COMMUNITY
HEALTH NEEDS

2019
IMPLEMENTATION STRATEGY

HEALTH IS WHERE WE LIVE, LEARN, AND WORK

Reading Hospital
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Advancing Health. Transforming Lives.

Reading.TowerHealth.org

LETTER TO THE COMMUNITY

William M. Jennings

resident & CEO
Reading Hospital

OUR MESSAGE TO THE RESIDENTS OF BERKS COUNTY

Reading Hospital is committed to meeting the health needs of our region and growing with our communities to provide access to high quality care, close to home. To achieve this goal, we must understand the community's evolving unmet health needs. To that end, Reading Hospital — in collaboration with all Tower Health hospitals and our local community partners — completed the 2019 Community Health Needs Assessment (CHNA), which identifies the region's health priorities and our collective path forward.

Based on the results of this process, our health system, hospitals and community partners have worked together to develop strategies to address each of the following regional health priorities:

- Access to Health Care
  - Increase access to healthcare services by community members, particularly those considered vulnerable and/or living in underserved areas
- Social Determinants of Health
  - Identify and address Social Determinants of Health
- Disease Prevention and Management
- Access to Behavioral Health Services
  - Improve access to screening, assessment, treatment and support for behavioral health
  - Decrease stigma related to behavioral health

As a healthcare leader, Reading Hospital is committed to advancing health and wellness in all the communities we serve. Our work extends far beyond the walls of our hospitals and health system. Together with our community partners focused on the health needs in our communities, we are implementing life-changing programs and services.

My sincere thanks to the more than 1,000 citizens and stakeholder participants throughout all of the Reading Hospital communities who generously offered their time and valuable insights during the comprehensive CHNA process. I would also like to recognize the time and talent of our hospital's advisory group, comprised of hospital staff and representatives from community organizations.

The most important aspect of the CHNA process is community partnership and engagement. Resident feedback pertaining to the health status of the community is integral to planning and executing interventions, programs and activities. Each of our community partners brings significant and unique expertise. We look forward to our continued work together to ensure that vulnerable individuals receive the care and services they need. We are much stronger together than we would be individually and the community benefits from our collaboration.

I am grateful for your continued feedback, involvement, and support. Together, we are "*Advancing Health, Transforming Lives*" across our region.

Sincerely,

William M. Jennings
President & Chief Executive Officer
Reading Hospital

Reading Service Area

For the 2019 assessment, the community is defined as the geography included on the map shown. The community encompasses the entire geography of Berks County, which represents the primary service area of Reading Hospital.

READING HOSPITAL
SERVICE AREA

Reading Hospital PSA
Lyon Station 19536
Fleetwood 19522
Blandon 19510
Laureldale 19605
Temple 19560
Reading East 19604
Reading Center City 19601
Wernersville 19565
Wyomissing 19610
Exeter 19606
West Lawn 19609
Reading South 19602
West Reading 19611
Sinking Spring 19608
Shillington 19607
Birdsboro 19508
Mohnton 19540
Geigertown 19523

READING HOSPITAL

At Reading Hospital, advancing your health and wellness is our mission. When you enter our facilities, you can expect the highest quality healthcare in the region, as well as access to cutting-edge technology and experienced, caring medical professionals.

More than 1,000 physicians and providers across 46 locations offer comprehensive care ranging from prevention, screenings and education to the latest clinical services and treatments. Our community health programs provide essential resources to residents of Berks County and surrounding areas. Whatever your healthcare needs, we are committed to meeting them.

READING HOSPITAL MISSION

The mission of Reading Hospital is to provide compassionate, accessible, high quality, cost effective healthcare to the community; to promote health; to educate healthcare professionals; and to participate in appropriate clinical research.

READING HOSPITAL VISION

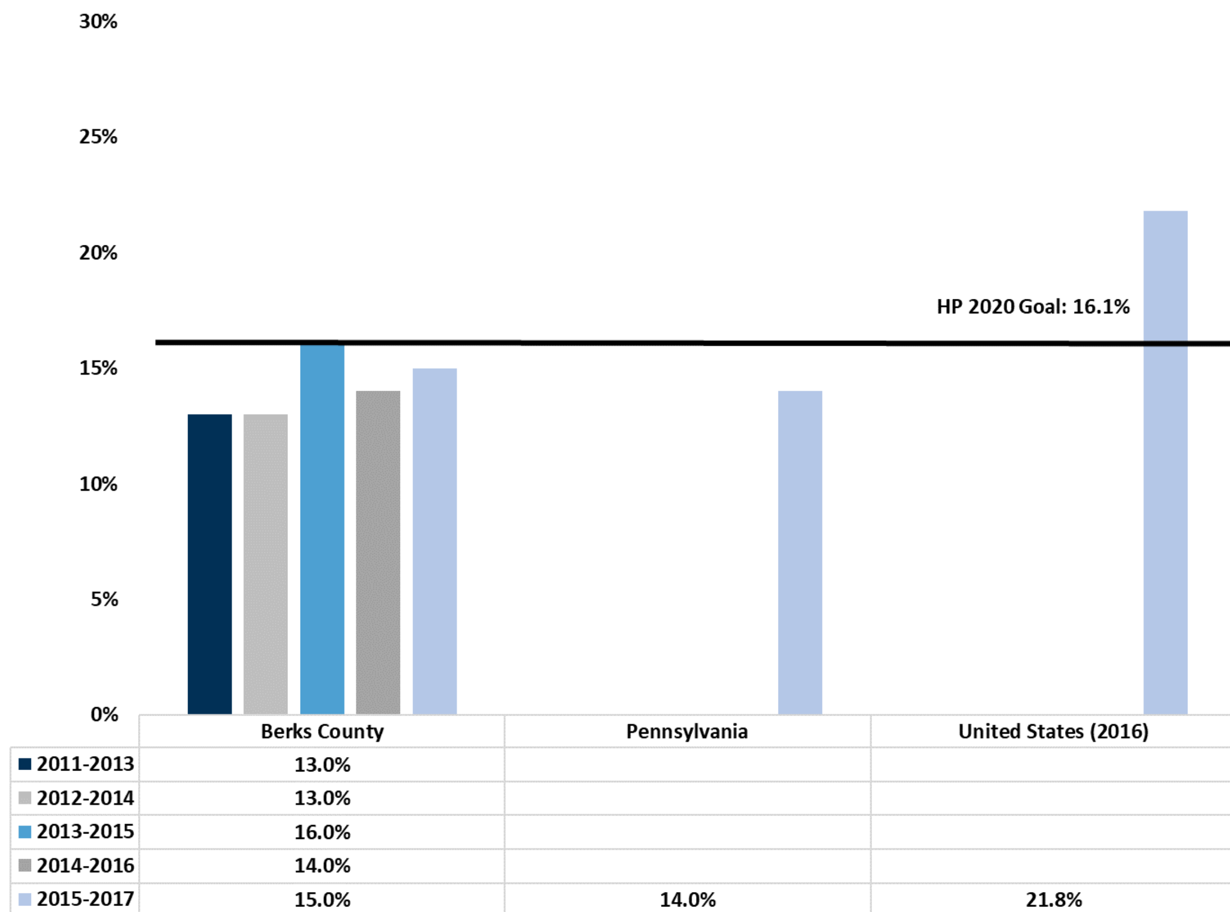
Reading Hospital will be an innovative, leading regional health system dedicated to advancing the health and transforming the lives of the people we serve through excellent clinical quality; accessible, patient-centered, caring service; and unmatched physician and employee commitment.

OUR PRIORITY
FOCUS AREAS

1 ACCESS TO HEALTH CARE SERVICES

While slightly lower than the Healthy People 2020 goal, the percentage of residents in Berks County who do not have a personal care provider has increased in recent years and is higher than the state of Pennsylvania.

No Personal Care Provider



	Berks County	Pennsylvania	United States (2016)
2011-2013	13.0%		
2012-2014	13.0%		
2013-2015	16.0%		
2014-2016	14.0%		
2015-2017	15.0%	14.0%	21.8%

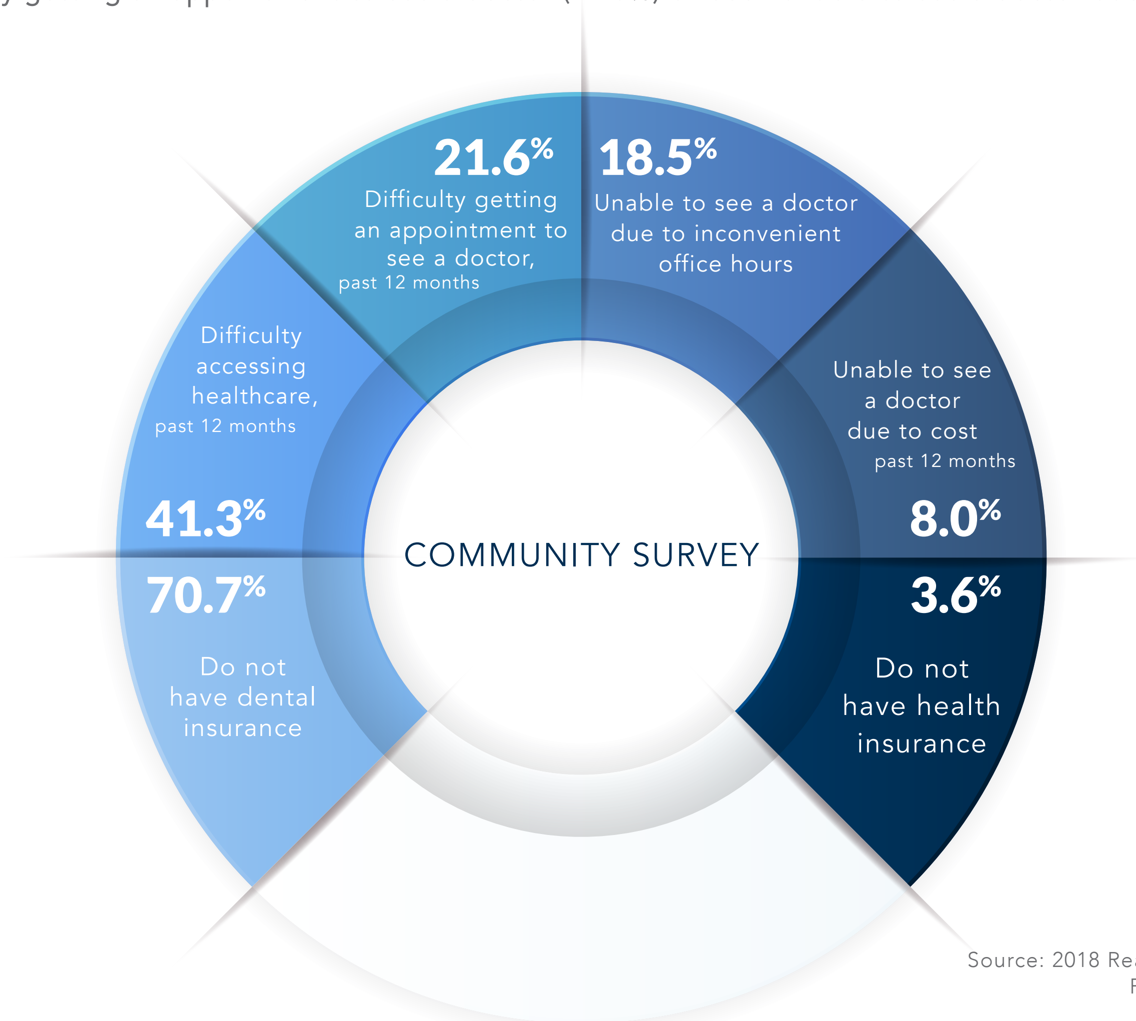
Source: Division of Health Informatics, Behavior Risk Factor Surveillance Survey, Pennsylvania Department of Health for Berks County, 2011-2017, Healthy People 2020, Center for Disease Control 2018

WHAT THE COMMUNITY IS SAYING

Over half (57.3%) of intercept survey respondents identified access to health care as having the highest impact on the health of an individual. The socioeconomic factor most frequently identified by intercept survey respondents was the cost of health care (69.1%).

Stakeholder interview participants spoke about the challenges residents experience accessing care due to cost, lack of transportation and cultural or language barriers. Focus group participants also noted the cost of care and transportation as barriers to accessing needed care.

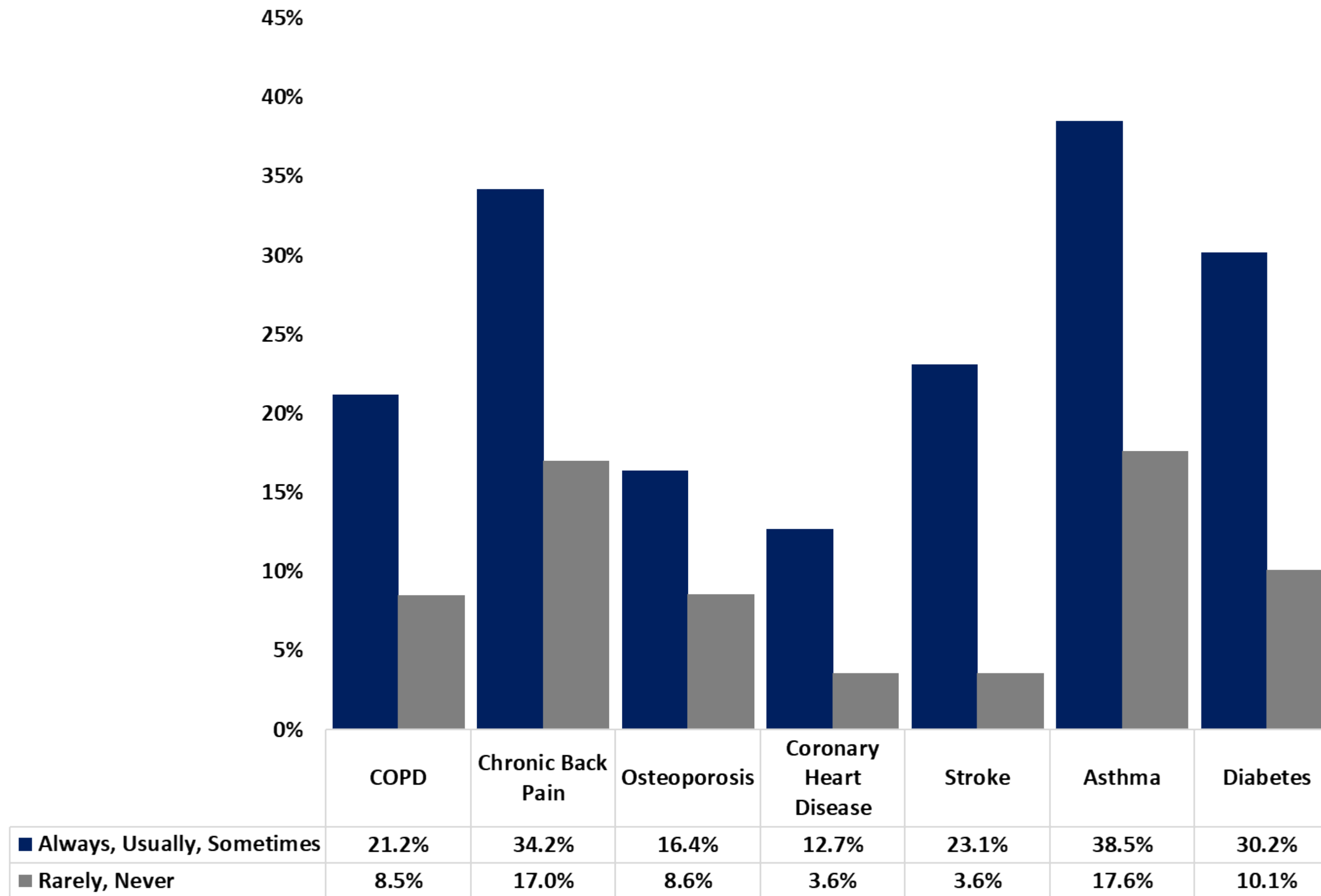
Less than one in three community survey respondents (29.3%) have dental insurance, while most have health insurance. One in five respondents have had difficulty getting an appointment to see a doctor (21.6%) or been unable to see a doctor due to inconvenient office hours (18.5%).



Source: 2018 ReadingHospital Community Survey, Professional Research Consultants

Stable housing also decreases the risk associated with further disease and violence. In many ways, housing itself can be considered a form of healthcare because it prevents new conditions from developing and existing conditions from worsening.[3] Those with housing insecurity are significantly more likely to have COPD, chronic back pain, osteoporosis, coronary heart disease, stroke, asthma and diabetes.

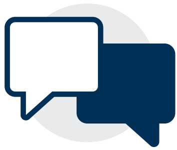
Housing Insecurity Impact On Health



	COPD	Chronic Back Pain	Osteoporosis	Coronary Heart Disease	Stroke	Asthma	Diabetes
Always, Usually, Sometimes	21.2%	34.2%	16.4%	12.7%	23.1%	38.5%	30.2%
Rarely, Never	8.5%	17.0%	8.6%	3.6%	3.6%	17.6%	10.1%

Source: Reading Hospital Community Survey, Professional Research Consultants, 2018

[3] National Health Care for the Homeless Council. What is the relationship between health, housing and homelessness? 2019



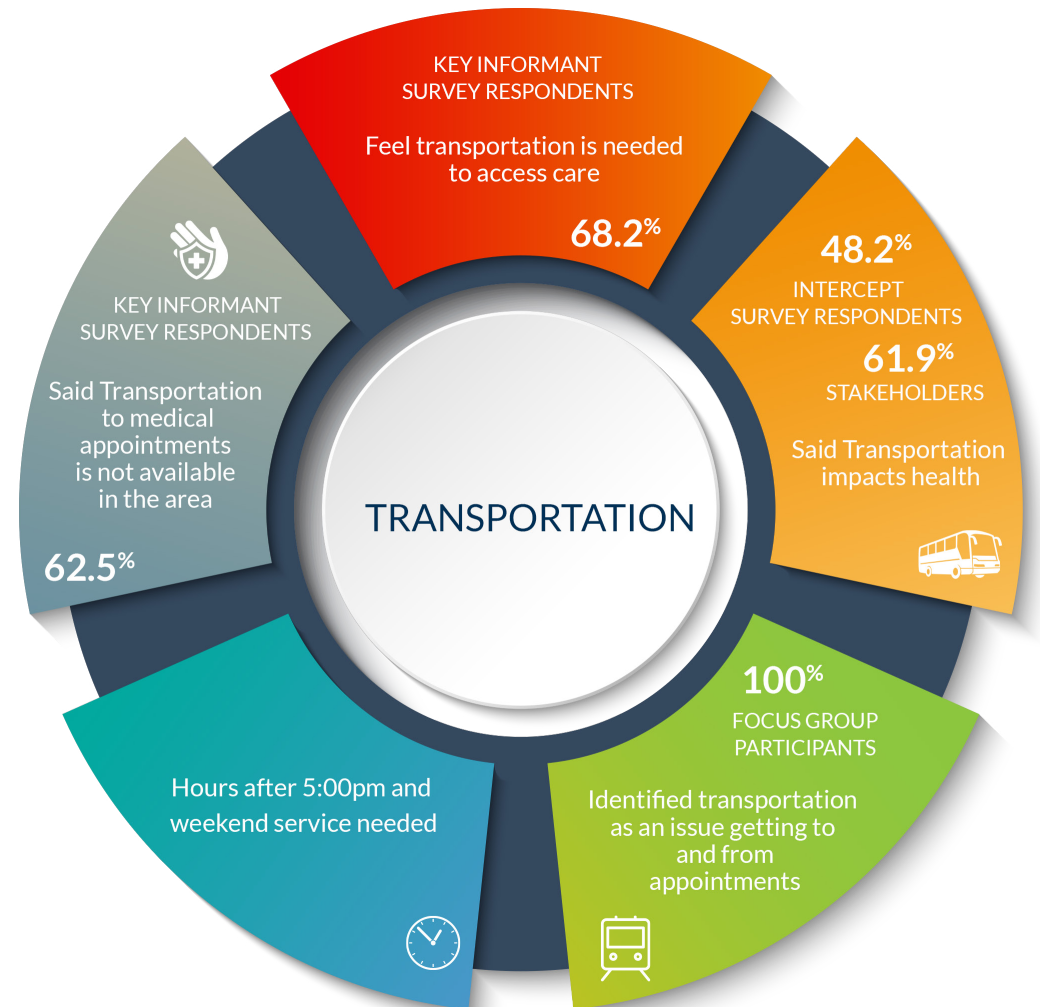
WHAT THE COMMUNITY IS SAYING

Primary research participants from the 2019 CHNA had much to say about the relationship between transportation and health.

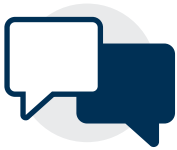
Issues identified in focus groups, intercept surveys, and key informant surveys due to a lack of transportation include:

- Better access to transportation is needed
- Lack of evening and weekend transportation options
- Transportation options are limited and time intensive
- Hours spent accessing transportation in order to get to an appointment
- Affordable transportation
- Cannot access grocery stores that sell fresh produce or exercise areas as no transportation
- Inability to navigate the transportation system
- Lack of transportation outside of the area to access specialty care
- Need for more senior transportation
- Need transportation outside of cities; more rural area transportation

Primary Data Sources – Transportation



Sources: Reading Hospital 2018 Focus Groups, 2018 Intercept Survey, 2018 Key Informant Survey, 2018 Stakeholder Interviews, Strategy Solutions, Inc.



WHAT THE COMMUNITY IS SAYING

One in five (20.2%) respondents were food insecure, while 18.2% find it very or somewhat difficult to buy fresh produce. Just over one-third of survey respondents (36.0%) report eating five or more servings of fruit and/or vegetables daily.

Community Food And Nutrition

- **20.2%** Food Insecure
- **36.0%** Eat 5+ Servings Fruit/Vegetables
- **18.2%** Very/Somewhat Difficult to Buy Fresh Produce

Source: Reading Hospital Community Survey, Professional Research Consultants, 2018

3 DISEASE PREVENTION AND MANAGEMENT

Males are more likely to rate their personal health status as fair or poor, always need help reading health information and less likely to understand health information or have a dental visit in the past year.

IMPACTS OF GENDER ON ACCESS TO HEALTHCARE

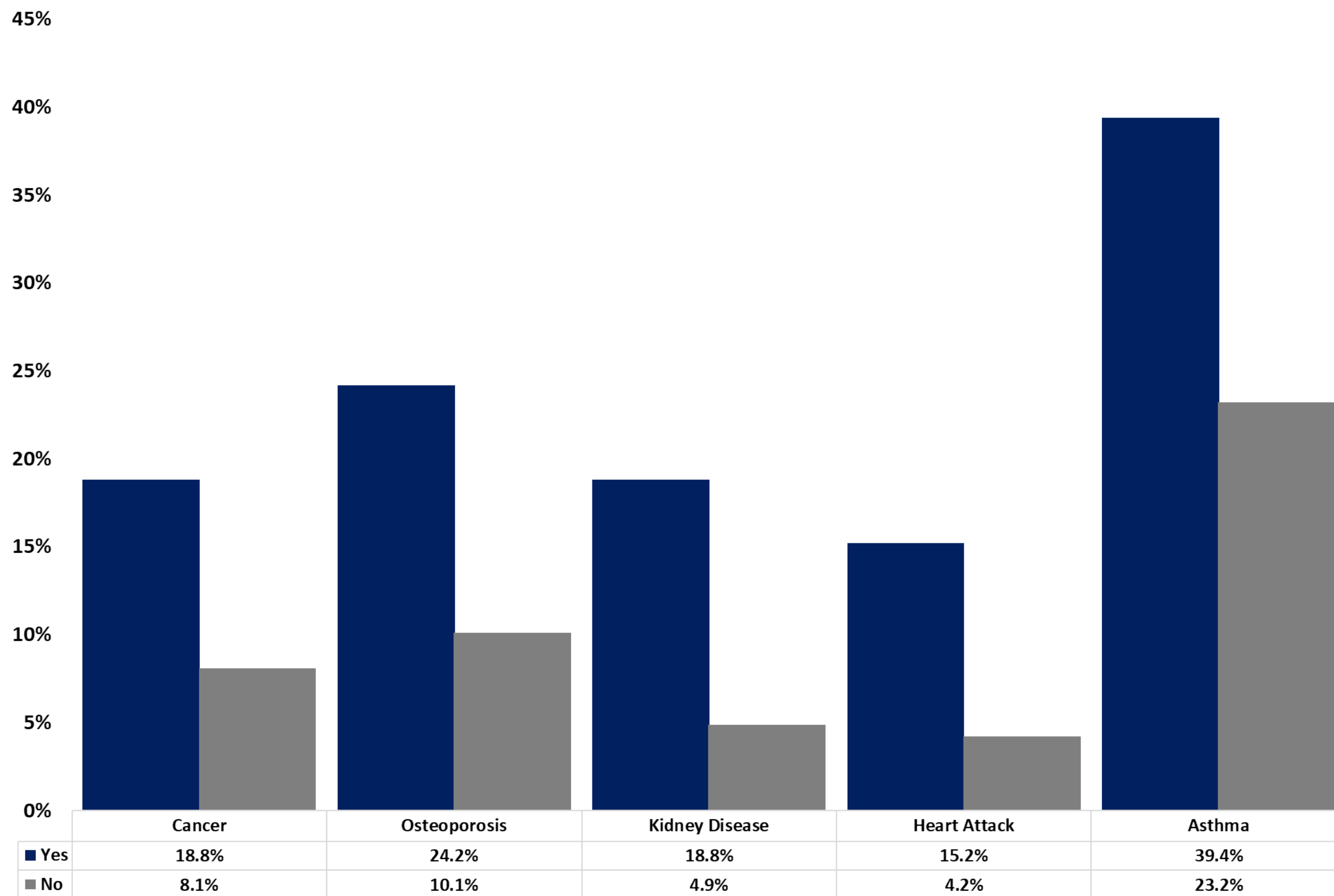
	Male	Female	Overall
Personal health fair or poor	18.7%	13.4%	16.0%
Always need help reading health information	13.4%	0.0%	6.4%
Health information never spoken in a way easy to understand	7.9%	1.7%	4.7%
Dental visit within the past year	68.7%	77.4%	73.2%

**Note: On this table the word overall is used to indicate the percentage for all respondents in the service area from the community survey.*

Source: 2018 Reading Hospital Community Survey, Professional Research Consultants

Community Survey Respondents who experience transportation barriers were significantly more likely than other residents to have cancer, osteoporosis, kidney disease, heart attack or asthma.

Transportation Impact On Health Status, Berks County



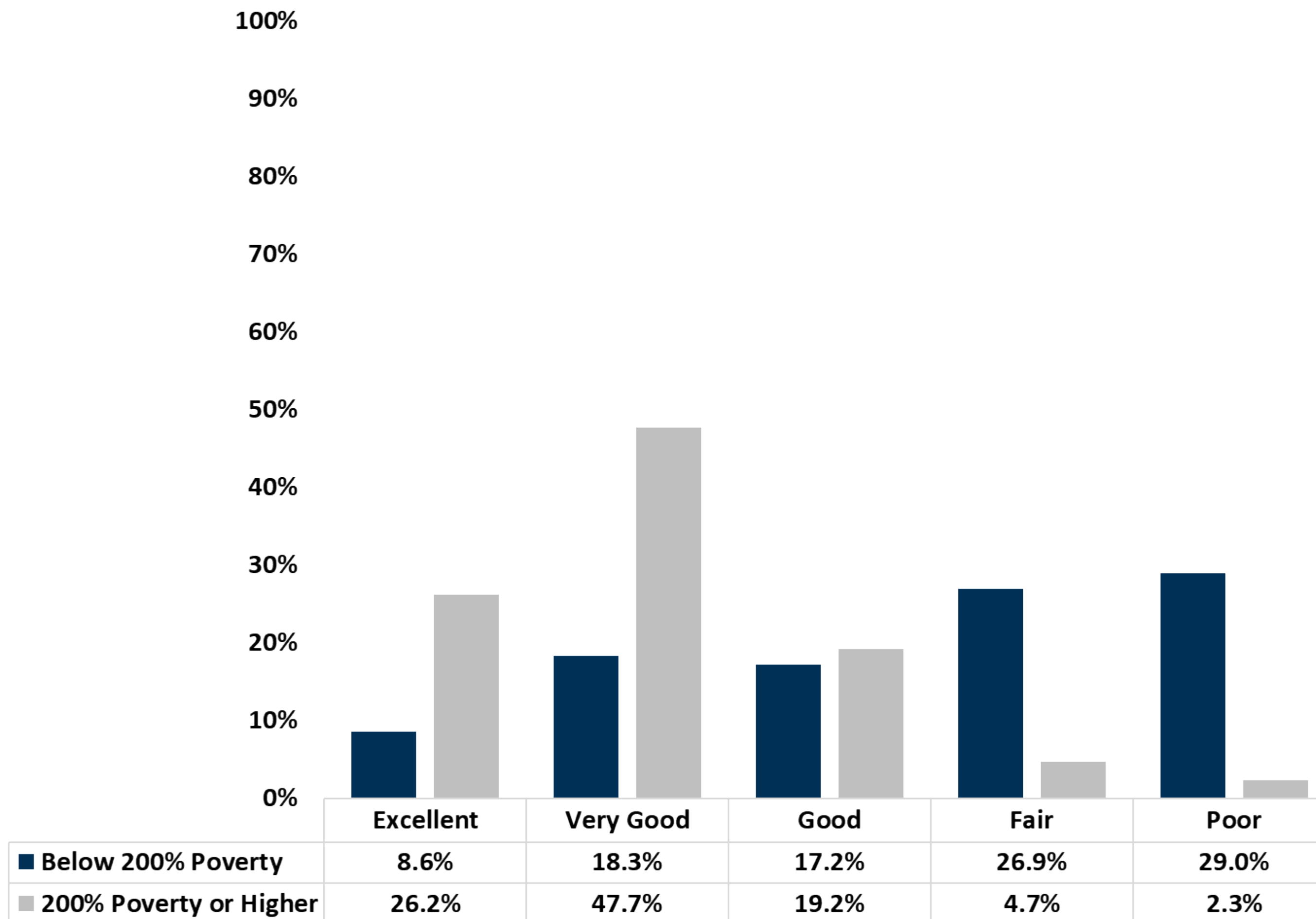
	Cancer	Osteoporosis	Kidney Disease	Heart Attack	Asthma
Yes	18.8%	24.2%	18.8%	15.2%	39.4%
No	8.1%	10.1%	4.9%	4.2%	23.2%

Source: Reading Hospital Community Survey, Professional Research Consultants, 2018

4 ACCESS TO BEHAVIORAL HEALTH SERVICES

Community Survey respondents in the Reading Hospital service area that are living below 200% of the poverty line* were significantly more likely to report their personal mental health as fair or poor than those with higher incomes.

Personal Mental Health Rating



	Excellent	Very Good	Good	Fair	Poor
Below 200% Poverty	8.6%	18.3%	17.2%	26.9%	29.0%
200% Poverty or Higher	26.2%	47.7%	19.2%	4.7%	2.3%

Source: Reading Hospital Community Survey 2018, Professional Research Consultants

*Note: https://www.thebalance.com/federal-poverty-level-definition-guidelines-chart-3305843

Hospital leaders and representatives from community agencies came together to review data compiled for the Community Health Needs Assessment. This group prioritized the most critical community needs identified as focus areas to hone in on areas of focus for the next three years. Hospital leaders met to review these prioritized needs, taking into consideration community needs, national benchmarks, and available resources. The following strategies were then identified to help address the identified priorities.

1 HEALTH PRIORITY: ACCESS TO HEALTH CARE

Goal 1. Increase access to health care services by community members, particularly those considered vulnerable and/or living in underserved areas.

STRATEGIES	ACTION STEPS	YEAR 2019	YEAR 2020	YEAR 2021	METRICS PER YEAR
Increase cultural awareness	Conduct Cultural Awareness Training	✓	✓	✓	12 sessions completed; 360 staff trained 75% of trainees report increased cultural awareness
	Conduct Train the Trainer sessions	☐	✓	✓	60 individuals certified to facilitate Cultural Awareness Training
	Create a Diversity and Inclusion Council	✓	☐	☐	Council Members will be selected
	Develop and execute an action plan	☐	✓	✓	Action plan will be created
Expand/Promote programs that educate students about careers in healthcare	Medical Explorers Shadowing College Internship Program Adventures in Health Science and Medicine High School Internship Program	✓	✓	✓	Host 200 Medical Explorer participants Host 175 student observers Host 25 college interns Increase AHSM Program to 6 classrooms/240 students Host 8 High School Interns

1 HEALTH PRIORITY: ACCESS TO HEALTH CARE

Goal 1 *(continued).* Increase access to health care services by community members, particularly those considered vulnerable and/or living in underserved areas.

STRATEGIES	ACTION STEPS	YEAR 2019	YEAR 2020	YEAR 2021	METRICS PER YEAR
Streamline access to care facilities	Implement the Tower Access Project	✓	☐	☐	Design and develop advanced access center Open advanced access center across ambulatory and specialty care service lines
Support programs that provide care to vulnerable populations	Street Medicine	☐	✓	✓	900 patient contacts 5% decrease in ED utilization
Be Well Berks	Update BWB website with community wellness events and updates from Reading Hospital	✓	✓	✓	Be Well Berks site content will be kept current
Enhance access to Specialty Care	Develop a plan that includes utilizing technology such as: virtual office visits, telecart, mobile apps and telemedicine 2019	☐	✓	☐	Decrease patient outmigration
	Implement the plan	☐	☐	✓	
Enhance the use of remote patient monitoring	Include obese, diabetic and CHF patients	☐	✓	☐	500 patients will be monitored remotely 75% will achieve improved health outcomes

2 HEALTH PRIORITY: SOCIAL DETERMINANTS OF HEALTH

Goal 1. Identify and address Social Determinants of Health (SDOH).

STRATEGIES	ACTION STEPS	YEAR 2019	YEAR 2020	YEAR 2021	METRICS PER YEAR
Identify and address SDOH in the clinical environment	Screen for SDOH in identified clinical areas Connect patients to appropriate resources Provide navigation services to high risk patients	✓	✓	✓	30,000 patients screened 20% decrease ED utilization 10,000 resource summaries generated 3,000 patients receive navigation
Medical Legal Partnership Program	Identify legal issues that have an adverse effect on health i.e., housing, income stability, etc.	✓	✓	✓	220 cases received 160 cases closed 80% of patients report MLP had a positive impact on their health and wellbeing
Implement the Ride Health Program to reduce transportation barriers	Develop a workflow, implementation plan, and guidelines for Ride Health Implement Ride Health	✓	☐	☐	Program implemented
Implement community-based intervention initiatives	Implement a Community Health Worker Program to work with pediatric asthma patients	✓	☐	☐	120 patients will be assigned to a Community Health Worker 75% of participants will report a better understanding of their diagnosis 75% of participants will report their health as good or great
	Expand CHW program to additional populations	☐	✓	✓	

3 HEALTH PRIORITY: DISEASE PREVENTION AND MANAGEMENT

Goal 1. Implement chronic disease prevention and management programs in the primary service area, specifically targeting vulnerable populations.

STRATEGIES	ACTION STEPS	YEAR 2019	 2020	 2021	METRICS PER YEAR
Bike Share	Promote Bike Share Program to encourage bike riding as a form of exercise and recruit new participants	✓	✓	✓	Enroll 40 new members 200 rides taken
Tower Wellness Programs	Implement short and long term wellness initiatives	✓	✓	✓	Increase baseline participation in major ongoing Tower Health sponsored wellness programs to 25% within the next one year (Currently 18%) Maintain engagement in major short-term wellness initiatives at 60% or greater for fitness/nutrition programs and 20% or greater for mental/spiritual health programs
Berks Trail Challenge	Work with Berks County Parks & Recreation to identify trails Develop marketing campaign using internal and external resources	✓	✓	✓	Enroll 780 participants Increase program to include 10 trails
Increase physical activity and knowledge of healthy eating habits among school aged youth (FITT Program)	Engage local college students to assist with program coordination	✓	✓	✓	12 participants per session Pre- and Post-survey data: 50% report increased motivation to make changes to help child's weight 25% report increase in positive daily nutrition/physical activity habits 25% report decrease in negative daily nutrition/physical activity habits 50% report increased confidence to make one change to help child's weight

3 HEALTH PRIORITY: DISEASE PREVENTION AND MANAGEMENT

Goal 1 *(continued)*. Implement chronic disease prevention and management programs in the primary service area, specifically targeting vulnerable populations.

STRATEGIES	ACTION STEPS	YEAR 2019	YEAR 2020	YEAR 2021	METRICS PER YEAR
Increase access to healthy food	Implement a Fresh Food Mobile Market	✓	✓	✓	75% of eligible patients will be screened for food insecurity 100% of food insecure patients will receive a referral to the Fresh Food Mobile Market 75% of patients will report an increase in healthy food consumption
Provide cervical cancer screeenings	Host 1 screening events per year	✓	✓	✓	1 screening session 16 patients screened 20% referred to care 20% early detection
Provide breast cancer screenings	Host 6 screening events per year	✓	✓	✓	6 screening sessions 48 patients screened 25% referred to care 25% early detection
Provide oral cancer screenings	Host 2 screening events per year	✓	✓	✓	2 screening sessions 40 patients screened 40% referred to care 40% early detection
Provide skin cancer screenings	Host 2 screening event per year	✓	✓	✓	2 screening sessions 100 patients screened 45% referred to care 45% early detection

4 HEALTH PRIORITY: ACCESS TO BEHAVIORAL HEALTH SERVICES

Goal 1.mprove access to screening, assessment, treatment and support for behavioral health.

STRATEGIES	ACTION STEPS	YEAR 2019	YEAR 2020	YEAR 2021	METRICS PER YEAR
Center of Excellence	Screen patients for opoid use disorder (OUD) and appropriate level of care, via standardized processes (SBIRT) and tools (ASAM placement criteria)	✓	✓	✓	275 patients screened 85% referred for follow up care
Tower Behavioral Health	Build a new 144-bed inpatient behavioral health facility	☐	✓	☐	Construction Completed
Promote mental health screenings	Mindkare Kiosk and online screenings	✓	✓	✓	1,200 screens completed Attend 10 community events Distribute 2,500 pieces of collateral
Behavioral Health Intergration	Integrate eight therapists into six primary care practices Screen patients for depression using a validated screening tool	✓	✓	✓	Screen 75% of patients for depression Connect 75% of patients screened positive for depression with the embedded therapist 40% of patients will see a decreased PHQ 2 score within 12 weeks

Goal 2. Decrease stigma related to behavioral health.

STRATEGIES	ACTION STEPS	YEAR 2019	YEAR 2020	YEAR 2021	METRICS PER YEAR
Provide Mental Health First Aid Training	Offer training six times per year	✓	✓	✓	6 trainings per year 180 community members trained 90% of participants report favorable results (Agree or Strongly Agree) on Course Evaluation

CONTACT//

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Reading Hospital

TOWER HEALTH

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