COMMUNITY HEALTH NEEDS

2019 IMPLEMENTATION STRATEGY

HEALTH IS WHERE WE LIVE, LEARN, AND WORK

Phoenixville Hospital
TOWER HEALTH
Advancing Health. Transforming Lives.

Phoenixville.TowerHealth.org

LETTER TO THE COMMUNITY

OUR MESSAGE TO THE RESIDENTS OF THE PHOENIXVILLE HOSPITAL SERVICE AREA

Stephen Tullman

resident & CEO

Phoenixville Hospital

Phoenixville Hospital is committed to meeting our community's health needs and growing with our community to provide high-value, quality care close to home. To achieve this goal, we must understand the community's evolving unmet health needs. To that end, Phoenixville Hospital — in collaboration with all Tower Health hospitals and our local community partners — conducted a comprehensive 2019 Community Health Needs Assessment (CHNA), which identifies local health priorities and recommends a collective path forward.

The 2019 CHNA is the first needs assessment that Phoenixville Hospital has completed as a nonprofit hospital. As part of the CHNA process, we conducted internal and external research including focus groups, stakeholder interviews, and key informant surveys. In addition, a community survey was completed among 350 external stakeholders.

Based on the results of this process, Phoenixville Hospital, along with our community partners and Tower Health colleagues, worked to develop strategies to address each of the following health priorities:

- Access to Health Care
    - Increase access to healthcare services by community members, particularly those considered vulnerable and/or living in underserved areas
- Social Determinants of Health
    - Identify and address Social Determinants of Health
- Disease Prevention and Management
- Access to Behavioral Health Services
    - Improve access to screening, assessment, treatment and support for behavioral health
    - Decrease stigma related to behavioral health

Our commitment to advance the health and wellness of our community extends far beyond the walls of our hospital. Together with our partners, we are developing and implementing innovative programs and services that will bring positive health improvements to our community.

My sincere thanks to the community stakeholders who generously shared their time and input throughout the comprehensive CHNA process. I would also like to recognize the time and talent of the Phoenixville Hospital CHNA Advisory Group, which was comprised of hospital staff and representatives from various community organizations.

I am grateful for your continued feedback, involvement, and support. Together, we are "*Advancing Health, Transforming Lives*" across our region.

Sincerely,

Stephen Tullman
President & Chief Executive Officer
Phoenixville Hospital

PHOENIXVILLE HOSPITAL
SERVICE AREA

Phoenixville Service Area

The community encompasses specific zip codes within Chester and Montgomery counties and are considered the primary service area of Phoenixville Hospital.

MONTGOMERY
CHESTER
Pottstown 19464
Pottstown 19465
Parker Ford 19457
Royersford 19468
Cedars 19423
Collegeville 19426
Spring City 19475
Phoenixville Hospital PSA
Eagleville 19408
Fairview Village 19409
Audubon 19403
Kimberton 19442
Mont Clare 19453
Oaks 19456
Phoenixville 19460

PHOENIXVILLE HOSPITAL

HEALING BEGINS HERE.

Phoenixville Hospital is your community healthcare provider; a 137-bed facility with an award-winning cardiovascular program, a fully-accredited cancer center, and the area's largest Robotic Surgery Center. We believe in the power of people to create great care. We provide comprehensive medical services through approximately 25,000 emergency room visits, 8,200 inpatient admissions, and more than 500 community outreach programs annually. We work hard every day to be a place of healing, caring and connection for patients and families in the community we call home.

PHOENIXVILLE HOSPITAL MISSION

At Phoenixville Hospital, "where caring comes first," we...

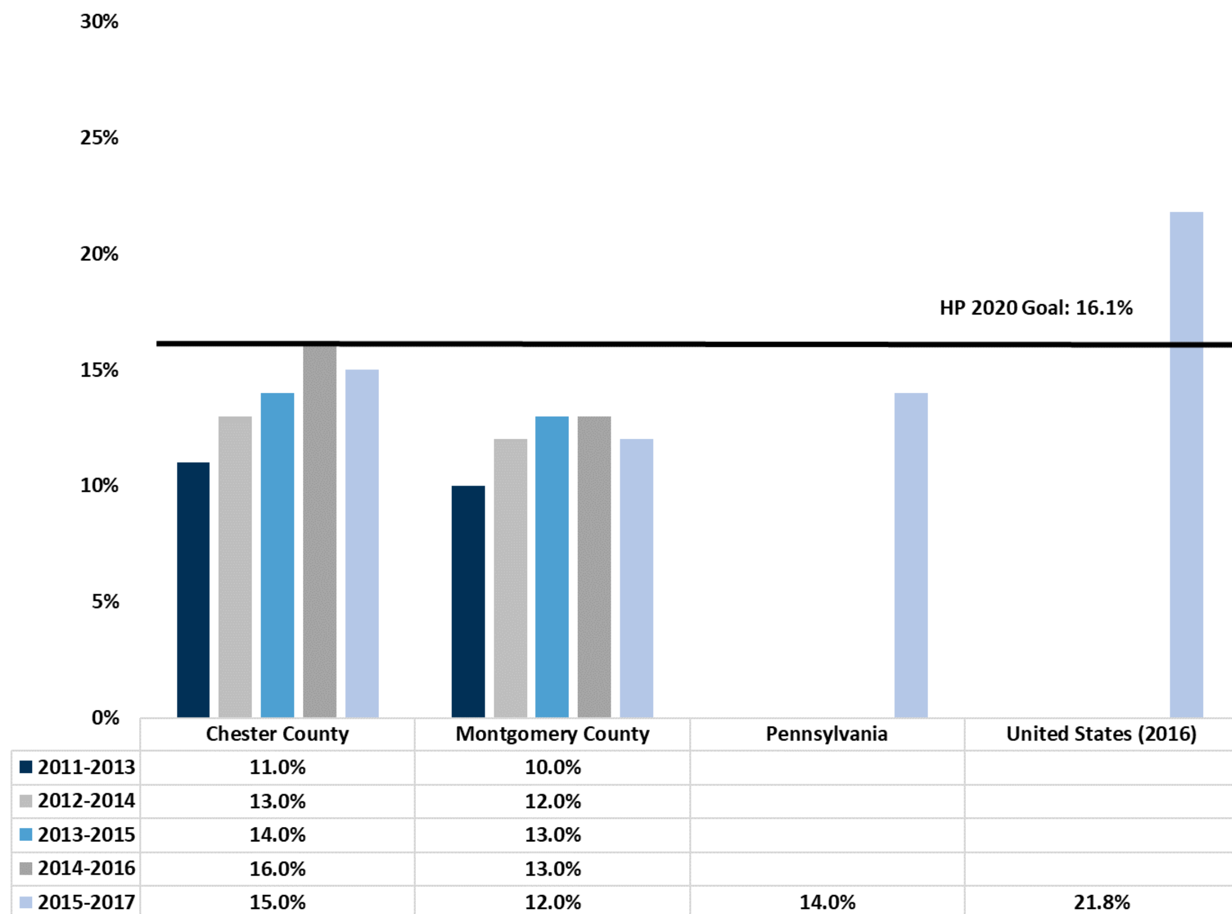
- care about quality,
- care about service,
- care about community.

OUR PRIORITY
FOCUS AREAS

1 ACCESS TO HEALTHCARE SERVICES

The residents in the Phoenixville service area who live in Chester County are more likely not to have a personal care provider than the state overall. While the percentage of patients who do not have a person care provider in Chester and Montgomery Counties is better than the Healthy People 2020 goal, they have been increasing in recent years.

No Personal Care Provider



	Chester County	Montgomery County	Pennsylvania	United States (2016)
2011-2013	11.0%	10.0%		
2012-2014	13.0%	12.0%		
2013-2015	14.0%	13.0%		
2014-2016	16.0%	13.0%		
2015-2017	15.0%	12.0%	14.0%	21.8%

Source (Figure 55 & 56, Pg 96): Division of Health Informatics, Behavior Risk Factor Surveillance Survey, Pennsylvania Department of Health for Chester, and Montgomery counties, 2011-2017, Healthy People 2020, Center for Disease Control

WHAT THE COMMUNITY IS SAYING

Focus group participants spoke about the challenges accessing care related to insurance, the complexity of the system and lack of transportation. They talked about the need for extended hours of service as well as the need for cultural training for hospital staff. This group also noted the need for more Spanish speaking professionals.

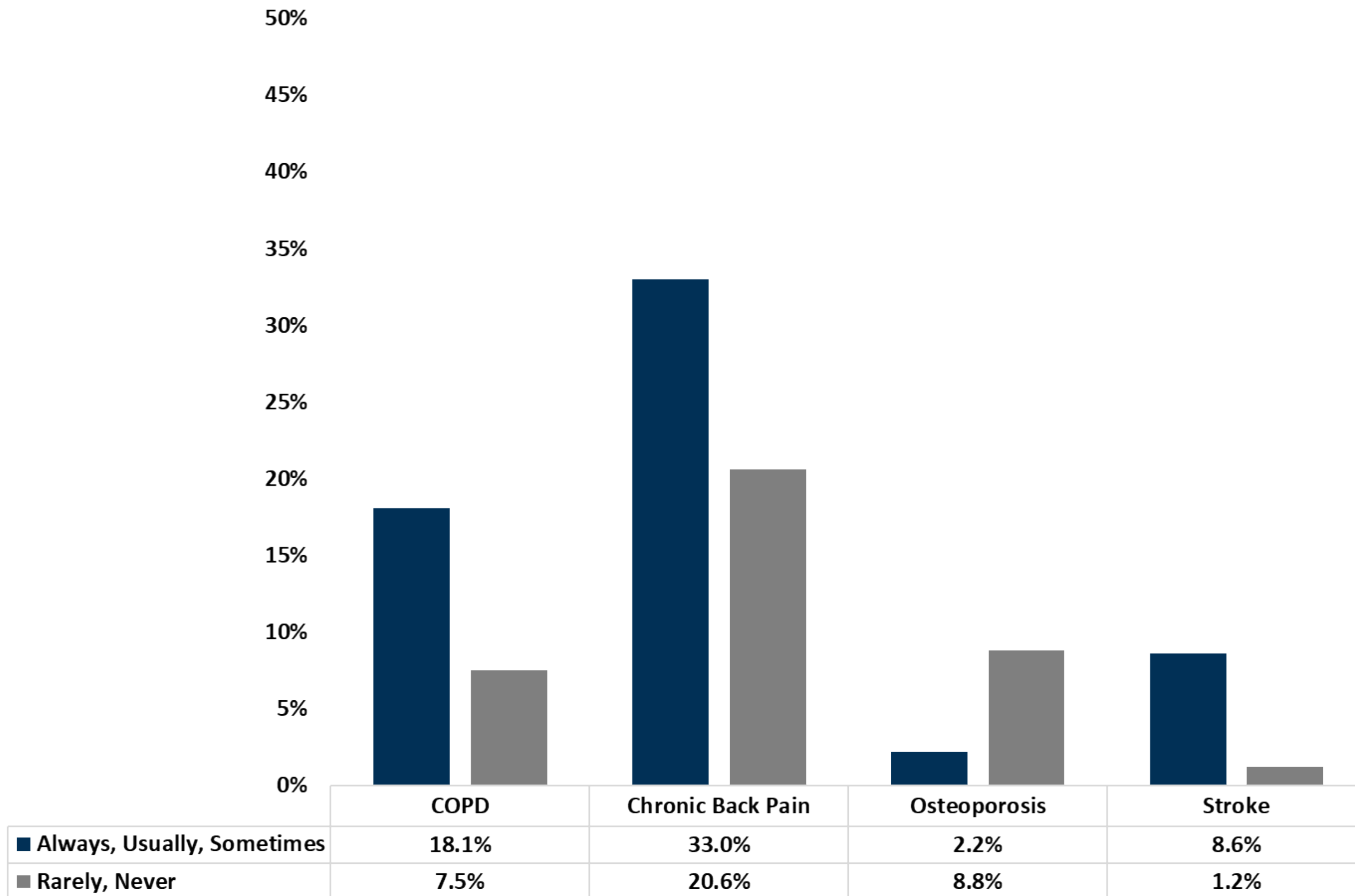
Stakeholders talked about the need for services for the uninsured and underinsured. Stakeholders talked about barriers to care including transportation. They added that healthcare is needed for the transgender community as well as for migrant workers.

Substantial percentages of residents in the Phoenixville Hospital service area have experienced difficulty accessing health care:

Source: 2018 Phoenixville Hospital Community Survey, Professional Research Consultants

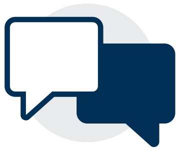
Those with housing insecurity are significantly more likely to have COPD, chronic back pain, and stroke.

Housing Insecurity Impact On Health



	COPD	Chronic Back Pain	Osteoporosis	Stroke
Always, Usually, Sometimes	18.1%	33.0%	2.2%	8.6%
Rarely, Never	7.5%	20.6%	8.8%	1.2%

Source: Phoenixville Hospital Community Survey, Professional Research Corporation, 2018



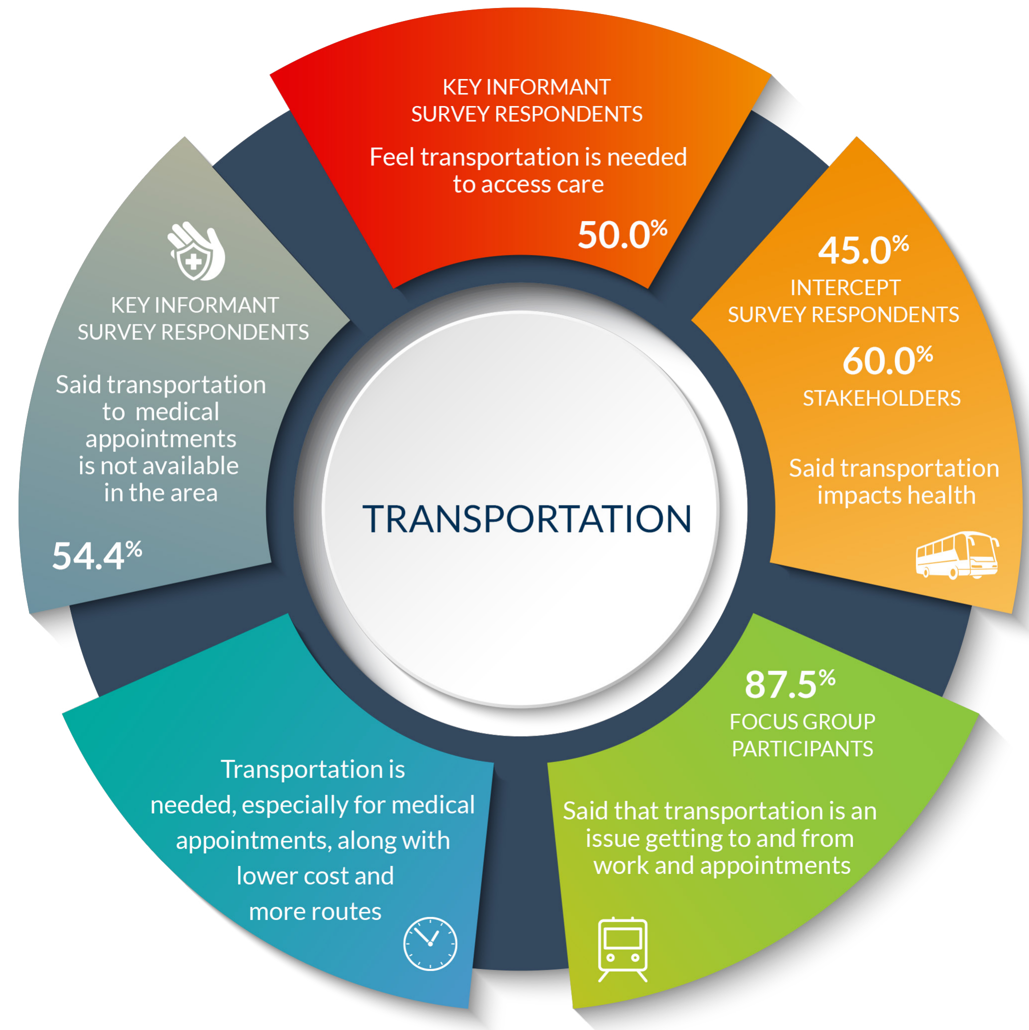
WHAT THE COMMUNITY IS SAYING

Primary research participants from the 2019 CHNA had much to say about the relationship between transportation and health.

Issues identified in focus groups, intercept surveys, and key informant surveys due to a lack of transportation include:

- Better access to transportation is needed
- Need cheaper transportation
- Lack of evening and weekend transportation options
- Transportation options are limited and time intensive
- Hours spent accessing transportation in order to get to an appointment; often causes cancellations
- Affordable transportation is needed throughout the region
- Can't access grocery stores that sell fresh produce or exercise areas as no transportation
- Inability to navigate the transportation system
- Need for more senior transportation
- Need transportation outside of cities; more rural area transportation

Primary Data Sources – Transportation



Sources: Phoenixville 2018 Focus Groups, 2018 Intercept Survey, 2018 Key Informant Survey, 2018 Stakeholder Interviews, Strategy Solutions, Inc.

WHAT THE COMMUNITY IS SAYING

Just over one-third of survey respondents (34.4%) report eating five or more servings of fruit and/or vegetables daily. Some of the respondents find it very or somewhat difficult to buy fresh produce (15.0%) or are considered food insecure (14.1%).

Community Food And Nutrition

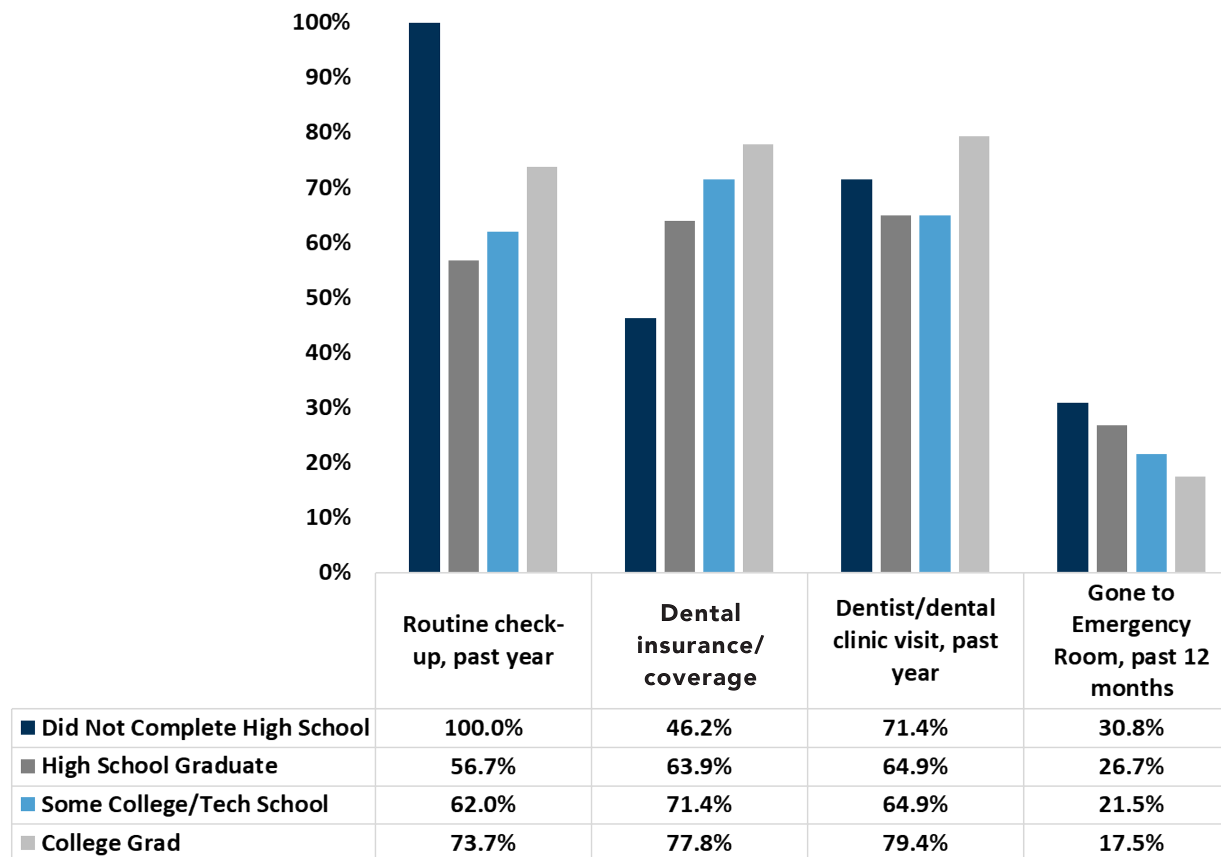
- **14.1%** Food Insecure
- **34.4%** Eat 5+ Servings Fruit/Vegetables
- **15.0%** Very/Somewhat Difficult to Buy Fresh Produce

Source: Phoenixville Hospital Community Survey, Professional Research Consultants, 2018

3 DISEASE PREVENTION AND MANAGEMENT

The chart below shows significant differences for access to care indicators based on highest level of educational attainment from the community survey respondents who reside in the Phoenixville Hospital's service area. Those respondents who did not complete high school were significantly more likely to have had a routine check up in the past year when compared to other respondents, although they are also significantly more likely to have gone to the emergency room in the past 12 months. This group were significantly less likely to have dental insurance. College graduates were significantly more likely to have visited a dentist in the past year when compared to other respondents.

Preventative Care



	Routine check-up, past year	Dental insurance/ coverage	Dentist/dental clinic visit, past year	Gone to Emergency Room, past 12 months
Did Not Complete High School	100.0%	46.2%	71.4%	30.8%
High School Graduate	56.7%	63.9%	64.9%	26.7%
Some College/Tech School	62.0%	71.4%	64.9%	21.5%
College Grad	73.7%	77.8%	79.4%	17.5%

Source: Phoenixville Hospital Community Survey 2018, Professional Research Consultants

Older residents age 65 and over were significantly more likely to have been told that they have all of the chronic conditions listed below with the exception of COPD. Respondents age 18 to 39 were significantly more likely to have COPD compared to their older counterparts.

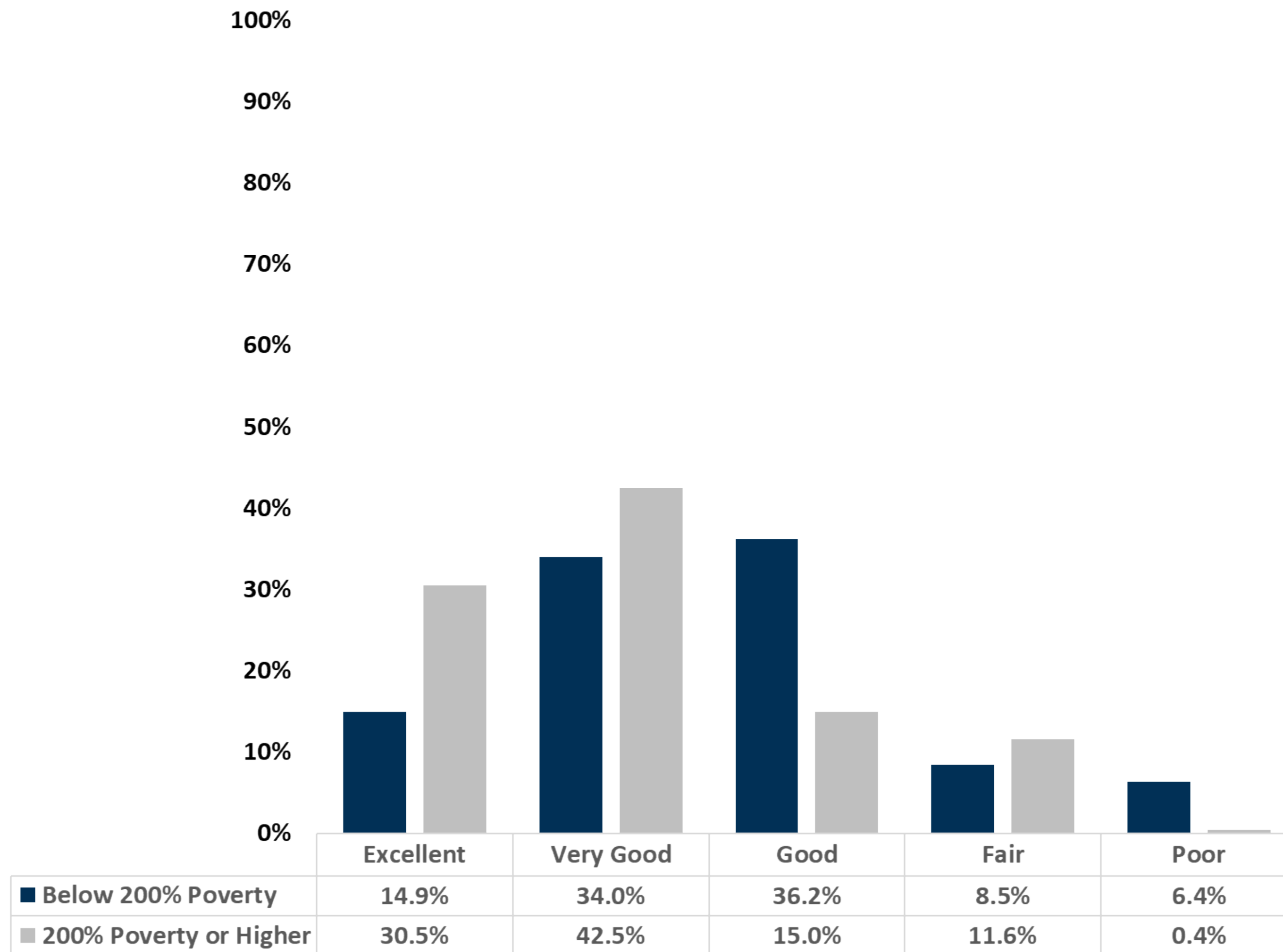
IMPACTS OF AGE ON CHRONIC DISEASE				
Ever Been Told That You Have:	18 to 39	40 to 64	65 and Over	Overall
Arthritis/rheumatism	11.8%	25.6%	39.7%	23.4%
COPD (Including bronchitis or emphysema)	15.8%	6.3%	12.5%	10.8%
Cancer	0.0%	6.8%	19.0%	6.7%
Skin cancer	1.7%	5.6%	20.6%	7.0%
Osteoporosis	0.0%	6.3%	23.8%	7.4%
Sciatica or chronic back pain	18.5%	24.4%	34.9%	24.3%
Had a heart attack	3.4%	1.9%	9.7%	3.8%
Heart disease	0.0%	3.1%	11.5%	3.5%
Pre-diabetes or borderline diabetes	4.7%	5.2%	17.0%	6.9%

Source: Phoenixville Hospital Community Survey, Professional Research Consultants, 2018

4 ACCESS TO BEHAVIORAL HEALTH SERVICES

Community survey respondents in the Phoenixville Hospital service area that are living below 200% of the poverty line* were significantly more likely to report their personal mental health as poor than those with higher incomes.

Personal Mental Health Rating



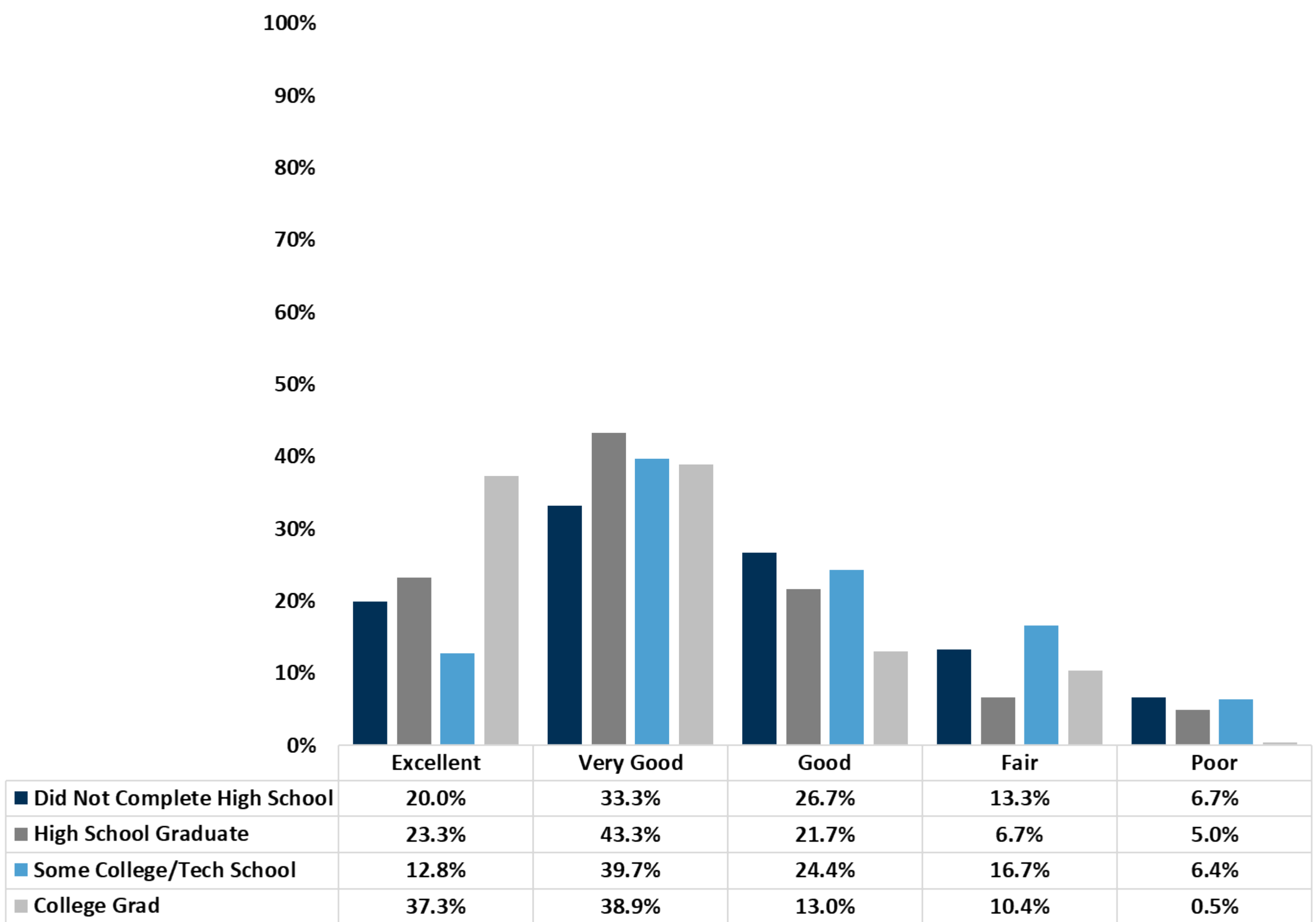
	Excellent	Very Good	Good	Fair	Poor
Below 200% Poverty	14.9%	34.0%	36.2%	8.5%	6.4%
200% Poverty or Higher	30.5%	42.5%	15.0%	11.6%	0.4%

Source: Phoenixville Hospital Community Survey 2018, Professional Research Consultants

*Note: https://www.thebalance.com/federal-poverty-level-definition-guidelines-chart-3305843

Those with some college as their highest level of educational attainment were significantly more likely to rate their mental health as fair or poor (23.1%) compared to other respondents.

Personal Mental Health Status



	Excellent	Very Good	Good	Fair	Poor
Did Not Complete High School	20.0%	33.3%	26.7%	13.3%	6.7%
High School Graduate	23.3%	43.3%	21.7%	6.7%	5.0%
Some College/Tech School	12.8%	39.7%	24.4%	16.7%	6.4%
College Grad	37.3%	38.9%	13.0%	10.4%	0.5%

Source: Phoenixville Hospital Community Survey 2018, Professional Research Consultants

Hospital leaders and representatives from community agencies came together to review data compiled for the Community Health Needs Assessment. This group prioritized the most critical community needs identified as focus areas to hone in on areas of focus for the next three years. Hospital leaders met to review these prioritized needs, taking into consideration community needs, national benchmarks, and available resources. The following strategies were then identified to help address the identified priorities.

1 HEALTH PRIORITY: ACCESS TO HEALTHCARE

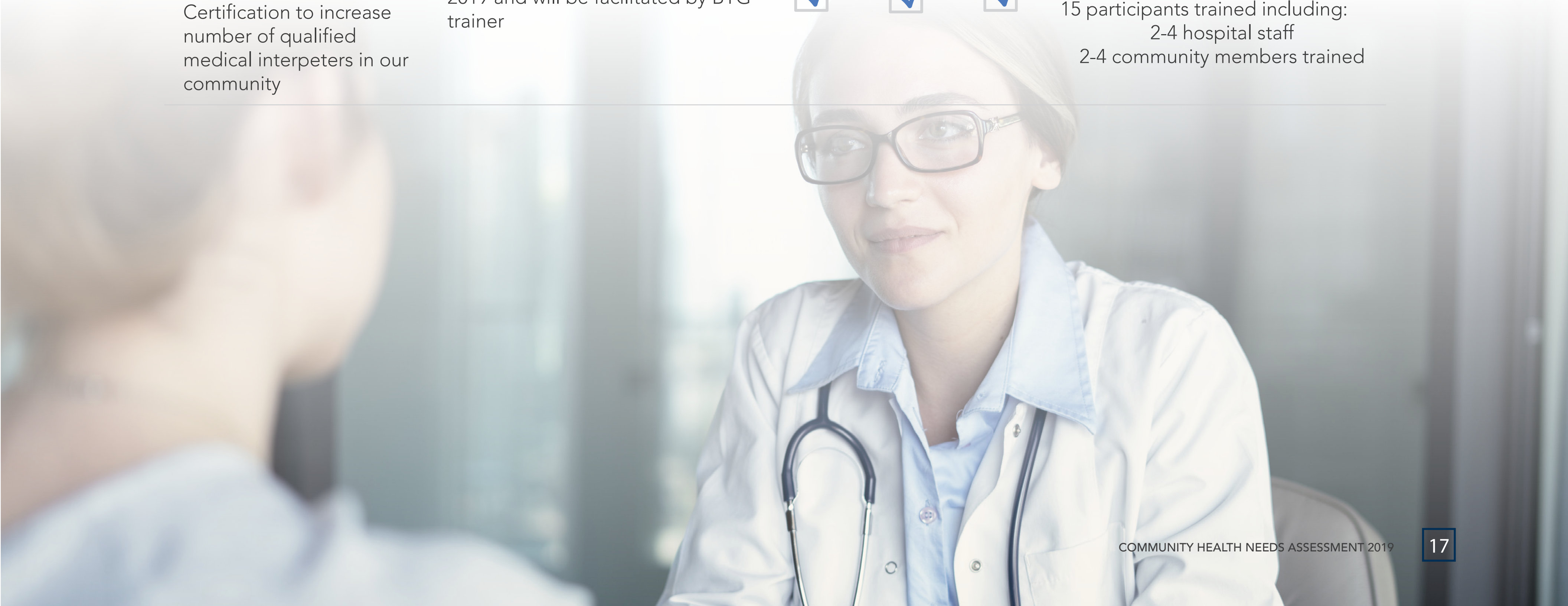
Goal 1. Increase access to healthcare services by community members, particularly those considered vulnerable and/or living in underserved areas.

STRATEGIES	ACTION STEPS	YEAR 2019	YEAR 2020	YEAR 2021	METRICS PER YEAR
Enhance and/or expand telemedicine opportunities	Evaluate opportunity for additional telehealth service	✓			3 telehealth services offered Complete telemedicine analysis
Streamline the access to care facilities	Implement the Tower Access Project	✓	✓	✓	Design and develop advanced access center Open advanced access center across ambulatory and specialty care service lines
Increase cultural awareness, diversity and inclusion	Staff members to attend train the trainer session	✓			1 train the trainer session
	Schedule and host trainings		✓	✓	1 staff training session 85% increased knowledge

1 HEALTH PRIORITY: ACCESS TO HEALTH CARE

Goal 1 *(continued)*. Increase access to healthcare services by community members, particularly those considered vulnerable and/or living in underserved areas.

STRATEGIES	ACTION STEPS	YEAR 2019	YEAR 2020	YEAR 2021	METRICS PER YEAR
Utilize outreach sites to connect vulnerable populations with resources to address unmet health care needs.	Community health nurses will provide health information and referrals to resources to vulnerable populations	✓	✓	✓	100 outreach visits 550 referrals
Host Bridging the Gap Medical Interpreter Certification to increase number of qualified medical interpeters in our community	BTG training scheduled for Oct 2019 and will be facilitated by BTG trainer	✓	✓	✓	1 training held each year 15 participants trained including: 2-4 hospital staff 2-4 community members trained



2 HEALTH PRIORITY: SOCIAL DETERMINANTS OF HEALTH

Goal 1. Identify and address Social Determinants of Health (SDOH).

STRATEGIES	ACTION STEPS	YEAR 2019	YEAR 2020	YEAR 2021	METRICS PER YEAR
Identify and address SDOH in the clinical environment	Screen for SDOH in identified clinical areas	☑	☑	☑	912 screened 5% decrease in ED utilization 90 receiving navigation 400 resource summaries generated
Reduce transportation barriers	Implement Ride Health Program	☑	☑	☐	Program implemented 500 rides

3 HEALTH PRIORITY: DISEASE PREVENTION AND MANAGEMENT

Goal 1.Implement chronic disease prevention and management programs in the primary service area, specifically targeting vulnerable populations.

STRATEGIES	ACTION STEPS	YEAR			METRICS PER YEAR
		2019	2020	2021	
Blood pressure screenings	BP screenings will be provided at outreach (low income housing, food pantry) by Community Health	✓	✓	✓	1000 participants 100 referred for follow up
	Make appropriate referrals for follow up				
Provide chronic disease education to target population at nurse managed outreach sites	Provide chronic disease specific education to vulnerable populations (Low income, veterans, disabled)	✓	✓	✓	125 sessions 2000 participants 85% increased knowledge
	Provide monthly education seminars focused on disease specific health				
Lung cancer screeenings	Promote lung cancer screening at various community events	✓	✓	✓	25 events 100 screened 10% referred for follow up
Mammogram screenings	Increase awareness of mammogram screeening program	✓	✓	✓	25 screened 10% referred for follow up
Vaping Cessation Programs	Coordinate student vaping cessation	✓	✓	✓	4 programs 12 participants
	Coordinate student and parent vaping education in local school districts				4 programs 500 participants

3 HEALTH PRIORITY: DISEASE PREVENTION AND MANAGEMENT

Goal 1 *(continued)*. Implement chronic disease prevention and management programs in the primary service area, specifically targeting vulnerable populations.

STRATEGIES	ACTION STEPS	YEAR 2019	YEAR 2020	YEAR 2021	METRICS PER YEAR
Tower Wellness Programs	Implement short and long term wellness initiatives	✓	✓	✓	Increase baseline participation in major ongoing Tower Health sponsored wellness programs to 25% within the next one year (Currently 18%) Maintain engagement in major short-term wellness initiatives at 60% or greater for fitness/nutrition programs and 20% or greater for mental/spiritual health programs
Provide programs that educate the community about diabetes	Promote Diabetes Support group meetings	✓	✓	✓	50 participants 10 completing program 85% increased knowledge
	Partner with community organizations to provide diabetes programs to at risk population	✓	✓	✓	10 programs 100 participants 85% increased knowledge
Raise awareness of available assistance to food programs	Attend community food coalition meeting	✓	✓	✓	Coalition developed with identified priorities
Promote awareness of community physical fitness programs	Collaborate with organizations for fitness/exercise programs	✓	✓	✓	4 collaborations
	Develop a physical activity prescription and pilot its use at two medical practices	✓	✓	✓	Year 1: 5 prescriptions provided Year 2: 10 prescriptions provided Year 3: 15 prescriptions provided

4 HEALTH PRIORITY: ACCESS TO BEHAVIORAL HEALTH SERVICES

Goal 1. Improve access to screening, assessment, treatment and support for behavioral health.

STRATEGIES	ACTION STEPS	YEAR 2019	YEAR 2020	YEAR 2021	METRICS PER YEAR
Utilize telemedicine to expand access	Warm Handoff	✓	✓	✓	Study conducted Year 1

Goal 2. Provide training to hospital staff and community members.

STRATEGIES	ACTION STEPS	YEAR 2019	YEAR 2020	YEAR 2021	METRICS PER YEAR
Increase provider awareness of suicide ideation	Schedule and host QPR training	✓	✓	✓	1 trainings 10 participants 85% increased knowledge
Equip providers and community members to provide mental health support	Schedule and host mental health first aid training	✓	✓	✓	1 training per year 10 participants 85% increased knowledge
Support providers	Provide resilience/self care training to staff	✓	✓	✓	1 training per year 10 participants 85% increased knowledge

4 HEALTH PRIORITY: ACCESS TO BEHAVIORAL HEALTH SERVICES

Goal 3. Promote positive messages/reduce stigma.

STRATEGIES	ACTION STEPS	YEAR 2019	YEAR 2020	YEAR 2021	METRICS PER YEAR
Develop communication campaign to reduce Mental Health stigma	Post monthly on social media pages Send press releases if applicable	✓	✓	✓	400 reached each year

Goal 4. Improve access to screening, assessment, treatment and support for behavioral health.

STRATEGIES	ACTION STEPS	YEAR 2019	YEAR 2020	YEAR 2021	METRICS PER YEAR
Explore the development of peer specialist in the ER	Identify need and explore resources available	✓	✓	✓	Complete feasibility report

CONTACT//

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Phoenixville Hospital

TOWER HEALTH

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