FOX CHASE CANCER CENTER

COMMUNITY HEALTH NEEDS ASSESSMENT 2019-2022 IMPLEMENTATION PLAN

October 2019

FOX CHASE CANCER CENTER
TEMPLE HEALTH

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FOX CHASE CANCER CENTER COMMUNITY COMMITMENT

From its founding in 1904 as one of the nation's first cancer hospitals, Fox Chase Cancer Center (FCCC) has distinguished itself as a leader in oncology research and care. FCCC has been home to Nobel laureates and other luminaries who have made important contributions to our understanding of cancer, and the Fox Chase legacy continues strongly in 2019 with a broad range of nationally competitive basic, translational, and clinical research, as well as special programs in cancer prevention, detection, survivorship, and community outreach.

FCCC is the only hospital in the Southeastern Pennsylvania region devoted solely to cancer treatment, research and prevention. Its mission is to prevail over cancer, marshaling heart and mind bold scientific discovery, pioneering prevention, and compassionate care.

A member of the Temple University Health System since 2012, FCCC was formed in 1974 by the union of American Oncologic Hospital (one of the nation's first cancer hospitals, established in 1904) and the Institute for Cancer Research (founded in 1927). In 1974, FCCC was among the first institutions to be designated as a National Cancer Institute (NCI) Comprehensive Cancer Center.

FCCC is one of only 50 NCI-designated Comprehensive Cancer Centers in the country. An NCI-designated cancer center means that a center has met NCI standards for cancer prevention, clinical services, or research. A Comprehensive Cancer Center meets NCI standards in all three categories. This NCI designation supports research, training, health information dissemination and other programs with respect to the cause, diagnosis, prevention, and treatment of cancer, rehabilitation from cancer, and the continuing care of cancer patients and the families of cancer patients. In addition, FCCC physicians and researchers are frequently involved in setting new guidelines for breakthrough medicine and comprehensive care and are involved in setting cancer-related strategies at a national level.

FCCC has many programs both in-house and offsite as part of its commitment to community health improvement. We bring the high quality cancer education, screening programs, research programs, clinical trials and other services expected from a National Cancer Institute-designated Comprehensive Cancer Center directly and conveniently to neighborhoods throughout the Greater Philadelphia region and South Jersey. Our programs are available to everyone, but we make a special effort to reach populations and neighborhoods that experience health disparities (populations that experience a higher cancer burden) because we believe that everyone deserves the same access to high quality health care.

To ensure we address the community's needs and interests, we partner with diverse community organizations and other programs within the Temple University Health System, such as the Temple Center for Population Health. These organizations and programs share our values about the health and well-being of their neighbors. Together, we help people learn how to lead healthier lives and lower their risk of cancer.

PROGRAMS TO IMPROVE COMMUNITY HEALTH

Fox Chase Cancer Center (FCCC) takes great pride in the broad array of community services that we provide to neighborhoods within the Southeastern Pennsylvania region. Our community education programs are offered in English and Spanish and are free of charge. Additional efforts to reach diverse audiences include our targeted media efforts, which involve working with media entities to produce both print and electronic information to selected populations.

Many of our programs address also the social determinants of health impacting health outcomes. Below is a summary of some of our programs and activities that advance the health of people and the quality of life in our communities:

- **Providing Critical Resources.** We connect hundreds of people with community-based social services, including free transportation services, legal services, meal plans and free pharmaceuticals, co-pays and medical supplies that provide our most vulnerable patients with the resources they need to help them heal after discharge.

- **Reaching out to our Communities.** Our Office of Community Outreach (OCO) includes three key programs: *Community Outreach and Education*; *Community Screening*; and *Community-based Research*. These programs help people better understand cancer risks, diagnoses, treatment options and prevention; provide opportunities to obtain screening; and help patients and families find supportive resources.

  Working through partnerships developed with community-based, faith-based, academic, healthcare and corporate partners we reach thousands of people each year through our community engagement programs. Through our *Speakers Bureau*, we deliver education programs in both English and Spanish, addressing multiple cancer sites, prevention and screening guidelines and discuss the importance of research and research participation. Our community cancer screening program offers breast cancer screenings via our mobile screening unit. Additional screenings include head and neck screenings. The OCO is committed to working with diverse communities to support health-focused efforts.

  Our social work and psychiatry departments facilitate an array of cancer support groups for patients and community members. We currently have support groups for: ostomy, laryngectomy, lymphedema, esophagectomy, breast cancer, gynecologic cancer, gastrointestinal (GI) cancers, prostate cancer, head and neck cancer, caregivers support, and bereavement. Our *Patient-to-Patient Network* (P2PN) is a telephone-based support program that is also designed to provide cancer patients with an additional level of support. Newly diagnosed patients are matched with cancer survivors who faced a similar cancer or underwent similar treatments. Trained volunteers (cancer survivors) share their experiences and tips with newly diagnosed or recurring cancer patients.

- **Connecting Patients with Financial Resources.** Our financial counselors are dedicated to helping uninsured and under-insured patients obtain medical coverage.

- **Developing the Next Generation of Scientists.** FCCC has a rich tradition in training the next generation of scientists and physicians and considers this one of FCCC's primary

objectives. We offer unique training programs for high school students interested in careers in science and medicine, host undergraduates in research laboratories for internships during the summer, and provide support for many graduate students and postdoctoral fellows. The *Immersion Science Program* (ISP) provides comprehensive science research training to high school students to prepare them for future careers in science and health. ISP hosts a number of events, training courses and programs for both students and teachers. Programs include an 11-week laboratory research training course for students, a summer fellows program, a laboratory program at Esperanza College serving primarily a Hispanic population, and a summer laboratory research experience for students ages 13-15, in partnership with Montgomery County Community College. These outreach programs expose young students to real science, and engage them to pursue additional science training in high school. An additional program, the *Immersion Science Teachers Program*, trains high school teachers to implement lab practices that allow students to participate in real time research experiments. The *Teen Research Internship Program* (TRIP) was launched to diversify the training opportunities available to high school students in and around Philadelphia interested in science, technology, engineering, art and math (STEAM). At its core, TRIP is about providing students with an opportunity to carry out independent research driven by their own curiosity, passion and experience. This goal is accomplished by having students design and perform their own research projects as well as collect, analyze and present their own data. FCCC also has a variety of undergraduate and graduate training programs and has academic partnerships with several universities in the Philadelphia area.

- **Promoting Multi-Cultural Services.** Reaching and serving multicultural audiences includes the ability to communicate with non-English or limited-English speaking populations. At FCCC, language services include the use of certified medical interpreters, available on-site as well as via telephone language lines and video remote units. Through Temple University Health System (TUHS), we are able to participate in the medical interpreter program led by the Cultural and Linguistic Services Department, further augmenting our linguistic services.

  In addition to enhancing our personnel's ability to verbally communicate with patients and the community, our health communication efforts addressing health literacy, strive to provide cancer information to support sound decision-making regarding cancer care. The translation of materials produced by FCCC is performed by a certified translation service to ensure accuracy as well as compliance with the National Standards for Culturally and Linguistically Appropriate Services in Health Care and other regulatory and accreditation requirements. Additional efforts are focused on service excellence to enhance staff's capacity to provide culturally competent care.

COMMUNITY HEALTH NEEDS ASSESSMENT SUMMARY

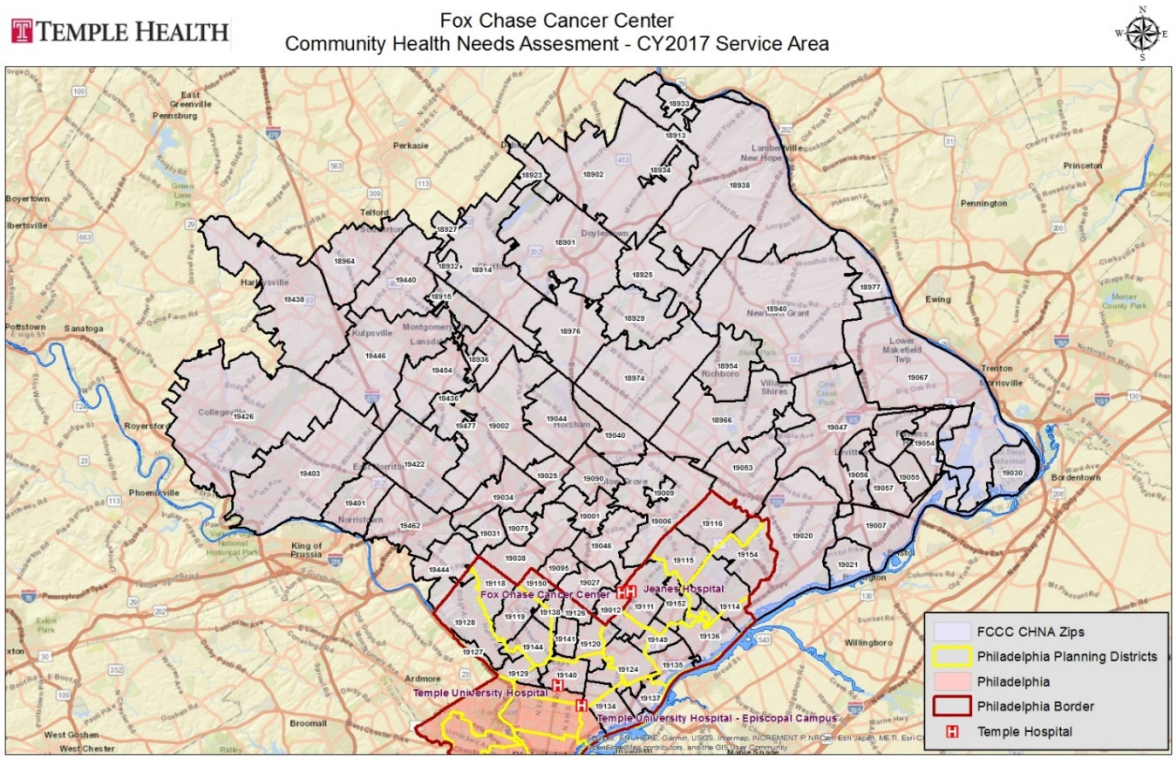
A Community Health Needs Assessment (CHNA) helps gauge the health status of a community and guides development and implementation of strategies to improve a community's health. The CHNA process also promotes collaboration among local agencies and provides data to evaluate outcomes and the impact of population health efforts. The purpose of the needs assessment is to identify and prioritize community health needs so that the hospital can develop strategies and implementation plans that address the needs identified in the CHNA.

The 2019 CHNA process followed best practices outlined by the Association for Community Health Improvement and met all Internal Revenue Service (IRS) requirements for nonprofit hospitals. The process was conducted to identify the primary health issues, current health status, and health needs of residents living within Fox Chase Cancer Center's (FCCC) service area, particularly those related to cancer prevention, screening, diagnosis, treatment and survivorship. The results enable our hospital and greater community to establish priorities, develop interventions, and direct resources to improve the health of those living in the surrounding community.

COMMUNITY DEFINITION:

For the purpose our 2019 CHNA, FCCC defined its service area as the 84 zip codes from which about 50% of its patients are seen on an inpatient or outpatient basis reside. Of those, Philadelphia County has 20 zip codes: 19111, 19114, 19115, 19116, 19119, 19120, 19124, 19126, 19128, 19134, 19135, 19136, 19138, 19140, 19141, 19144, 19149, 19150, 19152, 19154 that largely overlay the City of Philadelphia's Lower Northeast, Upper North, North, Upper Northwest, and Riverward Planning Districts as set forth in the City of Philadelphia Department of Public Health's *2017 Community Health Assessment for Philadelphia, PA*. The remaining 64 zip codes are in Central and Lower Bucks County and Lower East Montgomery County. Figure 1 outlines FCCC's service area.

Figure 1: FCCC Service Area

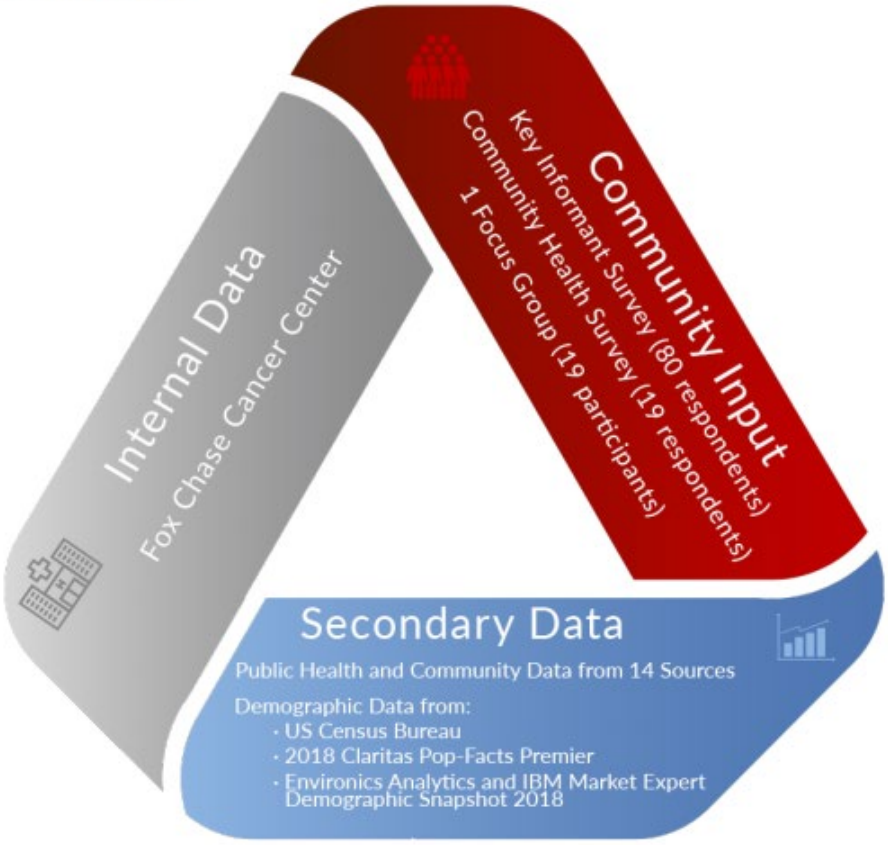


Source: Esri, HERE, USGS, Intermap, INCREMENT, P.NR

UNMET HEALTH NEEDS:

Unmet health needs for FCCC's community were identified during our 2019 CHNA by comparing the health status, access to care, health behaviors, and utilization of services for residents of our service area to data for the county, state, and the Healthy People 2020 goals for the nation. In addition, a key informant survey was sent to social and health service providers throughout our service area to obtain their perspective on the community's health needs. A focus group was also held to collect input from community stakeholders on problems with access to care, and populations with special health needs. During the focus group, a survey was also distributed to participants to gain further insight on their personal and greater community's health needs, issues and barriers. Figure 2 outlines the data sources used for the 2019 CHNA.

Figure 2: Data Triangulation



Source: Strategy Solutions, Inc., 2019

COMMUNITY FEEDBACK:

Below are major findings of the 2019 CHNA.

TUMOR REGISTRY

FCCC Tumor Registry data over the past three years shows the highest volume of cases include breast, male genital, respiratory, urinary and gastrointestinal cancer. More breast, urinary and skin cases are being identified in earlier stages. Gastrointestinal cases tend to be identified in later stages.

ACCESS TO QUALITY HEALTH CARE SERVICES

83% of focus group participants rated the health status of the community as "fair" or "poor." They explained that the population had barriers to care including literacy, housing, safety and transportation. Lack of trust, limited financial resources, language and cultural barriers, child care and out-of-pocket costs were also noted as barriers to care. As one survey respondent noted, "Stigma is still a challenge for cancer patients. It is often difficult getting care after treatments when families are working. Co-pays are high even if you are insured."

CHRONIC DISEASE

Obesity, diabetes, cancer incidence and mortality, coping with cancer diagnosis, late-stage cancer diagnosis, mental health issues related to cancer diagnosis, heart disease and food insecurity were identified as major health needs and issues.

MENTAL HEALTH

Public health data, survey results and focus groups similarly identified the following as mental health needs and issues: shortage of mental health providers; suicide; mental health issues related to cancer diagnosis; caregiver burnout; lack of trust, suspicion and fear; and depression, anxiety and post-traumatic stress syndrome.

SUBSTANCE USE

Nearly half of focus group participants indicated that trauma-informed and gender-specific drug and alcohol treatment is a top community need. The following were also identified as major health needs and issues: substance and alcohol use among adults and children, smoking and vaping among adults and children, complications of substance use affecting patients with cancer and substance use disorders among the HIV/AIDS population that leads to homelessness.

PHYSICAL ACTIVITY & NUTRITION

Public health data, survey results, and focus group participants similarly identified the following needs related to physical activity and nutrition: food insecurity and access to healthy food; and lack of physical activity, leisure time and green space.

HEALTHY ENVIRONMENT

Public health data, survey results and focus group participants similarly identified the following needs related to a healthy environment: gun violence and firearm mortality; poverty and lack of safe and affordable housing.

WOMEN AND CHILDREN'S HEALTH

The majority (87.5%) of focus group participants identified Child Care as a needed service to help people access health care services. Affordable child care, assistance with WIC and Medicaid benefits, low birth weight, smoking during pregnancy, lack of pre-natal care, teen pregnancy and infant mortality we also identified as needs and issues facing the community.

INFECTIOUS DISEASES

Focus group participants identified the HIV/AIDS population, especially those with mental health or substance use issues, as a medically vulnerable population given that those stricken often drop out of care and can become homeless.

HEALTH PRIORITIES:

On March 7, 2019, the FCCC CHNA Steering Committee (Committee) met to review primary and secondary data collected and discussed the health needs and issues present across the hospital's service area. The Committee is comprised of staff members responsible for leading key program areas that support our Community Benefit Program. Based on analysis of primary and secondary data, the following broad categories of community health needs and issues were identified:

- Access to Quality Health Services and Barriers to Healthcare
- Chronic Disease
- Mental Health
- Substance Use Disorder/Tobacco Use
- Physical Activity and Nutrition
- Healthy Environment
- Healthy Women, Mothers, Babies and Children
- Infectious Disease

During the Committee meeting, these needs and issues were identified based on health, social, economic and other health disparities found in the data (differences in sub-populations, comparison to state, national or Healthy People 2020 goals, negative trends, or growing incidence). The Committee completed a prioritization exercise using OptionFinder, an anonymous audience response polling tool, to rate all identified needs on a 1 to 10 scale for each of the selected criteria below:

- **Magnitude of the Problem** - The degree to which the problem leads to death, disability, or impaired quality of life and/or could be an epidemic based on the rate or percentage of the population that is impacted by the issue.
- **Impact on Other Health Outcomes** - The extent to which the issue impacts health outcomes and/or is a driver of other conditions.
- **Capacity** – The extent to which systems and resources are in place or available to implement evidence-based solutions.

On April 10, 2019, members of the Committee met to discuss the prioritization results and identified four (4) priority areas to focus on as a Hospital in order to address immediate community's health issues and care needs:

1. **Access to Health Care:** including mobile screening, education, health literacy and Spanish education materials
2. **Chronic disease:** including prevention, screening, , and worksite wellness to ensure all employees are able to access age-appropriate cancer screenings, smoking cessation, nutrition and educational materials addressing obesity
3. **Mental Health:** to establish a Patient to Patient Network for caregivers and caregiver support;
4. **Substance use:** to provide education and resources regarding the responsible prescribing and use of opioids in the un-informed surgical population.

These four priority areas are in line with the priority areas identified in our 2016 CHNA and addressed in the implementation strategies and programs implemented since then. Over the next

three years, FCCC will continue to review and expand programs and interventions based on the identified needs in our 2019 CHNA.

FCCC's latest Implementation Plan is based on the findings of our 2019 CHNA, which is available to the public on our website. See hyperlinks below:

- Fox Chase Cancer Center-Community Health

IMPLEMENTATION PLAN PROCESS

Following completion of Fox Chase Cancer Center's (FCCC) 2019 Community Health Needs Assessment (CHNA), the hospital's leadership formed an Implementation Strategy Work Group ("Group") to guide development of the 2019-2022 Implementation Plan. The Group began its planning process by reviewing needs identified during the 2019 CHNA. Using a consensus building process, the Group created implementation plan for addressing each priority that considered the following factors:

1) **Root Cause:** The root cause of the priority issue;
2) **Internal Capacity:** The internal resources of TUH and capacity to respond, including constraints or limitations.
3) **University Resources:** The Academic Resources of Temple University, including the Lewis Katz School of Medicine.
4) **External Community Capacity:** The external resources of TUH's surrounding communities and capacity to respond to the priority need.
5) **Consequences:** The public health consequences of not responding to the need.

Thereafter, the Group met regularly and worked with stakeholders to collaboratively develop implementation plans that outlined specific goals, objectives, and action plans as well as the resources FCCC would contribute in response to each priority need.

In collaboration with Temple's Center for Population Health, FCCC will work over the next three years to achieve mutual public health goals. We will align our efforts with the United States Department of Health and Human Services' three-part aim of improving patient care, better health for our communities and lowering costs through health care system improvement. In addition, we will closely monitor our progress in meeting goals, their impact and will develop annual progress updates.

PLAN TO IMPROVE CANCER SCREENING, NAVIGATION & EDUCATION

Priority: Enhance access to health care through cancer screening, community navigation, health education, health literacy and Spanish education materials.

1. *Cancer Screening and Navigation*

Rationale: Our current Community Health Needs Assessment (CHNA) identified that 15% of Philadelphia residents reported that there was a time in the past year when they needed healthcare, but did not seek it due to the cost. There is an unmet need in the service area for cancer screening and preventive care. Qualitative findings also show that area residents have difficulty navigating the health care system, that those without health insurance or with public insurance face additional barriers and that residents who speak languages other than English are in need of supplemental services to assist them in receiving care.

Our *Community Screening Program* currently provides breast and head and neck cancer screening in the community. The program has been in existence for 30 years and provides access to life-saving screenings. Most of the community-based screenings are held on our Mobile Screening Unit (MSU); other screenings occur onsite at partner sites. The MSU is considered a best practice by the U.S. Department of Health and Human Services' Community Preventive Services Task Force, eliminating structural barriers or obstacles that make it difficult for people to access cancer screenings.

Through our network partners, we screen at both corporate and community settings. In the corporate setting, the MSU is provided as a worksite wellness program and provides a convenient way to obtain screening to individuals that likely have health insurance. Within the community, the MSU works to ensure equal access to care among the medically underserved audiences that may have many barriers to obtaining proper healthcare including a lack of health insurance. Among both community and corporate partners, we have found that many women return to our mobile screening unit annually for their mammogram and many are likely to choose Fox Chase Cancer Center (FCCC) should they need follow-up diagnostic services or breast cancer treatment.

Starting in 2010, patient navigators with extensive experience working in the community and with our community partners have worked closely with patients who have inconclusive or abnormal screening results and/or who have financial or other issues (e.g. language barriers) to ensure that these individuals are able to access follow-up services as needed.

Goal: To address health insurance issues and lack of access to care, we will enhance access throughout the community to preventive cancer screening and programs and will provide navigation services to those patients that need follow-up services or have financial, language, or other barriers.

Metrics: Screening program metrics include- number screened, number of screening events held, number of abnormal findings, number of individuals that return to FCCC with abnormal screening findings and are diagnosed with cancer, demographics/underserved populations served. Navigation program metrics include- number of patients navigated, number of days until patients

come in for follow-up appointments, types of support provided, and feedback from patients navigated.

Available Resources: FCCC is committed to providing high quality, evidence-based cancer care to all patients.

- Community Cancer Screening Program, Office of Community Outreach (OCO)
- Diagnostic Imaging, Mammography Program
- Fox Chase faculty from multiple departments
- Patient Financial Services
- Nursing Department and Nurse Navigators
- Social Work Department
- Communications and Marketing Department
- Cultural and Linguistic Services – TUHS

Implementation Team:

- Executive sponsor
  - *Director of Community Cancer Screening, Office of Community Outreach, FCCC* - Linda Hammell

- Team Members*:*
  - *Director Mammography*, *Diagnostic Imaging, FCCC* - Catherine Tuite, MD
  - *Chief Technician, Mammography, Diagnostic Imaging, FCCC* - Jean Hummel, B.S. (R)RT
  - *Director, Diagnostic Imaging, FCCC* - Joan Keiper, ASRT (R)
  - *Mobile Screening Unit Staff Technician, Mammography, Diagnostic Imaging, FCCC*- Jennifer Primus (R)RT
  - *Mobile Screening Unit Driver, Diagnostic Imaging, FCCC*- Ed Wang
  - *Mobile Screening Unit Staff Technical Assistant, Diagnostic Imaging, FCCC*- Antoinette Ridley
  - *Assistant Director, Community Cancer Screening Program, Office of Community Outreach, FCCC* - Deb Resnick, MS
  - *Program Coordinator, Community Cancer Screening Program, Office of Community Outreach, FCCC* - Andrea Tillman, BS
  - *Director, Nurse Navigation, FCCC* - Mary Pat Winterhalter, MS, RN, NE-BC
  - *Senior Director, Office of Community Outreach, FCCC* - Evelyn González, MA
  - *Program Manager, Office of Community Outreach, FCCC* - Allison Zambon, MHS, MCHES
  - *Associate Marketing Specialist, Marketing Department, FCCC* - Maggie Wurst, BA

Community Participants: Partnerships with multiple community and corporate organizations within the service area.

- PA Healthy Woman Program
- Susan G. Komen Philadelphia
- Key community based agencies

Action Plans:

- Continue cancer-screening efforts with current partners, providing annual screenings.

- Identify new community sites to explore partnerships for both screening and preventive programs.
- Navigate patients who have inconclusive or abnormal screening results and/or who have financial or other issues (e.g. language barriers) into follow-up care.
- Provide patients transportation to hospital if needed through either the *Community Navigator* or the *Social Work/Nurse Navigator Round Trip program*.

Objectives:

- To provide breast cancer screening to 1,000 medically underserved women via Mobile Screening Program.
- To offer and assess navigation services to all patients screened in the community needing follow-up care.

Communication:

Communication regarding availability of services is achieved via:

- Direct communications with community organizations and corporations
- Fox Chase Website
- Community Screening Events
- Multiple Community Partners
- Multiple Healthcare Provider

Estimated Budget: $573,000 for the screening program, including community education, staffing for screening services via mobile screening unit, marketing materials and for translations and transportation as needed for patients.

2. *Cancer Education*

Rationale: Cancer education is a key component of the mission of a National Cancer Institute-designated Comprehensive Cancer Center, such as FCCC. By addressing educational needs throughout the community, we can better serve the health needs of those in our service area, including non-English speakers who may otherwise not receive or seek out cancer-related information and resources.

Our *Community Speakers Bureau* provides free, bilingual cancer education on breast, cervical, colorectal, lung, ovarian, prostate, skin and clinical trials. All the sessions are based on scientific-evidence and include a pre/posttest to evaluate increases in knowledge, changes in attitudes and likelihood to screen and/or participate in research. These one-hour education sessions are delivered through new or existing partner network. Sessions are conducted in English and Spanish by seasoned health educators. We have also developed several educational materials, written in plain language, on various cancer topics. Our program is planning to develop additional plain language materials, on topics such as HPV and liver cancer. We will also work to develop these plain language materials in other languages.

Goal: To deliver evidence-based cancer education and resources to address the regional cancer burden.

Metrics: Number of educational sessions, number of people reached, number of pre/post surveys collected, increase in knowledge and intent to screen from surveys, and number of plain language products developed.

Available Resources:

- Office of Community Outreach
- FCCC faculty
- Resource and Education Center
- Marketing and Communication Departments

Implementation Team:

- Executive sponsor:
  - *Program Manager, Office of Community Outreach, FCCC* - Allison Zambon, MHS, MCHES

- *Team Members*:
  - *Program Manager, Outreach*, *Office of Community Outreach, FCCC* - Armenta Washington, MS
  - *Health Educator, Outreach, Office of Community Outreach, FCCC* - Rosa Ortiz, BA
  - *Director, Health Communication Programs, Office of Community Outreach, FCCC* - Stephanie Raivitch, BA
  - *Project Manager, Resource & Education Center, Office of Community Outreach, FCCC* - Nina Galpern, MS
  - *Associate Marketing Specialist, Marketing Department, FCCC* - Maggie Wurst, BA

Community Participants: The Office of Community Outreach has developed partnerships with multiple organizations within our service area. These include:

- Community-based, faith-based, academia, corporate and legislative partners
- Pennsylvania Department of Health

Action Plans:

- To work with existing partner organizations to coordinate educational programming.
- To participate in community events to disseminate cancer information.
- To continue to develop plain language educational materials.

Objectives:

- To provide bilingual cancer education sessions to 1,500 people through the community Speakers Bureau, tailored presentations and community events.

Communication:

The availability of our free education programs is promoted:

- During initial partnership development meetings
- Fox Chase website

- Targeted mailings to community organizations
- Outreach events

Estimated Budget: $265,700 annually for community outreach, administrative staff, education materials, and other related program costs.

PLAN TO REDUCE CHRONIC DISEASE THROUGH CANCER PREVENTION

Priority: Reduce the burden of chronic disease, through cancer screening, smoking cessation, and obesity education.

Rationale: Chronic disease prevention was repeatedly mentioned as a need among the community in our Community Health Needs Assessment (CHNA). Specific conditions prioritized in the CHNA were cancer, heart disease, diabetes, obesity. As a cancer center, Fox Chase Cancer Center (FCCC) does not directly treat heart disease and diabetes, and therefore will focus their chronic disease efforts on cancer prevention and obesity as it relates to cancer risk.

Cancer screening will be conducted through our *Community Cancer Screening* program as mentioned in the access to care plan. In addition, FCCC will establish a worksite wellness program to ensure employees are able to access all age-appropriate cancer screenings. FCCC employs approximately 2,400 people and about 53% of employees live in the defined target community for our CHNA. Employees are one of FCCC's most effective communicators and are encouraged to spread the word to friends and family members about the importance of screening. In addition, it has been found that modifiable health risks that lead to disease can be decreased through workplace-sponsored health promotion and disease prevention programs. Employees will be given a screening passport to track the screenings they obtain and sessions will be conducted to educate staff on risk factors and current screening guidelines. In order to address the lung cancer burden, we will continue to develop and build on our community *Tobacco Cessation Program*. This program will be held at community partner sites and at FCCC where it will be open to patients, family members, staff, and other community members at no charge. Lastly, information on obesity as a risk factor for cancer will be added to all speakers bureau presentations. Patients that are overweight or obese will have access to nutrition services. Wellness initiatives, such as an onsite discounted Weight Watchers program, will also be available to FCCC employees.

Goal: To deliver evidence-based cancer screening, smoking cessation services, and obesity education.

Metrics: Worksite wellness program metrics include-number of communications, number of educational sessions, number of attendees at education sessions, number of people screened, and screening outcomes. Tobacco program metrics include number of sessions, number of attendees, and attendee reported level of smoking before and after program.

Available Resources:

- Office of Community Outreach
- Diagnostic Imaging
- Ambulatory Care
- Web Technology
- Fox Chase faculty
- Human Resources
- Tobacco Treatment Program
- Resource and Education Center
- Marketing and Communication Departments

- Patient Financial Services
- Nutrition Support
- Nursing Department and Nurse Navigators

Implementation Team:

- Executive sponsors:
  - *Chief Medical Officer, FCCC* - James Helstrom, MD, MBA
  - *Senior Director, Office of Community Outreach, FCCC* - Evelyn González, MA

- Team Members:
  - *Director Mammography*, *Diagnostic Imaging, FCCC* - Catherine Tuite, MD
  - *Assistant Vice President, Human Resources, FCCC*- Beverly Sherbondy, MS, MBA
  - *Advanced Practice Clinician – Department of Medicine - Tobacco Treatment Program, FCCC*- Donna Edmonson, MSN, CRNP, AOCNP
  - *Program Manager, Office of Community Outreach, FCCC* - Allison Zambon, MHS, MCHES
  - *Director, Health Communication Programs, Office of Community Outreach, FCCC* - Stephanie Raivitch, BA
  - *Associate Marketing Specialist, Marketing Department, FCCC* - Maggie Wurst, BA
  - *Senior Director, Communications Department, FCCC*- Jeremy Moore, MA
  - *Manager, Infection Control, FCCC*- Nancy Warren, MS
  - *Clinical Nurse Specialist, FCCC*- Jean Held-Warmkessel, MSN, RN, AOCN®, ACNS-BC
  - *Senior Corporate Director Financial Services, Accounts Receivable, FCCC*- Anita Colón, MHS
  - *Director, Diagnostic Imaging, FCCC* - Joan Keiper, ASRT (R)
  - *Director Finance, Treasury Services, FCCC*- Rich Bobroski, CPA
  - *Director, Nurse Navigation, FCCC* - Mary Pat Winterhalter, MS, RN, NE-BC
  - *Physician Practice Manager, Department of Medicine, FCCC*- Leanne Lyons
  - *Director of Web Technology, Web Development, FCCC*- Mark Siemon, BA

Community Participants: The Office of Community Outreach has developed partnerships with multiple organizations within our service area. These include:

- Community-based, faith-based, academia, corporate and legislative partners

Action Plans:

- To work with existing partner organizations to coordinate educational programming on cancer-related topics that includes obesity information and to offer a tobacco cessation program.
- To plan and establish worksite wellness program to educate Fox Chase employees about cancer screening.

Objectives:

- To offer cancer education and screening to all employees.
- The tobacco cessation program will be offered 3 times per year and the number of attendees and their level of smoking pre/post-program will be tracked.
- All relevant speakers bureau presentations will have information on obesity added.

- Wellness/nutrition services will be available to patients and employees.

Communication:

The availability of our cancer screening, education, and smoking cessations programs is promoted:

- During initial partnership development meetings
- Fox Chase website
- Targeted mailings to community organizations
- Targeted promotion to staff through emails, flyers, posters

Estimated Budget: $55,000 annually for staffing to conduct worksite wellness and tobacco cessation programs, for community education on obesity as well as supplies and printing of any materials needed for education sessions.

PLAN TO PROVIDE CAREGIVER SUPPORT

Priority: To address mental health concerns among caregivers, Fox Chase Cancer Center (FCCC) will establish a Caregiver Network similar to the Patient-to-Patient Network and open participation to our caregivers in support group**.**

Rationale: The Community Health Needs Assessment (CHNA) identified caregiver burnout as a mental health issue in our community. In response to this identified need, we will establish a Caregiver Network Modeled after our Patient to Patient Network, this program will be a telephone-based support program that connects trained caregivers to new caregivers. The extension of the program will allow caregivers to undergo volunteer training and then be matched with other caregivers for telephone support. In addition to our current caregiver support group, other support groups will be opened to the community that may need additional assistance supporting their loved one through cancer.

Goal: To address mental health concerns among caregivers through in-person support groups and a telephone-based patient to patient network.

Metrics: The Caregiver Network metrics to establish the program, to track include number of training sessions, number of volunteers, number of matches, and satisfaction with the program. Metrics to track for support groups include number of promotional activities conducted to alert the community that support groups are open to non-FCCC patients and number of patients vs. non FCCC patients/caregivers attending support groups.

Available Resources:

- Office of Community Outreach
- Resource and Education Center
- Social Work Department
- Marketing Department

Implementation Team:

- Executive sponsor:
  - *Project Manager, Resource & Education Center, FCCC* - Nina F. Galpern, MS

- Team Members:
  - *Manager, Social Services, Social Work, FCCC*- Mark Itzen, MSW, LCSW
  - *Associate Professor/MD, Psychiatry, FCCC*- Emmie Chen, MD
  - *Senior Director, Office of Community Outreach, FCCC*- Evelyn González, MA
  - *Program Manager, Office of Community Outreach, FCCC*- Allison Zambon, MHS, MCHES
  - *Director, Health Communication Programs, Office of Community Outreach, FCCC*- Stephanie Raivitch, BA
  - *Associate Marketing Specialist, Marketing Department, FCCC* - Maggie Wurst, BA
  - *Senior Director, Communications Department, FCCC*- Jeremy Moore, MA

Community Participants: The Office of Community Outreach has developed partnerships with multiple organizations within our service area that we will reach out to for our caregiver programs. These include:

- Community-based, faith-based, academia, corporate and legislative partners

Action Plans:

- Develop a caregiver support network.
- To broaden current support group participation to include community members (non-patients).

Objectives:

- To establish a caregiver network to provide telephone based support.
- To offer the current support groups to caregivers.

Communication:

The availability of our support groups and Patient to Patient Network is promoted:

- Fox Chase website, social media
- Targeted mailings to community organizations
- Posters, flyers and other promotional items around FCCC

Estimated Budget: $109,000 annually to cover the salary and benefits of the staff to plan and conduct the programs as well as promotion of both the Caregiver Network and support groups.

PLAN TO PREVENT PRESCRIPTION DRUG ABUSE

Priority: To provide education and resources regarding the responsible prescribing and use of opioids in the un-informed surgical population.

Rationale: The Community Health Needs Assessment (CHNA) identified substance use as a top community issue. To meet this need, Fox Chase Cancer Center (FCCC) is establishing a hospital-wide education campaign to educate patients and family members about the use of opioids in cancer care. With this new initiative, patients will receive education via video and written materials about the proper use of opioids. In addition, providers will prescribe less opioids in an effort to reduce the quantity these medicines prescribed to opioid naïve surgical patients. The program will also educate and inform patients that they can return unwanted/unfinished prescriptions to the FCCC outpatient pharmacy when they come for follow-up appointments.

Goal: To address the opioid crisis by educating patients and family members about proper usage of opioids in cancer care.

Metric: Opioid Prescription Use Dashboard demonstrated adherence to prescribing guidelines and reduced quantity of opioids prescribed to patients.

Available Resources:

- Opioid Stewardship Committee

Implementation Team:

- Executive sponsors:
  - *Chief Medical Officer, FCCC* - James Helstrom, MD, MBA
  - *Director, Performance Improvement, FCCC* - Mary Ellen Morba, RN, BSN

- Team Members:
  - *Director, Pain and Palliative Care Program, FCCC*- Marcin Chwistek, MD
  - *Instructor, FCCC Medical Group, Inc.*- Shreyas Joshi, MD
  - *Fellow, Department of Surgical Oncology, FCCC* - Maureen Hill, MD
  - *Attending Surgeon, Department of Surgical Oncology, FCCC*- John Daly, MD
  - *Clinical Manager, PACU, FCCC*-Julie Dameus, RN
  - *Director, Pharmacy, FCCC*- Dwight Kloth, PharmD
  - *Anesthesiologist, Surgical Oncology, Division of Anesthesiology, FCCC*- Felipe Suero, MD
  - *Assistant Clinical Manager, Ambulatory Care, FCCC*- Rebecca Farrell, MSN, BSN
  - *Clinical Nurse Specialist, FCCC*- Linda Schiech, MSN, RN, AOCN
  - *Director, Health Communication Programs, Office of Community Outreach, FCCC*- Stephanie Raivitch, BA
  - *Senior Marketing Specialist, Marketing Department, FCCC*- Emily O'Donnell, MS
  - *Patient and Family Advisory Council representative, FCCC*- Pat Callahan

Community Participants: FCCC will reach out to community partners, such as police and other government agencies that also have prescription medicine disposal services in order to work with them on proper disposal of opioids.

Action Plans:

- To educate patients and family members about the use of opioids in cancer care.
- To encourage Fox Chase doctors to prescribe opioids based on new guidelines.
- To encourage utilization of Fox Chase medicine disposal program.

Objectives:

- To educate patients that come to FCCC for surgery about the proper usage of opioids in cancer care.
- To reduce the quantity of opioids prescribed to surgery patients that have not taken opioids before.
- To translate opioid education video and fact sheet into other languages.
- To encourage utilization of FCCC medicine disposal and make community aware of other medicine disposal locations.

Communication:

The program will be promoted:

- FCCC website, social media
- Posters, flyers and other promotional items around FCCC
- List of disposal sites in community outreach efforts

Estimated Budget: $106,000 annually for program staffing, promotion and translation of materials.

APPROACH TO UNMET NEEDS

Access to Health Insurance. Our financial counselors screen all uninsured and underinsured patients (including those with high deductibles and co-pays) who are hospitalized or require elective outpatient hospital services to determine their eligibility for government funded medical insurance such as Medicaid and the Child Health Insurance Program. If eligible, we connect these patients with resources that can help them attain coverage.

While we are vigilant in our efforts to connect patients with insurance options, we do not have sufficient resources to conduct extensive community outreach related to health insurance access. This can be carried out by area health insurers, who are expected to conduct significant outreach efforts for the health insurance exchanges under the *Affordable Care Act*.

Addressing Social Determinants of Health. The Temple Center for Population Health (TCPH), Temple Faculty Practice Plan (TFP), Temple Physicians Inc. (TPI) and other health system affiliates developed a data collection tool for recording the assessment of the social determents' of health. This tool is imbedded into Temple University Hospital's (TUH) electronic medical record and administered to patients on a daily basis in its Emergency Department and inpatient and ambulatory clinics. In FY 20, Fox Chase Cancer Center (FCCC) may adopt the data collection tool into their EMR.

FCCC, TCPH and our employed physician practices will continue to connect our vulnerable patients with community-based services responding to the social determinants of health, such as free transportation, clothing, housing assistance, free pharmaceuticals, medical supplies and assistance with co-pays that provide them with the resources they need to heal after discharge.

Access to Primary and Preventative Care: As a dedicated cancer center, FCCC does not have the resources to address the comprehensive primary care needs in our community. However, as a member of the Temple University Health System (TUHS) family of hospitals and physicians, we will work with our affiliates to strengthen access to primary care and preventative services. Our affiliated network of community physicians, TPI, as well as TFP, provides our low income community access to for both primary and specialty services. Virtually all Temple physicians, whether community or faculty based, accept patients covered by Medicaid.

Additional Needs: Other needs FCCC has chosen not to address include those related to Physical Activity and Nutrition, Healthy Environment, Healthy Women, Mothers, Babies and Children, and Infectious Disease that are outside the purview of a cancer hospital and therefore were rated a low priority. FCCC also does not have interventions available to address these needs. In addition, other programs within TUHS are addressing these needs within the community.

PLANNING FOR A HEALTHIER POPULATION

Fox Chase Cancer Center (FCCC) is committed to improving the health of the communities we serve by prevailing over cancer. While our Implementation Strategy provides a broad outline of our current plans, we will continue to develop and refine our approach moving forward. In so doing, we plan to work with the City of Philadelphia's Department of Public Health and Department of Behavioral Health and Intellectual Disabilities to integrate our community outreach and education initiatives with theirs to make more efficient and effective use of resources already available, and to align our efforts, as appropriate, with the City's public health priorities. In partnership with community organizations, other health providers, the City of Philadelphia, the Commonwealth of Pennsylvania and the Temple family of hospitals and physicians, we hope to improve the health of our population and the quality of living in the neighborhoods we serve.

Temple Center for Population Health

As a member of TUHS, FCCC will continue to align its efforts with the Temple's Center for Population Health (TCPH), to support the clinical and financial objectives of TUHS in attaining a sustainable model of health care delivery through clinical and business integration, community engagement and the implementation of medical and nonmedical interventions to promote high value care, improved health outcomes and academic distinction.

Consistent with federal health priorities of providing better care, ensuring smarter spending and building healthier communities, TCPH is utilizing a series of population health building blocks to unite clinical and business models into a cohesive and robust series of programs. These include:

- Value-Based Contracting – TCPH works with Temple Health hospitals and ambulatory practices in partnership with third party payers to share risk and provide high value care to our patients
- A strong employed primary care model supported by a network of 27 NCQA-designated level three Patient Centered Medical Homes (PCMHs) in North Philadelphia.
- A Clinically Integrated Network of independent community primary care providers, focused on improving quality outcomes A network of alliances and partnerships with community agencies and organizations, many of whom specialize in managing the non-medical health-related social needs of our patients that ultimately influence health outcomes
- A robust care management infrastructure that identifies patients at risk for recurrent health care issues and intervenes to provide medical and non-medical support utilizing nurse navigators, social workers and community health workers.
- A connected and cohesive care delivery and transitions of care of care model implemented to assure a high level of communication and care when a patient is transferred to a different care setting or is discharged home
- Community Engagement focused on provider and community agency partnerships and community leaders
- Electronic Health Information Exchange (Health Share Exchange) to assure that electronic information is securely transferred and is available to health care providers across our region as needed

Key Programs for High Value Care

The TCPH coordinates and supports patient and family care by focusing on quality indicators and assuring accurate and timely communication between providers and between providers and patients. This is achieved through a variety of inter-related programs including:

Nurse Navigation: The TCPH nurse navigators are registered nurses who work with and in physician practices to improve patient outcomes related to quality measures, including the Healthcare Effectiveness Data and Information Set (HEDIS) measures. These measures are focused on management of chronic diseases including hypertension and diabetes; appropriate cancer screening; immunizations; appropriate use of medications and smoking cessation. The nurse navigators also smooth the way for transitions of care from the inpatient to the outpatient setting, calling patients shortly after discharge to make sure they are managing at home, understand their medications and have access to and appointments for timely post-hospitalization follow-up. Nurse navigators play a vital role in population health management.

Community health workers (CHWs): Temple University is a national leader in training and utilizing CHWs as coaches and support for patients with chronic disease and high utilization of health services. These individuals live and work in our community and visit our patients in their homes to link the patients with the support they need to enhance their care and health outcomes. The CHWs serve as liaisons between the patients and their providers to improve compliance with the care plan and prevent unnecessary emergency department visits and readmissions.

Wellness programs and chronic disease management: TCPH provides chronic disease management services and calcium score screening for defined populations affiliated with organizations that are self-insured. These programs identify individuals at risk for health issues and intervene to prevent progression of disease.

The Skilled Nursing Home and Home Health Collaborative: Initiated by the TCPH, this group of 22 skilled nursing home facilities and 7 home health agencies caring for Temple Health patients is working to reduce readmissions from the post-acute setting by establishing a clinical communication strategy, metric standardization and a care management competency inventory.

Transition of Care Program: In collaboration with the Temple Access Center, the TCPH *Transitions of Care Program* provides post-acute care contact for patients discharged from Temple University Hospital. The program schedules follow-up calls to assure that patients are compliant with scheduled appointments and helps resolve open issues. Complex problems are escalated to nurse navigators.

Collaborative Programs on Local, State and National Levels

The TCPH collaborates with a number of health care providers external to Temple Health to improve communication and transitions, and deliver high value care. These include Federally Qualified Health Centers, City Health District Clinics and community primary care practices. We also work with city, state and federal government agencies on the implementation of grant-funded programs to create resources for specific populations of patients. For example:

- The Diabetes Prevention Program (DPP) funded by the Center for Disease Control (CDC) through the Philadelphia Department of Health. At the core of this program, is the training of CHWs as peer coaches to target pre-diabetes, hypertension and obesity. The program includes patient education for newly diagnosed hypertension. The patients who have benefited from this grant are in TPI practices, the Bright Hope Baptist Church, or are part of the Law Enforcement Health Benefits program.

- The TCPH was invited to participate in a practice transformation network called the Transforming Clinical Practice Initiative (TCPI), a Center for Medicare and Medicaid Innovation (CMMI) grant, awarded to Vizient. The collaborative is designed to provide tools and data to support performance improvement. Metrics have been selected that support the clinical and business imperatives of TPI and TUP. The focus is on the patient experience, improvement in care coordination and a reduction of gaps in care. The collaborative is designed to prepare providers for alternative payment models being considered by CMS for implementation in the near future.

Collaboration with the Lewis Katz School of Medicine at Temple University

As part of the academic mission of Temple Health and the Lewis Katz School of Medicine, the TCPH contributes to the undergraduate and graduate curricula for teaching population health in collaboration with the Temple Center for Bioethics, Urban Health and Policy. This collaboration includes conducting research to compare different models of care and interventions focused on enhancing the delivery of high value care.