UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM

THE CHESTER COUNTY HOSPITAL
BOARD OF DIRECTORS
EXECUTIVE COMMITTEE

Resolution to Approve The Chester County Hospital's Amended Community Health Needs Assessment Strategic Implementation Plan for Fiscal Years 2020 through 2022

INTENTION:

The Chester County Hospital ("TCCH") is a licensed acute care hospital and a component of The Chester County Hospital and Health System ("TCCHHS") and of the University of Pennsylvania Health System ("UPHS") and Penn Medicine, the latter two of which are operating divisions of The Trustees of the University of Pennsylvania. As a not-for-profit 501(c)(3) hospital, TCCH is committed to identifying, prioritizing and serving the health needs of the community it serves. In fulfillment of the Patient Protection and Affordable Care Act, TCCH performed a Community Health Needs Assessment ("CHNA") for Fiscal Years 2020 through 2022 ("FY 2020 CHIP") which was approved by the TCCH Board of Directors on September 10, 2019. Following approval of the FY 2020 CHIP a scrivener's error was noted in Section V (3) regarding the statement about Racism and Discrimination in HealthCare Settings. The TCCH Board, through its Executive Committee, has reviewed the corrected statement and amended FY 2020 CHIP, as presented and attached as Exhibit A.

ACCORDINGLY, IT IS HEREBY

RESOLVED, that the corrected statement and amended FY 2020 CHIP as described in the foregoing Intention is hereby approved.

FURTHER RESOLVED, that the proper officers of TCCH be, and each of them hereby is, authorized to execute and deliver such additional documents, and to take such additional actions as may be necessary or desirable in the opinion of the individual so acting, to effectuate the intent of the foregoing resolution.

William W. Wylie, Jr.
October 8, 2019

Penn Medicine
Chester County Hospital

Community Health Needs Assessment

Strategic Implementation Plan

Penn Medicine Chester County Hospital

701 East Marshall Street, West Chester, PA 19380

FY 2020 – FY2022

I. General Information

Contact Person: Michael J. Duncan, President and Chief Executive Officer, Chester County Hospital

Date of Written Plan: September 10, 2019

Date Written Plan was Adopted by Organization's Authorized Governing body: September 10, 2019 (amended plan correcting scrivener error adopted October 8, 2019)

Date Written Plan was Required to be Adopted: November 15, 2019

Date Written Plan Posted to Website: September 11, 2019 (amended plan correcting scrivener error: October 9, 2019)

Authorizing governing Body that Adopted the Written Plan: Chester County Hospital and System Board of Directors (Amended plan adopted by Chester County Hospital Board of Directors Executive Committee)

Was Written Plan Adopted by Authorized Governing Body on or before the 15th day of the fifth month after the End of Tax Year in Which CHNA was Made Available to the Public? Yes

Date Written Plan Was Made Widely Available: September 11, 2019 (amended plan correcting scrivener error: October 9, 2019)

Date Facility's Prior Written Plan Was Adopted by Organization's Governing Body: March 28, 2017

Name and EIN of Hospital Organization Operating Hospital Facility:

Chester County Hospital, EIN: 23-0469150

Address of Hospital Organization: 701 East Marshall Street, West Chester, PA 19380

II. List of Community Health Needs Identified in the Written Report

The Affordable Care Act (ACA) mandates that tax-exempt hospitals must conduct a Community Health Needs Assessment (CHNA) every three years and develop a Community Health Improvement Plan (CHIP) plan outlining strategies to address priority needs identified by the assessment. For this reporting period Chester County Hospital participated in a collaborative effort conducted by the Philadelphia Department of Public Health (PDPH) and the Health Care Improvement Foundation (HCIF) to assess the needs of the broader Southeastern PA (SEPA) region, focusing on Bucks, Chester, Montgomery, and Philadelphia counties. This process increased collaboration among partner hospitals, reduced duplication of effort and promoted coordination of effort to address needs of high priority. While the CHNA presents the findings for the entire area, including Chester County, this plan addresses only Chester County's specific priority needs.

The complete list of community health priorities resulting from this report are as follows:

Health Issues	Access and Quality of Healthcare and Health Resources	Community Factors
• Behavioral health diagnosis and treatment • Chronic disease prevention • Homelessness • Maternal morbidity and mortality • Sexual and reproductive health • Substance/opioid use and abuse	• Access to affordable primary and preventive care • Access to affordable specialty care • Food access and affordability • Healthcare and health resources navigation • Linguistically and culturally appropriate healthcare • Racism and discrimination in healthcare	• Affordable and healthy housing • Neighborhood condition • Community violence • Socioeconomic disadvantage

III. Planned Collaborations to Address Health Needs

Chester County Hospital has many established and long-standing collaborations and community partnerships with whom we work to serve the needs of our shared community.

Act in Faith Greater West Chester	Financial Stability Center
Brandywine Health Foundation	Good Fellowship Ambulance and Training Center
ChesPenn Health Services	Health Promotion Council
Chester County Department of Community Development	Housing Partnership of Chester County
Chester County Dept. of Drug and Alcohol	La Comunidad Hispana
Chester County Dept. of Emergency Services	Longwood Fire Company
Chester County Faith Community	Maternal Child Health Consortium
Health Ministry Committee	Minquas Fire Company
Chester County Fire, Police, and EMS	Oxford Neighborhood Services
Chester County Food Bank	Oxford Presbyterian Church
Chester County Health Department	Shiloh Presbyterian Church
Chester County Intermediate Unit	St. Paul's Baptist Church Health Ministry Committee
Chester County Nurse Family Partnership	Surrey Services of Devon
Chester County Parks and Recreation	Surrey Services of East Goshen
Chester County Planning Commission	The COAD Group
Chester County Tobacco Free Coalition	The Melton Center
Chester County Women's Services	United Way of Chester County
Community Care Coalition of Chester County	West Chester Area School District
Community Volunteers in Medicine	West Chester Senior Center
Decade to Doorways Partnership	West Chester University
Downingtown Senior Center	YMCA of Brandywine Valley

IV. Health Needs planned to be Addressed by Chester County Hospital

Though the CHNA was produced as part of a joint collaborative assessing the broader geographic region in which the hospital is positioned, this plan addresses only those priorities specific to Chester County and which offer Chester County Hospital the opportunity to conduct community benefit and social accountability planning.

The goals and strategies presented in this document represents the intentions of Chester County Hospital to address those identified priorities which impact a significant portion of the population served by the hospital, and which have been deemed feasible to address.

These include:

Health Issues	Access and Quality of Healthcare and Health Resources
• Substance/opioid use and abuse • Chronic disease prevention • Maternal morbidity and mortality	• Access to affordable primary and preventive care • Access to affordable specialty care • Healthcare and health resources navigation • Linguistically and culturally appropriate healthcare

Below are listed the goals and strategies associated with the prioritized health needs. Further detail regarding resources, collaborations impact, and evaluation are found in the section following this listing.

Identification and Description of How Chester County Hospital Plans to Address Each Priority

Priorities 1 and 2: Access to Affordable Specialty, Primary and Preventive Care (presented together due to their similar nature)

Goal 1: Develop a collaborative plan to offer needed specialty and primary care to regions currently underserved.

Strategies:

a. Chester County Hospital will continue to evaluate the regional supply and demand of physicians within each of the core specialties via an analysis of both the current population and projected future totals.
b. Continue to evaluate the needs of vulnerable populations served by community partners.
c. Support the provision of screenings, lab, and diagnostic radiology services to underserved populations.

Goal 2: Provide health screenings, health promotion and support services to vulnerable or high-risk adults.

Strategies:

a. Increase participation in the free Preparation for Childbirth Classes held at ChesPenn Health Center in Coatesville.
b. Maintain offering of all Childbirth Programs to patients on Medical Assistance at no charge.
c. Provide cardiovascular risk, blood pressure and stroke screenings to the general community and in areas identified as high risk at no charge.
d. Utilize the Pastoral Care services to provide access to spiritual support during a hospital stay.
e. Maintain a Call Center to assist individuals in physician referral needs, wellness class registration and community resource information.
f. Maintain up-to-date listings of all health and social service agencies serving Chester County to provide appropriate information and referrals to community members.

Priority 3: Chronic Disease Prevention

Goal 1: Promote optimal health to reduce the impact of chronic diseases (e.g. cancer, obesity, diabetes, heart disease, stroke, etc.) and to enhance overall outcomes and quality of life.

Strategies:

a. Continue to provide the CDC National Diabetes Prevention Program.
b. Provide Reversing Prediabetes Classes in high risk areas.
c. Offer a chronic disease prevention program at a partner primary care clinic (e.g. CVIM, LCH, or ChesPenn) based on identified needs.
d. Continue to provide comprehensive diabetes self-management education and support in the American Association of Diabetes Educators (AADE) accredited outpatient diabetes program.
e. Collaborate with primary care practices to refer high risk patients into smoking cessation, prediabetes, diabetes and the Heart Failure support program.
f. Enhance participation in weight management programs.
g. Continue to offer smoking cessation programs.
h. Increase the capacity of the *Matter of Balance* program through partnering with other community groups.
i. Continue to provide Pre-Surgery Education Classes to help individuals and their support person to prepare for Joint Surgery.
j. Offer cancer prevention and cancer screening programs based on identified needs as required by the Commission on Cancer.
k. Provide nutrition counseling at no charge to cancer patients in treatment.

l. Provide support programs to individuals living with cancer (Care of the Care Provider, Metastatic Disease, Gyn Coping with Cancer, Survivorship: Next Steps).
m. Provide Early Heart Attack Care (EHAC) education, screening and outreach per the requirements of The Society of Chest Pain Centers for Chest Pain Center Accreditation.
n. Provide stroke awareness education and stroke screenings per requirements of JCAHO Disease Specific Certification as a Primary Stroke Center.
o. Address daily living needs of individuals living with heart failure and their caregivers through the provision of Heart Failure Support meetings and workshops.
p. Collaborate with First Responders and other emergency personnel to address the *Stop the Bleed* initiative.
q. Partner with West Chester University School of Health Sciences (WCU) to provide educational programs for the community based on an identified chronic disease issue.
r. Continue to respond to community requests for speakers on topics related to health promotion and disease prevention.
s. Maintain active involvement with the Community Care Coalition of Chester County (C5) to educate Medicare beneficiaries on issues important to their health and safety.
t. Implement a Chronic Disease Advisory Committee to assist with the planning and delivery of programs that meet the needs of the community.

Priority 4: Healthcare and Health Resources Navigation

Goal 1: Improve the patient experience through efforts to enhance healthcare navigation.

Strategies:

a. Explore transportation options to enhance transitions of care for patients among Penn Cancer sites in the healthcare system.
b. Explore options for virtual connection via use of technology.
c. Continue support of nurse navigator roles in oncology and cardiovascular services.
d. Enhance web content to include current community resource information.
e. Coordinate between the various entities in the UPHS system to assure appropriate and seamless care transitions.
f. Explore feasibility of adding additional disease specific patient navigators.
g. Provide convenient access to Medical Assistance and Financial Representatives for enrollment in public benefits and programs.

Priority 5: Linguistically and Culturally Appropriate Healthcare

Goal 1: Develop cultural sensitivity among employees to assure a positive healthcare experience for patients of different cultures and language needs.

Strategies:

a. Conduct monthly diversity awareness opportunities for employees.
b. Hold regular Diversity Committee meetings as a means of maintaining a focus on the provision of culturally appropriate healthcare.
c. Maintain the LGBTQ+ Advisory Council.
d. Complete pilot of Bias Training and roll out the training to all units.

Goal 2: Provide the tools and materials necessary to assure a positive healthcare experience for those with language or cultural needs.

Strategies:

a. Provide personalized prenatal education and maternity unit tours utilizing a bilingual nurse educator.
b. Provide Spanish-speaking expectant parents attending childbirth classes expectant parent folders and educational handout materials in Spanish.
c. Utilize annual grant for health literacy to improve assessment, screening and educational tools used by staff and patients in wellness programs.
d. Provide a bilingual diabetes educator to counsel Spanish speaking patients with gestational diabetes.
e. Utilize the Martti system to assist the hearing impaired and increase the availability of language services to our patients.
f. Provide interpreter services to the radiology scheduling department.
g. Provide discharge instructions in Spanish to hospitalized patients.
h. Provide in-person interpreter services to patients with language needs.

Priority 6: Maternal Morbidity and Mortality

Goal 1: Improve in-hospital and outpatient care of patients who present with eclampsia or pre-eclampsia.

Strategies:

a. Implement a process of closer follow up post discharge, to include increased visits and phone calls, and provision of home monitoring of blood pressure upon discharge.
b. Implement California Collaborative Algorithm to prevent and improve the care of the woman.
c. Provide AWHONN's Post Birth Warning sheet to all attendees of prenatal childbirth classes and incorporate education regarding warning signs into class content.

Goal 2: Expand Opioid Use Disorder Committee to include the Maternal Child unit.

Strategies:

a. Institute a perinatal screening program to identify perinatal patients with a substance use disorder. Goal is to screen at least 80% of our patients by December 2019.
b. Establish a treatment plan for at least 75% of perinatal patients with OUD by January 2020.
c. Provide education to all clinical staff treating women with OUD and their infants.

Goal 3: Decrease late entry into prenatal care among uninsured or underinsured women through the provision of outpatient clinic services.

Strategies:

a. Provide free or reduced care of prenatal patients seen in PMCCH's Prenatal Clinic who meet charity care guidelines.
a. Assist eligible patients in the Prenatal Clinic to apply for Medical Assistance.
b. Continue to provide prenatal clinic services one day a week in Kennett Square.
c. Continue to provide a nurse practitioner to ChesPenn to increase access to prenatal care services at this site.
d. Participate in the taskforce chaired by Chester County Health Department to address the needs of African American women seeking prenatal care.

Priority 7: Substance/Opioid Use and Abuse

Goal 1: Offer gold-standard, evidence-based treatment options for patients with Opioid Use Disorder (OUD)

Strategies:

a. Promote the current standard of care for management of the patient with OUD to improve consistency among providers.
b. Improve screening of patients for OUD and connect identified patients to appropriate outpatient resources.
c. Provide Naloxone nasal spray (Narcan®) upon discharge to patients identified to be at risk for an opioid emergency/opioid overdose.
d. Partner with the Comprehensive Treatment Center in Coatesville.
e. Increase the number of providers who complete the SAMHSA DATA 2020 waiver training (X-waivered) and can prescribe buprenorphine for Medication Assisted Treatment.

Goal 2: Increase education and awareness of OUD.

Strategies:

a. Provide a community-based Substance Use Disorder Panel Discussion program in Fall 2019.
b. Partner with Community Health Education and Chester County Drug and Alcohol Services to provide education and discussion of OUD on the community level.
c. Provide education on OUD to all clinical staff including providers, nurses, pharmacists, case managers and social workers.

V. Health Needs Chester County Hospital Does Not Intend to Address

Following the completion of the CHNA and the identification of all the health priorities, the needs were prioritized using a Modified Hanlon Method to score the need against several criteria. Following this process, the needs were further prioritized based on several feasibility factors to screen out priorities not feasible to address. This process is known as the "PEARL" test and looked at factors of propriety, economics, acceptability, resources and legality associated with each of the health priorities. Any community health need receiving an answer of "no" to any of these factors was removed from the list of priorities. Thus, the ones remaining on the list of priorities to address are all feasible to address.

Health needs that are not feasible for Chester County Hospital to address, and the reasons why, include:

1. Behavioral Health Diagnosis and Treatment

Though the issue of behavioral health is significant, the hospital does not have the resources to develop a program to provide for this need. There are two facilities in the broader area able to meet this need. These include Brandywine Behavioral Health in the Coatesville area, and Penn Medicine Lancaster General Behavioral Health Hospital in Lancaster, PA. Additionally, the Chester County Strategic Plan has set the goal of admitting 50% of overdose survivors referred to Community Outreach and Prevention Education (COPE) Program will be directly admitted to drug and alcohol treatment from the Emergency Department.

2. Food Access and Affordability

The Chester County Food Bank and its network of Food Pantries in the county are better suited to address this need. The hospital also lacks the resources to meet this need but collaborates with the Food Bank to provide supplemental food boxes to vulnerable patients.

3. **Racism and Discrimination in Healthcare Settings**

   Racism and discrimination in healthcare settings was not identified as a concern within the Chester County community, either statistically or within the community meetings. However, Chester County Hospital is proud of the several programs and initiatives developed to promote and assure that persons of all races, genders, ethnicities and sexual orientations are treated respectfully and equitably.

4. **Sexual and Reproductive Health**

   A program to address this need was not considered suitable since we have this need addressed well through the provision of the Outpatient Clinic that provides prenatal and GYN care that address sexual and reproductive health for underserved women.

Many community needs are addressed directly by the resource guide provided by Chester County. The following link includes information for community residents and providers to access these services.

https://www.chesco.org/DocumentCenter/View/4275/Community-Resource-Guide-August-2019?bidId=

5. **Homelessness**

   Homelessness was not specifically identified as a need with Chester County.

6. **Affordable and Healthy Housing**

   Chester County Hospital does not have the capacity to address a need for affordable housing within the community. Residents challenged with finding affordable and healthy housing may find assistance within cited county resources.

7. **Neighborhood Conditions**

   Poor neighborhood conditions were not specifically identified as a community need within the Chester County market. Findings from community meetings conducted in two separate segments identified neighborhood conditions as assets.

8. **Community Violence**

   Community violence was not identified as a concern within the Chester County community, either statistically or within the community meetings.

9. **Socioeconomic Disadvantage**

   Chester County Hospital has chosen to focus on healthcare disparities rather than socioeconomic disadvantages associated with income, education and employment.

Implementation Plan - 2020

Priority 1: Access to Affordable Specialty Care
Priority 2: Access to Affordable Primary and Preventive Care
(combined due to their similar nature)

Goal 1: Develop a collaborative plan to offer needed specialty and primary care to regions currently underserved.	
Strategy	**Impact Measure**
a. Chester County Hospital will continue to evaluate the regional supply and demand of physicians within each of the core specialties via an analysis of both the current population and projected future totals.	Completion of analysis to determine physician supply and demand in Year 1, 2 and 3.
b. Continue to evaluate the needs of vulnerable populations served by community partners through collaboration with CVIM, ChesPenn and LCH.	Annual Report documenting partnership activities.
c. Support the provision of screenings, lab, and diagnostic radiology services to underserved populations.	# procedures provided to patients of community clinics
Monitoring/Evaluation Approach 1a and 1b: annual review of data; 1c: annual financial analysis of services provided	
Resources (partners, financial contributions) Operational budget; 1b and cPartners: CVIM, ChesPenn, LCH	

Goal 2: Provide health screenings, health promotion and support services to vulnerable or high-risk adults.	
Strategy	**Impact Measure**
a. Increase participation in the free Preparation for Childbirth Classes held at ChesPenn Health Center in Coatesville.	5% increase in number of participants annually

Goal 2: Provide health screenings, health promotion and support services to vulnerable or high-risk adults.	
Strategy	**Impact Measure**
b. Maintain offering of all Childbirth Programs to patients on Medical Assistance at no charge.	Maintain current offerings.
c. Provide cardiovascular risk and stroke screenings in areas identified as high risk at no charge.	At least two programs offered in high risk areas annually.
d. Utilize the Pastoral Care services to provide access to spiritual support during a hospital stay.	Initiation of method to track usage of pastoral care services.
e. Maintain a Call Center to assist individuals in physician referral needs, wellness class registration and community resource information.	Maintain current utilization of Call Center.
f. Maintain up-to-date listings of all health and social service agencies serving Chester County to provide appropriate information and referrals to community members.	Annual review and update of county health and social service agencies.
Monitoring/Evaluation Approach Program rosters, Call Center statistics, Community Health Education (CHED) Activity Report, Pastoral Care Report	
Resources (partners, financial contributions) Operational budget; Partners: faith community, ChesPenn Health Center, Chester County Health Dept.	

Priority 3: Chronic Disease Prevention

Goal 1: Promote optimal health to reduce the impact of chronic diseases (e.g. cancer, obesity, diabetes, heart disease, stroke, etc.) and to enhance overall outcomes and quality of life.	
Strategy	**Impact Measure**
a. Continue to provide the CDC National Diabetes Prevention Program.	2 programs annually
b. Provide Reversing Prediabetes Classes in high risk areas.	4 programs annually
c. Offer a chronic disease prevention program at partner primary care clinic (e.g. CVIM, LCH, or ChesPenn) based on identified needs.	2 programs annually
d. Continue to provide comprehensive diabetes self-management education and support in the American Association of Diabetes Educators (AADE) accredited outpatient diabetes program	1-3% increase in participation annually
e. Collaborate with primary care practices to refer high risk patients into smoking cessation, prediabetes, diabetes and the Heart Failure support program	3 - 5% increase in participation in each program annually
f. Enhance participation in weight management programs.	10% increase in participation annually
g. Continue to offer smoking cessation programs.	7 programs annually; at least two off-site in high risk areas
h. Increase the capacity of the *Matter of Balance* program through partnering with other community groups.	At least 4 programs annually
i. Continue to provide Pre-Surgery Education Classes to help individuals and their support person to prepare for Joint Surgery.	2 programs per month annually

Goal 1: Promote optimal health to reduce the impact of chronic diseases (e.g. cancer, obesity, diabetes, heart disease, stroke, etc.) and to enhance overall outcomes and quality of life.	
Strategy	**Impact Measure**
j. Offer cancer prevention and cancer screening programs based on identified needs as required by the Commission on Cancer.	At least 1 prevention and 1 screening program/year annually
k. Provide nutrition counseling at no charge to cancer patients in treatment.	5% increase in visits annually
l. Provide support programs to individuals living with cancer (Care of the Care Provider, Metastatic Disease, Gyn Coping with Cancer, Survivorship: Next Steps).	2% increase in total participation annually
m. Provide Early Heart Attack Care (EHAC) education, screening and outreach per the requirements of The Society of Chest Pain Centers for Chest Pain Center Accreditation.	Meet or exceed requirements of Society of Chest Pain Centers
n. Provide stroke awareness education and stroke screenings per requirements of JCAHO Disease Specific Certification as a Primary Stroke Center.	Meet or exceed JCAHO Disease Specific Certification for Primary Stroke Center outreach requirements.
o. Address daily living needs of individuals living with heart failure and their caregivers through the provision of Heart Failure Support meetings and workshops	10% increase in participation annually
p. Collaborate with First Responders and other emergency personnel to address the *Stop the Bleed* initiative.	At least 2 programs annually
q. Partner with West Chester University School of Health Sciences (WCU) to provide educational programs for the community based on an identified chronic disease issue.	At least 1 program annually

Goal 1: Promote optimal health to reduce the impact of chronic diseases (e.g. cancer, obesity, diabetes, heart disease, stroke, etc.) and to enhance overall outcomes and quality of life.	
Strategy	**Impact Measure**
r. Continue to respond to community requests for speakers on topics related to health promotion and disease prevention.	# programs
s. Maintain active involvement with the Community Care Coalition of Chester County (C5) to educate Medicare beneficiaries on issues important to their health and safety.	Meet with C5 committee at least 8 times annually.
t. Implement a Chronic Disease Advisory Committee to assist with the planning and delivery of programs that meet the needs of the community.	At least 2 meetings annually
Monitoring/Evaluation Approach CHED Activity Reports; Class Rosters; EPIC; Cancer Program Reports; meeting minutes;	
Resources (partners, financial contributions) Trumba System; operational budgets; Partners: C5, WCU; Emergency Services; grant from Health Promotion Council for DPP; community clinics; Surrey Services; Senior Centers; YMCA of Brandywine Valley, The Melton Center; C5,	

Priority 4: Healthcare and Health Resources Navigation

Goal 1: Improve the patient experience through efforts to enhance healthcare navigation.	
Strategy	**Impact Measure**
a. Explore transportation options to enhance transitions of care for patients among Penn Cancer sites in the healthcare system.	Increased utilization of Ride Health by 5%.
b. Explore options for virtual connection via use of technology.	At least one online virtual support group.
c. Continue support of nurse navigator roles in oncology and cardiovascular services.	1-2% increase in new patient visits.
d. Enhance web content to include community resource information.	Addition and maintenance of community resource area on hospital website.
e. Coordinate between the various entities in the UPHS system to assure appropriate and seamless care transitions.	Absence of complaints/service failures
f. Explore feasibility of adding additional disease specific patient navigators.	Hiring of additional navigators (if determined to be feasible and necessary)
g. Provide convenient access to Medical Assistance and Financial Representatives for enrollment in public benefits and programs.	Increase enrollments by 5%
Monitoring/Evaluation Approach Cancer Committee Review; MA Office Enrollment statistics;	
Resources (partners, financial contributions) Operating budgets	

Priority 5: Linguistically and Culturally Appropriate Healthcare

Goal 1: Develop cultural sensitivity among employees to assure a positive healthcare experience for patients of different cultures and language needs.	
Strategy	**Impact Measure**
a. Conduct monthly diversity awareness opportunities for employees.	At least 6 diversity awareness activities/year
b. Hold regular Diversity Committee meetings as a means of maintaining a focus on the provision of culturally appropriate healthcare.	At least 6 meetings/year
c. Maintain the LGBTQ Plus Advisory Council.	At least 6 meetings/year
d. Complete pilot of Bias Training and roll out the training to all units.	House-wide training by Spring 2020
Monitoring/Evaluation Approach HROD oversight	
Resources (partners, financial contributions)	

Goal 2: Provide the tools and materials necessary to assure a positive healthcare experience for those with language or cultural needs.	
Strategy	**Impact Measure**
a. Provide personalized prenatal education and maternity unit tours utilizing a bilingual nurse educator.	Meet or exceed 2019 clinic tour volume
b. Provide Spanish-speaking expectant parents attending childbirth classes expectant parent folders and educational handout materials in Spanish.	# Spanish packets prepared and delivered to clinic and practices

Goal 2: Provide the tools and materials necessary to assure a positive healthcare experience for those with language or cultural needs.	
Strategy	**Impact Measure**
c. Utilize annual grant for health literacy to improve assessment, screening and educational tools used by staff and patients in wellness programs.	At least 4 patient education or screening tools developed and printed for use each grant year.
d. Utilize the Martti system to assist the hearing impaired and increase the availability of language services to our patients.	10% increase in real time minutes used by this service
e. Provide a bilingual diabetes educator to counsel Spanish speaking patients with gestational diabetes.	2% increase in # patients served
f. Provide interpreter services to the radiology scheduling department.	Interpreter hours/no. of calls
g. Provide discharge instructions in Spanish to hospitalized patients.	# inpatients with Spanish as primary language
h. Provide interpreter and translation services for patients with language needs.	# items translated # items submitted and approved by Breast Health Taskforce Increased use of Oncolink site
Monitoring/Evaluation Approach 2 a, b: Childbirth Program Statistics (# Spanish tours); # Spanish Packets prepared and given to patients;	
Resources (partners, financial contributions) 2c: Health Care Improvement Council	

Priority 6: Maternal Morbidity and Mortality

Goal 1: Improve in-hospital and outpatient care of patients who present with eclampsia or pre-eclampsia.	
Strategy	**Impact Measure**
a. Implement a process of closer follow up post discharge, to include increased visits and phone calls, and provision of home monitoring of blood pressure upon discharge.	# clinic patients identified as needing additional visits for BP within designated timeframe
b. Implement California Collaborative Algorithm to prevent and improve the care of the woman	# pts. identified as at risk for post-partum hemorrhage # pts. meeting clinical definition of hemorrhage # pts. Requiring blood transfusion/transfer to ICU/or hysterectomy
c. Provide AWHONN's Post Birth Warning sheet to all attendees of prenatal childbirth classes and incorporate education regarding warning signs into class content. (will be shared with partner community clinics)	# attendees in childbirth programs
Monitoring/Evaluation Approach Trumba class rosters, PennChart Report (1a) and chart reviews	
Resources (partners, financial contributions) ChesPenn, LCH	

Goal 2: Expand Opioid Use Disorder Committee to include the Maternal Child unit.	
Strategy	**Impact Measure**
a. Institute a perinatal screening program to identify perinatal patients with a substance use disorder.	At least 80% of patients will be screened.
b. Establish a treatment plan for perinatal patients with OUD.	At least 75% of perinatal patients with OUD will have a treatment plan.

Goal 2: Expand Opioid Use Disorder Committee to include the Maternal Child unit.	
Strategy	**Impact Measure**
c. Provide education to all clinical staff treating women with OUD and their infants.	Implementation of Clinical Guidance for Treating Pregnant and Parent Women with OUD and their Infants.
Monitoring/Evaluation Approach EPIC chart review, county statistics	
Resources (partners, financial contributions) Operating budget; County Opioid Taskforce, Chester County Health Dept.	

Goal 3: Decrease late entry into prenatal care among uninsured or underinsured women through the provision of outpatient clinic services.	
Strategy	**Impact Measure**
a. Provide free care or care at a reduced cost for prenatal patients seen in PMCCH's Prenatal Clinic who meet charity care guidelines.	% patients receiving charity care
b. Assist eligible patients in the Prenatal Clinic to apply for Medical Assistance.	% patients on Medicaid (MA)
c. Continue to provide prenatal clinic services one day a week in Kennett Square.	# visits
d. Continue to provide a nurse practitioner to ChesPenn to expand access to prenatal care services at this site.	NP visit volume

Goal 3: Decrease late entry into prenatal care among uninsured or underinsured women through the provision of outpatient clinic services.	
Strategy	**Impact Measure**
e. Participate in the taskforce chaired by Chester County Health Department to address the needs of African American women seeking prenatal care	Infant low birth weight rate >7.5%
Monitoring/Evaluation Approach Clinic statistics; EPIC, Penn Chart	
Resources (partners, financial contributions) ChesPenn Health Center, Maternal Child Health Consortium, Chester County Health Dept., United Way of Chester County	

Priority 7: Substance/Opioid Misuse and Use Disorder

Goal 1: Offer gold-standard, evidence-based treatment options for patients with Opioid Use Disorder (OUD)	
Strategy	**Impact Measure**
a. Promote the current standard of care for management of the patient with OUD to improve consistency among providers.	Documented patient care notes reflect standard of care.
b. Improve screening of patients for OUD and connect identified patients to appropriate outpatient resources.	Improvements noted in Taskforce Meeting Minutes and QI review.
c. Provide Naloxone nasal spray (Narcan®) upon discharge to patients identified to be at risk for an opioid emergency/opioid overdose.	Baseline of # products provided upon discharge.
d. Partner with the Comprehensive Treatment Center in Coatesville	Evidence of active partnership.

Goal 1: Offer gold-standard, evidence-based treatment options for patients with Opioid Use Disorder (OUD)	
Strategy	**Impact Measure**
e. Increase the number of providers who complete the SAMHSA DATA 2020 waiver training (X-waivered) and can prescribe buprenorphine for Medication Assisted Treatment.	10% increase in trained providers
Monitoring/Evaluation Approach EPIC, PennChart	
Resources (partners, financial contributions) Comprehensive Treatment Center, Coatesville, PA; Chester County Health Dept.	

Goal 2: Increase education and awareness of OUD.	
Strategy	**Impact Measure**
a. Provide a community-based Substance Use Disorder Panel Discussion program	Program held by Fall 2019
b. Partner with Community Health Education and Chester County Drug and Alcohol Services to provide education and discussion of OUD on the community level.	At least one event/quarter with display and literature on OUD
c. Provide education on OUD to all clinical staff including providers, nurses, pharmacists, case managers and social workers.	At least one provider level educational outreach for clinical staff
Monitoring/Evaluation Approach OUD Taskforce Minutes;	
Resources (partners, financial contributions) Chester County Dept. of Drug and Alcohol	