Holy Redeemer Hospital
2019 Community Needs Assessment Implementation Plan

Holy Redeemer Hospital's (HRH) Implementation Plan explains how HRH will address health needs identified in their 2019 Community Health Needs Assessment (CHNA). The action plans for the identified health needs will include both existing programs as well as new strategies, with a focus on collaborating with other organizations. This document will also explain why HRH cannot address all the needs identified in the CHNA. It is expected that this document will be subject to ongoing revision and enhancement as appropriate and needed.

I. Prioritizing Identified Needs

Holy Redeemer Hospital participated in a collaborative to complete the 2019 CHNA, participating with local non-profit hospitals and health systems, the Philadelphia Department of Public Health (PDPH), other health departments, and the Health Care Improvement Foundation (HCIF) for the Southeastern PA (SEPA) region, with specific focus on Bucks, Chester, Montgomery, and Philadelphia counties. The completed CHNA can be found on Holy Redeemer Health System's website.

Similar to its prioritization process with the 2013 and 2016 CHNAs, HRH's CHNA Steering Committee met and discussed each identified need from the collaborative CHNA, including the impact of this need on the community, what it will take to make an impact on the need, the ability of Holy Redeemer to make an impact, and what resources and collaboratives are already available in the community. Committee members again chose three criteria on which to base prioritization of the identified needs. These criteria included: 1) magnitude of the problem, 2) alignment with Holy Redeemer's strategic plan, and 3) availability of Holy Redeemer resources to make an impact.

The prioritization process resulted in the identification of the following needs which will be addressed in Holy Redeemer's Implementation Plan for 2019-2021.

- Chronic Disease Prevention
- Behavioral Health Diagnosis and Treatment
- Substance/Opioid Use and Abuse
- Maternal Morbidity and Mortality
- Access to Affordable Specialty Care
- Food Access and Affordability

II. Needs That Will Not be Addressed

There were needs identified in the collaborative CHNA that Holy Redeemer is choosing not to address as priorities. While important to the community and the hospital, they were not chosen based on the prioritization process and the limited availability of resources. Holy Redeemer does perform many activities that meet some of the identified needs of the community for these priorities. Some of those activities include transitional housing for women and children, housing modifications through our home health division, having a language line and translated surveys for patients who do not speak English, education of the staff on culturally appropriate healthcare, and many others. In addition, some of these needs are already provided by other community organizations.

Following are the needs identified in the CHNA that were not identified as priorities in Holy Redeemer's 2019 Implementation Plan after the prioritization process and because of limited resources. They will be addressed when resources, such as partnerships or grant opportunities, are available.

- Access to Affordable Primary/Preventive Care
- Affordable and Healthy Housing
- Community Violence
- Healthcare and Health Resource Navigation
- Homelessness
- Linguistically and Culturally Appropriate Healthcare
- Neighborhood Conditions (e.g. Blight, Greenspace, Parks/Recreation, etc.)
- Racism and Discrimination in Healthcare Settings
- Sexual and Reproductive Health
- Socioeconomic Disadvantage (Income, Education and Employment)

III. Action Plans

In addition to current activities being performed, the following details some initiatives that HRH will implement with the goal of making improvements to the health of its community.

Chronic Disease Prevention					
Situation	**Activities**	**Inputs/Resources**	**Collaborations**	**Lead**	**Metrics**
	What are the main things the project will do/provide?	*What resources will be used to support the project?*	*Who will we work with on implementing the project?*	*Person responsible*	*What results should follow?*
Overall rates of cardiovascular disease (CVD) related chronic disease continues to rise. Premature CVD deaths are 2-3 times higher in Philadelphia and the surrounding counties – related to higher rates of smoking, obesity and hypertension largely driven by higher rates of poverty. Smoking rates in Philadelphia are far higher than the national average. Vulnerable populations include African-Americans, Latinos, immigrants, individuals/families with low incomes. See Maternal Morbidity and Mortality for additional methods of chronic disease prevention from prenatal to postpartum care.	Organize the Healthy Kids Running Series a 5 week running program for ages 2-13 twice a year.	Staff time to set up the races Volunteers to help with running the program Give away items	-Healthy Kids Running Series -Organizations or hospital departments to provide healthy living information -Organizations as sponsors	Rebecca Binder, Marketing	Number of kids participating in the program
	Establish a Healthy Cafeteria Committee responsible for improving food presentation, increasing healthy options and education of staff all to promote healthy eating for staff and community members who use the cafeteria. Research continued participation in Good Food Healthy Hospital.	Staff time Resources needed for identified programs or events	Food vendor Food Fit Philly	John Ward, Nutrition Mallory Peterson, Nutrition	To be determined based on the resulting project
	Nutrition & diabetes education to outpatients (both group and one-on-one) and employees, nutrition care to inpatients and St. Joseph's Manor residents, health fairs, St. Hilary School program (2nd graders, 6 classes on health eating).	Staff time to provide education Materials Location to hold events	Organizations with Health Fairs St. Hilary School Divisions within health system Physicians	Mallory Peterson, Nutrition	Number of people counseled
	Continuation of the Trim-a-Weigh program which combines fitness and food counseling for people who want to lose weight.	Staff time to provide services Materials Location to hold exercise and nutrition classes		Bob Catalini, Fitness Center Mallory Peterson, Nutrition	Number of people who participate

Chronic Disease Prevention (continued)				
Activities	**Inputs/Resources**	**Collaborations**	**Lead**	**Metrics**
What are the main things the project will do/provide?	*What resources will be used to support the project?*	*Who will we work with on implementing the project?*	*Person responsible*	*What results should follow?*
Investigate implementation of a Cardiac Rehab program	Staff time to develop program Resources and equipment needed for the program	Physicians	Rehabilitation Department Bob Catalini, Fitness Ctr	Implementation of the program Number of people who participate
Provide programs which benefit community members to eat better, exercise and improve mental well being.	Staff time to provide the program Location to hold programs Materials	Simplex Nutrition Fitness Center Various partners to provide classes	Various Departments	Number of people who participate Number of programs
Smoking Cessation – Train two staff members to be certified in smoking cessation classes. Implement free smoking cessation classes 4 to 6 times a year. Participate in the Great American Smokeout. Continue with lung screening program for at risk community members.	Staff time to develop and market programs Staff time to counsel Marketing materials Smoking class materials Lung screening diagnostics	American Cancer Society Physicians	Smoking Cessation Coord Donna Miller, Cancer Center Coord & Research Asst to lung screening	Number of people who attend classes and participate in programs Number of community members screened for lung cancer
Health Screenings – Provide screenings for at risk populations, collaborating with organizations and community groups. Going out into the community with screenings as often as feasible.	Staff time to organize screenings Staff and physician time Screening cost for people with no insurance	Potential partners include community groups, insurance co, businesses, schools, churches, Healthy Women program, American Cancer Society, S. Firehouse event, among others	Donna Miller, Cancer Center	Number of screenings performed Number of people screened
Community events and walks – Hold events and walks with a focus on education about healthy living including obtaining screenings and prevention of diseases, targeted to at risk populations and conditions	Staff time to organize community events Staff time participating at community events Cost of materials Marketing efforts	Potential partners include community groups, businesses, schools, churches, American Cancer Society, Ladies of Port Richmond, among others	Donna Miller, Cancer Center Marketing Department	Number of community members who participated Number of events
Utilize Holy Redeemer public relations documents and stories, as well as social media outlets, to educate community members about healthy living behaviors.	-Staff time -Materials for print publications & cost of obtaining mailing lists -Other resources to be determined based on initiatives	Various organizations, clinicians and physicians who can contribute information to the various articles, media and social media posts	Mary Anna Rodabaugh, Marketing	Number of articles, posts, etc.

Behavioral Health Diagnosis & Treatment					
Situation	**Activities** *What are the main things the project will do/provide?*	**Inputs/Resources** *What resources will be used to support the project?*	**Collaborations** *Who will we work with on implementing the project?*	**Lead** *Person responsible*	**Metrics** *What results should follow?*
1 in 5 adults has a depressive disorder. Undiagnosed and untreated conditions like depression, anxiety and trauma-relation conditions result in: High utilization of emergency departments, particularly among youth, for mood and depressive disorders; persisting rates of suicide, particularly among men; substance us and abuse. Significant lack of community based, integrated and/or mobile behavioral health services. Vulnerable populations: individuals living in poverty, and those experiencing homelessness or housing insecurity; youth and young adults; older adults; racial and ethnic minorities, immigrants and refugees; and LGBTQ+ people.	Continue to expand training for clinical and non-clinical staff to improve their ability to identify behavioral health conditions and manage crises.	- Staff time to identify needs, identify training options and perform training - Cost of training and training materials - Training space & time	Philmont Guidance Center	Anne Catino, CNO	Pre and post knowledge tests Number of staff trained Other metrics as appropriate
	Continue to add therapists to current physician offices with co-located behavioral health specialists. Expand to new physician office locations and add additional appointment hours.	-Staff time to develop and implement the program - Office space and materials - Behavioral Health specialists - Training of staff to utilize specialists	Primary care physician practices Philmont Guidance Center	Susan Horowitz, Care Transitions	Number of physician practices with a co-located behavioral health specialist Number of patients assisted
	Evaluate implementing an imbedded model for behavioral health specialists in the physician practices.	-Staff time to develop and implement the program - Office space and materials - Behavioral Health specialists - Training of staff to utilize specialists	Primary care physician practices Philmont Guidance Center	Susan Horowitz, Care Transitions	Number of physician practices with an imbedded behavioral health specialist Number of patients assisted
	Implement the suicide risk Columbia Suicide Scale in all areas of the hospital. Includes training of staff and physicians on the screening and resources available.	- Staff time to identify needs, identify training options and perform training - Cost of training and training materials - Training space & time	Philmont Guidance Center	Anne Catino, CNO	Number of staff members trained Number of patients identified and referred
	Investigate working with area school security forces to train them to improve their ability to identify behavioral health issues and manage crises. Focus on de-escalation trainings.	- Staff time to identify needs, identify training options and perform training - Cost of training and training materials - Training space & time	Philmont Guidance Center Area schools	Daniel Hartman, MD, Medical Director Bruce Rice, Director	Number of security personnel trained

	Behavioral Health Diagnosis & Treatment (continued)				
	Activities *What are the main things the project will do/provide?*	**Inputs/Resources** *What resources will be used to support the project?*	**Collaborations** *Who will we work with on implementing the project?*	**Lead** *Person responsible*	**Metrics** *What results should follow?*
	Investigate a lecture or lecture series for the community on the topic of behavioral health potentially including depression, suicide, anxiety and other topics.	- Staff time to identify needs, identify training options and perform - Cost of lecture and training materials - Training space & time - Marketing resources	Philmont Guidance Center Physicians and Behavioral Health specialists	Susan Hurowitz, Care Transitions	Number of presentations Number of people attending
	Continue collaboration with the COACH Collaborative, implementing appropriate initiatives that will benefit the community.	-Staff time and travel expenses to attend meetings, provide information and develop initiatives	Includes hospitals, behavioral health hospitals, health department and other community representatives	Barbara Tantum, Planning Behavioral Health staff	Metrics developed for specific initiatives
	Utilize Holy Redeemer public relations documents and stories, as well as social media outlets, to educate community members about behavioral health.	-Staff time -Materials for print publications & cost of obtaining mailing lists -Other resources to be determined based on initiatives	Various organizations, clinicians and physicians who can contribute information to the various articles, media and social media posts	Mary Anna Rodabaugh, Marketing	Amount of publications specific to behavioral health

Substance/Opioid Use and Abuse					
Situation	**Activities** *What are the main things the project will do/provide?*	**Inputs/Resources** *What resources will be used to support the project?*	**Collaborations** *Who will we work with on implementing the project?*	**Lead** *Person responsible*	**Metrics** *What results should follow?*
Drug overdose deaths have tripled and are the leading cause of death among young adults (ages 18-34) in the region. Increases in infectious illnesses like HIV and Hepatitis C, neonatal abstinence, and homelessness. Geographic disparities across the region.	Increase awareness of physicians and other health care workers about the best practices of treating patients with opioid addictions.	- Staff time to identify needs, identify training options and perform training - Cost of training materials - Training space & time	Physicians	Avrahom Gurwitz, MD	Number of people who attend a presentation
	Open a subloxone clinic which will provide medication and therapy to people addicted to opioids.	Staff time, location, clinical staff, medications, and other services	Physicians Opioid and substance abuse organizations	Avrahom Gurwitz, MD	Number of people who use the clinic
	Investigate the opening of a program for prenatal and postpartum women who are addicted to opioids, using a trauma informed approach. Provide support for NAS babies and connection to supportive services for the mothers and families. (See Maternal Morbidity & Mortality)	Staff time to develop the program Location for program Staff time to deliver services Materials for education and training Other resources to be determined	Physicians Organizations to provide supportive services Opioid and substance abuse organizations Other partners to be determined	Anne Catino, RN	Number of women who participate in the program Further metrics to be determined as the project is defined
	Continue multiyear project to institute a warm handoff program in the Emergency Department, providing a connection for people with addictions to treatment.	-Staff time -Materials for print publications & cost of obtaining mailing lists -Other resources to be determined based on initiatives	Hospital Association of Pennsylvania Treatment facilities	Anne Catino, RN, CNO Dominica Leisey, RN, Nurse Manager	Number of patients referred for treatment Number of patients who connected to treatment
	Continue education of the community on the appropriate use of opioids.	- Education materials - Signs/handouts - Resources to develop ancillary materials	Potential collaborations include physicians, other clinical staff, EMS, county health departments, various community organizations	Dominica Leisey, RN, Nurse Manager	
	Utilize Holy Redeemer public relations documents and stories, as well as social media outlets, to educate community members about substance/opioid abuse.	-Staff time -Materials for print publications & cost of obtaining mailing lists -Other resources to be determined based on initiatives	Various organizations, clinicians and physicians who can contribute information to the various articles, media and social media posts	Mary Anna Rodabaugh, Marketing	Amount of publications specific to behavioral health

Maternal Morbidity & Mortality					
Situation	**Activities**	**Inputs/Resources**	**Collaborations**	**Lead**	**Metrics**
	What are the main things the project will do/provide?	*What resources will be used to support the project?*	*Who will we work with on implementing the project?*	*Person responsible*	*What results should follow?*
Late access or inadequate access to prenatal care is 2 times higher in lower-income communities, up to 50% of pregnancies in some communities. Often related to preexisting chronic conditions including obesity, hypertension, diabetes and CVD. African-American mothers are 3 times more likely to die from pregnancy-related complications. Fatal drug overdoses have caused a spike in maternal deaths not related to pregnancy.	Investigate the opening of a program for prenatal and postpartum women who are addicted to opioids, using a trauma informed approach. Provide support for NAS babies and connection to supportive services for the mothers and families. (SEE Opioid/ Substance Abuse)	Staff time to develop the program Location for program Staff time to deliver services Materials for education and training Other resources to be determined	Physicians Organizations to provide supportive services Opioid and substance abuse organizations Other partners to be determined	Anne Catino, RN	Number of women who participate in the program Further metrics to be determined as the project is defined
	SafeCare Project – Work with partners to implement this program, providing medical, social and behavioral health resources for women and their families at risk from pre-pregnancy through postpartum .	Staff time to develop the project with the partners Other resources to be determined with potential need from IT and materials	Bucks, Montgomery & Philadelphia county DOH Various medical and social community organizations Physician practices	Julie Greenfield & Dottie Fesmire	To be determined as the project is defined
	Connect Medicaid population to programs and services for opioid/substance abuse and other needs earlier in pregnancy.	Staff time to develop the project with the partners Other resources to be determined with potential need from IT and materials	Health Partners Maternity Care Coalition Physicians	Julie Greenfield & Dottie Fesmire	To be determined as the project is defined
	Participant with the PA Perinatal Quality Collaborative and other organizations to combat hypertension, postpartum hemorrhage, addictions and other clinical conditions which increase morbidity and mortality.	Staff time to develop the project with the partners Other resources to be determined with potential need from IT and materials	PA Perinatal Quality Collaborative Montgomery County Maternal & Early Childhood Council CA Maternal Quality Care Collaborative	Julie Greenfield & Dottie Fesmire	To be determined as the projects are defined
	Co-locate obstetric, pediatric urgicare with lab and diagnostic services in northeast Philadelphia. (SEE Access)	Staff time Physicians & clinical staff Office furniture & supplies Diagnostic and lab services and equipment	Physicians Urgicare vendor	Ryan Mee & HRPAS division	Volume of patients for each services

Access to Affordable Specialty Care					
Situation	**Activities**	**Inputs/Resources**	**Collaborations**	**Lead**	**Metrics**
	What are the main things the project will do/provide?	*What resources will be used to support the project?*	*Who will we work with on implementing the project?*	*Person responsible*	*What results should follow?*
Financial and logistical barriers to specialty care for uninsured people and those with high co-pays and deductibles. Referrals from safety net providers (e.g. FQHCs) are challenging. Lack of care coordination, affordability and appointment availability (e.g. long wait times) result in patients not seeking needed specialty care and use of emergency departments for acute needs.	Provide transportation options for patients who need them. In Cancer Center track patients who need transportation and why to determine additional means of transportation needed.	Staff time to provide information, set up transportation and track need Financial resources	Patriot van transportation Uber Taxi Services American Cancer society Other organizations	Social Worker in Cancer Center	Number of patients who receive transportation services
	Addition of social worker in Cancer Center responsible for identifying social determinant needs of patients and provide resources.	Staff member Staff time to id needs of patients and resources	Various social service organizations to meet needs of Cancer Center patients	Donna Miller, Cancer Center	Number of patients who are identified as needing resources and receive the resources
	Increase number of patient navigators in Cancer Center and addition of a patient intake coordinator to help coordinate the clinical care of patients.	Staff members Staff time	Physicians	Donna Miller, Cancer Center	Number of patients who are helped with navigation of care Number of new patients who are helped with coordination of care
	Implementation of a single Electronic Medical Record (EMR) in the Cancer Center and additional areas which will improve access and coordination of care for oncology patients.	EMR IT staff time Staff time to implement	EMR vendor Physicians	Donna Miller, Cancer Center	Implementation of the EMR
	Addition of a Financial Counselor to assist with insurance, referrals and payments in the Cancer Center.	Staff member	Finance and insurance companies	Donna Miller, Cancer Center	Number of patients helped with financial counseling
	Co-locate obstetric, pediatric urgicare with lab and diagnostic services in northeast Philadelphia. (SEE Maternity Morbidity and Mortality)	Staff time Physicians & clinical staff Office furniture & supplies Diagnostic and lab services and equipment	Physicians Urgicare vendor	Ryan Mee & HRPAS division	Volume of patients for each services
	Improve the experience of patients whose primary language is not English.	Staff time Signs Materials	Language Line Translation Services	Donna Miller	Percent of appropriate signs and materials translated

Food Access & Affordability					
Situation	**Activities**	**Inputs/Resources**	**Collaborations**	**Lead**	**Metrics**
	What are the main things the project will do/provide?	*What resources will be used to support the project?*	*Who will we work with on implementing the project?*	*Person responsible*	*What results should follow?*
Access to and affordability of healthy foods is a driver of poor health in many communities. Low access is largely driven by poor food environments which lack grocery stores or other sources of fresh food and produce, and are saturated with fast food outlets, convenience and corner stores, and other sources of unhealthy, often less expensive food option. In communities where food insecurity is highest, the food environment is the poorest.	Continue in partnership with the COACH collaborative to address food access in vulnerable populations which includes food insecurity screening, referral process development and a menu of other interventions. Advocate for legislation that supports access to food and supports.	Staff time to participate on the collaborative, attending meetings and participating in follow up activities	COACH which includes hospitals and other community and government organizations	Barbara Tantum, Planning	Implementation of new and improved food insecurity projects
	Investigate the implementation of food insecurity screening and referral in various areas including the Emergency Department, physician practices and Cancer Center.	Staff time in the development of the program and education of staff on the process. Potential IT staff time for the addition of a tracking measurement. Materials needed for the program	COACH Physician practices Community and government organizations (referral process)	Barbara Tantum, Planning Dept. heads	Number of people/families identified Number of referrals
	Continue work of existing food pantries in PA, NJ and the Green Light food pantry at Drueding. - Expand the amount of fresh produce available at the food pantries. - Investigate providing more self choice options. - Implement an electronic intake system for better tracking of demographics and needs. - Add wrap around services at the pantries such as flu shots, etc.	Staff time to develop programs IT support Electronic intake system Wrap around services	COACH Philabundance and other food related community organizations Grocery Stores Community Gardens	Josh Jenkins, Mission Integration	Number of people/families assisted in each program