Doylestown Health

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2019 Community Health Needs Assessment
Implementation Plan

Introduction

Doylestown Hospital completed a comprehensive Community Health Needs Assessment (CHNA) in June 2019, working with Public Health Management Corporation. The purpose was to gain information to:

- Gauge the health of the communities we serve
- Inform future strategy and planning efforts to meet identified needs gaps in programs and services

The CHNA addressed the geographic areas served by the hospital, as required in Section 501(r) of the Internal Revenue Code (Section 501(r)). The Doylestown Hospital Service Area, from which the majority of the hospital's admissions originate, is composed of 45 zip codes in Central Bucks and Eastern Montgomery Counties (detailed in the full Community Health Needs Assessment). The estimated total population of the hospital's service area in the 2010 census was approximately 371,362 in the primary service area and 441,771 in the secondary service area. The estimated population of Doylestown primary service area increased between 2010 and 2018 by 3%, while the Doylestown secondary service area population negligibly decreased by -0.2%.

A copy of the full 2019 Needs Assessment is published on the hospital's website at https://www.doylestownhealth.org/community

Summary of Community Health Needs

Poor health status can result from the interaction of challenging social, economic, environmental and behavioral factors, combined with a lack of access to care.

Overall, our service area has a higher socioeconomic profile than that of Pennsylvania as a whole. Education and median household income are higher than Bucks County, and substantially higher than the state of Pennsylvania. Access to care in our service area was also reported to exceed the Healthy People 2020 goal, as well as the average levels for the county and state experience.

Overall the Doylestown Hospital Service Area ranks higher on almost all the measured health metrics than the state of Pennsylvania and for Bucks County. There are a few exceptions, and several issues that while improved, remain a concern for our community.

(continued)

Based on our hospital's strengths and the outcomes of this needs assessment, we have prioritized five key areas for intervention during the next three-year period (FY 2019-2021):

1. **HEALTH BEHAVIORS**
2. **MENTAL HEALTH**
3. **SCREENINGS**
4. **OLDER ADULT HEALTH**
5. **ACCESS TO CARE**

Prioritizing Community Health Needs

While the overall health indicators compared favorably with local and regional norms, and the national Healthy People 2020 goals, the issues identified above were mentioned in the Assessment as potential areas for intervention and improvement.

Additionally, specific demographical community forums were held in conjunction with the assessment to identify priority health concerns for pediatric, general, and senior populations. On-going community forums will increase the community partnerships to strategically hone in on key health objectives to increase effectiveness and outcomes.

A system-wide strategic planning process took place in June 2013, which identified key strategic drivers toward the goal of remaining relevant and indispensable to our community and the marketplace. The following CHNA implementation plan is designed to work in conjunction with the strategic plan to meet identified gaps in our community.

As of July 2019, Doylestown Health adopted a reallocation of resources that created a unified approach in addressing the Community Health Needs Assessment. Through this reallocation process, a unified department; Strategic Innovations and Outreach was developed to executive all levels of the Community Health Needs in a directed focus to create consistency and efficiency throughout the health system. Through this team, collaboration among health system service providers will be coordinated to drive community health change.

There were some additional unmet needs mentioned in the CHNA that we will not address directly, because they are already being addressed by other health care providers, government services and/or other local health service agencies. Some of these unmet needs are also beyond the mission and potential for direct impact by our hospital.

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Priority Community Health Needs

Over the course over the next three years, the five key focus areas listed above which were identified in the 2019 CHNA will be core focus areas for the health system.

Focus Area 1: Health Behaviors

1. **Nutrition**

Method	Goal	Plan
Education	-Increase awareness of food impact to the whole body -Increase attendance on nutrition programs offered	A. Healthy cookbooks I. Associate Health and Wellness Program to lead development of healthy cookbook created by Doylestown Health staff and clinicians in year 1. Once developed, print and distribute at community and corporate events to promote healthy eating behaviors. B. Healthy eating on the go I. Associate Health and Wellness Program to develop a healthy meal service program for Doylestown Health Associates through a local partnership. Years 1-2 offer healthy meal services to Doylestown Health staff for those unable to meet the demanding needs of busy schedule, providing the option for local, wholesome pre-made meals. II. Evaluate effectiveness of internal program and identify opportunities for expansion in Doylestown Health patients and volunteer program. C. Sugar/Salt demonstration I. Bring interactive demonstrations, visually portraying appropriate amounts of healthy parameters of sugar and salt intake as designated by clinical oversite. Perform through year at outreach

		centers, community events, health fairs and corporate settings. On-going throughout 3 years. D. Increase education I. Provide seminars and educational programs in outreach centers, community and corporate events. Seminars to focus on healthy eating guidelines through non-processed foods and balanced lifestyles. On-going throughout 3 years. II. Collaborate with United Way Fresh Connect Program for low-income families through Doylestown Health registered dietitians to provide food, education and hands on recipes for food distribution. On-going throughout 3 years.
Screenings	Increase awareness of waist circumference, BMI and body fat percentage through screenings	E. Maximize community partnerships to offer onsite screenings. I. Community Screenings to be coordinated by outreach team through DH satellite offices, senior centers, & large community facing events. On-going throughout 3 years. II. Screenings to be set-up with corporate business clients through Workplace Wellness Solutions program to provide employee screenings and referrals back into provider networks. On-going throughout 3 years.
Resources	Connect to resources with access to healthy food	F. Expand lifestyle behavior change programs I. Expand Doylestown Health's "A Healthy Weigh" weight management program into other site locations through community and corporate promotion. Identify areas of opportunity through corporate client wellness programming. On-going throughout 3 years.

		II. Year 1 develop coaching programming to focus on all aspects for one on one health improvement, goal setting and self improvement.

2. **Physical Activity**

Method	Goal	Plan
Education	-Increase awareness of positive and negative health effects. -Increase awareness of correlation between extra body weight and specific disease states.	A. Increase programs regarding importance and correlations of physical activity to heart disease, mental health and overall health and well-being. Placement of these programs will occur in various community settings. Engage community, schools and businesses in interactive programs and seminars. On-going throughout 3 years.
Resources	-Increase access to resources. -Increase connections to physical activity through community partnerships.	B. Grow community partnerships with organizations that focus on physical health through community outreach and associate health and wellness program. These partnership will focus on the physical activity sector with supporting all ages and stages of life. On-going throughout 3 years.

3. **Tobacco**

Method	Goal	Plan
Education	-Grow educational partnerships with tobacco cessation	A. Grow education partnerships with tobacco cessation providers in primary and secondary markets. On-going throughout 3 years.

	providers in all areas - Increase awareness and programs on “newer” tobacco issues such as vaping.	B. Increase awareness and programs on “newer” tobacco issues and forms such as vaping. A direct focus on education and prevention on vaping in teens and children. Year two focus programming. C. Explore other modalities of cessation programs rather than traditional in person smoking cessation programs. To begin in year 1. D. Explore Doylestown Health Associate Health and Wellness Program to include spouse incentives for being a non-smoker. To start in year 1.

Focus Area 2: Mental Health

Method	Goal	Plan
Education	-Increase awareness on different types of mental and behavioral health conditions. -Decrease stigma associated with mental health conditions. -Reduce child sex abuse.	A. Grow Doylestown Health Mental Health Series by increasing participation through expanded community partnerships. The mental health series will focus on an array of conditions for community and is series of four programs to be held every year. Purpose to start the conversation and connect individuals to appropriate community resources. B. Expand BCHIP Mental Health Stigma Campaign into community by reducing stigma through various communication platforms. C. Provide Darkness to Light trainings through the Beau Biden Foundation Partnership and Shoprite of Warminster to community, schools, businesses and associates to prevent child sex abuse and increase reporting cases. On-going

	-Reduce suicide fatalities.	throughout 3 years. D. Partner with the County of Bucks to offer QPR (question, persuade, refer) trainings to staff and community for suicide prevention and awareness training. To begin in year 1 and expand throughout three years.
Behavior Modification	-Reduce anxiety in children and teens in community and school setting. - Increase lifestyle coping mechanisms for well-being in children and teens. -Reduce reoccurring substance abuse visits through ER intervention.	E. Develop and implement mindfulness programs tailored to stress coping mechanisms for children and teens that will be held in community and school settings, lead by pediatric outreach manager. On-going throughout 3 years. F. Grow BCARES Warm Handoff program through Dr. Breda Foley, ER and Penn Foundation.
Resources	-Increase access to care through resource guide and community referrals. -Increase community partnerships.	G. Build out and utilize 211 United Way project as a community referral source. H. Utilize mental health and behavioral health partners in community programming, health fairs, and education.

Focus Area 3: Screenings

Method	Goals	Plan
Education	-Increase education efforts regarding cancer related topics and screenings in community and corporate settings	A. Increase education efforts in the community and business settings through the following cancer focal areas: I. Genetics and breast cancer |

	-Increase cancer specific programs offered.	Genetics and colon cancer. II. Lung Cancer III. Colorectal Cancer IV. Skin Cancer V. Blood Pressure screenings and cholesterol screenings
Screening	-Increase screenings for uninsured and underinsured.	B. Offer screenings for uninsured and underinsured population in the following <u>Cancer specific areas:</u> I. Breast cancer screenings and free mammography program. II. Radon screenings to reduce lung cancer. III. Colon cancer screenings | colorectal screenings. C. Increase awareness of risk factors and chronic health conditions in the following general health areas: I. Blood pressure screenings. II. Cholesterol screenings. III. Biometric screenings to community who do not currently utilize a primary care doctor to connect them back into health system for preventative care. IV. Biometric screenings in business to promote a culture of awareness, health and well-being. On-going throughout 3 years.
Resources	-Creation of screening education guidelines.	D. Hire colorectal navigator for Doylestown Health system, year 1.

Focus Area 4: Older Adult Health

Utilize Pine Run Retirement Community a member of Doylestown Health as a core outreach point in providing CHNA outreach efforts.

Method	Goal	Plan
Education & screenings	-Increase education efforts regarding seniors and screenings in community. -Connect seniors to physicians and resources needed within the community.	A. Expand education efforts in community and business settings focusing specifically on increasing participation and attendance. I. Senior centers II. Senior expos III. Senior living facilities IV. Doylestown Health outreach centers V. Pine Run Retirement Community
Behavior modification	-Contribute to reducing senior isolation.	B. Create senior isolation project to focus on social interaction, health and wellness components. Lead by Doylestown Health, senior volunteers and community partners. To begin in year 1.
Resources	-Reduce difficulties navigating health system and community resources.	C. Connect seniors with resources and/or help them navigate the health system through utilization of directories. I. Connect seniors with appropriate hospital internal navigators or support resources. II. Connect seniors to educational programs offered in person or online.

Focus Area 5: Access to Care

Method	Goal	Plan
New program development	-Increase access to care for insured and underinsured.	A. Partner with new platforms I. Pilot program for transportation platform utilized by Doylestown Health Cancer Navigators to assist cancer patients in accessing transportation for visits and follow up appointments. To be developed year 1. II. Evaluate year 2 and 3 to determine potential expansion efforts into health system and potential into primary and specialty care offices.
	-Increase access to education and screening events.	B. Increase access to education events by utilizing technology such as interactive webinars, one on phone calls and health coaching.
	-Increase access to primary care and specialty care visits/follow-up visits to increase population health management and chronic care management.	C. Partner with township and county regarding access and utilization of Dart bus through additional stops and increased access to community members.
	-Develop collective community partnerships to increase access to care through transportation.	D. Partner with United Way and 211 platform to build out Doylestown Health service offerings and availability for 211 system offered for Bucks county to serve as a referral network of community resources.

Conclusion

While our service area generally enjoys good health and has above average socio-economic and educational standings, Doylestown Health is committed to improving the health of our

community.

This implementation plan will evolve over the FY 2019-2021 period, with updates and adjustments based on local factors and developments, consistent with our evolving health system strategic plan.

The full 2019 Community Health Needs Assessment document is available on the hospital's website at DoylestownHealth.org/community, or from the home page you can select "About Us" to see Doylestown in the Community.