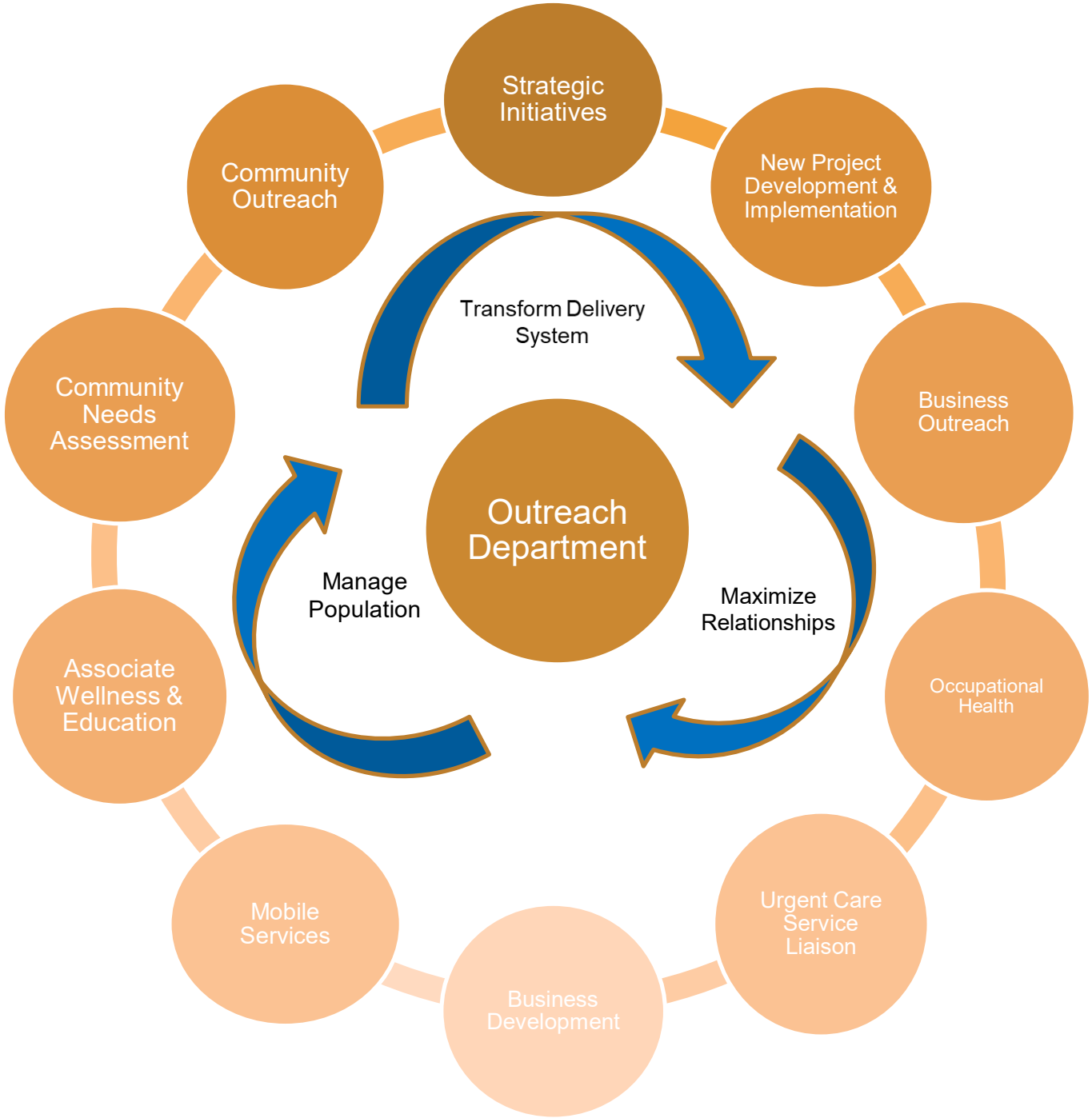
Southeastern PA Regional Community Health Needs Assessment

April 2022

Community Health Needs Assessment

- The Affordable Care Act (ACA) mandates tax-exempt hospitals to conduct a Community Health Needs Assessment (CHNA) every three years and implement strategies focused on emergent priorities from the assessment. Federal requirements for the CHNA include:
  - A definition of the community served and a description of how the community was determined
  - A description of the process and methods used to conduct the CHNA
  - A description of how the facility solicited and took into account input received from persons who represent the broad interests of the community it serves
  - A prioritized description of the significant health needs of the community identified through the CHNA and a description of the process and criteria used in identifying certain health needs as significant and prioritizing those needs
  - A description of resources potentially available to address the significant health needs identified
- The Internal Revenue Code (IRS) requires preparation and reports to maintain a 501(c)3 status


Strategic Initiatives
New Project Development & Implementation
Business Outreach
Occupational Health
Urgent Care Service Liaison
Business Development
Mobile Services
Associate Wellness & Education
Community Needs Assessment
Community Outreach
Transform Delivery System
Maximize Relationships
Manage Population
Outreach Department

Southeastern PA Regional CHNA

- Hospitals and health systems have collaborated on a **Southeastern Pennsylvania (SEPA) Regional CHNA** (rCHNA), focused on **Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties.**
- Regional Collaboration enables continuity for the rCHNA, while also providing opportunities to expand and improve upon the last assessment process.
- The 2022 rCHNA is explicitly grounded in an approach that seeks to **advance health equity** and **authentic community engagement.**

Participating Health Systems

- Children's Hospital of Philadelphia
- Doylestown Health
- Grand View Health
- Jefferson Health
- Main Line Health
- Penn Medicine
- Redeemer Health
- Temple University Health System
- Trinity Health Mid-Atlantic

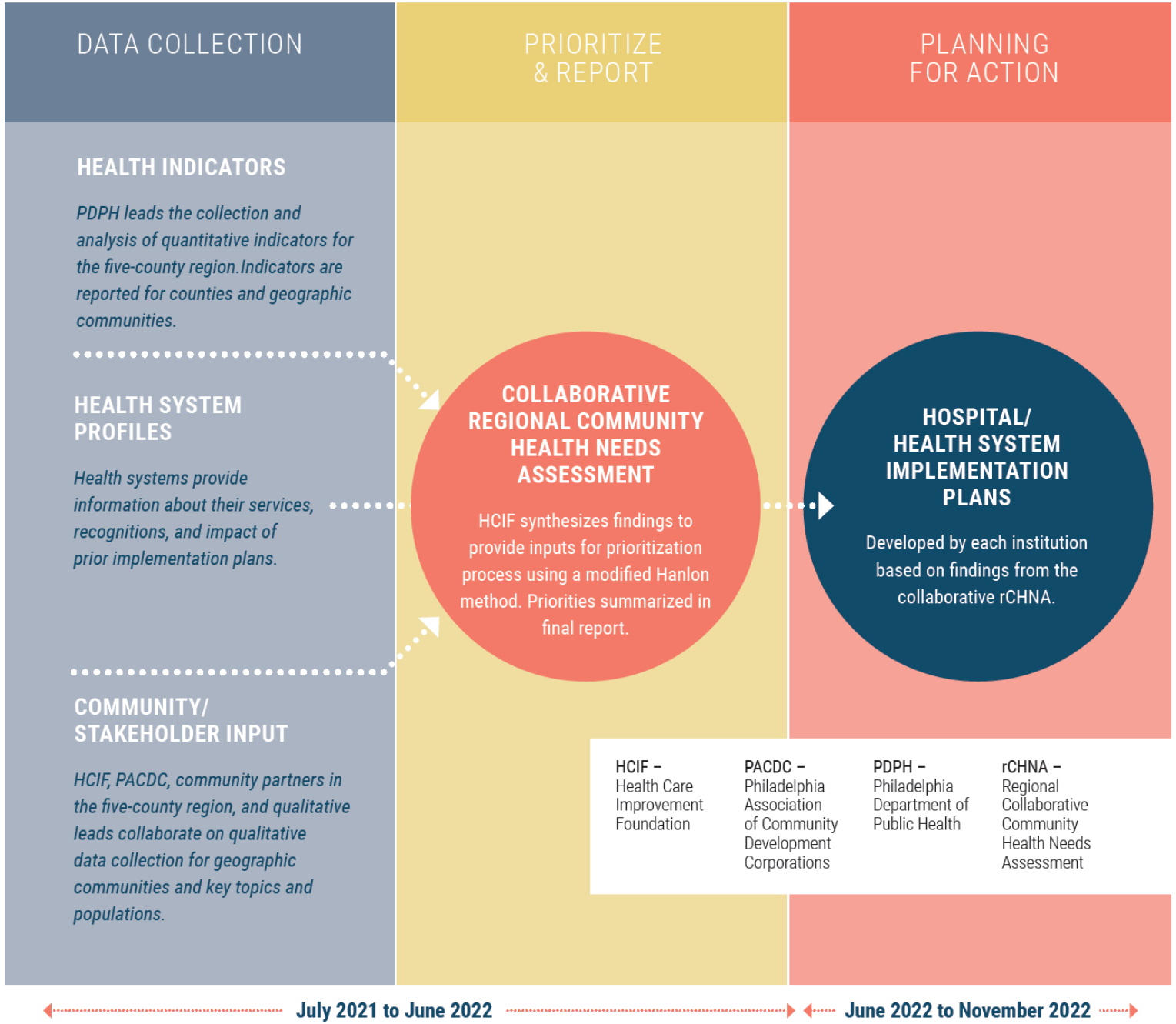
Partner Organizations

- Chester County Health Department
- Delaware County Health Department
- Health Care Improvement Foundation*
- Montgomery County Office of Public Health
- Philadelphia Association of Community Development Corporations*
- Philadelphia Department of Public Health*

* Project team members, with HCIF as lead

Our Collaborative Approach

The unique impacts of the COVID-19 pandemic on data collection efforts, it is important to note that comparability with the 2019 rCHNA report (especially as related to quantitative data) is limited.



2022 Implementation Plan

Overview of Community Health Needs

Health Issues	Access and Quality of Healthcare and Health Resources	Community Factors
• Chronic Disease Prevention and Management • Mental Health Conditions • Substance Use and Related Disorders	• Access to Care (Primary and Specialty) • Food Access • Healthcare and Health Resources Navigation (Including Transportation) • Culturally and Linguistically Appropriate Services • Racism and Discrimination in Health Care	• Housing • Neighborhood Conditions (e.g., Blight, Greenspace, Air and Water Quality, etc.) • Community Violence • Socioeconomic Disadvantage (e.g., Poverty, Unemployment)

- Addressing
- Not addressing

Priority #1: Mental Health Conditions / Substance Use and Related Disorders

- Youth and adult community members and community partners prioritize mental health as their top health need.
- Significant mental health needs across the region are indicated by rates of depression among youth and adults, frequent mental distress among adults, and suicide mortality and attempts among youth.
- These concerning trends were exacerbated by the social isolation, stress, and fear experienced due to the COVID-19 pandemic.
- Substance use disorders often co-occur with mental health conditions.
- Drug overdose rates continue to be high due to opioid epidemic.
- Opioid epidemic associated with increases in other health conditions including HIV, Hepatitis C, and Neonatal Abstinence Syndrome (NAS).
- Binge drinking among adults and youth, as well as cigarette, marijuana, and vape use among youth increasingly prevalent. High rates of marijuana vaping among youth in the four suburban counties

Priority #1: Mental Health Conditions / Substance Use and Related Disorders

Implementation includes:

- Work with community partners to increase access to safe, structured activities and spaces for youth.
  - Partners like Central Bucks Police Department, Access Services
  - Trainings like child sexual abuse prevention trainings, mock teen room trainings
- Expand knowledge of Doylestown's use of Certified Recovery Specialists in warm handoffs for drug overdose and other behavioral health issues.
  - Bcares/Warm Hand off
  - Partners like Bucks Co Drug and Alcohol Commission, Lenape Valley
- Increase knowledge of the MAT (medical assisted treatment) program at Doylestown through outreach
- Work to increase mental health awareness and decrease stigma
  - Patient advocacy aims to increase mental health literacy
  - Work on yearly mental health month
  - Create 9-8-8 mental health campaign
  - Partners like BCHIP (Bucks Co Health Improvement Partnership)

Priority #1: Mental Health Conditions / Substance Use and Related Disorders

Implementation:

- Partner with community organizations to expand prevention programs, ranging from school-based educational programs to community drug take-back programs.
- Expand Narcan training and distribution by working with community partners
- Partner with community organizations to bring education and awareness on binge drinking, vaping, marijuana and opioid use – particularly in the youth population
- Implement and expand suicide prevention programs by providing more QPR training and partnering with community partners like Buck Co Dept of Behavioral Health
- Promote and implement Pennsylvania's first stand-alone crisis intervention unit

Priority #2: Access to Care (Primary and Specialty)

- Uninsured rates improving regionally, but challenges remain with increasing provider acceptance of new patients with Medicaid.
- Barriers to primary care for communities due to lack of providers in neighborhoods, issues of affordability, and language/cultural barriers.
- Above issues exacerbated with specialty care, with added challenges posed by even more limited availability of appointments, high cost, and lack of care coordination/linkage with primary care.
- Impacts of COVID-19 pandemic include increased enrollment in Medicaid, longer wait times for appointments (especially for specialty care), and gaps in access to preventive services.

Priority #2: Access to Care (Primary and Specialty)

Implementation:

- Increase knowledge of Ann Silverman Clinic and Family Practice Residency Clinic
  - ASC - services provided to uninsured including dental health
  - Warrington Clinic – services provided to underinsured
- Bring services to communities through mobile medical clinics for biometric screenings
- Increase Language Line use, volunteer translators at ASC, and provide health education materials in diverse languages.
- Increase awareness that Doylestown Primary Cares accept Medicaid patients
- Reduce fear of calling 9-1-1 and using EMS when experiencing chest pain
  - Build better partnerships with EMS
  - Stroke and Heart Failure coordinator out in the community

Priority #3: Chronic Disease Prevention and Management

- Heart disease, cancer, stroke, and chronic lower respiratory diseases continue to constitute majority of top 5 leading causes of death in all counties.
- Across and within 5 counties, disparities in burden of chronic disease correlate with poverty, disproportionately affecting communities of color.
- COVID-19 pandemic negatively impacted chronic disease prevention and management, notably seen in delays in care and indicators of poor disease control.

Priority #3: Chronic Disease Prevention and Management

Implementation:

- Heighten community awareness on Doylestown Health's clinical services including primary care networks, disease specific programs and care management resources
- Increase the number of community members attending in-person or online educational events pertaining to chronic disease prevention and management
- Leverage community partners to create events for large engagement and expand resources
- Engage trusted community leaders to spread key messages (for example, promoting cancer screening).
- Expand successful innovations from the pandemic, such as virtual wellness programs.
- Bring screenings and health education to faith-based institutions, wellness fairs, and public events where people are.
    - Screen patients for disparities in the social determinants of health and link to FindHelp and 2-1-1
    - Being referrals to primacy care physicians

Priority #5: Healthcare and Health Resources Navigation

- Navigating healthcare services and other health resources challenging due to lack of awareness, fragmented systems, and resource constraints.
- Healthcare providers can link patients directly to health resources or to community health workers or care coordinators.
- Navigation includes information as well as transportation. Lack of accessible, affordable transportation options was raised in a large majority (70%) of qualitative meetings, with the need spanning urban and suburban counties.

Priority #5: Healthcare and Health Resources Navigation

Implementation:

- Increase public awareness of community resources that local health systems have invested in and support community members with using them.
  - Including BCHIP's FindHelp and United Way's 2-1-1 systems
- Expand healthcare navigators in specialty areas
- Expand website use for patient navigation
  - Patient Family Advisory Council

Priority #6: Racism and Discrimination in Health Care

- Racism recognized as ongoing public health crisis in need of urgent, collective attention.
- Higher rates of COVID-19 infection, hospitalization, and mortality experienced by Black communities are examples of inequities stemming from structural racism.
- Representatives of communities of color shared mistrust of healthcare providers and institutions arising from seeing such disparities and personally experiencing discriminatory treatment in healthcare settings. This can lead to forgoing of needed care, resulting in increased morbidity and mortality.
- Anti-Asian hate crimes increased during the COVID-19 pandemic.

Priority #6: Racism and Discrimination in Health Care

Implementation:

- Expand and improve training of healthcare providers around anti-racism, discrimination, structural racism, implicit bias, and trauma-informed care.
    - Trauma-informed care approach to care acknowledges that HCO need to have a complete picture of patient's life situation –past and present – to provide effective health care
- Ensure diversity, equity, and inclusion efforts by integrating the DEI committee in hospital events.

Community Health Needs Assessment

- Full link
- https://www.doylestownhealth.org/about-us/community-health-needs-assessment#dh-accordion-423f6c9f-2ed7-4954-a9b6-19627e96279e-item

Next Steps

- Board approval
- Implementation plan on website by September
- Setting Baseline Goals
- Creating Tactics & Measureable Metrics