UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM

THE CHESTER COUNTY HOSPITAL
BOARD OF DIRECTORS

Resolution to Approve The Chester County Hospital's
Community Health Needs Assessment Strategic Implementation
Plan for Fiscal Years 2026 through 2028

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") which was approved by the TCCH Board of Directors on May 20, 2025. TCCH has now prepared a written CHNA strategic implementation plan for Fiscal Years 2026 through 2028 ("FY 2026-28 CHIP").

The TCCH Board of Directors has reviewed the FY 2026-28 CHIP, as presented and as attached as Exhibit A.

ACCORDINGLY, IT IS HEREBY

RESOLVED, that the FY 2026-28 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.

Edward J. Breiner
September 16, 2025

Exhibit A

Community Health Needs Assessment Strategic Implementation Plan (CHIP) for Fiscal Years 2026 through 2028

Penn Medicine

July 2025

CHESTER COUNTY HOSPITAL

Community Health Needs Assessment Strategic Implementation Plan (CHIP) FY 2026 – 2028

Table of Contents

Background 3
- Contact Information
- Planning Milestones
- Collaborating Agencies
- Southeastern Pennsylvania Community Health Needs Assessment
- Chester County Hospital Prioritization of Needs

Racism and Discrimination in Health Care 6
- Goal 1: Foster a workplace culture that empowers the delivery of services, addresses disparities in health care, and provides equitable treatment regardless of background.
- Goal 2: Analyze health disparity data to identify opportunities for improving processes and outcomes.

Chronic Disease Prevention and Management 8
- Goal: Promote optimal health to reduce the impact of chronic diseases such as cancer, obesity, diabetes, COPD, heart disease, and stroke.

Trust and Communication 10
- Goal: Build mutual trust and open communication with the community to encourage collaboration and drive improved health outcomes.

Mental Health Access / Youth Mental Health 12
- Goal 1: Expand access to mental health screening and treatment across the continuum of care to ensure timely treatment, support, and improved outcomes for patients.
- Goal 2: Provide community health education programs to raise awareness of mental health issues and to help reduce stigma associated with mental health conditions.

Access to Primary and Specialty Care 15
- Goal 1: Create a collaborative plan to eliminate barriers and improve access to primary and specialty health care.
- Goal 2: Provide clinical health services, health screenings, and education, with priority given to populations identified as high-risk.

Healthcare Resources Navigation 17
- Goal: Empower patients with knowledge of available resources to improve their ability to navigate health care seamlessly across the continuum of care.

Healthy Aging 19
- Goal 1: Support the physical health, mental health, and safety needs of seniors as they navigate their healthcare journey.
- Goal 2: Foster a health system culture that honors the priorities and upholds the autonomy of the senior population.

Culturally and Linguistically Appropriate Services 20
- Goal 1: Enhance awareness of and sensitivity to cultural differences and the influence of those differences on healthcare delivery and outcomes.
- Goal 2: Ensure access to resources and materials that support a positive healthcare experience for individuals with language, religious, or cultural needs.

Substance Use and Related Disorders (Adults and Youth) 21
- Goal 1: Offer evidence-based treatment options for patients with substance use and related disorders.
- Goal 2: Raise community awareness about substance use disorders and promote available prevention, education, and treatment options.

Background

Contact Information

- **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
- **Point Contact**: Karen Pinsky, MD, Chief Executive Officer, Penn Medicine Chester County Hospital

Planning Milestones

- **Date of written plan**: September 16, 2025
- **Date written plan adopted by organization's authorized governing body:** September 16, 2025
- **Deadline for written plan to be adopted**: November 15, 2025
- **Authorizing governing body that adopted written plan:** Chester County Hospital and System Board of Directors
- **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 facility's prior written plan adopted by organization's governing body:** September 20, 2022

Collaborating Agencies

Chester County Hospital has a rich history of collaborating with community and faith-based organizations. The following agencies, institutions, and community groups are among the many entities who have worked and continue to work with Chester County Hospital to develop and facilitate health-related outreach programs:

2nd Century Alliance

ACAC Fitness & Wellness

AHHAH - Arts Holding Hands and Hearts

Aidan's Heart Foundation

Alzheimer's Association, Delaware Valley Chapter

Be A Part of the Conversation

Brandywine YMCA

Bridging the Community - Kennett Square

BVAA - Brandywine Valley Active Aging

CARN - Coatesville Area Resource Network

Charles A. Melton Arts and Education Center

Chester County ACEs Coalition

Chester County Community Foundation

Chester County Dept. of Drug and Alcohol Services

Chester County Food Bank

Chester County Health Department

Chester County Suicide Prevention Partnership

Chester County Tobacco Free Coalition

Chester County United Way

Church Street Towers

Coatesville Area Public Library

Coatesville Center for Community Health

Coatesville NAACP

Coatesville Towers

Coatesville Youth Initiative

CVIM - Community Volunteers in Medicine

CYWA - Community Youth and Women's Alliance

El Buen Samaritano United Methodist Church

Episcopal Church of the Trinity

Filet of Soul Culinary Institute

FILM - Forward Impact Life Ministries

Freedom Village

Good Fellowship Ambulance & EMS Training Institute

Health Promotion Council

Jenner's Pond

Jennersville YMCA

Jubilee Evangelistic Ministries

Kennett Area YMCA

Kennett Library

LCH Health and Community Services

Longwood Fire Company

Maris Grove

Maternal Child Health Consortium

MNECC - Minority Nurse Educators of Chester County

NAMI Chester County

New Life in Christ Fellowship

PA LINK – Pennsylvania Link to Aging and Disability Resources

PA MEDI - Medicare Education and Decision Insight

Penn State Extension Chester County

St. Agnes Parish Outreach Services

St. James Place Apartments

St. Paul's Baptist Church

Tabernacle Baptist Church

The Alliance for Health Equity

The GIANT Company

Two Fishes Five Loaves Community Café Inc.

Union Community Care

W.C. Atkinson Memorial Community Service Center

West Chester Area Senior Center

West Chester Area YMCA

West Chester Chamber of Commerce

West Chester Communities That Care

West Chester Food Cupboard

West Chester NAACP

West Chester University

YMCA of Greater Brandywine

Southeastern Pennsylvania Community Health Needs Assessment

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)** outlining strategies to address priority needs identified by the assessment. The purpose of the CHNA is to identify and assess the health needs of the community served, including input from people who represent the broad interests of the community.

For this three-year reporting period, Chester County Hospital (CCH) participated in a collaborative effort conducted by the Health Care Improvement Foundation (HCIF) to assess the community needs of the broader Southeastern Pennsylvania region, focusing on Bucks, Chester, Delaware, Montgomery, and Philadelphia counties. This process helped to ensure the active participation of community members throughout the region, identify high-priority needs, increase the collaboration among partner hospitals, and reduce any duplication of efforts.

Regional Community-Identified Health Priorities: General Population

- Trust and Communication
- Racism and Discrimination in Health Care
- Chronic Disease Prevention and Management
- Access to Care (Primary and Specialty)
- Healthcare and Health Resources Navigation
- Mental Health Conditions
- Substance Use and Related Disorders
- Healthy Aging
- Culturally and Linguistically Appropriate Services
- Food Access
- Housing
- Neighborhood Conditions (e.g., blight, green space, air/water quality)

Regional Community-Identified Health Priorities: Youth

- Youth Mental Health
- Lack of Resources / Knowledge of Resources
- Substance Use and Related Disorders
- Bullying
- Gun Violence
- Access to Physical Activity
- Activities for Youth
- Access to Good Schools

Chester County Hospital Prioritization of Needs

Process and Priorities Excluded from the Plan

Following the completion of the regional 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 (known as the PEARL test) 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. Therefore, Chester County Hospital eliminated the following community-identified health priorities from this CHIP:

- Housing
- Neighborhood conditions
- Bullying (Youth)
- Gun Violence (Youth)
- Access to Physical Activity (Youth)
- Activities for Youth
- Access to Good Schools

It should be noted that other local and county organizations monitor, manage, and offer programs to address these priorities.

Priorities Included in the Plan

Although the CHNA assessed the broader Southeastern Pennsylvania region, this plan only addresses those priorities specific to the service area of Chester County Hospital. The goals, strategies, and impact measures presented in this CHIP represent the intentions of Chester County Hospital to address the following community-identified health priorities which impact a significant portion of the population served by the hospital and are feasible to address:

1. Racism and Discrimination in Health Care
2. Chronic Disease Prevention and Management
3. Trust and Communication
4. Mental Health Access / Youth Mental Health
5. Access to Primary and Specialty Care
6. Healthcare Resources Navigation
7. Healthy Aging
8. Culturally and Linguistically Appropriate Services
9. Substance Use and Related Disorders (Adults and Youth)

Racism and Discrimination in Health Care

Goal 1: Foster a workplace culture that empowers the delivery of services, addresses disparities in health care, and provides equitable treatment regardless of background.

Strategy: Ensure that staff training efforts and plans include explicit focus avoiding discrimination.
Annual Impact Measures:
- Number of employee forums that help staff recognize discriminatory behaviors
- Number of online training modules completed by all CCH staff

Strategy: Provide educational forums that reflect cultural inclusion and equal opportunity for all staff and align with recognition awareness months (e.g., Black History, AAPI, Pride, Hispanic Heritage).
Annual Impact Measures:
- Number of cultural/religious/specialty group recognitions
- Number of times calendar is accessed by employees

Strategy: Identify and attract individuals from various populations and service areas that reflect the patients we serve, especially for patient-facing clinical roles, medical staff, and administrative leadership roles.
Annual Impact Measure:
- Number of employee recruitment events in targeted regions, including universities

Strategy: Provide breastfeeding education folders in OB offices for Black birthing families.
Annual Impact Measure:
- Number of OB offices giving out folders

Strategy: Penn Primary Care Medical Director and Manager will meet to discuss socially responsible care to avoid disparities.
Annual Impact Measure:
- Number of meetings that addressed socially responsible care

Strategy: Use available data platforms/dashboards to identify and address health disparities.
Annual Impact Measure:
- Report on quality measures using available data to help identify potential disparities

Strategy: Train new RNs in principles of health equity.
Annual Impact Measure:
- Number of nurses who attend RN Orientation, which includes information on health equity

Strategy: Develop awareness and sensitivity to the differences among patients and staff through relationships with CCH Pastoral Care Team and volunteers.
Annual Impact Measures:
- Number of internal Pastoral Care Team meetings
- Number of staff/volunteers on Pastoral Care Team
- Number of Pastoral Care visits/interactions

Goal 2: Analyze health disparity data to identify opportunities for improving processes and outcomes.

Strategy: Evaluate, update, and utilize the health equity dashboard to identify health disparities.
Annual Impact Measures:

- Number of times health equity dashboard data was reviewed and reported
- Number of meetings with Penn Medicine Center for Health Equity Advancement (CHEA)

Strategy: Continue mandatory health equity reporting at Clinical Effectiveness and Quality Improvement (CEQI) monthly meetings.
Annual Impact Measure:

- Number of CEQI meetings where health equity outcomes were addressed

Strategy: Collaborate with community leaders as requested to share health disparity data.
Annual Impact Measure:

- Number of meetings with community leaders

Strategy: Analyze Emergency Department data (Health Equity Dashboard) to identify areas of improvement in health care disparities.
Annual Impact Measures:

- Percentage of restraints (all types) used in Emergency Department across populations
- Percentage of hallway beds used in Emergency Department across populations

Chronic Disease Prevention and Management

Goal: Promote optimal health to reduce the impact of chronic diseases such as cancer, obesity, diabetes, Chronic Obstructive Pulmonary Disease (COPD), heart disease, and stroke.

Strategy: Continue collaboration with local community-based organizations to expand food access in the OB Clinic for people who identify as food insecure.

Annual Impact Measures:

- Number of community organizations who assisted with providing food access
- Total number of households served by OB Clinic Food Pantry

Strategy: Utilize Penn Primary Care RNs to conduct hypertension clinics that are coordinated with the care management team.

Annual Impact Measures:

- Number of hypertension clinics held
- Number of patients
- Number of care gaps (controlled hypertension) closed

Strategy: Utilize Penn Primary Care RNs to conduct diabetes clinics for complication prevention.

Annual Impact Measures:

- Number of diabetes clinics held
- Number of patients
- Number of care gaps (A1C, retinal exam, foot exam, microalbuminuria) closed

Strategy: Promote Heart Safe Motherhood among OB clinic population.

Annual Impact Measure:

- Number of OB clinic patients with sustained severe-range blood pressure who participate in Heart Safe Motherhood

Strategy: Offer free, high-quality, interactive wellness programs provided by experts on chronic disease prevention and management that result in increased knowledge and intent to change health behavior.

Annual Impact Measures:

- Number of presentations
- Number of participants
- Report results from participant evaluations for quality, knowledge, and intent to take an action or change lifestyle

Strategy: Provide health screenings, education, and referrals as needed for individuals to assess risk for chronic disease.

Annual Impact Measures:

- Number of screenings for individuals identified as high risk due to health disparities
- Additional number of screenings

Strategy: Collaborate with community partners to provide wellness education and resources at health promotion events.

Annual Impact Measure:

- Number of health promotion events

Strategy: Continue to provide high-quality diabetes education classes for the community.
Annual Impact Measures:

- Number of diabetes education classes
- Number of participants
- Average A1C change of class participants
- Average weight change of class participants
- Percentage of time education session met needs of the participant

Strategy: Continue to provide support programs for individuals living with chronic disease.
Annual Impact Measure:

- Number of support groups and participants by condition

Strategy: Continue to meet selective community outreach requirements for American College of Cardiology (ACC) Chest Pain Center Accreditation.
Annual Impact Measures:

- Number of cardiovascular disease screenings to external and internal communities
- Number of Early Heart Attack Care (EHAC) and Hands-only CPR trainings provided
- Provide resources to educate community primary healthcare providers and their patients on EHAC

Strategy: Collaborate with the Chester County Food Bank in providing educational programs to raise community awareness of available resources for people experiencing food insecurity.
Annual Impact Measure:

- Number of programs in collaboration with the Chester County Food Bank

Strategy: Continue to provide the Outpatient Cardiopulmonary Rehabilitation program in compliance with the standards of the American Association of Cardiovascular and Pulmonary Rehab (AACVPR).
Annual Impact Measure:

- Number of new cardiopulmonary patients enrolled in the Cardiopulmonary Rehabilitation program

Strategy: Provide post-discharge support for COPD patients through enrollment in the Breathe Better Together follow-up program.
Annual Impact Measures:

- Number of COPD patients enrolled in Breathe Better program
- Number of patient need escalations addressed by COPD Navigator

Strategy: Provide heart failure/COPD patients with access to materials and monitoring equipment to promote optimal health.
Annual Impact Measures:

- Number of heart failure patients provided with digital BP monitors, pulse-oximeters, digital scales, salt-free seasoning, measuring cups and/or pill organizers
- Number of COPD patients receiving pulse-oximeters

Strategy: Email monthly newsletter with resources to help support individuals living with heart failure.
Annual Impact Measures:

- Average monthly number of newsletters sent
- Average monthly open rate

Strategy: Provide nutrition counseling at no charge to cancer patients in treatment as appropriate.
Annual Impact Measure:

- Number of nutrition counseling visits for oncology patients

Trust and Communication

Goal: Build mutual trust and open communication with the community to encourage collaboration and drive improved health outcomes.

Strategy: Provide staff training and education for trauma informed care for Mother Baby Unit (MBU).
Annual Impact Measure:
- Number of educational initiatives

Strategy: Provide exceptional patient experience and evaluate care coordination in order to treat our community members with courtesy and respect.
Annual Impact Measure:
- Evaluate Press Ganey/Patient Experience survey questions

Strategy: Improve care for babies diagnosed with neonatal abstinence syndrome.
Annual Impact Measure:
- Number of referrals from NAGs (a neonatal opioid withdraw syndrome advocacy group)

Strategy: Provide community education/training on health literacy to encourage participants to take an active role in their health care.
Annual Impact Measure:
- Number of health literacy programs for the community

Strategy: Train CCH staff in effective communication to improve patient safety through health literacy.
Annual Impact Measures:
- Number of CCH staff that attended UPHS Teach-Back course
- Number of users who have completed modules in Knowledge Link “Stronger Together – Improving Patient Safety through Health Literacy" or any new health literacy trainings

Strategy: Train new RNs in effective communication.
Annual Impact Measure:
- Number of RNs who attend RN health literacy orientation session

Strategy: Incorporate Trauma-Informed Care principles into staff education for improved patient care.
Annual Impact Measure:
- Number of classes in which Trauma-Informed Care is integrated into the curriculum

Strategy: Collaborate with community and faith-based organizations (e.g., CARN, PARN, Bridging the Community, SCCON) to share information and plan health-related programs.
Annual Impact Measure:
- Number of meetings with community and faith-based organizations.

Strategy: Engage community members to provide constructive feedback and dialogue to guide programming and provision of resources to improve health outcomes.
Annual Impact Measures:
- Number of community meetings (e.g., forums, focus groups)
- Number of attendees
- Number of zip codes targeted

Strategy: Continue monthly Building Respect, Inclusion, Dignity, Grace, and Equity (BRIDGE) Council meetings to plan community events, develop resources and provide appropriate trainings to build community trust.

Annual Impact Measures:

- Number of community-facing events with BRIDGE participation
- Number of times resources are promoted hospital-wide
- Number of internal trainings sponsored by BRIDGE

Strategy: Ensure all communications are clear, concise, consistent, culturally appropriate, and linguistically accurate by increasing the percentage of bilingual staff.

Annual Impact Measure:

- Percentage of OB Clinic staff who are bilingual

Strategy: Improve communication and health literacy of patients with diabetes by utilizing the "teach-back" method.

Annual Impact Measure:

- Percentage of diabetes and nutrition patients whose educators made sure they clearly understood and could verbalize ("teach-back") their care plan

Strategy: Integrate health literacy into planning, evaluation measures, patient safety, and quality improvement for OB Clinic staff.

Annual Impact Measure:

- Number of OB clinic staff trained in health literacy

Strategy: Continue to build positive relationships with patients through volunteer-supported programs (e.g., Listening Ear, Pet Therapy, Harmonies in Healing).

Annual Impact Measures:

- Number of visits for Listening Ear
- Number of volunteer service hours for Listening Ear
- Number of Pet Therapy volunteers
- Number of Harmonies in Healing volunteers

Strategy: Provide access to trackable education and training modules (e.g., HIPAA, Safety Essentials) for volunteers without a Penn Medicine email address.

Annual Impact Measures:

- Number of trainings
- Number of volunteers who access the trainings

Strategy: Continue to facilitate and promote open access and communication to faith-based leaders and community congregations through CCH Pastoral Care Team.

Annual Impact Measures:

- Number of interactions with outside faith leaders
- Completion and maintenance of contact database for the purpose of sending updates to faith leaders

Strategy: Increase communication with patients and family members in the Emergency Department using automated text messaging.

Annual Impact Measure:

- Number of patients and family members receiving and/or engaging in text message service

Mental Health Access / Youth Mental Health

Goal 1: Expand access to mental health screening and treatment across the continuum of care to ensure timely treatment, support, and improved outcomes for patients.

Strategy: Increase information to educate the community about human trafficking.
Annual Impact Measure:

- Number of public education materials provided throughout the Emergency Department

Strategy: Increase awareness of paternal postpartum depression.
Annual Impact Measure:

- Number of paternal postpartum resources provided (English/Spanish).

Strategy: Provide trainings on suicide screening and prevention to hospital staff.
Annual Impact Measures:

- Number of staff trained in suicide screening and prevention via Knowledge Link
- Number of CCH staff trained in Mental Health First Aid (MHFA)

Strategy: Evaluate the mental health of cardiopulmonary patients to improve quality of life outcomes.
Annual Impact Measures:

- Number of Initial PHQ-9 screenings for depression
- Number of pre and post Quality of Life (QOL) assessments completed to determine overall well-being
- Percentage of patients who improved their QOL

Strategy: Screen and assess patients for suicidal ideation.
Annual Impact Measures:

- Utilize the Columbia-Suicide Severity Rating Scale (C-SSRS) screening tool for all emergency department and admitted patients
- Perform suicide risk level stratifications for at least 95% of Emergency Department and inpatient patients who have a positive screening for suicide on the C-SSRS

Strategy: Develop safety plans for patients identified as low or moderate risk for suicide, who are assessed to be safe for a community-based discharge plan.
Annual Impact Measures:

- Establish a process to develop and quantify safety planning interventions
- Implement warm-handoff program that will support discharged patients within the community

Strategy: Provide trainings for hospital staff that enhance de-escalation skills and physical behavioral management to mitigate potentially violent situations.
Annual Impact Measures:

- Number of staff trained in verbal de-escalation skills
- Number of staff trained in physical behavioral management

Strategy: Improve access to screening, assessment, and referral of patients with identified mental health needs.
Annual Impact Measures:

- Maintain Behavioral Health service line to streamline and enhance processes to meet the needs of patients with mental health needs
- Develop Behavioral Health Governance Committee(s) for improved oversight as well as a multi-disciplinary approach to providing trauma-informed care for patients with mental health needs
- Assess and maintain staffing of behavioral health team as needed to allow for appropriate and timely access to assessment, care, and treatment

Strategy: Provide greater access to treatment for patients with behavioral health needs in the Emergency Department and hospital.

Annual Impact Measures:

- Assess and maintain available staffing of the psychiatric consult liaison team as needed to provide greater access to psychiatric medication management
- Number of brief therapeutic interventions provided by Licensed Behavioral Health Counselors

Strategy: Collaborate with programs throughout the county to better meet the mental health needs of the community.

Annual Impact Measure:

- Record hospital participation and attendance at the following meetings: Chester County Mental Health/Intellectual and Development Disabilities Advisory Board, Human Needs Network Community Advisory Board, NAMI Chester County Advisory Board, and Chester County Psychiatric Advisory Board

Strategy: Identify and collaborate with behavioral health organizations to improve access to inpatient and outpatient mental health treatment.

Annual Impact Measures:

- Number of meetings with the organizations
- Programmatic updates on identified outcome measures

Strategy: Lower the diabetes distress scores of patients.

Annual Impact Measure:

- Measure and compare average pre-class and post-class diabetes distress scores

Strategy: Continue screening for depression in Penn Primary Care practices.

Annual Impact Measures:

- Percentage of patients screened with PHQ-2
- Percentage of patients with positive PHQ-2 that are screened with PHQ-9

Goal 2: Provide community health education programs to raise awareness of mental health issues and to help reduce stigma associated with mental health conditions.

Strategy: Continue the Penn Integrated Care program to increase access to behavioral health services for Penn Primary Care patients.

Annual Impact Measure:

- Number of patients referred to behavioral health services

Strategy: Provide mental health evaluations to OB Clinic patients during hospital stay, after delivery and at postpartum visits.

Annual Impact Measures:

- Number of patients evaluated
- Number of mental health referrals provided

Strategy: Attend meetings of mental health community agencies to identify the mental health needs of the community members.

Annual Impact Measure:

- Number of meetings

Strategy: Provide suicide prevention trainings for community members (e.g., Question, Persuade, Refer - QPR, MHFA, Youth MHFA).

Annual Impact Measures:

- Number of community suicide prevention trainings
- Number of participants

Strategy: Provide mental health resources to the community (e.g., PA Navigate, 211, and 988 Suicide Hotline).

Annual Impact Measures:

- Number of programs where mental health resources were provided
- Provide Community Health Resource Fair
- Number of months that the CCH Digital Desktop included mental health resources
- Update of Penn Medicine website with local mental health resources

Strategy: Collaborate with community-based organizations to provide evidence-based trainings that help the community understand the impact of trauma, identify prevention strategies, and build resilience.

Annual Impact Measure:

- Number of trauma and resilience education programs provided

Strategy: Collaborate with community-based organizations to provide educational programs focused on the mental health needs of youth.

Annual Impact Measure:

- Number of educational programs focused on youth mental health

Strategy: Provide Moms Supporting Moms support group led by a Maternal Mental Health Specialist/Clinic RN to provide emotional support for expectant and new mothers.

Annual Impact Measures:

- Number of groups
- Number of participants

Strategy: Provide Dads Support Group to provide emotional support for expectant and new fathers.

Annual Impact Measures:

- Number of groups
- Number of participants

Strategy: Increase bereavement services to support grieving parents.

Annual Impact Measures:

- Number of UNITE groups
- Number of participants
- Number of support carts provided to families

Access to Primary and Specialty Care

Goal 1: Create a collaborative plan to eliminate barriers and improve access to primary and specialty health care.

Strategy: Increase collaboration with County Emergency Medical Services (EMS) to develop appropriate referral system/methods.
Annual Impact Measure:
- Number of EMS patients rerouted to Haven, instead of Chester County Hospital Emergency Department

Strategy: Support the provision of ancillary services (screenings, lab and diagnostic radiology) to underserved populations in clinics.
Annual Impact Measure:
- Number of ancillary service registrations at community clinics

Strategy: Increase access to care for COPD patients through the Breathe Better Together Program.
Annual Impact Measure:
- Number of escalation calls identified through the Breathe Better Together Program

Strategy: Provide convenient access to Medical Assistance (MA) enrollment utilizing CCH Financial Representatives.
Annual Impact Measures:
- Number of MA applications completed
- Number of MA applications approved

Strategy: Continue to identify appropriate candidates for primary and specialty care in-home patient visits.
Annual Impact Measure:
- Number of in-home patient visits

Strategy: Evaluate and optimize utilization of Penn on Demand to provide telehealth visits that increase access to care.
Annual Impact Measure:
- Number of telehealth visits utilizing Penn on Demand

Strategy: Coordinate care for new primary care patients in the Chester County region.
Annual Impact Measure:
- Number of patients scheduled through New Patient Coordinator

Strategy: Increase appointment navigation for transient ischemic attack (TIA) pathway patients discharged from the Emergency Department.
Annual Impact Measure:
- Number of appointments confirmed for outpatient neurology and cardiology testing scheduled after discharge from Emergency Department

Strategy: Increase potential for new primary and specialty care providers in the region.
Annual Impact Measures:
- Number of residents in the CCH Residency Program
- Number of West Chester University PA students

Strategy: Facilitate iron infusions for Labor & Delivery patients with low hemoglobin.
Annual Impact Measure:
- Number of patients

Strategy: Increase outpatient pharmacy access to non-employees.
Annual Impact Measure:

- Number of non-employee prescriptions filled by pharmacy

Goal 2: Provide clinical health services, health screenings, and education, with priority given to populations identified as high-risk.

Strategy: Utilize the Home Providers program to provide follow-up primary care to homebound patients.
Annual Impact Measure:

- Number of consults ordered

Strategy: Continue to provide free and reduced care for OB/GYN patients in CCH's Clinic.
Annual Impact Measure:

- Number of OB/GYN clinic visits

Strategy: Continue to offer all childbirth education programs at no cost to patients on Medical Assistance.
Annual Impact Measure:

- Number of participants

Strategy: Provide mobile mammogram screenings.
Annual Impact Measures:

- Number of mobile mammography screenings
- Number of participants

Strategy: Continue to provide free and reduced-cost cancer screenings through the PA Access Program / BCEEDP.
Annual Impact Measure:

- Number of patient screenings

Strategy: Collaborate with the YMCA of Greater Brandywine to bring their Mobile Fit Truk to targeted communities in efforts to increase access to exercise programming, health screenings, and education.
Annual Impact Measure:

- Number of community programs/screenings done utilizing the Fit Truk

Strategy: Offer telehealth diabetes education and nutrition counseling visits for patients who lack transportation or have other barriers to access education.
Annual Impact Measure:

- Number of telehealth visits provided

Healthcare Resources Navigation

Goal: Empower patients with knowledge of available resources to improve their ability to navigate health care seamlessly across the continuum of care.

Strategy: Continue utilization of cardiovascular nurse navigators to enroll eligible patients into the outpatient cardiac rehabilitation program.
Annual Impact Measure:
- Achieve a capture rate (eligible/enrolled) of at least 35%

Strategy: Maintain a Call Center to register individuals for programs and refer them to medical services/providers and other community resources as needed.
Annual Impact Measures:
- Number of registration calls (childbirth, pre-surgery joint class, and wellness programs)
- Number of medical services/provider referrals
- Number of other calls

Strategy: Continue to provide free transportation for eligible patients receiving cancer treatment.
Annual Impact Measures:
- Number of rides
- Cost of rides

Strategy: Continue the utilization of nurse navigators for the oncology program.
Annual Impact Measure:
- Number of oncology patients navigated by category.

Strategy: Continue to provide free transportation for eligible parents of NICU patients.
Annual Impact Measure:
- Number of rides

Strategy: Have Continuum of Care social workers contact patients post-discharge to ensure smooth transitions back into the community.
Annual Impact Measure:
- Number of contacts

Strategy: Have case managers conduct intake assessments on admitted patients to identify discharge needs.
Annual Impact Measures:
- Number of assessments
- Number of discharged referrals by category

Strategy: Utilize Penn Partners in Care nurse care managers in each of the Penn primary care practices to assist patients with transitions in care.
Annual Impact Measure:
- Number of interactions

Strategy: Utilize Penn Partners in Care pharmacist to provide pharmacy consults and review of medications.
Annual Impact Measure:
- Number of consults by region

Strategy: Provide resources to all NICU mothers with positive Social Determinants of Health (SDOH) screenings that indicate financial resource strain, transportation needs, and/or food insecurity.

Annual Impact Measure:

- Number of social work consults generated from positive SDOH screenings

Strategy: Continue to utilize nurse navigators for the Heart & Vascular (H&V) service line.

Annual Impact Measure:

- Number of patients navigated by category

Healthy Aging

Goal 1: Support the physical health, mental health, and safety needs of seniors as they navigate their healthcare journey.

Strategy: Provide educational programs for seniors that address health-related needs (e.g., injury prevention, mental and social well-being, and chronic disease prevention and management).
Annual Impact Measure:
- Number of programs

Strategy: Provide targeted education for suicide prevention among seniors.
Annual Impact Measure:
- Number of QPR suicide prevention programs focused on seniors

Strategy: Collaborate with senior living facilities to provide educational programs.
Annual Impact Measure:
- Number of programs offered to senior-living facilities

Strategy: Collaborate with senior-facing organizations to identify strategies and programs to meet the needs of seniors (e.g., PA Link, PA Medi, Surrey).
Annual Impact Measure:
- Number of meetings

Strategy: Attend senior expos to promote wellness programs.
Annual Impact Measures:
- Number of expos attended
- Number of staff

Strategy: Provide Pre-Surgery Joint Replacement Classes.
Annual Impact Measure:
- Number of participants in the Pre-Surgery Joint Replacement classes

Goal 2: Foster a health system culture that honors the priorities and upholds the autonomy of the senior population.

Strategy: Train healthcare staff on geriatric care principles, effective communication with seniors, and age-related cultural sensitivity.
Annual Impact Measure:
- Number of classes

Strategy: Reduce barriers to address ageism, and identify age-related social and mental health risks and interventions.
Annual Impact Measures:
- Number of healthcare staff trainings or communications aimed at improving healthcare access for the elderly
- Number of healthcare staff trainings or communications aimed at improving mental or social wellbeing of the elderly

Culturally and Linguistically Appropriate Services

Goal 1: Enhance awareness of and sensitivity to cultural differences and its potential influence on healthcare delivery and outcomes.

Strategy: Collaborate with community organizations that serve varied cultural communities in our area.
Annual Impact Measure:
- Number of organizations

Strategy: Increase interpreter capabilities for Physical Therapy.
Annual Impact Measure:
- Number of certified interpreters

Strategy: Provide community education and trainings in Spanish.
Annual Impact Measure:
- Number of community programs

Goal 2: Ensure access to resources and materials that support a positive healthcare experience for individuals with language or cultural needs.

Strategy: Refer OB patients who are at high-risk for chronic diseases to culturally appropriate diabetes and nutrition education.
Annual Impact Measure:
- Number of OB clinic patients referred to diabetes education and nutrition services

Strategy: Provide pre-recorded, virtual maternity tours in Spanish.
Annual Impact Measure:
- Number of clients receiving link to view recorded Spanish tour

Strategy: Increase the availability of maternal and child educational materials in Spanish.
Annual Impact Measures:
- Assess current state of educational materials that are provided in Spanish
- Percentage of written materials that are available in Spanish

Strategy: Continue to provide a bilingual diabetes educator to counsel Spanish-speaking patients with gestational diabetes.
Annual Impact Measure:
- Number of Spanish-speaking patients with gestational diabetes served

Strategy: Provide language interpretation tools for a broad range of languages as needed by clinical and non-clinical areas.
Annual Impact Measures:
- Number of in-person interpreter minutes
- Number of phone interpreter minutes
- Number of video interpreter minutes
- Number of video remote interpreter iPad carts

Strategy: Provide Spanish translations of critical documents.
Annual Impact Measure:
- Number of documents translated into Spanish

Substance Use and Related Disorders (Adults and Youth)

Goal 1: Offer evidence-based treatment options for patients with substance use and related disorders.

Strategy: Provide training for RNs to eliminate bias toward individuals with history of substance abuse.
Annual Impact Measure:

- Number of classes that include training to eliminate bias to individuals with history of substance abuse

Strategy: Minimize the use of opioids following a cardiac device implant.
Annual Impact Measure:

- Percentage of patients prescribed opioids following a cardiac device implant

Strategy: Promote the current standard of care for management of patients with Opioid Use Disorder (OUD) to improve consistency among providers.
Annual Impact Measures:

- Percentage of patients administered medications for OUD (MOUD)
- Percentage of patients with active Narcan® prescription
- Percentage of discharges Against Medical Advice (AMA)
- Number of times order set was utilized/number of opioid withdraw encounters

Strategy: Promote the current standard of care for management of patients with alcohol use disorder to improve consistency among providers.
Annual Impact Measures:

- Number of times alcohol order set was utilized
- Number of alcohol withdraw encounters

Strategy: Improve screening of patients for OUD and connect identified patients to appropriate outpatient resources.
Annual Impact Measures:

- Implementation and utilization of universal single screening question to identify any substance use disorder during Emergency Department triage
- Total number of OUD screenings
- Number of positive OUD screenings

Strategy: Provide naloxone nasal spray (Narcan®) upon discharge to patients identified to be at risk for an opioid emergency/opioid overdose.
Annual Impact Measure:

- Number of units of naloxone nasal spray (Narcan®) provided to patients that are identified at risk for an opioid emergency/opioid overdose upon discharge

Strategy: Utilize Certified Recovery Specialists (CRSs) to provide additional support to patients in the Emergency Department and hospital setting.
Annual Impact Measures:

- Number of patients seen by a CRS through Community Outreach & Prevention Education (COPE)
- Number of patients connected to drug and alcohol treatment services via CRS intervention (CCH-specific county data)

Strategy: Review and renew Opioid Use Agreements in the Penn Primary Care practices.
Annual Impact Measures:

- Percentage of patients on opioids with active opioid agreements
- Percentage of medication reconciliations completed

Strategy: Provide training to all clinical staff treating maternity patients with substance use disorder.
Annual Impact Measure:

- Number of substance use disorder education programs provided to clinical staff treating maternity patients

Strategy: Provide pediatric consults to mothers with OUD.
Annual Impact Measure:

- Number of patients seen

Goal 2: Raise community awareness about substance use disorders and promote available prevention, education, and treatment options.

Strategy: Partner with community organizations to provide education programs and resources for adults and youth with addiction/substance use disorders.
Annual Impact Measure:

- Number of education events

Strategy: Identify and update patient education materials and resources for perinatal patients who screen positive for substance use disorder.
Annual Impact Measures:

- Take inventory of existing education materials and resources
- Number of updated educational materials and resource lists