

Allegheny Health Network

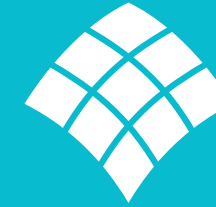


Jefferson
Hospital

COMMUNITY HEALTH NEEDS ASSESSMENT IMPLEMENTATION STRATEGY PLAN

March 2019





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Our Mission

To create a remarkable health experience, freeing people to be their best.

Our Vision

A world where everyone embraces health.

Our Values

People Matter

Every person contributes to our success. We strive for an inclusive culture, regarding people as professionals, and respecting individual differences while focusing on the collective whole.

Stewardship

Working to improve the health of the communities we serve and wisely managing the assets which have been entrusted to our care.

Trust

Earning trust by delivering on our commitments and leading by example.

Integrity

Committing to the highest standards encompassing every aspect of our behavior including high moral character, respect, honesty, and personal responsibility.

Customer-focused Collaboration

Because no one person has all the answers, we actively seek to collaborate with each other to achieve the right outcomes for our customers.

Courage

Empowering each other to act in a principled manner and to take appropriate risks to do what is right to fulfill our mission.

Innovation

Committing to continuous learning and exploring new, better, and creative ways to achieve our vision.

Excellence

Being accountable for consistently exceeding the expectations of those we serve.



INTRODUCTION

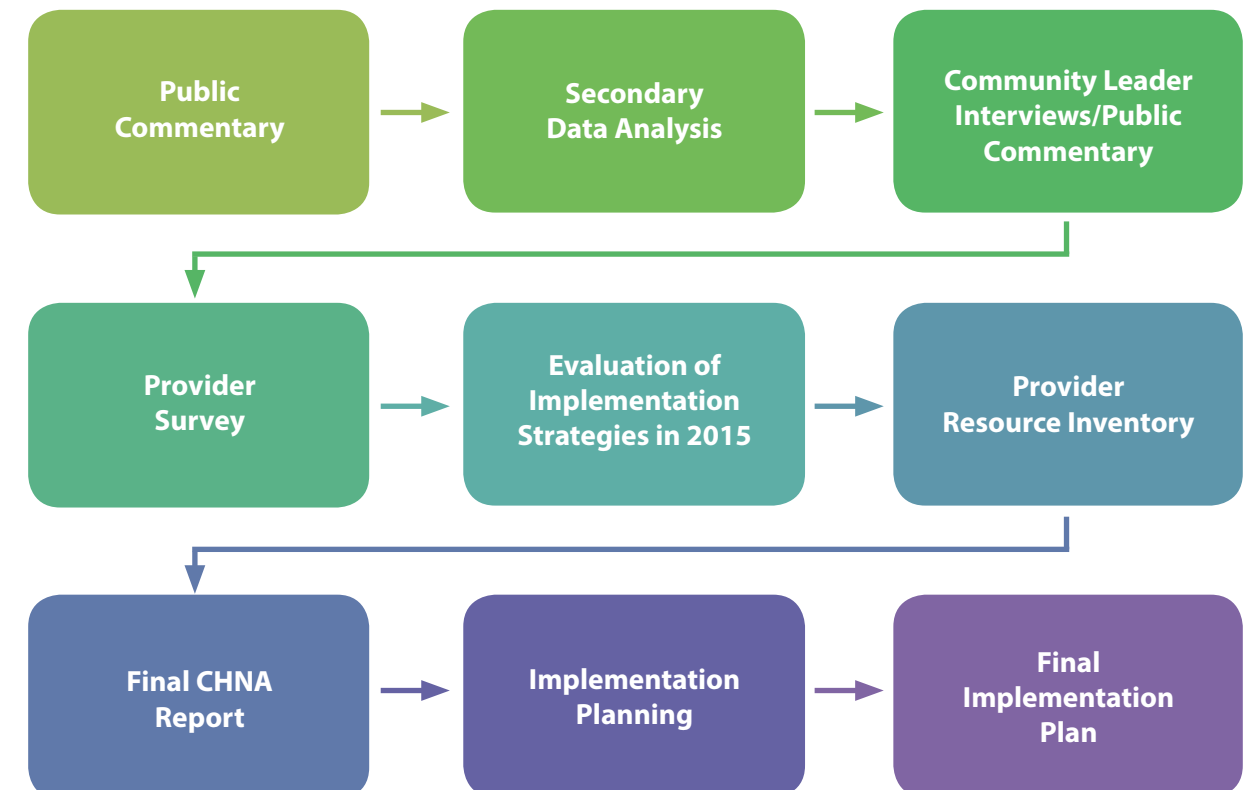
Serving the communities of the South Hills and lower Mon Valley since 1977, Jefferson Hospital has evolved into a 341 licensed bed hospital with more than 500 physicians and 1,700 staff members. The leadership and staff are dedicated to providing patients with innovative treatments, pioneering research discoveries, and personalized medical care.

Jefferson Hospital provides comprehensive inpatient and outpatient surgical services, as well as a Cardiovascular Institute, Cancer Institute, Orthopedic Institute, Neurosciences Institute, Women and Infants Center, Women's Diagnostic Center, Bariatric and Metabolic Institute, Sleep Disorders Center, Wound Care Center, Behavioral Health Services including outpatient Child and Adolescent Psychiatry, plus Therapy Services, the only midwives program in the

South Hills, and Spiritual Care. Jefferson Hospital includes the Bethel Park Health + Wellness Pavilion as well as several outpatient, primary care, and therapy sites across the South Hills and neighboring areas.

In 2018, AHN joined together with Tripp Umbach to conduct a comprehensive community health needs assessment (CHNA) for the Jefferson Hospital service area of Allegheny, Fayette, Washington and Westmoreland counties. The CHNA process included input from persons who represent the broad interests of the community served by the hospital, including those with special knowledge of public health issues and representatives of vulnerable populations. Various methodologies were utilized to ascertain the needs of the communities (see Graph 1).

GRAPH 1 – CHNA METHODOLOGY



IMPLEMENTATION STRATEGIES

The results of the CHNA identified the following as the priorities for the Jefferson Hospital service area:



The CHNA and implementation strategy plan meets the requirements of the Patient Protection and Affordable Care Act. The act has changed how individuals are obtaining care and promotes reduced healthcare costs, greater care coordination, and better care and services. Healthcare organizations and systems are striving to improve the health of the community they serve through collaboration with local, state and national partners.

The requirements imposed by the IRS for tax-exempt hospitals and health systems must include:

- ◆ Conduct a CHNA every three years.
- ◆ Adopt an implementation strategy to meet the community health needs identified through the assessment.
- ◆ Report how it is addressing the needs identified in the CHNA and a description of needs that are not being addressed, with the reasons why.

Tripp Umbach worked with the Jefferson Hospital staff to complete the CHNA and it was adopted by the board of directors in December 2018. This implementation strategy plan outlines the needs identified in the CHNA and documents how Jefferson Hospital will be addressing the needs over the next three years. All needs identified in the CHNA will be addressed by Jefferson Hospital.



HEALTH PRIORITY ACCESS TO CARE

Approximately 1 in 5 Americans (children and adults under age 65) do not have medical insurance.¹ People without medical insurance are more likely to lack a usual source of medical care, such as a PCP, and are more likely to skip routine medical care due to costs, increasing their risk for serious and disabling health conditions. When they do access health services, they are often burdened with large medical bills and out-of-pocket expenses.

Access to health care impacts one's overall physical, social, and mental health status and quality of life. Barriers to health services include high cost of care, inadequate or no insurance coverage, lack of availability of services, and lack of culturally competent care. These barriers to accessing health services lead to issues such as unmet health needs, delays in receiving appropriate care, inability to get preventive services, financial burdens, and preventable hospitalizations/readmissions.

¹ Healthy People 2020.

² Henry J. Kaiser Family Foundation.

Community Need Cost of Care

The results of the CHN show that a barrier to accessing behavioral health services is the awareness of community resources and services. During the stakeholder interview process, when interviewees were asked to name the top three health issues in their community, mental health was the number one response, as it was mentioned in 71% of the responses. The following strategies will be implemented by the staff of Jefferson Hospital in order to increase the knowledge and access to mental health programs and services. Allegheny Health Network providers were asked to list the biggest barriers for their patients to receive care, high out of pocket costs/high deductibles was the leading response (mentioned 75.1%) of the time.

GOAL #1

Reduce costs that may have a direct benefit to reducing patients' out-of-pocket and risk adjusted per member per month insurance healthcare expenses.

IMPACT

(1) Increased use of generic medication; (2) decreased out of pocket costs for patients' medication; (3) reduced readmission rates; and (4) reduced ED visits due to negative side effects or ineffective antibiotic treatment.

STRATEGIES AND ACTION STEPS COST OF CARE – GOAL #1

Strategies	Action Steps	Measure	Impact
<p>1. Implement at least one project(s) aimed at reducing Rx expenditures.</p>	<ul style="list-style-type: none"> Review patients high cost Rx, target restricting high cost generics in favor of lower cost manufacturers for the identical generic medication. Engage AHN Quality Specialists to provide PCP and specialists with educational campaigns designed to promote the use and benefits of generics and other lower cost options to patients. 	<ul style="list-style-type: none"> The cost savings of moving the patients to the lower cost medications. 	<ul style="list-style-type: none"> Increased use in generics from lower cost manufactures. Decreased out of pocket expenditures for medications.
<p>2. Reduce incidence of negative side-effects or ineffective antibiotic treatment for infection.</p>	<ul style="list-style-type: none"> Pharmacists will be involved in culture follow-up process for ED visits for UTIs, wound infections, throat cultures, and STDs. Develop an algorithm or a standardized protocol by which pharmacists can recommend appropriate actions. Review culture alerts received after discharge from ED and when appropriate, modify treatment recommendations based on consult between ED pharmacist and ED provider. 	<ul style="list-style-type: none"> Percent of appropriate antibiotic based on bacteria. Percent of appropriate duration of treatment based on type of infection. Percent of readmissions return visits to ED for same issue or side-affect from treatment drug. 	<ul style="list-style-type: none"> Reduced readmissions due to incidence of negative side effects or ineffective antibiotic treatment. Reduced ED visits due to incidence of negative side effects or ineffective antibiotic treatment.
<p>3. Implement a project to address medication needs of discharged patients.</p>	<ul style="list-style-type: none"> Develop Meds to Bed program to improve patient outcomes with medication adherence through upfront education, clarification of questions and resolution of insurance issues. 	<ul style="list-style-type: none"> Number of patients utilizing the Meds to Beds program. Number of patients utilizing Meds to Beds with medication related readmissions. 	<ul style="list-style-type: none"> Decreased medication related readmission rates. Reduced out of pocket expenses to the patient.



GOAL #2

Address the Social Determinants of Health in order to improve health outcomes.

IMPACT

(1) Decreased non urgent ED visits; (2) decreased readmission rates; (3) increased community referrals; (4) increased number of food packages provided; (5) improved adherence to medical appointments and follow-up appointments; and (6) improved quality of life.

STRATEGIES AND ACTION STEPS COST OF CARE – GOAL #2

Strategies	Action Steps	Measure	Impact
1. Implement Phase I of Front Door Initiative for Social Emergency Medicine grant to address social determinants of health.	<ul style="list-style-type: none"> Screen/assess social factors impacting patient health and acute physical emergencies Establish referral process with community partners for coordinated care outside of the ED. Reinforce a sense of pride and trust of the ED by the community as a central asset. Establish advisory council inclusive of internal staff, community organizations and visionaries. Review national models of excellence in Social Emergency Medicine. Understand and analyze community and ED population data. Improve referral and follow up process. Implement staff training on cultural competency, social determinants of health, ENCP. Integrate Social Determinants of Health screening tool in EPIC for ED patients. 	<ul style="list-style-type: none"> ED utilization for target population. Hospital readmissions for target population. Referrals to needed community services. 	<ul style="list-style-type: none"> Decreased non urgent ED visits. Decreased readmission rates. Increased community referrals.
2. Implement a program designed to address food insecurity and lack of nutrition.	<ul style="list-style-type: none"> Collaborate with the Greater Pittsburgh Community Food Bank to provide a medically-tailored food package for patients at discharge. Screen for food insecurity. Provide food packages with food assistance resources. 	<ul style="list-style-type: none"> 30-day unplanned readmissions Adherence to medical test and follow up appointments Patient reported quality of life improvement. 	<ul style="list-style-type: none"> Increased number of food packages provided Reduced readmission rates Improved adherence to medical test and follow-up appointments Improved quality of life.

GOAL #3

Reduce unnecessary ED utilization and 30-day readmissions.

IMPACT

(1) Decreased 30-day readmission rate; (2) decreased ED utilization for target population; and (3) increased PCP utilization.

STRATEGIES AND ACTION STEPS COST OF CARE – GOAL #3

Strategies	Action Steps	Measure	Impact
1. Engage Transitional Care Management Team to conduct outreach to patients upon discharge from hospital and after ED visits.	<ul style="list-style-type: none"> PCP office contacts patients within 2 days of a hospital discharge to review discharge instructions and medications. Identify barriers to patients following up with the care plan. Schedule a Transitional Care Management visit with the PCP. Place high priority on patients with frequent ED utilization. Provide patient education on when to use the ED vs. PCP. Schedule follow-up PCP appointments. 	<ul style="list-style-type: none"> Hospital 30 day readmissions for target population. ED utilization for targeted populations. 	<ul style="list-style-type: none"> Decreased readmission rates. Decreased non urgent ED utilization. Increase in PCP utilization to avoid escalation to acute health conditions.

HEALTH PRIORITY BEHAVIORAL HEALTH

Mental health is a growing issue across the U.S. Approximately one in five adults in the U.S. – or 43.8 million residents – experiences mental illness in a given year. 21.5% of youth age 13 through 18 experiences a severe mental disorder at some point during their lives. In many instances, mental illness and substance abuse go hand-in-hand; among the 20.2 million adults in the U.S. with a substance abuse issue, approximately 10.2 million have a co-occurring mental health issue.⁴

Approximately 20% of youth (13-18) experience severe mental disorders in a given year (13% for ages 8-15) and about 10.2 million adults in the U.S. have co-occurring mental health and addiction disorders. 60% of adults and nearly 50% of youth (8-15) with a mental illness received no mental health treatment in the previous year.⁵

With high rates of mental illness and substance abuse across the nation and in the state of Pennsylvania, it is increasingly important for residents to be able to seek and obtain quality care and treatments in order to manage their conditions. However, many struggling with mental and behavioral health issues are unable to access treatment. 56.5% of adults with mental illness received no past year treatment, and for those seeking treatment, 20.1% continue to report unmet treatment needs.⁶ The rate of behavioral health providers, cost of care, and uninsured levels play a role in a person's ability to receive behavioral health care.

Community Need Mental Health Services

The results of the CHN show that a barrier to accessing behavioral health services is the awareness of community resources and services. During the stakeholder interview process, when interviewees were asked to name the top three health issues in their community, mental health was the number one response, as it was mentioned in 71% of the responses. The following strategies will be implemented by the staff of Jefferson Hospital in order to increase the knowledge and access to mental health programs and services. Allegheny Health Network providers were asked to list the biggest barriers for their patients to receive care, high out of pocket costs/high deductibles was the leading response (mentioned 75.1%) of the time.

GOAL

Improve awareness of mental health conditions and treatment options.

IMPACT

(1) Increased number of patients that attend education sessions, (2) increased awareness of available resources to support recovery; (3) increased number of Behavioral Health Consultants in practices; and (4) improved PHQ9 score.

STRATEGIES AND ACTION STEPS MENTAL HEALTH SERVICES

Strategies	Action Steps	Measure	Impact
1. Provide education to public about mental health issues and treatment options.	<ul style="list-style-type: none"> Collaborate with Jefferson Regional Foundation to sponsor Mental Health First Aid train-the-trainer and community MHFA trainings to the public. 	<ul style="list-style-type: none"> Number of events Number of participants 	<ul style="list-style-type: none"> Increased awareness of signs of mental health illness. Increased awareness of available resources for recovery.
2. Recruit, hire, train and integrate Behavioral Health Consultants (BHC) into ambulatory practices.	<ul style="list-style-type: none"> Identify patients who may be in need of behavioral health support Administer the PHQ-2 at every primary care visit and PHQ-9 for patients who screen positive on the PHQ-2 Offer consultation & treatment with the practice's BHC. Monitor PHQ-9 scores over time for improvement 	<ul style="list-style-type: none"> Number of BHCs integrated into physician & ambulatory practices. Behavioral Health and psycho social issue reduction by monitoring PHQ-9 scores. 	<ul style="list-style-type: none"> Increased number of BHCs in practices. Improved PHQ9 scores.

³ "Mental Health by the Numbers" National Alliance on Mental Illness. 2016.

⁴ "Mental Health by the Numbers" National Alliance on Mental Illness. 2016.

⁵ National Alliance on Mental Illness, Mental Illness Facts and Numbers, 2016

⁶ Mental Health American, 2018.



HEALTH PRIORITY CHRONIC DISEASE

Chronic diseases, generally defined as conditions that last one year or more and require ongoing medical attention or limit daily activities, are the leading causes of death and disability in the United States.⁷ Common chronic diseases include hypertension, heart disease, and diabetes. Obesity underlies most chronic diseases. Obesity is a risk factor for type 2 diabetes, hypertension and hyperlipidemia. Although there is not a cure for most chronic diseases, they can be managed in ways that reduce the symptoms of the disease and/or minimize the risk of developing more serious symptoms.

More than half of adults ages 18 and older have at least one chronic condition; more than one-quarter have at least two. Eighty-six percent of the nation's \$2.7 trillion annual health care expenditures in 2014 were on behalf of people with chronic diseases and mental health conditions.⁸

⁷ Aspen Health Strategy Group. (2019). *Reducing the Burden of Chronic Disease*. Washington DC: The Aspen Institute. <http://aspeninstitute.org/AHSGreport2019>.

⁸ *ibid.*

Community Need Diabetes

Diabetes was the seventh leading cause of death in the United States in 2015 based on the 79,535 death certificates in which diabetes was listed as the underlying cause of death. In 2015, diabetes was mentioned as a cause of death in a total of 252,806 certificates.⁹

The results of the CHNA show that diabetes is one of the top three greatest health needs in the service area and education and proper disease management is a barrier to improving health outcomes. The following strategies will be implemented by the staff of Jefferson Hospital in order to improve quality outcomes associated with diabetes.

⁹ American Diabetes Association.



GOAL

To improve quality outcomes associated with diabetes.

IMPACT

(1) Increased number of RN Navigators; (2) decreased A1c levels in the managed population; (3) improved outcomes for diabetes measures; and (4) improved quality of life for diabetic patients.

STRATEGIES AND ACTION STEPS DIABETES

Strategies	Action Steps	Measure	Impact
<p>1. Develop chronic disease specialty centers in all AHN hospitals.</p>	<ul style="list-style-type: none"> • Embed RN Navigators at all AHN hospitals. • Develop diabetes transition of care models. • Develop inpatient care pathways. • Educate PCPs and patients on diabetes management. • Promote lifestyle change interventions and intensive case management to reduce risk of diabetes and cardiovascular disease in high-risk individuals. 	<ul style="list-style-type: none"> • Number of RN Navigators at AHN hospitals. • A1C levels for target population. 	<ul style="list-style-type: none"> • Increase number of RN Navigators. • Decreased A1c levels among target population.
<p>2. Provide support to primary care providers with data about performance on diabetes measures and support for quality improvement activities to enhance performance on diabetes care.</p>	<ul style="list-style-type: none"> • Continue partnership with Primary Care Redesign. • Provide quarterly data summary of practice and region performance on diabetes measures and on-demand patient-level data via the EMR to guide population health management activities. • Provide training and workflow redesign support for diabetes QI efforts via coaching from a Practice Transformation Specialist and consultation with endocrinologists from the AHN Diabetes Primary Care Support Initiative. 	<p>Performance on diabetes measures:</p> <ul style="list-style-type: none"> • HbA1c at goal; • retinal eye exam; • statin therapy; • BP control; • annual urine microalbumin re: nephropathy; • foot exam; • % of diabetics who are non-smokers. 	<ul style="list-style-type: none"> • Improved outcomes for diabetes measures. • Improved quality of life for diabetic patients.



Community Need Cancer

Cancer is a local, national, and worldwide chronic disease that has affected millions of people. In 2018, an estimated 1,735,350 new cases of cancer will be diagnosed in the United States and 609,640 people will die from the disease. In Pennsylvania, there are projected to be 80,960 estimated new cases in 2018 and 28,620 estimated deaths in 2018 alone.¹⁰ The most common cancer diagnoses in Pennsylvania are breast (female), lung, prostate, and colon.¹¹

The results of the CHNA show that cancer is one of the top health needs in the service area and education and proper disease management is a barrier to improving health outcomes. The following strategies will be implemented by the staff of Jefferson Hospital in order to reduce the number of cancer related deaths and improve the quality of life for those diagnosed with cancer.

¹⁰ American Cancer Society.

¹¹ American Cancer Society.

GOAL #1

Reduce the number of cancer related deaths.

IMPACT

(1) Increased number of education events at AHN hospitals; (2) increased number of hospital employees trained on tobacco cessation counseling; (3) increased number of trained community partners; (4) increased number of cancer screenings; and (5) increased number of early cancer diagnoses.

STRATEGIES AND ACTION STEPS CANCER – GOAL #1

Strategies	Action Steps	Measure	Impact
1. Provide resource to help individuals stop the use of tobacco products.	<ul style="list-style-type: none"> Collaborate with Jefferson Regional Foundation to provide a grant to Consumer Health Coalition to train tobacco cessation counselors and organize quitting workshops. Train hospital employees on tobacco cessation counseling. Offer workshops at Jefferson Hospital. 	<ul style="list-style-type: none"> Number of educational events. Number of participants. 	<ul style="list-style-type: none"> Increased number of education events at AHN hospital sites, especially high-risk areas. Increased number of trained hospital employees. Increased number of trained community partners.
2. Increase the number of adults who receive timely age appropriate cancer screenings based on the most recent guidelines.	<ul style="list-style-type: none"> Plan free cancer screenings for prostate, breast, skin, cervical, colon/rectal, and lung cancer. Distribute booklet on Age-Appropriate Cancer Screenings. 	<ul style="list-style-type: none"> Number of screenings performed. Number of abnormal screenings identified and referred for additional testing. Number of individuals screened for at least one cancer. 	<ul style="list-style-type: none"> Increased number of cancer screenings. Increased number of patients diagnosed early for better outcome.

GOAL #2

Improve the life of those diagnosed with cancer.

IMPACT

(1) Increased number of education events at AHN hospitals; (2) increased number of patients accessing services provided by cancer support programs.

STRATEGIES AND ACTION STEPS CANCER – GOAL #2

Strategies	Action Steps	Measure	Impact
1. Increase the volume of patients participating in programs that help people dealing with a cancer diagnosis and the challenges related to treatment	<ul style="list-style-type: none"> Promote Cancer Care Center's Cancer Support Group Promote The Look Good Feel Better Promote AHN Cancer Institute has started pre-chemo treatment visits for all patients undergoing chemotherapy at the Jefferson Hospital. Partners with Our Clubhouse, to offer Living Life Post Cancer Treatment. Partner with the American Cancer Society to promote a Free Wig Salon Provide Satchels of Caring for cancer patients. Provide free nutrition consultation to oncology patients. Engage an oncology social worker to offer free assistance to oncology patients with their social determinants of need. Utilize a nurse navigator to provide coordination of their care as patients go through their cancer journey. 	<ul style="list-style-type: none"> Number of programs Number of participants 	<ul style="list-style-type: none"> Increased number of cancer support events. Increased number individuals accessing services of support groups.

Community Need Obesity

Obesity is one of the largest contributing factors of preventable chronic conditions, including diabetes, hypertension, and stroke. Adults who are overweight are more likely to have high blood pressure and high cholesterol, both of which can lead to major health issues such as heart disease and stroke. As obesity rates are on the rise, so are chronic diseases. The CDC estimates that health care costs due to obesity and the chronic diseases that stem from obesity are estimated to be anywhere between \$147 billion to \$210 billion per year.¹²

The results of the CHNA show that obesity is one of the top three greatest health needs in the service area and education and proper disease management is a barrier to improving health outcomes. The following strategies will be implemented by the staff of Jefferson Hospital in order to increase knowledge about the risks of obesity and to increase access to obesity management resources.

¹² "The Healthcare Costs of Obesity." *The State of Obesity*.



GOAL

Reduce rate of obesity in the service area.

IMPACT

(1) Increased number of children educated on physical activity; (2) increased number of people enrolled in physical activity programs; (3) increased number of community events; and (4) increased opportunities for physical activity and nutrition.

STRATEGIES AND ACTION STEPS OBESITY

Strategies	Action Steps	Measure	Impact
1. Collaborate with local school, after school program, and pediatric practices to encourage children to become more active.	<ul style="list-style-type: none"> Work with local schools/ after school program to implement CATCH® Kids Club (NIH program) or similar evidence-based curriculum. 	<ul style="list-style-type: none"> Number of children enrolled in programs. Number programs offered. 	<ul style="list-style-type: none"> Increased awareness of healthy behaviors for children grades K-5.
2. Implement a program to reduce obesity in adults.	<ul style="list-style-type: none"> Offer Eat Healthy, Be Active Community Workshops (Office of Disease Prevention and Health Promotion program) or similar program. Collaborate with Venture Outdoors or similar programs to get people active. 	<ul style="list-style-type: none"> Number of community-based education events. Number of participants. Number of activities. 	<ul style="list-style-type: none"> Increased number of community-based events on obesity. Increased number of opportunities for physical activity, education, and nutrition. Increased number of people engaged in activities to reduce obesity.
3. Improve health literacy on issues related to obesity.	<ul style="list-style-type: none"> Establish a Speakers Bureau to provide education to community organizations on topics such as nutrition, diabetes, and exercise. 	<ul style="list-style-type: none"> Number of programs provided Number of participants 	<ul style="list-style-type: none"> Improved ability to obtain, process, and understand health information needed to make informed health decisions.
4. Offer support to individuals working on weight management.	<ul style="list-style-type: none"> Offer a monthly support group for people to share personal experiences, feelings, and coping strategies on weight management. 	<ul style="list-style-type: none"> Number of programs provided Number of participants 	<ul style="list-style-type: none"> Fill the gap between medical treatment and emotional support for those with weight management challenges.



CONCLUSION

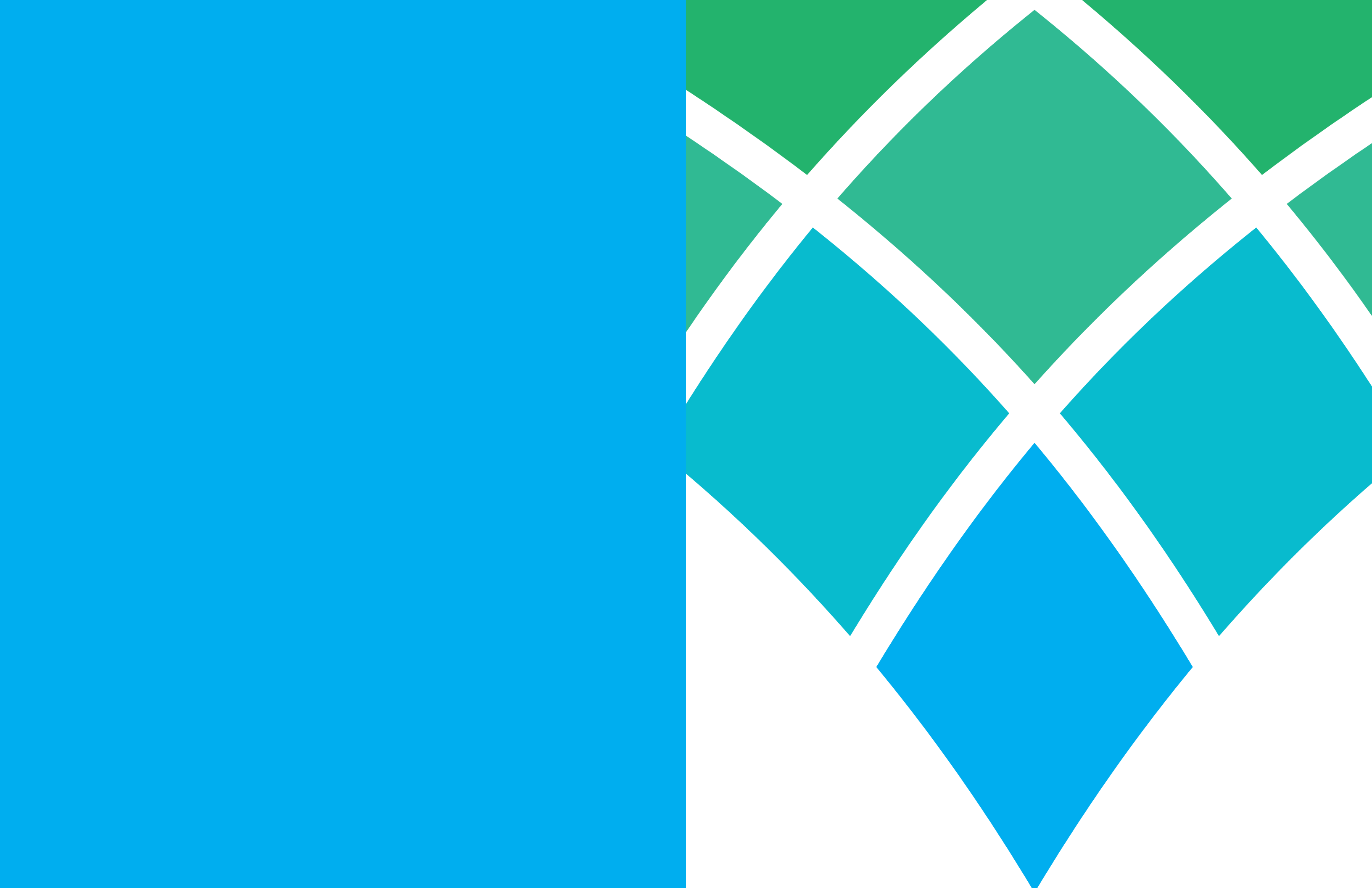
This CHNA Implementation Strategy Plan defines Jefferson Hospital's commitment to the community, documents how the strategies and goals will meet the identified community needs, and ensures that the results of the assessment and its impact on the health of the community are being reported and communicated. Each community strategy and action initiative has a set of measurable objectives and is aligned with the 2018-2019 CHNA priorities. Evaluation and progress on the implementation of these initiatives including updates on the measurable outcomes will be conducted and documented periodically over the next three years.

The hospitals of the Allegheny Health Network will continue to work to close the gaps in health

disparities and continue to improve health services for residents by leveraging the region's resources and assets; while existing and newly developed strategies can be successfully employed. The collection and analysis of primary and secondary data armed the steering committee and hospital teams with sufficient data and resources to identify key health needs. Local and regional partners understand the CHNA is an important building block towards future strategies that will improve the health and well-being of residents in their region. Jefferson Hospital will continue to work closely with community partners, as this implementation strategy plan is the first step to an ongoing process to increase access to health care services, address behavioral health issues, and improve health outcomes related to chronic disease.

Through collaboration with community partners, other AHN hospitals, and AHN Institutes, Jefferson Hospital will complete the necessary action and implementation steps of newly formed activities or revise strategies to assist the community's residents. The available resources and the ability to track progress related to the implementation strategies will be measured over the next three years.

Upon adoption of the CHNA Implementation Strategy Plan by the hospital board of directors, Jefferson Hospital is compliant with IRS regulations as outlined by The Patient Protection and Affordable Care Act.





Allegheny Health Network

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Hospital**

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