READING HOSPITAL
Community Health Implementation Plan
2016

The core responsibility of Reading Hospital is to protect, improve and sustain the wellness of the community we serve. Carrying out that responsibility means reinvesting resources in the community in many forms – from providing free health services, to screenings and immunizations, to organizing the community to address emerging health needs, to employees donating their time to Berks County non-profit organizations. Reading Hospital remains committed to engaging our community partners to make Berks County residents happier and healthier.

"Let's make a commitment to the residents of Berks County. Let's commit to using this data to make sustainable and measured change in our community."

- Key Informant

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INTRODUCTION

Reading Hospital is a 647-bed acute care hospital located in West Reading (Berks County), Pennsylvania. Berks County (2015 Pop. 415, 271) was defined as the community for the purposes of this assessment. Berks County includes urban, suburban and rural areas with distinct populations and health resources. The population of Berks County is relatively homogeneous overall, with the exception of the City of Reading, where the majority of residents are Latino.

Reading Hospital partnered with Berks County Community Foundation, United Way of Berks County, Berks Community Health Center and Penn State Health St. Joseph to complete the Community Health Needs Assessment (CHNA). Franklin and Marshall College and Holleran Consulting served as research partners. Together, the most prevalent community health needs and underlying social determinants were identified. The graph below depicts the research methodology and Reading Hospital's implementation planning process.

Focus Group

Key Informant Survey

Health Summit

Behavioral Risk Factor Survey

Secondary Data Analysis

Organizational Assessment

County Health Ratings Data

Social Determinants Mapping

Organizational Priorities

Berks County CHNA Community Health Priorities

Community Health Implementation Plan

Access to Care | Obesity | Mental Health | Addiction

- **Goals:** Where do we want to be in 5+ years?
- **Objectives:** What can we accomplish in three years or by the next CHNA?
- **Tactics:** What must be accomplished within a one-year period?

Reading Hospital

Demonstrated Impact

- **Community Benefit Report**

COMMUNITY HEALTH NEEDS ASSESSMENT SUMMARY

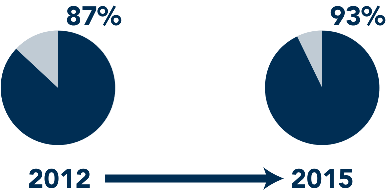
The objective of the CHNA was to provide the following necessary information:

1. Identify key health issues/concerns facing the residents of Berks County.
2. Identify communities and specific groups within these communities experiencing health disparities.
3. Further identify contributing factors that create both barriers and opportunities for these populations to live healthier lives.

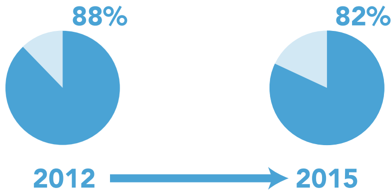
Access to Health

Access indicators for Berks County are generally favorable, with most residents reporting they have healthcare coverage and a personal physician. Still, more than two out of five residents had some economic hardships, around one in 11 skipped medical treatment due to cost and around one in nine did not fill a prescription due to cost in the past year.

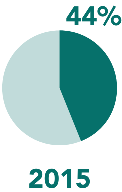
HAS HEALTHCARE COVERAGE



HAS A PERSONAL PHYSICIAN

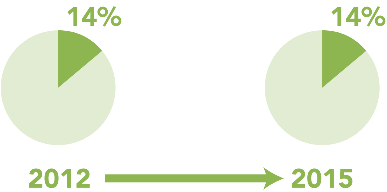


ECONOMIC HARDSHIP *(one or more)*

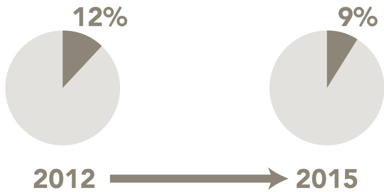


2015

DID NOT FILL PRESCRIPTION BECAUSE OF COST



DID NOT RECEIVE HEALTHCARE IN PAST YEAR BECAUSE OF COST

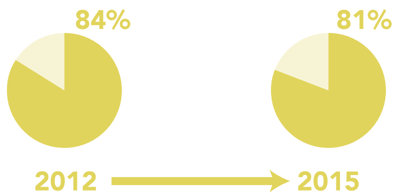


*New indicator.

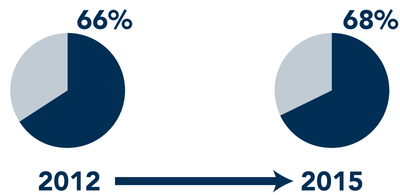
Behavioral Risk Factors

Behavioral risk indicators show that few residents exercise regularly and even fewer eat three servings of vegetables every day. In fact, twice as many eat fast food three or more days a week. They also show that more than one in six residents is a current smoker and that around two in three residents are overweight or obese.

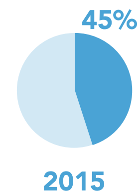
PARTICIPATED IN PHYSICAL ACTIVITIES OR EXERCISE IN PAST MONTH



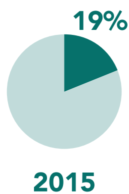
BODY MASS INDEX CATEGORY (OVERWEIGHT AND OBESE)



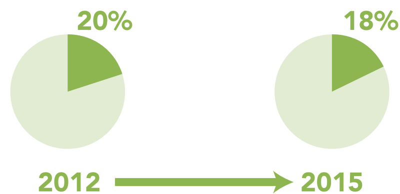
STRENGTH TRAINING IN PAST MONTH



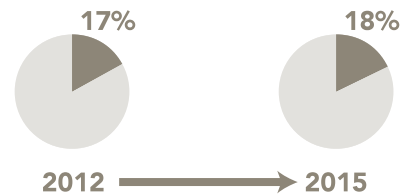
EXERCISED 30 MINUTES ON FIVE DAYS IN PAST WEEK



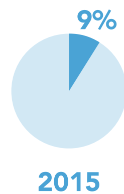
SMOKING BEHAVIOR (REGULAR SMOKER)



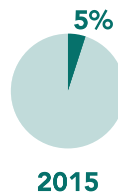
BINGE DRINKING BEHAVIOR



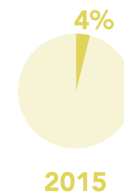
ATE FAST FOOD THREE OR MORE TIMES IN PAST WEEK



USED ILLEGAL DRUGS IN PAST YEAR



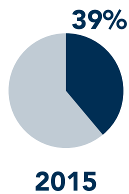
CONSUMED THREE SERVINGS OF VEGETABLES DAILY



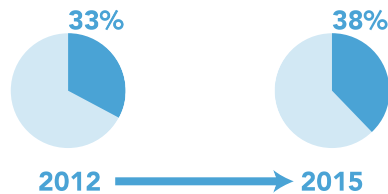
Health Conditions

Rates of health conditions such as diabetes, heart conditions, breathing conditions and cancer are not comparatively high, but a plurality of residents have high cholesterol and high blood pressure and about one in five has been diagnosed with either an anxiety or depressive disorder.

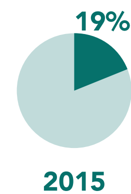
HAS HIGH CHOLESTEROL



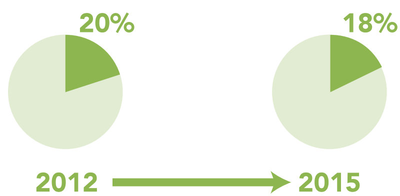
HAS HIGH BLOOD PRESSURE



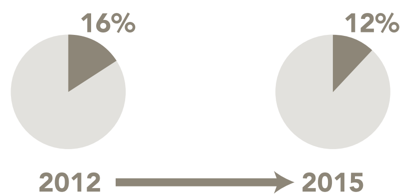
HAS AN ANXIETY DISORDER



HAS A DEPRESSIVE DISORDER

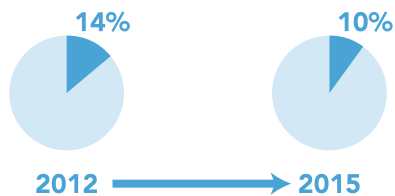


HAS ASTHMA

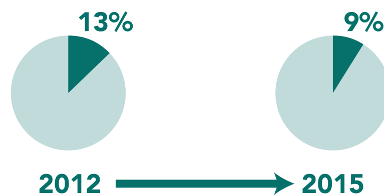


HAS EVER HAD CANCER

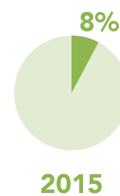
RESPONDENT IS DIABETIC



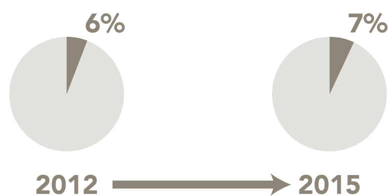
TOLD HAS HEART DISEASE, HEART ATTACK OR STROKE



PHQ-8 CURRENT DEPRESSION INDICATOR-CURRENTLY DEPRESSED



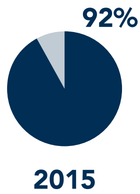
EVER HAD COPD, EMPHYSEMA OR CHRONIC BRONCHITIS



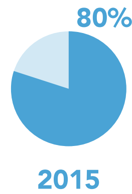
Prevention Behaviors and Context

Over half of residents exhibited some depressive symptoms, and around two in five say their normal activities have been limited by their health.

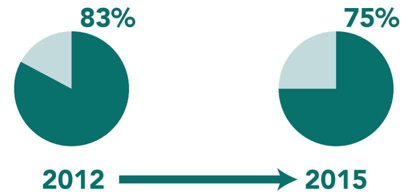
GETS NEEDED SOCIAL AND EMOTIONAL SUPPORT



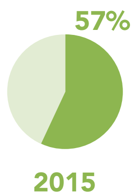
HAS EVER HAD BLOOD CHOLESTEROL CHECKED



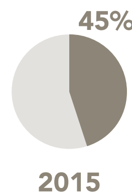
VISITED DOCTOR FOR ROUTINE CHECKUP IN THE PAST YEAR



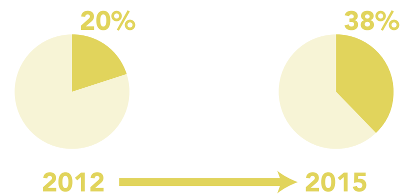
ONE OR MORE DAYS WITH DEPRESSIVE SYMPTOMS IN PAST TWO WEEKS



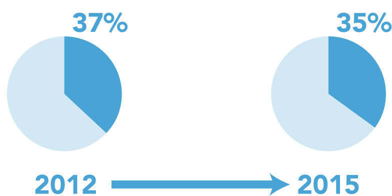
HAS HAD FLU SHOT IN PAST YEAR



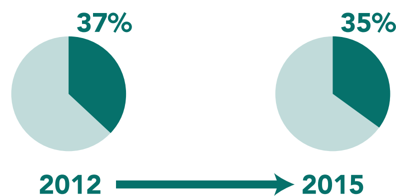
POOR HEALTH LIMITED PARTICIPATION IN NORMAL ACTIVITIES IN PAST MONTH



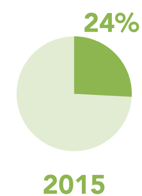
AT LEAST ONE DAY PHYSICAL HEALTH WAS NOT GOOD IN PAST MONTH



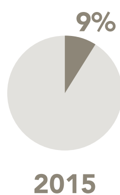
AT LEAST ONE DAY MENTAL HEALTH WAS NOT GOOD IN PAST MONTH



STRESSED ABOUT PAYING RENT OR MORTGAGE

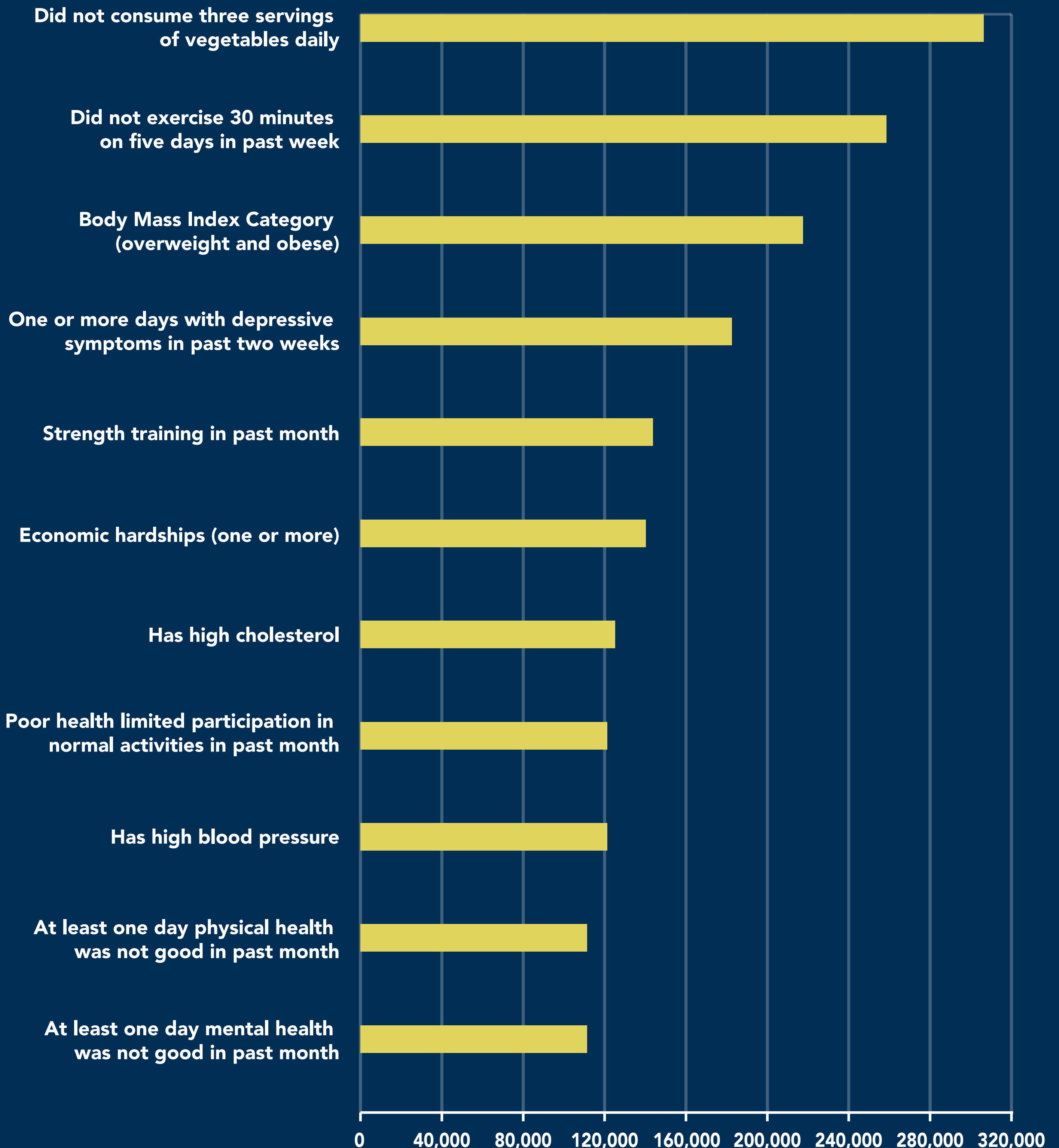


AVOIDS OR NEVER USES HEALTHCARE SYSTEM



Population Totals

The estimates produced by the Behavioral Risk Factor survey provide a tool for translating the proportion of citizens with a specific characteristic into an estimate of the number of adult residents with that characteristic. In aggregate terms, diet, exercise, obesity and mental health issues affect large numbers of Berks County residents. In Berks County, more than 300,000 adults did not consume three vegetables each day, and more than 200,000 adults were overweight or obese. Additionally, more than 175,000 adults in the county experienced one or more days with depressive symptoms in the two weeks preceding the survey.



Demographics

The CHNA identifies the presence of numerous health disparities, i.e. gaps in access, conditions or behaviors that are larger for some demographic groups than for others. The area's health disparities, generally speaking, show clear patterns.

First, poverty is significantly associated with differential outcomes related to access to health venues, health conditions and prevention-related behaviors. Low-income or poor residents are more likely to have poor access to healthcare as well as asthma, mental health problems and money concerns.

Second, age is significantly associated with differential outcomes related to all indicator groups. Older residents are more likely to have better access to healthcare and have better rates on most prevention-related indicators. However, they are also more likely to have specific health conditions. Younger residents are more likely to have better rates for behavioral indicators, notably for overweight and obesity as well as physical activity, although they are more likely to smoke, drink and use illegal drugs. Race and ethnicity are also significantly associated with differential outcomes related to access to care and prevention behaviors.

Finally, although not direct measures of health, specific contextual factors that influence health and well-being appear as significant issues for the county. Berks County receives its poorest relative rankings for quality of life (which includes premature death, fair or poor health, poor physical and mental health days and low birth weight) and social and economic factors (which includes educational attainment, children in single parent households and injury deaths).

Health-Related Social Characteristics

A review of U.S. Census and other existing data about Berks County shows specific community needs related to housing, education and poverty. Census data show that housing affordability is a problem for many county residents; more than half (56 percent) of renters pay more than 30 percent of their incomes on rent and more than a quarter (26 percent) of homeowners pay more than 30 percent of their incomes on mortgage costs.

A second related need is improved educational attainment. Few county residents have post-secondary credentials; only 23 percent have a bachelor's degree or higher, and the rates of 18 to 24 year olds enrolled in college are below national and state rates. Moreover, only two in five (43 percent) three and four year olds are enrolled in pre-school, which is below state and national rates.

A third issue for county residents, which is likely related to the previous two, is poverty. A large portion of Blacks (28 percent) and Hispanics (40 percent) live in poverty, and one in seven households (15 percent) receive food stamp benefits. It is important to note that these demographic disparities are geographically concentrated and contribute to poor health outcomes and increased health risks.

To access the full 2015 Community Health Needs Assessment, visit: **www.readinghealth.org/CHNA**

KEY INFORMANT OVERVIEW

Key informants were invited to complete an online survey to gather a combination of quantitative ratings and qualitative feedback through open-ended questions. Key informants were defined as community stakeholders with expert knowledge, including public health and healthcare professionals, social service providers, non-profit leaders, business leaders, faith-based organizations and other community leaders.

Key informants were asked to rank the five most pressing health-related issues from a list of 13 focus areas identified in the survey. The issues of Substance Abuse/Alcohol Abuse, Overweight/Obesity, Mental Health/ Suicide, Diabetes and Access to Care/Uninsured were ranked as the top five health issues.

Key informants were also asked of those health issues mentioned, which one issue they felt was the most significant.

Rank	Key Health Issue
1	Substance Abuse/Alcohol Abuse
2	Overweight/Obesity
3	Mental Health/Suicide
4	Diabetes
5	Access to Care/Uninsured
6	Dental Health
7	Heart Disease
8	Cancer
9	Maternal/Infant Health
10	Tobacco
11	Sexually Transmitted Diseases
12	Stroke
13	Other

It was important to Reading Hospital and its partners to research health disparities and social determinants and incorporate those findings in the final report. Key influencers on health are listed below:

1. Poverty
2. Food insecurity
3. Housing stability
4. Limited opportunities for physical activity
5. Lack of access to primary and mental healthcare services
6. Lack of culturally and linguistically competent care

DETERMINING THE NEEDS TO BE ADDRESSED

Prioritization Session

Individuals representing both non-profit and for-profit organizations reviewed the results of the CHNA.

The following issues were identified and prioritized:

- Obesity
- Chronic Illness
- Mental Health
- Access to Care

The team eventually concluded that chronic illness could be addressed by focusing on reducing the percentage of overweight and obese individuals living in Berks County. In addition, the team felt strongly that our community would be best served if we focused on addressing the issue of addiction. After much thought and consideration, prioritization is as follows:

- Obesity
- Mental Health
- Addiction
- Access to Care

COMMUNITY HEALTH IMPLEMENTATION PLAN

Community Health Implementation Plan

Priority Area: Overweight and Obesity

Long Term Goals:
1) Reduce the number of overweight/obese residents.
2) Convene a community coalition of diverse stakeholders.

"I would consider obesity as one of the major issues with all its consequences (high blood pressure, high cholesterol and diabetes). I would recommend a campaign to reach out to the whole population with a persistent and penetrating message about a proper healthy lifestyle."

- Key Informant

Strategy	Target Population	Activity Description	Performance Measures	Resources/ Partners	RH Initiative	Community Initiative
1. Conduct an educational marketing campaign focusing on the importance of making healthy choices and highlighting evidence based programs.	Overweight/ obese residents in targeted zipcodes	**1.** Engage target population through sponsorship or provision of: education, cooking classes, demos, community screenings (blood pressure, BMI, cholesterol, etc.)	**Reach:** # of campaigns # of events # of people attending events **Outcomes:** # of people screened % of referrals after screening % followed through for follow up # of pounds lost *Self reported knowledge and awareness through pre and post surveys*	Community organizations		
	All residents	**2.** Develop a web presence that offers education and resource material. Develop a resource guide for distribution.	Website developed	Consultant		
		3. Develop healthy weight material to be distributed at every event.	Material developed and distributed	Consultant		
2. Promote implementation of workplace wellness programs.	Berks County Employers & Employees	**1.** Partner with the Chamber of Commerce to encourage Berks County employers to implement or enhance wellness programs.	# of WPW programs implemented or enhanced	Chamber of Commerce		
3. Increase access to healthy food.	All residents	**1.** Conduct a food security assessment.	Report completed and shared with community	Consultant		
		2. Support Penn St. Farmer's Market.	Sponsorship dollars	RH		
		3. Explore expansion of Farm Bucks Program.	Implementation of Farm Bucks match program	RH		
		4. Explore healthy food drives.	# of healthy food drives	RH, Community Organizations		
		5. Raise awareness of available assistance programs.	Print and web resources	Consultant		
4. Promote increased physical activity and exercise.	All residents	**1.** Expand and enhance the FITT program.	Increased FITT participants, additional FITT sessions	RH, Community Organizations		
		2. Promote community walking programs.	Increased # and communication of walking program	RH, Community Organizations		

Community Health Implementation Plan

Priority Area: Mental Health

Long Term Goals:
1) Increase access to and integration of mental health services.

"Our community would benefit from much needed access to mental/behavioral health in the community for all age groups." - Key Informant

Strategy	Target Population	Activity Description	Performance Measures	Resources/ Partners	RH Initiative	Community Initiative
1. Integrate mental health services with primary care.	Adult patients, PCP's	**1.** Develop CME training module to help PCP's and staff treat mild to moderate mental health issues.	# of CME's or training conducted	RH, RHPN		
		2. Develop appropriate referral process.	Implement new referral process	RH, RHPN		
		3. Explore the Community Health Worker module.	Submit CHW feasibility report	RH		
2. Improve access to mental health services.	All residents; vulnerable populations	**1.** Develop a process for target population to receive immediate care through methods telepsychiatry.	Implement telepsychiatry program	RH		
		2. Trial web based mental health therapies such as CBT in RHS employee population.	Implement CBT therapy program	RH		
3. Participate in a coalition to address the mental health of the community.	Diverse, community stakeholders	**1.** Develop an anti-stigma marketing campaign.	Reach: # of campaigns # of events # of people attending events	Consultant		
	Providers, stakeholders	**2.** Train key people in suicide prevention.	# of people trained	RH, Community Organizations		
		3. Explore the development of a crisis residential center.	Complete feasibility report	RH, Community Organizations		

Community Health Implementation Plan

Priority Area: Addiction

Long Term Goals:
1) Increase coordination and availability of services to treat addiction.

"Drug addiction is a major issue impacting mental health, crime, housing, employment, child welfare, physical well-being, etc. We've pushed the work onto the justice system but it needs to be handled as a health issue instead." - Key Informant

Strategy	Target Population	Activity Description	Performance Measures	Resources/ Partners	RH Initiative	Community Initiative
1. Support the development of community based services to reduce unnecessary hospitalization.	Addiction patients	**1.** Implement Community Based Care teams to aid in addiction recovery.	Create and deploy CBC teams	RH, Community Organizations		
		2. Explore creating a community-based pain management clinic.	Submit feasibility report	RH, Community Organizations		
		3. Coordinate discharge for addicted patients on Medical Service to allow appropriate treatment, reduce readmissions and reduce recidivism.	Reduction of readmission and recidivism	RH		
2. Convene a community learning network.	Relevant stakeholders	**1.** Partner with community agencies to provide additional support services to aid in addiction recovery.	Track utilization of referrals	RH, Community Organizations		
		2. Partner with community-based programs to provide support for patients a) With a dual diagnosis (of mental health disorder and addiction); b) Who need NA/AA support groups in Spanish; and c) Programs that combine Medication-Assisted Treatment with the Twelve Step approach used by NA/AA.	Track utilization of referrals	RH, Community Organizations		

Community Health Implementation Plan

Priority Area: Access to Care

Long Term Goals:
1) Decrease barriers to access healthcare.

> **"Cultural competency is so important in meeting the needs of our community. Until we address this issue and build stronger relationships with the community on healthy living and prevention care, things will not change."**
> ***- Key Informant***

Strategy	Target Population	Activity Description	Performance Measures	Resources/ Partners	RH Initiative	Community Initiative
1. Utilize GIS technology to identify subpopulations who are at risk for higher readmission rates, chronic conditions or diseases, and overlay with data sets to help support program development, placement of services and messaging.	High utilizers, vulnerable populations	**1.** Support the development of programs that deliver care to vulnerable populations. (ex. Street Medicine, Community Paramedicine)	Pilot programs transition into fully operational	RH, Community Organizations		
		2. Assess non-emergent ED use and develop strategies to reduce the use of emergency services. (ex. health coaches, community health workers, community partnerships)	Strategy developed and implemented	RH		
		3. Expand and promote programs that educate the community about careers in healthcare.	Create website and materials detailing educational opportunities	The Cleveland Clinic		
2. Improve cultural competence.	RH Staff	**1.** Explore opportunities to implement cultural competence training for providers and other healthcare employees for vulnerable populations such as LGBT, older adults, mentally ill, homeless, racial minorities and those that are low income.	Training is delivered to identified staff and provided	RH		
		2. Inventory the need for interpreting services at RHPN primary care offices and implement a plan to provide necessary services.	Recommendations submitted	RH		
3. Improve access for healthcare services.	High utilizers, vulnerable populations	**1.** Explore strategies to remove transportation barriers.	Recommendations submitted	RH		
		2. Analyze data to monitor how long Medicaid and Medicare (separately) patients wait to see an RHPN primary care physician.	Recommendations submitted	RH		

ADDRESSING OUTSTANDING ISSUES THROUGH COMMUNITY BENEFIT

Reading Hospital responds to priority health needs in many unique ways. In 2015, Reading Hospital provided:

- $61,040,310 unreimbursed Medicare
- $56,608,251 unreimbursed Medicaid
- $3,488,651 patient care community services. This includes:
    - Free flu shots
    - Cancer screenings
    - Medications
    - Medical equipment
    - Transportation assistance
- $696,395 community health education. This includes:
    - CPR training
    - Support groups
    - Worksite health education

Reading Hospital contributed $1,019,000 in direct support of local non-profit organizations that are qualified with specialized expertise to serve targeted populations. This organization will continue to support and encourage the development of programming that will address the remaining health needs identified. Our strategy will include strengthening existing partnerships and exploring new collaboration opportunities.

MOVING FORWARD

Reading Hospital felt strongly that community-wide implementation would require a coalition comprised of dedicated and diverse stakeholders. The graphic below portrays the recommended coalition composition.

Get Healthy Berks
Community Coalition

READING HOSPITAL INTERNAL INFRASTRUCTURE

In tandem with community-wide implementation, Reading Hospital has formed internal strategic planning teams focused on the identified key health issues. The graph below portrays the internal composition.

IMPLEMENTATION TIMELINE

Year 1 | November 2017

Year 2 | November 2018

Year 3 | November 2019

Marketing campaign will include:

- Farmer's Market Awareness
- Sugary Drink Avoidance
- Suicide Prevention Education

Year one will also include analyzing data regarding:

- Wait times for specific patient populations
- Availability of language assistance during night/weekend shifts
- Obese patients with chronic illness

READING HOSPITAL

READING HEALTH SYSTEM

Advancing Health. Transforming Lives.