Community Health Needs Assessment

Implementation Strategy

2022-2025

FOX CHASE CANCER CENTER

FOX CHASE
CANCER CENTER
TEMPLE HEALTH

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OVERVIEW OF COMMUNITY HEALTH NEEDS

FOX CHASE CANCER CENTER COMMUNITY COMMITMENT

Fox Chase Cancer Center (FCCC) includes the **American Oncologic Hospital** and the **Institute for Cancer Research**. Our 100-bed non-profit specialty hospital is devoted entirely to cancer patients and includes robust outpatient services. Located in the heart of Northeast Philadelphia, our main campus serves the surrounding community with state-of-the-art cancer technology, leading physicians, novel therapies, and cutting-edge clinical trials. Patients can also access our one-of-a-kind care through our North Philadelphia, East Norriton, and Buckingham campuses.

FCCC was among the first institutions in the nation designated by the National Cancer Institute (NCI) as a **Comprehensive Cancer Center** in 1974. In 2012, FCCC joined the Temple University Health System family, bringing our NCI-designated level care to the underserved populations of North Philadelphia, one of highest poverty communities in the United States.

FCCC is committed to health equity and addressing cancer and other health disparities among underserved populations. We believe everyone deserves access to high quality cancer care and treat all individuals regardless of race, ethnicity, socio-economic status or background.

Our dedicated *Community Outreach Team* partners with government, community, faith and other organizations to provide cancer education, screening and other services to diverse at-risk populations.

As a clinical teaching site, FCCC provides a wide range of oncology residencies and fellowships. Our residents receive a diverse educational experience from among the most renowned and widely-published oncology experts. Many move on to distinguished careers at academic and community medical centers across Pennsylvania, the U.S. and the world.

In addition to providing outstanding oncology care, we are an epicenter for cancer research. We have made several seminal discoveries that shaped the future of cancer prevention and treatment, including identifying tumor suppression, reprogramming tumor cells, understanding genetic cancer risks, advances in radiotherapy, and many others. **Two FCCC researchers have been Nobel Prize recipients** and we have received many other research accolades.

FCCC holds the prestigious Magnet designation for nursing excellence from the American Nurses Credentialing Center. We were the first cancer center in the country and the first hospital in Pennsylvania to achieve this in 2000. In 2018, we became one of only nine hospitals in the world to achieve this designation five consecutive times.

For our clinical services, we also received a Guardian of Excellence Award from Press Ganey, a leader in patient satisfaction measurement. Our *Bone Marrow Transplant Program* has been recognized for excellent performance by the Center for International Blood & Bone Marrow Transplant Research.

Our affiliated **Temple Center for Population Health** advances our health equity and population health efforts. Its mission is to attain a sustainable model of health care delivery through clinical and business integration, community engagement, and academic distinction to promote healthy populations. The Center includes a comprehensive inpatient and outpatient community health worker program, chronic disease management programs for at risk populations and more.

MISSION STATEMENT

Fox Chase Cancer Center's mission is to prevail over cancer, marshalling heart and mind in bold scientific discovery, pioneering prevention and compassionate care.

FOX CHASE PROGRAMS TO ADVANCE HEALTH EQUITY

Below we describe a few of our initiatives to advance health equity in the communities we serve.

Connecting Patients with Financial & Other Resources. Our Financial Counselors are dedicated to helping un- and under-insured patients obtain medical coverage. Patients requiring assistance with travel or housing accommodations are supported by our social work department.

Promoting Multi-Cultural Services. Our patients with limited English proficiency are supported by our certified medical interpreters to ensure accurate translation of medical and non-medical information in their preferred language.

Educating our Communities. Our outreach team partners with faith-based, government, academic and other community-based organizations to provide community education, cancer screening and access to research opportunities. Our ***Bilingual Speakers Bureau*** conducts free evidence-based education on breast, cervical, colorectal, liver, lung, ovarian, prostate, and skin cancers.

Prevailing over Cancer. Our ***Community Screening Program*** in existence for more than 30 years provides life-saving cancer screenings throughout our region. We screen onsite and at community and corporate settings using our Mobile Screening Unit (MSU). We work to ensure equal screening access for medically underserved communities experiencing healthcare barriers including lack of health insurance. Our experienced patient navigators connect patients with inconclusive or abnormal screening results facing financial issues to the resources they need to receive follow-up services.

We focus on providing breast cancer screenings. Many women we screen return to our mobile unit annually for mammograms and choose FCCC for follow-up care. Our MSU is considered a best practice by the U.S. Department of Health and Human Services' Community Preventive Services Task Force through its elimination of barriers to cancer screening.

Providing Community Resources. Our ***Lippincott Resource and Education Center (REC)*** includes a fully staffed multi-media information and education center on our main campus and three self-serve locations at our Women's Cancer Center, East Norriton and Buckingham locations. We provide cancer prevention, detection, treatment information and referrals for patients, caregivers, families, staff and community members. Our REC is staffed by highly trained, professional cancer educators joined by regular volunteers and student interns who use technology enhanced educational approaches.

Responding to Community Behavioral Health Needs. Our on-site psychiatry and social work team provide one-on-one counseling and support groups. All support groups are open to the public at no charge. Our ***Patient-to-Patient Network*** program matches newly diagnosed patients with cancer survivors who faced a similar cancer or treatment process for emotional support. The program has evolved to meet the broader regional and global needs of non-FCCC patients. Our ***Caregiver Network*** also matches new caregivers with existing caregivers for support.

Addressing the Opioid Epidemic. We established a hospital-wide campaign to educate patients and families about proper opioid use in cancer care through video and written materials. To prevent opioid misuse, our healthcare providers are prescribing less opioids to surgical and other patients. We also provide patients the option to return unwanted or unfinished prescriptions to our outpatient pharmacy.

Developing Tomorrow's Workforce. Our ***Immersion Science Program*** trains high school students in cancer research. The program builds confidence, preparing students for rigorous science, technology, engineering and math majors. *Sixty percent of the students are from the School District of Philadelphia, more than 70% are female and more than 60% are minorities*. Our Diversity and Inclusion efforts also seek to diversity our workforce and provide ongoing cultural competency training to our staff to strengthen our ability to serve diverse communities.

Engaging Patients, Families & Communities. Our ***Patient Family Advisory Council*** (PFAC) serve as a "voice" for FCCC patients and families. Our PFAC is dedicated to strengthening collaboration between patients, family members and the healthcare team to enhance our ability to deliver patient-centered, comprehensive and compassionate healthcare. Our ***Community Advisory Board*** is comprised of individuals living in our service area that represent cancer survivors, caregivers, businesses, Federally Qualified Health Centers, faith-based institutions and social service providers. Members provide guidance on FCCC programs and initiatives, share community concerns and conduct neighborhood outreach to educate on our services.

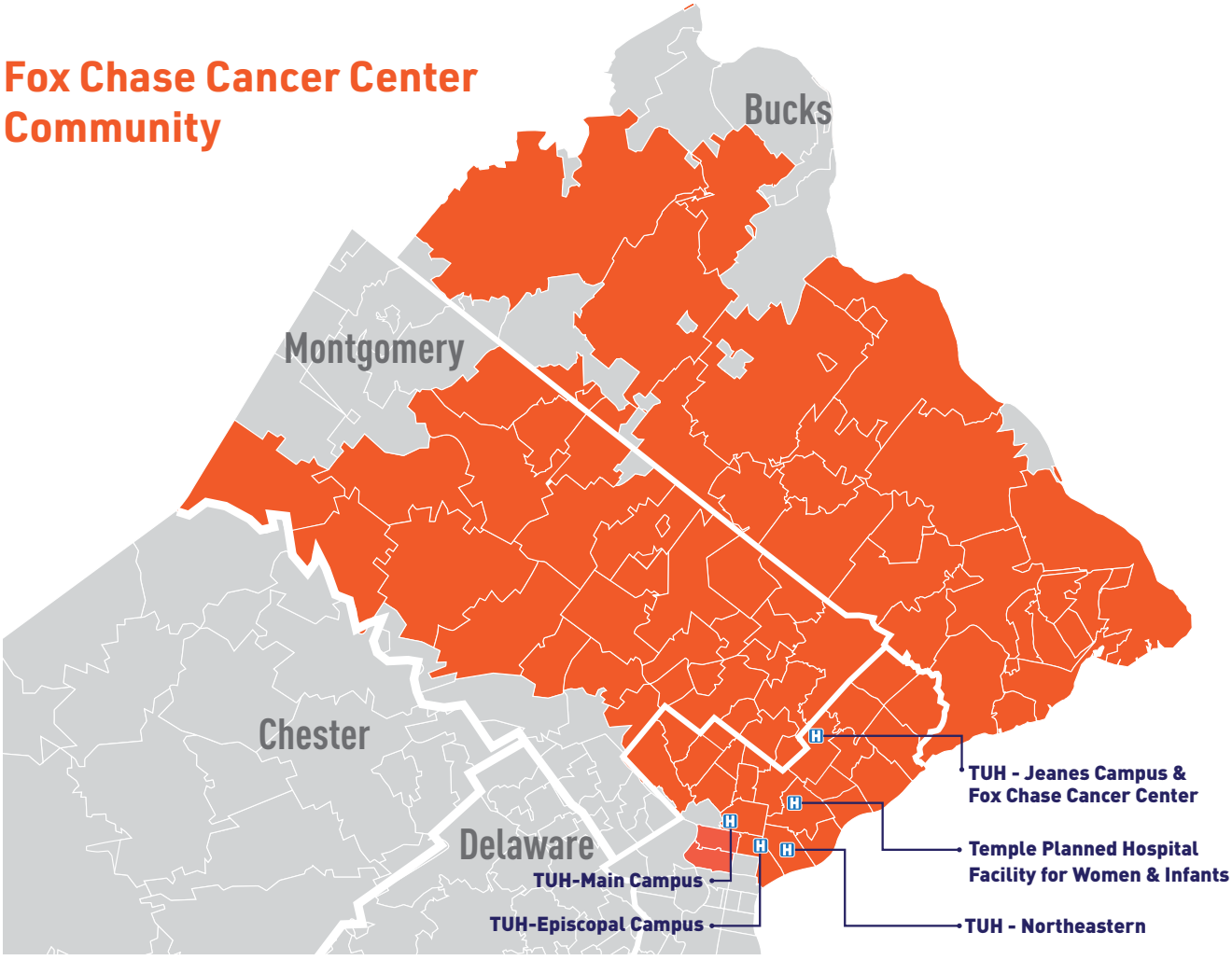
See Fox Chase Cancer Center's Community Health Page for more information on our programs.

COMMUNITY HEALTH NEEDS ASSESSMENT SUMMARY

Community Definition

For the purpose of our 2022 Community Health Needs Assessment, Fox Chase Cancer Center defined its community as comprised of 80 zip codes. These are the zip codes from which about 67% of our patients seen on an inpatient or outpatient basis reside. These zip codes largely overlay with the *Lower Northeast Philadelphia, Far Northeast Philadelphia, North Philadelphia-East, North Philadelphia-West, River Wards, Far North Philadelphia, Montgomery County and Bucks County* service areas identified in the 2022 Southeastern Pennsylvania Regional Community Health Needs Assessment done in collaboration with the Philadelphia Department of Public Health and Healthcare Improvement Foundation. These zip codes are mapped below.

Fox Chase Cancer Center Community



Philadelphia County: 19111, 19114, 19115, 19116, 19118, 19119, 19120, 19121, 19124, 19125, 19126, 19128, 19132, 19133, 19134, 19135, 19136, 19137, 19138, 19140, 19141, 19144, 19149, 19150, 19152, 19154

Montgomery County: 18964, 18969, 19001, 19002, 19006, 19012, 19025, 19027, 19031, 19034, 19038, 19040, 19044, 19046, 19075, 19090, 19095, 19401, 19403, 19422, 19426, 19438, 19440, 19444, 19446, 19454, 19462, 19464, 19468, 19473

Bucks County: 18901, 18902, 18914, 18925, 18929, 18938, 18940, 18944, 18951, 18954, 18966, 18974, 18976, 19007, 19020, 19021, 19030, 19047, 19053, 19054, 19055, 19056, 19057, 19067

Community Health Needs Assessment Process

In assessing community health needs, we compared residents of our community's health status, access to care, health behaviors, and utilization of services to data from our region. Focus groups were held to gather input from residents living in the 80 zip codes representing our community. Qualitative data about community needs related to cancer were collected through topic specific group discussions held with representatives of community organizations and government agencies serving Southeastern PA counties. We also conducted a focus group discussion with our ***Community Advisory Board*** to further gather input on cancer needs. Additionally, we evaluated primary and secondary data focused on unmet health needs associated with other conditions requiring specialized care. We also considered data on the needs of historically underrepresented communities such as immigrants, refugees, youth and LGBTQ+ individuals.

CHNA Health Disparities Snapshot

- **43.5%** of residents in *North Philadelphia-West* & **40.8%** in *North Philadelphia-East* live in poverty.
- **13.0%** of residents in *Norristown*, **10.7%** in *North Philadelphia-East* and **9.9%** in Lower Northeast Philadelphia do not have health insurance.
- **45%** of *North Philadelphia-East* residents are covered by Medicaid.
- **22.8%** of residents in *North Philadelphia-East*, **22.3%** in *North Philadelphia-West* and **21.6%** in the *River Wards* report poor mental health.
- *North Philadelphia-West's* drug overdose mortality rate is Philadelphia's highest.
- *North Philadelphia-West's* homicide rate is Philadelphia's highest.

COMMUNITY HEALTH NEEDS ASSESSMENT FINDINGS & COMMUNITY FEEDBACK

Below are the major findings of Fox Chase Cancer Center's (FCCC) 2022 Community Health Needs Assessment (CHNA). As defined by our CHNA, our community is predominantly divided into the *Lower Northeast Philadelphia, Far Northeast Philadelphia, North Philadelphia-East, West and River Wards, Far North Philadelphia, Montgomery County and Bucks County* service areas.

Cancer

Community discussions on cancer revealed that misunderstanding about cancer types, prognoses and outcomes can lead to stigma, fear and avoidance of screening or treatment. Cancer screening delays were attributed to COVID, staffing shortages, and increases in people working remotely and not receiving worksite wellness support. Cancer mortality rates are the highest in *Delaware* and *Philadelphia Counties* and there is a regionally higher burden of lung, liver and breast cancer in the FCCC community area.

- ***Community Request:*** Increase evidence-based cancer control interventions, screening and public education efforts to reduce cancer burden. Improve mental health services and social support for cancer patients.

Mental Health Conditions

Significant mental health needs across the region are indicated by high rates of depression and frequent mental distress. To optimize cancer care, cancer focused community discussions and other research revealed the need to integrate mental health services into overall care for people with chronic disease as well stress management and social supports. Focus group participants indicated that the mental health aspect of cancer is often neglected. Over 20% of residents *North Philadelphia -East, West* and the *River Wards* report poor mental health, the highest in Philadelphia.

- ***Community Request:*** Improve behavioral health care coordination and awareness of resources. Increase access to support groups and behavioral health services in community settings.

Chronic Disease Prevention & Management

Heart disease, cancer, stroke, and chronic respiratory diseases continue as leading causes of death in Philadelphia, which disproportionately affect communities of color. Chronic disease prevention was repeatedly mentioned as a need by the community.

- ***Community Request:*** Increase community-based cancer and other health screening. Provide public education on chronic disease prevention and management.

Healthcare & Health Resources Navigation

Community members and partners widely viewed navigating healthcare services as a challenge due to lack of awareness, cultural barriers, fragmented systems and resource constraints.

- ***Community Request:*** Increase availability of healthcare navigators. Raise public awareness of local community resources.

Access to Care

Community residents identified access to healthcare as a major need. Barriers to cancer, other specialty and primary care identified include: lack of providers in neighborhoods, affordability, medical insurance, transportation, immigration status, language/cultural barriers, misinformation and fear. About 10% of residents in *North Philadelphia-East, Far North and Lower Northeast Philadelphia* do not have health insurance, the highest in Philadelphia. Over 45% of *North Philadelphia-East* residents are covered by Medicaid, also the highest in Philadelphia. More than 10% of *Norristown* residents are uninsured, significantly higher than *Montgomery County* overall.

- ***Community Request:*** Educate community on healthcare services through outreach and mobile screening. Provide home-based cancer testing such as the colorectal Fecal Immunochemical Test (FIT) to reduce care barriers.

Substance Use & Related Disorders

Co-occurrence of substance use disorders and other mental health conditions was commonly raised and as associated with homelessness, community violence and other social and health disparities. Drug overdose rates continue to be high due to the opioid epidemic. Drug overdose rates in *Bucks, Delaware, and Philadelphia Counties* exceed the overall Pennsylvania rate and is the leading cause of death for young adults.

- ***Community Request:*** Sustain and expand substance use prevention programs. Increase number of certified peer recovery specialists and other resources to support warm handoffs to the next level of care.

Racism & Discrimination in Healthcare

Racism was recognized as a public health crisis in need of collective attention. Higher rates of COVID-19 infection, hospitalization, and mortality experienced by Black communities were identified as stemming from structural racism.

- ***Community Request:*** Train and hire healthcare workers with lived experience to work in in historically underserved communities. Increase diversity, equity, and inclusion efforts within healthcare institutions.

Food Access

Financial challenges brought on by the COVID-19 pandemic have led to greater food insecurity rates across all counties and a sharply rising demand for emergency food assistance. Nearly a quarter of Philadelphia households are receiving Supplemental Nutrition Assistance Program (SNAP) benefits. Black and Latino communities, older adults and immigrant communities are disproportionately impacted by food insecurity.

- ***Community Request:*** Provide "warm handoffs" to patients discharged from the hospital to connect with community health and social service organizations that address hunger and other needs.

Culturally & Linguistic Appropriate Services

The need for culturally concordant providers and resources to address language barriers was raised in over 50% of focus group meetings.

- ***Community Request:*** Develop hospital language access plans that outline protocols for identifying and responding to language needs.

Community Violence

Violent crime and homicide rates are 8-10 times higher in Philadelphia compared to suburban counties with this public health crisis disproportionately impacting *North Philadelphia* communities. *North Philadelphia-West* has the highest homicide rate in Philadelphia. Community violence driven by community disadvantage disproportionately impacts Philadelphia's *North*, *Northwest*, and *Southwest* service areas.

- ***Community Request:*** Increase advocacy for policies and programs to prevent and reduce violence.

Housing

Lack of stable housing is associated with 27.3 fewer years of life expectancy. In 2018, 40% of Philadelphia households were cost burdened with this figure expected to grow as a result of the pandemic. Community residents identified safe, stable housing as critical for physical and mental well-being.

- ***Community Request:*** Increase investments by hospitals, managed care organizations, and others in supportive housing programs to reduce housing insecurity and prevent homelessness.

Socioeconomic Disadvantage

Individuals living at or near poverty have higher rates of adverse health behaviors and outcomes. Community members identified poverty resulting from structural racism as an underlying determinant for many racial and ethnic health disparities. Inadequate education, limited opportunities, and unemployment were identified as key drivers of poverty in focus groups.

Poverty rates are nearly 4 times higher in Philadelphia compared to suburban counties overall, with pockets of high poverty clusters seen in suburban counties. Over 40% of families in *North Philadelphia-East* and *West* service areas are in poverty, the highest in Philadelphia. Over 25% of families in *Far North Philadelphia* and the *River Wards* are in poverty. In addition, *Norristown* and *Pottstown* in *Montgomery County* have higher rates of poverty than the county overall. Communities with higher poverty rates were found to have lower life expectancy, limited resource access and higher rates of adverse health behaviors and outcomes.

- ***Community Request:*** Screen for social determinants of health and connect community members with social supports. Greater collaboration between community colleges and universities on developing programs focused on skills training to increase access to family-sustaining careers.

Neighborhood Conditions

Abandoned homes, vacant lots, trash and others forms of neighborhood blight are associated with increased community violence. Youth expressed avoiding going outside to exercise due to fears of violence, which negatively impacts physical health. Communities expressed concerns about air pollution and climate change, particularly in *South Philadelphia, Delaware County,* and flood prone *Southwest Philadelphia.*

- ***Community Request:*** Strengthen investment in transit infrastructure near hospitals and improve vacant lots with green space to encourage socialization and physical activity.

IMPLEMENTATION STRATEGY PROCESS

Upon completion of our 2022 Community Health Needs Assessment (CHNA), Fox Chase Cancer Center's (FCCC) leadership formed a multidisciplinary Steering Committee (Committee) to guide development our 2022-2025 CHNA Implementation Strategy. During initial meetings, the Committee's purpose was outlined and an overview of our CHNA findings was provided. As a center solely focused on cancer, discussions on our capacity to address our community's multiple needs were held. The Committee decided to focus on needs directly impacting access to cancer care resources, education and other support. Using a consensus building process, the Committee identified health priorities based on the following factors:

ROOT CAUSE	INTERNAL CAPACITY	STRATEGIC ALIGNMENT	COMMUNITY CAPACITY	COMMUNITY IMPORTANCE
Root cause of priority issue	FCCC capacity to respond, including Temple University Health System Resources	Alignment with FCCC and NCI strategic priorities to improve cancer care access, disparities and outcomes	External resources of FCCC community and capacity to respond	Importance to community and public health consequences of not responding

The Committee worked with internal and external partners to collaboratively develop implementation plans that outlined specific goals, objectives, action plans and resources FCCC would contribute in response to each priority need.

In developing our implementations plans, we also considered our role as a National Cancer Institute (NCI) designated *Comprehensive Cancer Center.* To support our designation, each plan advances our delivery of state-of-the-art cancer care to all patients regardless of their economic status or background. An important component of our designation is also medical research. Our plans are designed to strengthen our broad array of research to address health disparities and discover improved methods to prevent, detect and treat cancer.

Additionally, our CHNA Implementation Strategy aligns with NCI's mission and the National Institutes of Health Minority Health and Health Disparities 2021-2015 Strategic Plan which seeks to strengthen institutional capacity to understand cancer disparities and social determinants of health that impact health outcomes. We will closely evaluate results, adjust or supplement as needed and develop annual progress updates.

HEALTH PRIORITIES

Our Implementation Strategy focuses on the 4 below priority areas that are interrelated with the health needs identified in our 2022 Community Health Needs Assessment (CHNA). Our latest CHNA builds upon previously identified health needs using more recent data and community input. Our priorities were selected through our aforementioned implementation strategy process. Over the next three years, we will continue to review and expand programs and interventions based on the needs identified in our CHNA.

Interrelated Priority Areas

We will advance health equity by focusing on the following interrelated areas:

- **Access to Cancer Care**
- **Chronic Disease Burden**
- **Racial, Ethnic & Other Healthcare Disparities**
- **Behavioral Health Conditions**

IMPLEMENTATION PLANS ADDRESSING HEALTH PRIORITIES

Enhance Cancer Care Access

Community members identified healthcare access as a major health need in the 2022 Community Health Needs Assessment. Barriers to specialty and primary care and cancer screening include: lack of neighborhood providers, affordability, medical insurance, transportation, immigration status, language/cultural barriers, misinformation and fear. In response, FCCC's ***Community Advisory Board*** recommended increased public education on cancer healthcare services, mobile health screening and cancer home-based testing, such as a colorectal Fecal Immunochemical Test (FIT) test.

Health Equity Goals

1. Increase availability of community cancer screening services to underserved communities.
2. Increase access to research/clinical trials opportunities, especially among high-risk, underrepresented minorities.
3. Provide healthcare navigation services to patients that need follow-up services or have financial, language, transportation or other barriers.
4. Provide cancer screening services to patients in the Fox Chase survivorship clinics and their families.

Executive Sponsors

Chair, Department of Hematology/ Oncology, FCCC- Martin Edelman, MD

Director, Community Cancer Screening Program, Office of Community Outreach, FCCC- Linda Hammell

Internal Team

Office of Community Outreach, Community Cancer Screening Program

Clinical Trial Research Office

Diagnostic Imaging Department

Nurse Navigation Team

Biorepository Facility

Medical & Surgical Oncology

Communications & Marketing

Community Participants

Access Matters – PA Healthy Woman Program

Philadelphia Department of Public Health/Health Care Centers

Federally Qualified Health Centers, Health Resources Services Administration clinics

Community Physician Practices

Community & corporate organizations within catchment region

Metrics

1. Total number of individuals screened and underserved/uninsured screened.
2. Number and type of healthcare navigation services provided.
3. Number of screenings provided in *Fox Chase Cancer Prevention Clinic*.
4. Number of activities to increase awareness of research/clinical trials.

Objectives

1. Provide cancer screening to 1,500 persons via *Community Cancer Screening Program* each fiscal year.
2. Provide healthcare navigation services to all patients needing follow-up care.
3. Increase the diversity and number of research participants.

Action Plans

1. Launch *Fox Chase Cancer Prevention Clinic* to streamline and reduce barriers to cancer screening for multiple cancer types that is accessible for patients and families.
2. Pilot Colorectal Cancer Screening home-based Fecal Immunochemical Test (FIT) program with high-risk populations in North Philadelphia.
3. Evaluate efficacy of home-based cancer screening tools in reaching underserved communities.
4. Develop survey to engage community members and organizations in catchment area in development of Fox Chase's research agenda.
5. Collect community input on research participation barriers, especially among diverse underserved populations to determine how to address barriers.
6. Continue community cancer-screening efforts with current and new partners via mobile screening unit, specifically for at-risk communities.
7. Utilize lay bilingual navigator and nurse navigators to support patients requiring follow-up care that do not speak English as their primary language.

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Enhance Cancer Care Access

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8. Continue ongoing evaluation of regional cancer burden, high-risk populations and related open studies to focus research participation promotion efforts on high-risk, underrepresented minorities.

9. Extend research participation to the Temple University Hospital community.

Communication Plan

- Promote cancer screening services and research opportunities though flyers, emails, and mailings sent to community organizations and other groups.
- Announce services on FCCC website, social media and at community events.

Resources Committed

Departmental budgets of the Office of Community Outreach, Nurse Navigation Team, and Clinical Trials Office.

Lower Burden of Chronic Disease

Community members identified the need for chronic disease prevention programs during the 2022 Community Health Needs Assessment. Conditions recognized include cancer, heart disease, stroke and respiratory diseases. Cancer mortality rates are the highest in Delaware and Philadelphia Counties and there is a regionally higher burden of lung, liver and breast cancer in the Fox Chase community area. Lack of cancer understanding, especially related to different types, prognoses and outcomes leads to stigma, fear and avoidance of getting screening or treatment. In response, the community requested public education and implementation of evidence-based cancer prevention interventions.

Health Equity Goals

1. Increase evidence-based cancer education and resources to address the regional cancer burden.
2. Increase bilingual cancer education materials to strengthen outreach to diverse communities.
3. Enhance evidence-based smoking cessation services to reduce community's tobacco use.

Executive Sponsor

Associate Director, Office of Community Outreach, FCCC- Charnita Ziegler-Johnson, PhD, MPH

Internal Team

Office of Community Outreach, Outreach Team, Health Communications Team

Fox Chase Medical Staff & Faculty

Tobacco Treatment Program

Nursing Department & Nursing Councils

Communication & Marketing

Community Participants

Community-based, faith-based, academic, corporate & government partners

Approved translation services health system vendor

Metrics

1. Number of cancer educational sessions and attendees.
2. Number and topic of plain language, bilingual outreach materials.
3. Number of community *Tobacco Treatment Program* sessions and attendees.
4. Number of patients utilizing in-house tobacco treatment services.

Objectives

1. Provide bilingual cancer education sessions and resources to 1,000 people each fiscal year.
2. Reduce community tobacco use following participation in community *Tobacco Treatment Program*.
3. Increase number of patients and those using navigation services for the in-house *Tobacco Treatment Program*.

Action Plan

1. Deliver cancer education to underserved communities and populations experiencing a high cancer burden in the region.
2. Develop plain language, multi-lingual educational materials.
3. Participate in community events to disseminate cancer prevention and screening information using trusted community leaders to share cancer-related information.
4. Continue work with existing and new partner organizations to deliver a community *Tobacco Cessation Program* to address lung cancer burden.
5. Expand *Tobacco Treatment Program* to provide navigation services and smoking cessation support to patients across Temple Health system via the *Temple Healthy Chest Initiative*.

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Lower Burden of Chronic Disease

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Communication Plan

- Promote tobacco education programs on FCCC's website, patient portal, social media, newsletters and through targeted mailings, emails, flyers and posters.
- Attend health fairs and other community events to increase knowledge of FCCC services.
- Promote tobacco education programs through community referrals from the *Temple Healthy Chest Initiative.*

Resources Committed

Departmental budgets of the Office of Community Outreach, Tobacco Treatment Program, and Communications & Marketing.

Address Racial, Ethnic & Other Healthcare Disparities

Racism was recognized as an ongoing public health crisis in need of collective attention during the 2022 Community Health Needs Assessment. Communities of color expressed mistrust of healthcare providers arising from health disparities and discriminatory treatment in healthcare settings, which can lead to forgoing needed care. Equitable and affirming healthcare was a concern for LGBTQ+ community members. In response, the community requested a more diverse healthcare workforce with lived experience and increased diversity, equity, and inclusion training programs in healthcare institutions. More culturally concordant healthcare providers and resources to address language barriers, including high quality oral and written language translation resources were also requested.

Health Equity Goals

1. Implement Diversity, Equity and Inclusion (DEI) training for faculty and staff on racism, implicit bias, diversity awareness, and trauma-informed care to support culturally and linguistically appropriate care.
2. Foster a diverse, equitable, and inclusive environment for patients, healthcare providers and other staff from historically marginalized backgrounds.
3. Establish an LGBTQ+ Affirming Healthcare Provider training process.

Executive Sponsor

Associate Director, Diversity and Inclusion, FCCC- Camille Ragin, PhD, MPH

Internal Team

Fox Chase Senior Leadership

Office of Community Outreach

Linguistic & Cultural Services

Human Resources

Fox Chase LGBTQ Task Force

Temple Health LGBTQ Task Force

Community Participants

Local organizations representing minority & LGBTQ+ groups

Approved translation services health system vendor

Metrics

1. Number of language services requests and top languages requested.
2. Number of cultural competence, anti-racism, diversity awareness trainings provided.
3. Number of affirming LGBTQ providers at FCCC.

Objectives

1. Increase number of staff and physicians educated on the delivery of culturally competent and affirming care for diverse communities.
2. Provide high quality, safe and culturally appropriate care to patients with language needs.
3. Increase number of affirming LGBTQ providers at FCCC.

Action Plans

1. Educate employees on health disparities and their impact through symposiums, trainings, and continuing education on cultural humility, trauma-informed practices, and anti-bias communication.
2. Examine how structural racism and discrimination impact cancer screening and care for patients at increased risk for liver and other cancers.
3. Strengthen DEI practices within health system's policies, procedures, and quality measures.
4. Provide ongoing education to staff regarding language access and availability of multi-language resources.
5. Continue to develop educational materials in languages needed by the community we serve.
6. Investigate opportunities to have more onsite medical interpreters and/or staff certified in medical interpretation.
7. Collaborate with Temple Health LGBTQ Task Force to provide *Affirming Provider Program* at FCCC.

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Address Racial, Ethnic & Other Healthcare Disparities

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Communication Plan

- Promote DEI initiatives through FCCC newsletters, website and physician webpages.
- Send targeted communications from Senior leadership on DEI programs to faculty and staff.
- Conduct DEI program updates at department meetings.

Resources Committed

Departmental budgets of the Office of Diversity, Equity, and Inclusion and Cultural and Linguistic Services.

Increase Behavioral Health Support

Community members identified behavioral health as a top need exacerbated by the pandemic during the 2022 Community Health Needs Assessment. Significant mental health needs are indicated by high rates of depression and frequent mental distress. Patients diagnosed with cancer experience mental distress and depression, especially those diagnosed with advanced cancer. In response, community members requested improved care coordination and increased access to support groups and behavioral health services in community settings. To optimize cancer care, integrated mental health services, stress management and social supports were requested.

Health Equity Goals

1. Increase cancer patients and caregivers access to support groups and other behavioral health supports, including Spanish-language patients and community members.
2. Provide evidence-based mental health services for patients with anxiety, depression, fear of recurrence, insomnia, chronic pain and end of life distress.
3. Increase community's awareness of behavioral health services and resources available at Fox Chase and in the community.

Executive Sponsor

Director, Psychiatry Department, FCCC- Emmie Chen, MD

Internal Team

Social Work Department

Psychiatry Department

Nurse Navigation Team

Office of Community Outreach, Lippincott Resource & Education Center

Communications & Marketing

Community Participants

Community behavioral health physician practices

Community-based health organizations

Metrics

1. Number of volunteers and matches in Patient-to-Patient (P2PN)/Caregiver Network.
2. Number of support group participants, including patient and non-patient community members.
3. Number of patients referred to behavioral health services.

Objectives

1. Increase number of volunteers and matches in P2PN/Caregiver Network.
2. Increase support group utilization by patients and community members.
3. Increase referrals to behavioral health services.

Action Plans

1. Increase volunteer pool for P2PN/Caregiver Network at Fox Chase Main, East Norriton and Buckingham Campuses; and Temple University Hospital.
2. Develop Spanish-language training module for P2PN.
3. Increase promotion and utilization of P2PN and support groups to patients and community members.
4. Expand Psychiatry department staffing to serve more patients.
5. Develop in-service healthcare provider trainings to enhance referrals and ensure patients are linked back to necessary behavioral health services.
6. Navigate patients to community-based behavioral health services and develop a resource database of community-based behavioral health.

Communication Plan

- Promote support groups and P2PN/Caregiver Network on FCCC website, social media, at community events and on FCCC and TUH Campuses through posters, flyers and other materials.
- Send targeted mailings to community organizations on behavioral health programs.

Resources Committed:

Departmental budgets of the Office of Community Outreach, Social Work, Psychiatry, and Communications and Marketing.

APPROACH TO OTHER NEEDS

Our 2022 Community Health Needs Assessment revealed needs beyond a cancer hospital and research center's traditional mission. Nevertheless, we address some of these needs in our day-to-day operations or through innovative collaborations with private and public partners. We discuss a few below.

Addressing Social Determinants of Health. The Temple Center for Population Health (TCPH), Temple Faculty Practice Plan (TFP), Temple Physicians Inc. (TPI) and our other Temple University Health System affiliates developed a data collection tool for assessing social determinants of health. This tool is embedded into Temple University Hospital's (TUH) electronic medical record (EMR) and administered to patients on a daily basis in its Emergency Department and inpatient and ambulatory clinics. Fox Chase Cancer Center (FCCC) has adopted 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.

Access to Health Insurance. Our financial counselors screen all uninsured and underinsured patients such as those with high deductibles and co-pays to determine eligibility for Medicaid, the Children's Health Insurance Program and other government funded medical insurance. If eligible, we connect patients with resources to help them attain coverage. We provide free or discounted care to patients who cannot afford to pay for their care under our *Emergency Care, Charity Care, Financial Assistance, and Uninsured Discount Policy*.

Our financial counselors are also trained and certified in Federal and Pennsylvania health insurance marketplace enrollment under the *Affordable Care Act*. They assist uninsured patients that do not qualify for Medicaid or Medicare during open and special enrollment periods throughout the year. We sponsor open enrollment events on-site and partner with government offices and other organizations on enrollment community outreach. Additionally, we assist Medicare recipients with assessing Medicare Advantage options.

Access to Primary and Preventative Care. As a member of Temple University Health System's family of hospitals and physicians, we will work with our affiliated Temple Physicians Inc. and Temple Faculty Practice Plan to strengthen access to primary care and preventative services. Virtually all Temple physicians accept patients covered by Medicaid and Medicare for both primary, preventative and specialty care. Temple Physicians, Inc. is a network of community-based healthcare providers that delivers primary care in over 40 practice sites. Temple Faculty Practice Plan represent about 20 academic departments providing specialty care in emergency medicine, gastroenterology, obstetrics, orthopedics, neurosurgery, neurology, general and specialty surgery and psychiatry.

Our affiliated Temple University Hospital partners with the City of Philadelphia, the Philadelphia Corporation for Aging, and the United States Department of Health and Human Services, other hospitals and community stakeholders in efforts to strengthen access to primary and preventative care.

PLANNING FOR A HEALTHIER POPULATION

Our affiliated Temple Center for Population Health (TCPH) includes a robust care management infrastructure that identifies at risk patients for recurrent health care issues and intervenes with medical and social supports. TCPH's programs help patients and caregivers manage medical conditions at home to enhance care coordination and reduce hospital readmissions. TCPH collaborates Federally Qualified Health Centers, City Health District Clinics and community primary care practices to deliver high value care for those most in need. We work with local, state, and federal government agencies on the implementation of grant-funded programs for high need populations. We are leaders in unique partnerships to address health disparities and advance health equity. Below are a few of TCPH's programs to address community needs and improve health outcomes.

Temple Care Integrated Network. This clinically integrated network of independent community primary care providers in North Philadelphia was established with Health Partners Plans to improve care quality and outcomes for mutual patients. Independent practices are invited into a formal partnership with TCPH to collaboratively coordinate care and address significant health and wellness challenges facing their patients.

Long-term Care Resiliency Infrastructure Supports & Empowerment (LTC-RISE) Program. Through an innovative partnership with Penn Medicine, TCPH was selected to participate in the Pennsylvania Department of Health's LTC-RISE Program, a regional response health collaborative to improve COVID-19 care in long-term residential care facilities in Philadelphia, Bucks, Chester and Lancaster counties. TCPH covers 300 assisted living, personal care homes and skilled nursing facilities by providing consulting services on COVID care, PPE use and sourcing, testing, infection control and palliative care.

Community Health Worker (CHW) Programs. In partnership Temple University College of Public Health's Center for Social Policy and Community Development and the District 1199C Training and Upgrading Fund, TCPH trains community members to serve as CHWs for many populations and healthcare specialties. Many graduates transition into employment at Temple University Hospital. CHWs assist with patient care management, connect with social supports and conduct home visits and other community outreach to serve the most vulnerable community members.

Skilled Nursing Home & Home Health Collaborative. This independent group of 22 skilled nursing home and rehabilitation facilities and 7 home health agencies provide collaborative care management for Temple Health patients from post-acute settings. These facilities and TCPH have developed and implemented a shared clinical communication strategy, care standards, patient education practices and other interventions that address care barriers to reduce hospital readmissions for mutual patients.

Transition of Care Program. This program provides post-acute support for patients discharged from TUH. After clinical staff identify inpatients with complex social and medical health issues, they are connected with CHWs and Nurse Navigators who assist with scheduling appointments, coordinating transportation, obtaining home support, and educating patients on how they can manage health issues and avoid future hospitalization.

Chronic Disease Prevention & Education. Our ***Diabetes Education Program*** provides those with diabetes personalized Spanish and English counseling on diabetes self-management, blood sugar levels monitoring, insulin pump use, meal planning and more. The ***Diabetes Prevention Program*** serves adults diagnosed with pre-diabetes, gestational diabetes and those at risk for type 2 diabetes through education on weight loss, exercise, stress management, food label reading and other topics to prevent diabetes onset. TCPH also provides significant education on stroke prevention and hypertension management.

CMS ACO Realizing Equity, Access & Community (REACH) Health Model Implementation. Beginning in 2023, TCPH's affiliated network of Temple Physician Inc. and Temple Faculty Practice plan primary care and family medicine practices will participate in this Center for Medicare and Medicaid Services (CMS) Innovative Alternative Payment model. The model advances health equity by bringing accountable care's benefits to traditional Medicare Fee-For-Service beneficiaries in underserved communities while managing healthcare cost. TCPH is developing a robust health equity plan to identify underserved communities and implement initiatives to reduce health disparities within our patient beneficiary populations.

FOX CHASE
CANCER CENTER
TEMPLE HEALTH