

Doylestown Hospital 2013 Community Health Needs Assessment Implementation Plan

Introduction

Doylestown Hospital completed a comprehensive Community Health Needs Assessment (CHNA) in 2013, working with Public Health Management Corporation. The purpose was to gain information to

- gauge the health of the communities we serve, and
- 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 total population of the hospital's service area in the 2010 census was approximately 361,800 which was an 8% increase over the last full census in 2000. The population is predicted to continue increasing in 2013 (to 366,100 residents) and 2018 (to 372,400).

A copy of the full 2013 Needs Assessment is published on the hospital's website at www.dh.org/community. Overall the Doylestown Hospital Service Area ranks higher on almost all the measured health metrics than the state of Pennsylvania and for Bucks County.

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.

Almost all of the Community Health Indicators were reported as either meeting or exceeding the Healthy People 2020 goals, and were better than Bucks County and the Southeastern PA region.

The exceptions were:

- Binge drinking (reported by 27% of our service area, versus the Healthy People 2020 goal of 18.3%.)

- Overweight children (reported at 20% for our service area, versus Southeastern PA average of 18.2%).

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

Based on Doylestown Hospital's strengths and the outcomes of this needs assessment, we have prioritized several issues for interventions over the three year period from 2013-2015. Prioritization was based on the results of the CHNA, on the availability of resources and potential to impact.

An additional priority test was relationship to our strategic plans. We began a system-wide strategic planning process in June 2013, targeted for completion at the end of the calendar year. Some prioritization could change based on the outcome of our strategic planning process.

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 other local health service agencies. Some of these unmet needs are also beyond the mission and potential for direct impact by our hospital, such as transportation.

Priority Community Health Needs

For Year 1, our primary focus area as identified in the CHNA will be on additional support for cancer and heart disease prevention programs. Interventions mentioned include smoking cessation, nutrition counseling and diabetes awareness, and physical activity programs.

Using cancer and heart disease prevention as our major focus area, the chart below lists the community health needs identified in the 2012 CHNA as priorities. Documentation of the findings presented in this summary is provided in the full CHNA found on the hospital's website at www.dh.org/community.

(see chart next page)

| Issue | Specific Action Plan to Address |
|--|---|
| 1) Additional support for cancer & heart disease prevention programs, including smoking cessation & prevention, nutrition counseling, and physical activity programs | <p>Yes</p> <p>Action Plan developed for Year 1, to be reviewed and revised for 2014-15 in conjunction with strategic plan updates. Includes strategies for increasing resource awareness via healthcare concierge, education and prevention materials in community locations, and social media and technology solutions.</p> |
| 2) Health Indicators below Healthy People 2020 goals <ul style="list-style-type: none"> • Binge drinking • Childhood Obesity | <p>No</p> <p>We do not offer dedicated inpatient services for substance abuse or pediatrics. However other area agencies are dealing with these issues, and we would continue to support and collaborate with them. These include Lenape Valley Foundation, Bucks Council on Alcoholism, CB Cares, BCHIP.</p> |
| 3) Access to specialty care and preventative care is difficult for patients with Medicaid, particularly in certain specialties (dentists, dermatology and orthopedics) | <p>No</p> <p>This issue is beyond the hospital’s scope of direct influence, although we will continue to participate in Managed Medicaid plans and to support the Ann Silverman Free Clinic for access by uninsured or underinsured residents. BCHIP is also working on this issue at the County level.</p> |
| 4. Transportation barriers are a burden for low income residents. | <p>No</p> <p>This issue is not within the hospital’s mission, affects a small percentage of the primary service area. We are on the route for local transport services including DART. Others who are addressing this issue include BCHIP, United Way, and other area service agencies. Bucks County Transport also provides no- or low-cost transportation to low income residents/seniors.</p> |

Implementation Strategy for Priority Health Needs

For our top priority health issues of additional support for cancer and heart disease prevention programs, we have identified at least one intervention activity to address improving the health of the community. The table below shows each activity, identifies responsibility for implementation/collaboration, and lists required resources for execution.

| Priority One Health Issues | Activity | Responsibility | Resources |
|---|--|---|--|
| Increase health resources awareness and access | Establish Health Resource Center Satellite pilot in Community retail location with Healthcare Concierge; expand as appropriate to include additional locations | DH, Health Connections at ShopRite of Warminster, local health service organizations other retail partners as need warrants | Staffing, inpatient departments, local health organizations |
| Heart Health Screenings (Blood pressure, weight, cholesterol) | Periodic blood pressure, weight, cholesterol screenings at hospital and outreach centers | DH Satellite at ShopRite Warminster, clinical departments, education department | Clinical staff, community locations, monitors and scales, supplies |
| Increase health education and awareness | Periodic health education programs on smoking cessation, nutrition counseling; displays and information stations at community locations | Education department, DH Satellite at ShopRite, clinical departments, area health agencies | Training and workshop materials, instructors, partner with BCHIP, Bucks County Dept of Health, other community agencies including United Way |
| Integrate social media as education tool | Establish social media presence with messaging and health promotion reminders (Facebook, other) | Marketing, Community relations, Education | Communications staff, IT, web partners |
| | | | |

Target Population and Goals

Populations in our focus areas could benefit from health improvement activities. While healthy interventions could benefit the whole population, we will focus on specific population needs for appropriate interventions. Note that this assessment was based primarily on secondary data, and it would be ideal to have primary data sources that would allow for more targeted information collection. As this plan evolves, we will seek further information that will facilitate more targeted intervention methods.

| Focus Issue | Target Population | Goals |
|--------------------------|--|--|
| Heart Disease Prevention | Adults with high blood pressure or hypertension | Increase community awareness of hypertension; Increase % of people screened for hypertension; Conduct screenings at Health Connections satellite at ShopRite Warminster and at other outreach locations in the community |
| | Smokers | Increase awareness of smoking risks; Increase participation in local smoking cessation programs; |
| | Adults who are overweight/obese | Increase community awareness of weight and heart disease relationship; Increase attendance at nutrition programs and workshops; Increase BMI screening in the community |
| Cancer Prevention | Adults who fit current screening guidelines | Increase community awareness of cancer screening guidelines |
| | Women who have not gotten a baseline or followup mammogram | Increase number of women getting mammograms within recommended period |
| | Adults who are at risk for | Increase awareness and |

| | | |
|-----------------------|---|--|
| <p>Support Groups</p> | <p>lung cancer</p> <p>Adults in the service area who are impacted by issues dealing with current support groups</p> <p>Community members in need of health resource information</p> | <p>increase attendance at community education/screening events</p> <p>Increase awareness and attendance at current support groups (Cancer, AA, AlAnon, AlaTeen, Smoking Cessation, Caregivers, etc), Lymphadema, etc.;</p> <p>Support satellite Health Connections resource center at ShopRite Warminster with health information and directories; increase number of visits to the Center.</p> <p>Identify and match additional support group needs with community offerings.</p> |
|-----------------------|---|--|

Conclusion

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

This implementation plan will evolve over the 2013-2015 period, with updates and adjustments based on local factors and developments with our strategic planning initiative that will set new directions beginning in 2014.

The full 2013 Community Health Needs Assessment document is available on the hospital’s website at <http://www.dh.org/community>, or from the home page you can select “About Us” to see Doylestown in the Community.

Approved Doylestown Hospital Board of Directors 9.19.13

Approved Doylestown Health Foundation Board of Directors 9.23.13