashboard:

Metric	Baseline FY22	FY23	% Change
Number of community members enrolled in disease management programs	2882	3048	+5.8%
Number of patients served by Temple Multi-Visit Clinic	940	973	+3.5%
Temple Multi-Visit Clinic patient Emergency Department (ED) utilization after Multi-Visit Clinic enrollment) *(for 60 days post-enrollment compared to the 60 days prior to first clinic visit)*	-54%	-50%	
Temple Multi-Visit Clinic patient inpatient utilization after Multi-Visit Clinic enrollment *(for 60 days post-enrollment compared to the 60 days prior to first clinic visit)*	-62%	-72%	
Outpatient follow-up visits within 7 days of hospital discharge	33%	31%	-6.0%

Metric Progress Summary:

1. Number of community members enrolled in disease management programs
    - The Temple Center for Population Health provides two distinct disease management programs to its patients and the community in both English and Spanish:
        - Diabetes Self-Management Education & Support (DSMES)
        - Diabetes Prevention Program (DPP)
    - The DSMES served 2789 community members in FY22 and 2910 community members in FY23 (+4%). The DSMES saw an increase of encounters in FY23 in both English (+15%) and Spanish (+29%) in FY23. Participants who complete the program have an average A1C reduction of 1.9%, indicating improvement in glucose control.
    - The DPP served 93 community members in FY22 and 138 community members in FY23 (+48.4%). On average, patients lost 5.1% of their total weight, which is shown to reduce their risk of developing type 2 diabetes by 58%.

2. Number of patients served by Multi-Visit Patient (MVP) Clinic
    - The number of patients seen in the MVP Clinic increased this year from 940 to 973. This was accomplished by increasing both inpatient and ED referrals.

3. Temple Multi-Visit Clinic patient utilization outcomes
    - In FY23, MVP clinic continued to decrease ED and inpatient utilization for patients who attend the clinic.
        - Inpatient utilization decreased by 72%
        - ED utilization decreased by 50%

4. Outpatient follow-up within 7 days of hospital discharge
    - 7-day follow-up rates fell slightly from FY22 (33%) to FY23 (31%). This does not include patients that follow up with physicians at non-Temple practices.

Action Plans Implementation Summary:

1. Use accurate and timely data to initiate activities that address areas and populations at risk for poor health outcomes.
    - EPIC tools were built to identify Emergency Department patients with Medicaid who present with an ambulatory-sensitive condition that should ideally be managed in a primary care setting rather than the Emergency Department. ED physicians receive a BPA offering follow-up in the MVP Clinic. A Community Health Worker (CHW) was also hired to work in the ED as an ED Navigator to see these patients and address social determinants of health.
    - EPIC tools were built to identify inpatients with Medicaid who are hospitalized with an ambulatory sensitive condition. These patients are seen by Patient Advocacy to ensure adequate outpatient follow-up, including MVP Clinic appointments if needed.

2. Connect uninsured and underinsured patients with financial resources needed to access care.
    - CHWs are well-versed in various social service benefits and programs for patients who are underinsured or uninsured. If patients are eligible for Medicaid, both CHWs and Financial Services assist patients in completing necessary applications to receive insurance coverage. CHWs also assist patients with Medicaid renewal forms.
    - The MVP Clinic sees patients regardless of insurance status and is a safety net for the most vulnerable patients. Each MVP clinic patient is assigned a CHW to assist them with navigation and benefits.
    - CHWs work with patients who are not eligible for any health insurance, including Medicaid, to help them obtain follow-up care at one of the city health centers. Several of these health centers participate in the Temple Clinically Integrated Network (TCIN), which promotes collaboration.

3. Expand the TUH MVP for the high-risk, high hospital-utilizer population to provide the right care in the right setting at the right time.
    - The MVP Clinic was expanded to five days per week.
    - A small group of hospitalists provide consistent medical coverage for the MVP Clinic.
    - An APP was hired to supplement MVP Clinic coverage and assist with transitions of care calls.
    - Three Community Health Workers were dedicated full-time to the MVP Clinic to provide additional support for social determinants of health.

4. Expand culturally-appropriate community disease management programs to include community faith-based institutions and venues where Temple's community shops, congregates and works.
    - The Diabetes Prevention Program and Diabetes Self-Management, Education & Support Program have partnered with community-based practices, such as Maria de los Santos and practices within the Temple Care Integrated Network, to offer their programming and expand their community footprint.
    - In FY23, Temple's "Healthy Together" mobile health van participated in 29 events, engaging with 2,737 community members at various community and faith-based locations in the North Philadelphia corridor and surrounding areas.

5. Improve access and doctor appointment attendance rate for patients requiring a 7-day post-discharge appointment.
    - The Emergency Department (ED) navigator stationed at TUH interacts with patients who meet the criteria for the MVP Clinic. The ED Navigator is able to screen patients for social determinants of health and provide key resources to patients who meet those needs, and has the capacity to coordinate patient appointments and arrange transportation prior to ED discharge.

- To improve follow-up care for patients hospitalized at TUH Main Campus who have a Temple primary care physician, Patient Advocacy is conducting bedside visits to schedule appointments and set up transportation before patients leave the hospital.
- Additional telehealth capacity has been added to support post-discharge primary care appointments with Temple Family and Community Medicine and Temple Internal Medicine Associates for patients who do not want to come to an in-person appointment.
- Hospitalized high-risk patients who lack a primary care physician are offered follow-up care in the MVP Clinic, as described above.

Conclusion & Next Steps:

Temple successfully grew its disease management programs for diabetes in FY23, as evidenced by increased numbers of participants in both our diabetes education and prevention programs. In FY24, we anticipate continuing to expand these programs as follows:

- TUH is exploring the addition of inpatient diabetes educators to complement the pre-existing outpatient Diabetes Self-Management Education and Support program.
- Outpatient diabetes educators will expand telehealth access to ensure services can be easily accessed by all community members.
- Diabetes prevention program classes will continue to be held both in-person and virtually to optimize accessibility for those with transportation barriers, complex medical needs, or childcare responsibilities.

Additionally, several new disease management programs will launch in FY24:

- A structured self-monitoring blood pressure program is being implemented throughout Temple's primary care networks. Patients are given Bluetooth-enabled blood pressure devices to transmit blood pressure readings from home directly into EPIC, where they are monitored by a nurse or pharmacist. Disease education and SDOH support are integrated into this structured program.
- Temple Health will launch the Healthy Together hub in Brown's Shoprite @ Fox Street. Staffed by a nurse and community health worker, the Healthy Together hub will conduct screenings and health education in a location where over 24,000 community members shop annually. The site will be fully operational by Fall 2023.

The MVP Clinic will continue its efforts to reach more patients in FY24 and to maintain reductions in ED and inpatient utilization for its patients. A planned move in FY24 will afford additional space for MVP Clinic expansion. Additionally, the MVP Clinic will continue to partner with the Emergency Department to identify and refer appropriate patients directly from the ED. The MVP Clinic is also partnering with Community Behavioral Health (CBH) to have a CBH representative onsite in the clinic one day per week. This should expedite access to mental health resources for MVP Clinic patients.

Additional work is needed in FY24 to improve rates of 7-day follow-up appointments following inpatient admissions. Patient Access has already begun a program of bedside visits to hospitalized patients to assist with scheduling a follow-up appointment in either the MVP Clinic or a Temple primary care office. We will monitor and optimize this program. The primary care clinics are also streamlining their scheduling practices for post-discharge appointments and conducting regular audits of processes.

CHNA Progress Report

Plan Title: Address Racial, Ethnic and Other Healthcare Disparities

Executive Sponsors:
Abiona Berkeley, MD, JD – *Interim Senior Associate Dean, Office of Diversity, Equity, & Inclusion, Lewis Katz School of Medicine at Temple University; President Medical Staff, TUH*
Steven Carson, MHA, BSN, RN – *President & CEO, Temple Center for Population Health*
Rebecca Armbruster, DO, MS – *Chief Medical Officer, TUH – Jeanes Campus*

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.

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.

Metrics Data Dashboard:

Metric	FY2022	FY2023
Number of faculty, trainees, and staff completing cultural competency training	1,726	4,308
Number of staff representing diverse and inclusive backgrounds	3,107	3,207
Number of TUH community members participating in diversity workforce pathway programs	21	35

Metric Progress Summary:

- Number of faculty, trainees, and staff completing cultural competency training
    - 4,308 unique staff members completed an online cultural competency training through HealthStream or attended a symposium on cultural competency in FY2023.

- Number of staff representing diverse and inclusive backgrounds
    - Temple University Hospital saw a modest 3.2% increase in the number of staff representing diverse and inclusive backgrounds from 3,107 in FY22 to 3,207 in FY23. While the number of staff representing diverse and inclusive backgrounds increased, the proportion of staff, as compared to White, shrank by 0.94% in FY23.

- Number of TUH community members participating in diversity workforce pathway programs
    - Four pathway programs in Lewis Katz School of Medicine:
        - Mini Medical School – 9 participants
        - Health Careers Exploration Day – 3 participants
        - Diversity Scholars – 16 participants
        - Prep Program – 7 participants

Action Plans Implementation Summary:

1. Educate employees on health disparities and their impact through symposiums, training and continuing education on cultural humility, trauma-informed practices, and anti-bias communication.

- Temple provides an array of training on cultural competency on the online platform HealthStream. Over 90 courses are available and discuss a variety of topics related to trauma, bias, diversity, and inclusion.
- In FY2023, 4294 courses were completed by 4,207 unique members of Temple staff and faculty. In FY2023, over 101 staff attended the Cultural Competency in Healthcare Symposium, which focused on culturally and linguistically competent patient care in a post-pandemic world.
- Temple requires new leaders, physicians, staff and residents to complete the Civil Treatment curriculum. The program addresses issues of discrimination, harassment, bullying and the ability to create a civil environment. In FY2023, more than 250 staff members completed this specific training.
- LGBTQ trainings were added to the Health Stream modules to support the LGBTQ affirming provider initiative, run by the Alliance Task Force. In 2023, 600 staff members completed this online course.

2. Strengthen diversity, equity, and inclusion (DEI) practices within health system's policies, procedures, and quality measures.

- Temple University Health System remains committed to DEI by integrating it into its mission and vision. Policies and procedures within the health system are assessed and updated regularly to ensure they promote inclusivity and maintain legal compliance.
- Equal employment opportunity (EEO) and anti-harassment policies are a part of the new employee onboarding process and departmental onboarding to ensure employees have knowledge of TUH's standards of behavior.
- Temple's performance management system "We Perform" aligns employees performance to leadership competencies and diversity and inclusion. Since 2020, Temple has consistently rated above benchmark on the Employee and Physician Feedback survey in terms of workplace inclusion and diversity.

3. Partner with local organizations to increase community's access to workforce diversity pathway programs.

- The Lewis Katz School of Medicine offers several pathway programs to amplify diversity within Temple's workforce and in medicine.
- The Mini Medical School takes place annually and exposes high school students from the community to careers in the health professions. At Temple, 17 students participated in FY2022, and 9 students participated in 2023.
- The Health Careers Exploration Day is another event that exposes students from the community to learn more about medical school and careers in health. In FY2023, 3 students from Temple participated in the event.
- Diversity Scholars is an 8-week program designed to engage college students from backgrounds historically underrepresented in medicine. The program had 12 staff from Temple participate and 4 staff from Fox Chase Cancer Center in FY2023.
- Lastly, the Pre-Matriculation Readiness and Enrichment Program (PREP) is a program open to all first-year medical students. This program supports participants' smooth transition to medical school and academic success by providing early exposure to the medical curriculum and assisting the development of learning and study-skill strategies. In FY2022, 4 TUH employees completed PREP. In FY2023, 7 TUH employees completed PREP, a 75% increase.

4. Collaborate with community relations team to develop culturally relevant educational materials for patients, community partners, providers, trainees, students, and staff.

- Temple founded the TUH Community Advisory Council in January 2023. The committee is co-chaired by Ms. Amelia Price, Corridor Manager for Called to Serve (CTS) organization and Susan Akinyi-Okumu, AVP of Patient Experience. This committee consists of members of Temple's surrounding community with the intention of

facilitating collaboration, engagement and collaboration with local community members, organizations, and places of worship. The committee meets quarterly.

- Temple has worked with the Community Advisory Council to strengthen communications, gather feedback on current community outreach approaches and partner with local organizations, churches, and places of worship to promote Temple offerings and services.
- In preparation of the largest job fair in Philadelphia, the Community Advisory Council partnered with Temple University to host a pre-job fair preparation event which included mock interviews and seminars such as dress for success and employer expectations. Held June 14, 2023, at Zion Baptist Church, the event included free business attire, haircuts, hair styling and healthy snacks.

5. Develop process to quantify patient dissatisfaction related to gender, race/ethnicity, sexual orientation, gender identity, disability status, and other cultural competency indicators.

- The Patient Relations department continues to review grievance cases to identify issues related to gender, race, ethnicity, sexual orientation, and other cultural competency indicators. In FY2023, three cases were identified as discrimination based on age, race and gender. These cases were resolved with inclusivity training mandated for the departments, with the intention of creating a more welcoming and inclusive environment for all patients.
- Patient Experience / Customer Service pilot was launched in FY2023. This training focuses on the importance of customer service and the need for empathy and acceptance in the healthcare sector. More than 1900 employees and leaders were trained in FY2023.

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.

- “Real Data” fields are collected at the time of new patient registration and updated, as needed, in the electronic medical record. In terms of inclusivity, Temple collects gender related information, transgender and LGBTQ+ affiliations. These questions remain optional for FY2024.
- Temple has established a consistent and comprehensive approach to data collection across different patient care settings to ensure meeting data requirements for external organizations and to ensure all necessary data fields are maintained. Temple ensures the data collection is inclusive and encompasses various demographic intersections, while also anticipating future demographic reporting criteria set to external bodies.

- Temple continues to be a leader in terms of health equity work and has hosted several health equity lectures to continue to educate staff and promote continued progress.
- In July 2023, Temple University Hospital was recognized by the Lown Institute Hospitals Index for its work on health equity. TUH ranked #1 hospital in Pennsylvania and Top 1% in the nation for health equity. Temple was also recognized for its work on community benefit, social responsibility, patient safety and value of care.
- TUHS is an active member of Health Care Improvement Foundation's (HCIF) Health Equity Data Strategy (HEDS) Collaborative. The goal of this initiative is to leverage the synergy of multiple organizations to decrease disparities in health outcomes through collection of REaL and SOGI data.
    - Temple Faculty Physicians (TFP) primary care practice completed the HEDS survey. This survey served as a baseline assessment for how TFP collect and utilize REaL data.

Conclusion & Next Steps:

In FY2024, Temple is participating alongside other Philadelphia-area health organizations in a regional coalition to eliminate race-based medicine. The coalition aims to remove race-based medicine adjustments in 15 clinical decision support tools to combat systemic racism in healthcare. Additionally, the DEI Steering Committee is exploring the utilization of the American Hospital's Association, Health Equity Roadmap as a framework of transformation in the equity space.

The team aims to make continued progress in the new year by focusing on the following:

Objective 1: Increase the number of faculty, trainees, and staff completing cultural competency training.

1. Identify existing training gaps in the current array of courses available to staff. Adding Building Trust to Management Foundations program to continue inclusivity focus at all levels.
2. Provide customized DEI training for front desk staff in practices across the community.
3. Utilize in-person and online formats to accommodate different learning preferences.
4. Inclusion Series training is now held annually. The training sessions include a focus on implicit bias and cultural competence.
5. Monitor participation and track the number of participants completing the training modules.
6. Regularly evaluate the effectiveness of the training modules.

Objective 2: Increase the number of staff from diverse and inclusive backgrounds.

1. Develop strategies to attract diverse candidates for open positions, including targeted outreach and partnerships with community organizations.

2. Implement inclusive hiring practices to ensure equitable selection of candidates.
3. Ongoing review of EEO and anti-harassment policies to ensure legal compliance.
4. Continue to offer leadership development opportunities that nurture and promote employees from diverse backgrounds to leadership roles.
5. Increase mentorship and sponsorship opportunities for underrepresented staff.
6. Continue to review and update HR policies to ensure inclusivity and diversity.

Objective 3: Increase community members participating in diversity workforce pathway programs.

- Conduct targeted outreach to community members, schools, and organizations to promote existing pathway programs.
- Track the number of community members who participate in the pathway programs.
- Assess the effectiveness of the programs in terms of participants' career advancement and contributions to healthcare.
- Regularly engage with community partners to review program outcomes and make necessary adjustments.

By following this action plan, the organization can work towards achieving its health equity goals and objectives, thereby creating a more culturally sensitive and inclusive healthcare environment that serves historically marginalized populations effectively.

CHNA Progress Report

Plan Title: Addressing Social Determinants of Health (SDOH)

Executive Sponsors:

Nina O'Connor, MD – *Chief Medical Officer, Temple Center for Population Health*
Steven Carson, MHA, BSN, RN – *President & CEO, Temple Center for Population Health*
Lakisha R. Sturgis, MPH, BSN, RN – *Director, Community Care Management, Temple Center for Population Health*

Health Equity Goals:

4. Strategically position TUH to accurately identify SDOH that cause health disparities and implement strategies to deliver equitable care.
5. 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.
6. Build the confidence of staff to increase collection of race, ethnicity, language and other SDOH data.
7. Identify and address non-medical barriers to improving individual and community health.

Objectives:

5. Increase number of staff participating in continuing education sessions on trauma-informed approaches to assessing SDOH.
6. Increase number of patients screened for SDOH.
7. Increase number of CHW referrals that result in patients being connected with resources to address identified SDOH.

Metrics Data Dashboard:

Metric	FY22 Baseline	FY23	% Change
Number of staff attending continuing education sessions on trauma informed approaches to assessing SDOH	0	185	+185%
Number of completed SDOH screenings	110,664	190,563	+72.2%
Percent of patients referred to a Community Health Worker (CHW) and connected with resources to address the identified SDOH	87.0%	83.7%	-3.8

Metric Progress Summary:

- Number of staff attending continuing education sessions on trauma-informed approaches to assessing SDOH
    - This is a new measure for FY23. 185 staff attended the educational session.
- Number of completed SDOH screenings
    - Social Determinants of Health are the conditions and factors in the social and physical environments in which people are born and live that can impact their overall health and well-being. Screenings take place in Ambulatory Care, the Emergency Department, and in inpatient units at Temple University Hospital-Main Campus, Episcopal Campus, and Jeanes Campus., Episcopal and Jeanes campus.
    - The number of completed SDOH screenings increased from 110,664 in FY22 to 190,563 in FY23.
- Percent of patients referred to a Community HealthWworker connected with resources to address the identified social determinants of health.
    - The CHW connection rate decreased from 87.0% to 83.7% [between which years?].

Action Plans Implementation Summary:

7. Participate in interdisciplinary workgroups to review SDOH data and develop strategies for data collection and response improvement.
    - A SDOH Steering Committee was formed, which includes leadership as well as medical, nursing, and social work representatives from across the health system. Screening data is presented to this group quarterly, followed by discussion of interventions and response improvement.
    - SDOH screening data is also reviewed in ambulatory quality meetings for both TFP and TPI, including discussions about response with frontline providers/staff.

8. Promote staff continuing education on assessing patients for SDOH using a trauma-informed approach.
    - A custom HealthStream module was created and launched in January 2023 that reviews SDOH screening questions and trauma-informed communication skills for conducting the screening.
    - In Spring 2023, all TFP and TPI clinic staff who conduct SDOH screenings were required to complete the module.
    - The module is available to all employees in HealthStream and can be assigned by managers.

Consult trusted community advisors on how nurse navigation and community health worker services can be designed and implemented to maximize community participation and benefit.[Remove space here]

- A Community Advisory Council was launched in December 2022 to advise Temple University Hospital Inc. on community priorities and feedback. After the initial launch, the council had two additional meetings in FY23.
- Temple's comprehensive SDOH program was presented to the council, including screening processes and results. The Community Health Worker program and other community outreach initiatives to address SDOH were reviewed in detail with the council, which provided valuable feedback.
- Patient feedback was also recently obtained in the TFP Primary Care Clinics through their Patient and Family Advisory Councils.

9. 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.
    - Temple is extensively involved with various community-based organizations to connect patients to resources for SDOH. For example:
        i. Temple partners with Uber Health to provide rides to appointments for patients who lack access to reliable transportation.
        ii. Temple partners with Philadelphia Legal Assistance to provide a legal aid program embedded in high-risk primary care clinics.
        iii. Temple partners with a local internet provider to provide low-cost internet as part of our Digital Equity Program that also includes computer training.
    - Temple partnered with Health Partners Plans to address SDOH and has received funding for SDOH programming including a new Community Health Worker position in the Emergency Department at Temple Main, as well as urgent food deliveries, home remediation, and pest control for patients in need who are referred to the Community Health Worker program.
    - Together, Temple and Jefferson Health Systems lead the Frazier Family Coalition (FFC). The goal of the FFC is to reduce the instances of stroke in North Philadelphia. To address food insecurity and reduce the risk of chronic conditions, the FFC delivers fresh produce with recipes on a weekly basis to community members in the FFC target zip codes.

10. Collaborate with the community relations team to develop educational materials to increase staff and community partners' participation in SDOH training and other efforts.

- Temple participates in a city-wide collaborative effort led by the Philadelphia Department of Public Health and FindHelp to promote city-wide education and training around SDOH, including education of community partners.

11. Promote the use of the Temple Community Health Connect resource directory (FindHelp) among internal and external stakeholders.
    - Temple Community Health Connect (aka FindHelp) is widely promoted throughout Temple via strategically placed posters. Additionally, the QR code for the site is printed on After Visit Summaries in outpatient clinics whenever a patient screens positive for SDOH. In the Emergency Department, flyers including the same QR code are given to patients.
    - Temple Community Health Connect is also promoted at community events including health screenings and programs offered by Healthy Together, our mobile health van.

12. Lead and participate in culturally-appropriate community events that connect community members with needed resources.
    - In FY23, Temple's Healthy Together mobile health van participated in 29 events, engaging with 2,737 community members at various retail establishments, community and faith-based locations in the North Philadelphia corridor and surrounding areas.

Conclusion & Next Steps:
Temple continues to make steady progress in SDOH screening with significant year-over-year increases in screening rates. In FY23, navigators at Fox Chase Cancer Center began screening for SDOH.. Quality improvement projects also successfully increased screening rates in primary care and the TUH-Main Campus Emergency Department. A monthly dashboard detailing screening completion, positivity rates, and referrals to CHWs and social work is circulated monthly to stakeholders. This has been an effective monitoring strategy and will be continued in FY24.

In FY24, the following major initiatives will further increase SDOH screening:

- In July 2023, inpatient screening went live for all inpatients at Temple Main Campus, Episcopal Campus, and Jeanes Campus for any patients not already screened in the Emergency Department. SDOH is now a required component of the nursing admission tool in EPIC, and patients cannot be discharged without a completed screening. Patients with positive screenings who indicate a desire for help are referred to social work.
- In September 2023, inpatient screening will go live at Temple Health-Chestnut Hill Hospital. SDOH screening in the Chestnut Hill physician practices will follow in Fall 2023.
- In early 2024, Fox Chase Cancer Center will go live with inpatient SDOH screening.

As screening is added in additional locations, the HealthStream module will remain a key tool for ensuring staff training in trauma-informed approaches to screening. We will continue to assess the need for additional training strategies.

- With the new partnership and funding from Highmark, during FY24 several new FTE's will be added to the team:
    - A Community Health Worker will be placed in Episcopal Hospital's Emergency Department to address SDOH.
    - A Social Worker will be placed in the Multi-Visit Patient Clinic to address the complex needs for patients that present with behavioral health and substance use disorder.

The Community Health Worker team connected patients with SDOH-related resources across multiple settings throughout FY23. To continue to improve SDOH response, CHW documentation and tracking in EPIC was recently redesigned to 1) increase visibility to referring clinicians and 2) allow weekly tracking of referrals, interventions, and response time. We anticipate that this additional data will facilitate continued optimization of SDOH response as well as evaluation for any additional needed resources.

CHNA Progress Report

Plan Title: Addressing the Public Health Crisis of Gun Violence

Executive Sponsors: Abhijit Pathak, MD, Jill Volgraf, RN

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.

Objectives:

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

Metrics Data Dashboard:

Data Element	Baseline	FY23
Patients receiving case management services	0	557
Patients referred to crime victim service agencies	226	411
Patients referred to outside behavioral health services	0	115
Patients engaged through workforce development programs	0	348
Number of job readiness workshops hosted	0	9

Metric Progress Summary:

- Increased the number of violently-injured patients receiving wraparound case management services.
- Increased the number of patients referred to crime victim services by 82%.
- Increased the number of patients receiving counseling through community-based mental health providers.
- Increased the number of survivors of violence offered employment assistance.

Action Plans Implementation Summary:

- Recruited, hired, and trained a workforce development specialist in 8/23.
- Recruited, hired and trained a case manager in 8/23.
- Created a new process by which referrals are now vetted by the case manager each morning for accuracy and completeness, reducing delays in service delivery.
- Developed a stopgap data collection system through REDcap as we await the acquisition and implementation of new case management software.
- Established a case review process with area victim service agencies to ensure patients are receiving the support they require.
- Developed a referral system with area victim service agencies that quickly connected survivors of violence to mental health counseling.
- Created a series of monthly job readiness workshops tailored specifically for patients with significant obstacles to employment.
- Established a relationship with Temple University's Lenfest Center for Community Workforce Partnerships that assists patients with GED test prep, job training, and ESL classes.
- Developed an evaluation plan with the Genoa Group, an outside contractor enlisted to assess program performance.

Conclusion & Next Steps:

We have faced challenges with hiring an on-site therapist. Fortunately, we have been able to utilize a network of local behavioral health practitioners to provide counseling to our patients. With financial support from local foundations, we will be expanding our program in several significant ways in FY24. We will be hiring a program operations manager to support day-to-day administrative tasks. During this next fiscal year, we will also begin providing direct assistance for patients for emergency housing, food, and clothing.