Temple University Hospital

COMMUNITY HEALTH NEEDS ASSESSMENT IMPLEMENTATION PLAN

FY24 PROGRESS REPORT

TEMPLE HEALTH
TEMPLE UNIVERSITY HOSPITAL

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CHNA Progress Report

Plan Title:
Increase Behavioral Healthcare Access and Education

Executive Sponsors:
John Robison - Executive Director, TUH-Episcopal Campus
Luciano Rasi – Director of Behavioral Health, TUH-Episcopal Campus

Health Equity Goals:

1. Increase community's behavioral health care access across other healthcare areas.
2. Strengthen patients' behavioral health services coordination following hospital treatment to the next most appropriate community healthcare provider for best outcomes.
3. Improve healthcare professional and community's knowledge of behavioral health treatment importance, options and how to access care.

Objectives:

1. Increase patients receiving behavioral health services within both behavioral health specific and non-specific medical settings (i.e. primary care).
2. Increase warm handoffs to next community behavioral healthcare provider.
3. Improve patient behavioral health appointment adherence post-hospital discharge.
4. Reduce behavioral health inpatient and Crisis Response Center (CRC) 30-day readmission rates.

Metrics Data Dashboard:

1. Number of patients receiving behavioral health services across health system.
2. Number of same day patient after care appointment "warm handoff" made to other community behavioral healthcare providers following inpatient psychiatry admission.
3. Patient behavioral health appointment adherence post-hospital discharge.
4. Behavioral health hospital inpatient and CRC readmission rates respectively.

Data Element	Baseline	FY23	FY24	FY25
1	67,152	66,699	66,425	
2	145	127	82	
3	38.5%	44.9%	37.5%	
4	13.6%/12.2%	12.9%/10.3%	16.3%/13.3%	

Metric Progress Summary:

1. This calculation includes CRC visits, 23 hour beds, inpatient behavioral health census days, outpatient psychiatry visits, psychiatric consults and progress notes at the patient encounter level. Integrated care behavioral health visits began in FY24 and are included in this metric. While overall volume did not increase, the addition of integrated

behavioral health services provides another location within the system where patients can access such services.

2. A newly implemented strategy had warm handoffs on track for a total of 208 in FY23 after the first six months. However, staffing and regulatory issues resulted in modifications to the strategy. Alternative linkage options with community partners were initiated in FY24, but none have been as successful as the initial approach. . A new community service program , opened in August 2024 and located at the Episcopal campus, may aid this effort in FY25. We are working closely with this program to enhance successful warm hand offs.
3. This rate is also impacted by the slow down in warm handoffs noted above. Patients waiting longer to sync with the next level of care are often less motivated and confronted by other barriers that ultimately impact the likelihood of linkage.
4. Readmission rates also increased which correlates with the decrease in warm handoffs, showing the importance of these linkages on both aftercare and recidivism. Recently, there have been some errors in this data which is received from an external source. Temple has been working with the external provider to correct these errors as they occur. However, this could account for some of the variance on measures 3 and 4.

Action Plans Implementation Summary:

- Work on a newly designed and relocated CRC is currently taking place, with hopes for the space to be in use by the end of calendar year 2024. Improving CRC space will allow for increased services to our community.
- Integrated behavioral health supports continue to be added to locations throughout the health system.
- There have been over a dozen educational collabroations between community programs and Temple this year. The exchange of resource and service information has proven valuable to both parties. Efforts on increasing these opportunities will remain a priority.
- The behavioral health social worker assigned to the department of medicine last fiscal year has morphed into a behavioral health community liaison role, with a dual focus on placing patients into behavioral health services and educating the community about Temple University Health System behavioral health services .
- Behavioral health services took part in several health fairs throughout the fiscal year. In June 2024, a campus wide health fair and large community event specifically focusing on the Crisis Response Center took place. Participation in this particular event was significant. Plans are underway to ensure this becomes an annual event for the community.
- Behavioral health screening events have been conducted by the outpatient Psychiatry department, including an upcoming one at a charity walk for suicide prevention, sponsored by Temple.

Conclusion & Next Steps:

One of the main tactics used to impact objectives 2, 3 and 4 has been stopped due to a combination of external staffing and regulatory challenges. A few different strategies were

tried but additional ones will be needed to regain the full impact. There are two potentially promising new options located on the Episcopal Campus to strengthen these metrics. The newly designed CRC should also support better patient throughput and linkage.

CHNA Progress Report

Plan Title:
Expand Substance Use Disorder Recovery Opportunities

Executive Sponsors:
John Robison, Executive Director, Temple University Hospital Episcopal Campus
Patrick Vulgamore, Director of Addiction Medicine Service Line

Health Equity Goals:

1. Increase community's access to best practice SUD treatment and other interventions to prevent drug overdose and advance recovery.
2. Improve SUD patient coordination to the most appropriate next level of care at all healthcare levels to support best outcomes.
3. Improve healthcare professionals' and community's knowledge of SUD treatment importance, options and how to access treatment.

Objectives:

1. Increase number of patient encounters made by SUD Navigation Team.
2. Increase number of successful same-day patient appointment "warm handoffs" made by SUD navigation team.
3. Increase number of healthcare professional best practice SUD treatment presentations and community events attended.

Metrics Data Dashboard:

Data is reported in averages per month.

Data Element	Baseline	FY23	FY24	FY25
Number of patient encounters by the SUD treatment navigation team.	**157.5**	**321.2**	**428.4**	
Number of successful warm handoffs by the SUD treatment navigation team.	**28.5**	**147.2**	**192.1**	
Number of educational outreach events Temple Health addiction professionals attend.	**0.41**	**1.17**	**3**	

Metric Progress Summary:

The Substance Use Disorder (SUD) treatment navigation team at Temple Health achieved significant growth in patient engagement and outreach activities over the past fiscal years. The average number of patient encounters increased by 172% from a baseline of 157.5 to 428.4 per month. The team also saw a substantial rise in successful warm handoffs, with a 574% increase from 28.5 to 192.1 per month over the same period. Additionally, the participation in educational outreach events expanded by 631% from 0.41 to 3 events per month, underscoring the team's commitment to community engagement and education.

Action Plans Implementation Summary:

1. Objective 1: Increase number of patient encounters made by SUD Navigation Team.

- A new director of SUD Engagement was hired in FY'24 who has dramatically improved the operations of the team.
- This service transitioned from a grant funded program to a reimbursable service, allowing for potential expansion.
- A new comprehensive licensed outpatient SUD Clinic was established that specializes in addiction and psychiatry treatment.

2. Objective 2: Increase number of successful same-day patient appointment "warm handoffs" made by SUD navigation team.
    - THE SUD treatment navigation team has expanded options for both inpatient and outpatient referrals by:
        - Actively engaging community-based programs.
        - Regularly meeting with referral sites to understand each referral destination's requirements and key personnel.
        - Regularly meeting with community behavioral health to understand expectations placed on their network from a referral source and destination perspective.

3. Objective 3: Increase number of healthcare professional best practice SUD treatment presentations and community events attended.
    - The SUD treatment navigation team has actively pursued opportunities to exhibit at community functions and health fairs.
    - Episcopal has started our own health fairs.
    - TUH, Inc. has received a grant from the State of Pennsylvania that contains funds for increasing awareness of best practices for addiction treatment.

Conclusion & Next Steps:
By integrating best practice treatment of Substance Use Disorder (SUD) into physical and behavioral healthcare settings, we have significantly expanded recovery opportunities, with the SUD treatment navigation team at Temple Health achieving a 172% increase in patient encounters, a 574% rise in successful same-day handoffs, and a 631% growth in educational outreach events. Despite staff turnover challenges, the team has created substantial population-level impacts in Philadelphia. The transition from a grant funded program to a reimbursable service has been crucial for establishing opportunities for the team to expand. Over the next six months, the primary focus will be on developing a financially sustainable operating model to ensure the long-term success and impact of this essential service while standing up other addiction treatment services.

CHNA Progress Report

Plan Title:
Prevent & Manage Chronic Disease by Improving Access to Care

Executive Sponsors:
Daniel Del Portal, MD, MBA – Senior Vice President, Chief Clinical Officer, TUHS
Steven Carson, MHA, BSN, RN – President & CEO, Temple Center for Population Health
Meaghan Kim, MHA, BSN, RN – Assistant Vice President, Population Health, Temple Center for Population Health

Health Equity Goals:

1. Identify and address health outcome disparities in the community
2. Decrease percent of preventable hospitalizations among Black and Hispanic individuals
3. Provide Temple community with equitable access to proactive health screenings and disease-specific education and management to attain health and wellness.

Objectives:

1. Increase number of community members enrolled in disease management programs.
2. Increase number of patients served by Multi-Visit Patient (MVP) Clinic.
3. Decrease MVP Clinic patient acute care hospital utilization.
4. Increase rate of outpatient office visits within 7 days of hospital discharge.

Metrics Data Dashboard:

Data Element	Baseline	FY23	FY24	FY25
Number of community members enrolled in disease management programs	1612	1930	2081	
Number of patients served by Temple Multi-Visit Clinic	940	973	*925	
Temple Multi-Visit Clinic Patient Emergency Department (ED) utilization after Multi-Visit Clinic enrollment) *(for 60 days post-enrollment compared to the 60 days prior to first clinic visit)*	-54%	-50%	*64%	
Temple Multi-Visit Clinic patient inpatient utilization after Multi-Visit Clinic enrollment *(for 60 days post-enrollment compared to the 60 days prior to first clinic visit)*	-62%	-72%	*-68%	
Outpatient follow-up visits within 7 days of hospital discharge	33%	31%	*33%	

Data source in FY24 is Epic EMR. Previous years data was collected from both Optum and Epic.

Metric Progress Summary:

1. Consistent Yearly Improvement in Patient Impact: The Temple Diabetes Program and Temple's Diabetes Prevention Program has shown sustained enhancement in assisting patients with diabetes.

Temple Diabetes Program:

- **FY22 Performance**:
  - 1,514 unique patients served
  - 2,784 visits completed
- **FY23 Performance**:
  - 1,792 unique patients served (18% increase from FY22)
  - 3,275 visits completed
- **FY24 Performance**:
  - 1,818 unique patients served (1% increase from FY23)
  - 3,824 visits completed

Temple Diabetes Prevention Program:

- **FY22 Performance:**
  - 98 program participants
- **FY23 Performance:**
  - 138 program participants (41% increase from FY22)
- **FY24 Performance:**
  - 263 program participants (91% increase from FY23)

2. The Multi-Visit Clinic continues to serve as a safety net for patients who need care for short periods of time. The data reflected in FY24 is solely Epic EMR, whereas in previous years, the data was collected from both Optum and Epic.

Number of patients served:

- **FY22 Performance:**
  - 940 patients
- **FY23 Performance:**
  - 973 patients (4% increase from FY22)
- **FY24 Performance:**
  - 925 patients (5% decrease from FY23)

ED Utilization:

- Baseline (-54%): After enrollment in the Multi-Visit Clinic, there was a 54% reduction in ED visits within the first 60 days compared to the 60 days before the first clinic visit. This indicates a positive impact in reducing ED utilization post-enrollment.
- FY23 (-50%): The reduction in ED visits slightly decreased to 50%, but the clinic still achieved a significant reduction in ED utilization.

- FY24 (+64%): This is a concerning increase. Instead of reducing ED visits, there was a 64% rise in ED utilization after enrollment. This suggests a reversal of the prior positive trend and could indicate emerging issues or challenges in patient management in FY24.

Inpatient Utilization:

- Baseline (-62%): There was a 62% reduction in inpatient admissions within the first 60 days after clinic enrollment compared to the 60 days prior, reflecting a substantial improvement.
- FY23 (-72%): The clinic further improved its performance with a 72% reduction in inpatient utilization in FY23, showing even greater success.
- FY24 (-68%): While there was a slight decline from FY23's peak, the clinic still maintained a strong reduction of 68% in inpatient utilization, continuing its positive impact.

Action Plans Implementation Summary:

- Implementation of a Hub and Spoke Model:
  - Restructured onsite offerings to improve geographic accessibility for community members within the Temple catchment area.
  - Ensured consistent educator availability for follow-up visits (Improvements in EPIC templates).
- Expansion of Services in FY24:
  - Introduced an inpatient diabetes education program at Temple Main Campus.
  - Facilitated a smooth transition of care for ongoing diabetes education and support.
- Growth of Diabetes Prevention Program:
  - Expanded program offerings to the Chestnut Hill area.
  - Tapped into new referral sources and reached patients eager for education.
- Community Engagement and Marketing:
  - Continued participation in community events.
  - Collaborated with the Temple Population Health Mobile Health Van to promote program offerings.

Conclusion & Next Steps:

Temple Diabetes Program:

- Enhancing Follow-Up Visits: The Temple Diabetes Program aims to increase the percentage of patients returning to complete the education curriculum. Structural changes have been implemented to support this goal.
- Accessibility of Services: Virtual visits remain available for patients facing transportation challenges to and from office sites.
- Support Group Initiative: The inpatient education team at Temple Main Campus will host a monthly Free Diabetes Support Group to aid those requiring additional assistance in managing their diabetes.

Diabetes Prevention Program Goals:

- Focus on increasing the graduation rate of participants in the year-long program.
- Collaboration with Shop Rite to host the Diabetes Prevention Program within the grocery store, merging real-life shopping experiences with healthy living education to combat diabetes.

CHNA Progress Report

Address Racial, Ethnic and Other Healthcare Disparities

Executive Sponsors:

Abiona Berkeley, MD, LD – *Interim Senior Associate Dean, Office of Diversity, Equity, & Inclusion, Lewis Katz School of Medicine at Temple University; President Medical Staff, TUH*
Steven Carson, MHA, BSN, RN – *President & CEO, Temple Center for Population Health*

Health Equity Goals:

1. Strengthen healthcare providers, trainee and other staff training on structural racism, implicit bias, diversity and trauma-informed care to improve culturally appropriate care delivery.
2. Foster a diverse, equitable, and inclusive environment for patients, healthcare providers and other staff from historically marginalized backgrounds.
3. Expand community partnerships to build trust and collaboratively improve healthcare quality, outcomes and value for populations with greatest needs served by the hospital.

Objectives:

1. Increase number of faculty, trainees, and staff completing cultural competency training.
2. Increase number of staff from diverse and inclusive backgrounds.
3. Increase community members participating in diversity workforce pathway programs.

Metrics Data Dashboard:

Metric	FY2022	FY2023	FY2024
Number of faculty, trainees, and staff completing cultural competency training	1,726	4,308	6,696
Number of staff representing diverse and inclusive backgrounds	3,107	3,207	3,757
Number of TUH community members participating in diversity workforce pathway programs	21	35	42

Metric Progress Summary:

- Number of faculty, trainees, and staff completing cultural competency training
    - 6,696 unique staff members completed an online cultural competency training through HealthStream or attended a symposium on cultural competency in FY24.
- Number of staff representing diverse and inclusive backgrounds
    - Temple University Hospital saw a 17% increase in the number of staff representing diverse and inclusive backgrounds from 3,207 in FY23 to 3,757 in FY24.
- Number of TUH community members participating in diversity workforce pathway programs
    - Four pathway programs in Lewis Katz School of Medicine:

Program	Participants 2023	Participants 2024
Mini Medical School	9	9
Health Career Exploration Day	3	2
Diversity Scholars	16	18
PREP Program	7	13

- This year, at the request of members of the Community Advisory Board, TUH collaborated with LKSOM to host a healthcare's exploration day at Kenderton Middle School, located two blocks away from the hospital. 41 members of the TUH administration and staff attended the event which was very well received by all.

Action Plans Implementation Summary:

1. Educate employees on health disparities and their impact through symposiums, training and continuing education on cultural humility, trauma-informed practices, and anti-bias communication.
    - Temple provides an array of training on cultural competency on the online platform HealthStream. Over 90 courses are available and discuss a variety of topics related to trauma, bias, diversity, and inclusion.
    - In FY24, 6,696 courses were completed by 6,696 unique members of Temple staff and faculty.
2. Strengthen diversity, equity, and inclusion (DEI) practices within health system's policies, procedures, and quality measures.
    - Temple University Health System remains committed to DEI by integrating it into its mission and vision. Policies and procedures within the health system are assessed and updated regularly to ensure they promote inclusivity.
3. Partner with local organizations to increase community's access to workforce diversity pathway programs.
    - The Lewis Katz School of Medicine offers several pathway programs to amplify diversity within Temple's workforce and in medicine.

- The Mini Medical School takes place annually and exposes high school students from the community to careers in the health professions. At Temple, 17 employees participated in FY2022, 9 in 2023, and 9 in 2024.
- The Health Careers Exploration Day is another event that exposes students from the community to learn more about medical school and careers in health. In FY2023, 3 employees from Temple participated in the event and 2 in FY 2024.
- Diversity Scholars is an 8-week program designed to engage college students from backgrounds historically underrepresented in medicine. The program had 12 researchers from Temple participate and 4 staff from Fox Chase Cancer Center in FY2023. In FY 2024, 11 researchers from Temple participated and 2 from FCCC.
- Lastly, the Pre-Matriculation Readiness and Enrichment Program (PREP) is a program open to all first-year medical students. This program supports participants' smooth transition to medical school and academic success by providing early exposure to the medical curriculum and assisting the development of learning and study-skill strategies. In FY2022, 4 TUH employees volunteered to work with PREP. In FY2023, 7 TUH employees joined the PREP team, a 75% increase. This year, 13 TUH employees participated, increasing participation by just over 85%.

4. Collaborate with community relations team to develop culturally relevant educational materials for patients, community partners, providers, trainees, students, and staff.
5. Develop process to quantify patient dissatisfaction related to gender, race/ethnicity, sexual orientation, gender identity, disability status, and other cultural competency indicators.
    - The Patient Relations department continues to review grievance cases to identify issues related to gender, race, ethnicity, sexual orientation, and other cultural competency indicators. In FY2023, three cases were identified as discrimination based on age, race and gender. These cases were resolved with inclusivity training mandated for the departments, with the intention of creating a more welcoming and inclusive environment for all patients.
6. Strengthen collection of patient self-reported demographic information "Real Data" on race, ethnicity, gender identity, veteran status, and other areas to improve disparities identification and response.
    - "Real Data" fields are collected at the time of new patient registration and updated, as needed, in the electronic medical record.
    - Temple has established a consistent and comprehensive approach to data collection across different patient care settings to ensure meeting data requirements for external organizations and to ensure all necessary data fields are maintained. Temple ensures the data collection is inclusive and encompasses various demographic intersections, while also anticipating future demographic reporting criteria set to external bodies.

- In terms of inclusivity, Temple has begun collecting gender related information for employment purposes, transgender identifies and LGBTQ+ affiliations, as well. These questions remain optional for FY2024.

Conclusion & Next Steps:

In terms of health equity goals. The team aims to make continued progress in the new year by focusing on the following:

Objective 1: Increase the number of faculty, trainees, and staff completing cultural competency training.

1. Identify existing training gaps in the current array of courses available to staff.
2. Utilize in-person and online formats to accommodate different learning preferences.
3. Monitor participation and track the number of participants completing the training modules.
4. Regularly evaluate the effectiveness of the training modules.

Objective 2: Increase the number of staff from diverse and inclusive backgrounds.

1. Develop strategies to attract diverse candidates for open positions, including targeted outreach and partnerships with community organizations.
2. Implement inclusive hiring practices to ensure equitable selection of candidates.
3. Continue to offer leadership development opportunities that nurture and promote employees from diverse backgrounds to leadership roles.
4. Increase mentorship and sponsorship opportunities for underrepresented staff.
5. Continue to review and update HR policies to ensure inclusivity and diversity.

Objective 3: Increase community members participating in diversity workforce pathway programs.

1. Conduct targeted outreach to community members, schools and organizations to promote existing pathway programs.
2. Track the number of community members who participate in the pathway programs.
3. Assess the effectiveness of the programs in terms of participants' career advancement and contributions to healthcare.
4. Regularly engage with community partners to review program outcomes and make necessary adjustments.

By following this action plan, the organization can work towards achieving its health equity goals and objectives, thereby creating a more culturally sensitive and inclusive healthcare environment that serves historically marginalized populations effectively.

CHNA Progress Report

Plan Title: Addressing Social Determinants of Health (SDOH)

Executive Sponsors:
Nina O'Connor, MD – *Professor, Chair, Family and Community Medicine and Primary Care Service Line Director.*
Steven Carson, MHA, BSN, RN – *President & CEO, Temple Center for Population Health*
Lakisha R. Sturgis, MPH, BSN, RN – *Director, Community Care Management, Temple Center for Population Health*

Health Equity Goals:

1. Strategically position TUH to accurately identify SDOH that cause health disparities and implement strategies to deliver equitable care.
2. Expand and improve staff continuing education on trauma-informed approaches to assessing SDOH that address the impact of structural racism and implicit bias on healthcare access.
3. Build the confidence of staff to increase collection of race, ethnicity, language and other SDOH data.
4. Identify and address non-medical barriers to improving individual and community health.

Objectives:

1. Increase number of staff participating in continuing education sessions on trauma-informed approaches to assessing SDOH.
2. Increase number of patients screened for SDOH.
3. Increase number of CHW referrals that result in patients being connected with resources to address identified SDOH.

Metrics Data Dashboard:

Metric	FY22 Baseline	FY23	FY24
Number of staff attending continuing education sessions on trauma informed approaches to assessing SDOH	0	185	104
Number of completed SDOH screenings	110,664	190,563	243,594
Percent of patients referred to a Community Health Worker (CHW) and connected with resources to address the identified SDOH	87.0%	83.7%	94.7%

Metric Progress Summary:

- Number of staff attending continuing education sessions on trauma-informed approaches to assessing SDOH
    - This was a new measure for FY23 where 185 staff attended the educational session and 104 completed the module in FY24
- Number of completed SDOH screenings
    - Social Determinants of Health refer to the conditions and factors in the social and physical environments in which people are born and live that can impact their overall health and well-being. Screenings are conducted in Ambulatory Care, the Emergency Department, and inpatient units at Temple University Hospital-Main Campus, Episcopal Campus, Jeanes Campus, and Chestnut Hill campus.
    - The number of completed SDOH screenings increased significantly from 110,664 (FY22), 190,563 (FY23) to 243,594 (FY24), >120% increase from baseline.
- Percent of patients referred to a Community Health Worker connected with resources to address the identified social determinants of health.
    - The CHW connection rate fluctuated from 87.0% (FY22) to 83% (FY23) and then increased to 94.7% in FY24.

Action Plans Implementation Summary:

1. Participate in interdisciplinary workgroups to review SDOH data and develop strategies for data collection and response improvement.
    - The SDOH Steering Committee includes leadership as well as medical, nursing, and social work representatives from across the health system. Screening data is presented to this group quarterly, followed by discussion of interventions and response improvement.
    - The steering committee is also focused on opportunities for performance improvement at the inpatient unit level.

2. SDOH screening data are reviewed in ambulatory quality meetings for Chestnut Hill Physicians (CHP), Temple Faculty Practice Plan and Temple Physicians Inc. Promoting staff continuing education on assessing patients for SDOH using a trauma-informed approach.
    - A custom HealthStream module created and launched in January 2023 that reviews SDOH screening questions and trauma-informed communication skills for conducting the screening.
    - In Spring 2023, all TFP and TPI clinic staff who conduct SDOH screenings were required to complete the module. CHP providers were added in 2024.
    - The module is available to all employees in HealthStream and can be assigned by managers.

- In FY24, 104 staff members completed the SDOH HealthStream module.

3. Consult trusted community advisors on how nurse navigation and community health worker services can be designed and implemented to maximize community participation and benefit.
    - A Community Advisory Council was launched in December 2022 to advise Temple University Hospital Inc. on community priorities and feedback. After the initial launch, the council had two meetings in FY23 and five meetings in FY24
    - Temple's comprehensive SDOH program was presented to the council, including screening processes and results. The Community Health Worker program and other community outreach initiatives to address SDOH were reviewed in detail with the council, which provided valuable feedback.
    - Patient feedback was also recently obtained in the TFP Primary Care Clinics through their Patient and Family Advisory Councils.

4. Partner with other trusted local health systems, managed care organizations, social service providers and other organizations that provide housing, food, transportation, internet access and other SDOH resources. Engage in shared learning to advance health equity.
    - Temple is actively involved with various community-based organizations to connect patients to resources for SDOH. For example:
        - Temple partners with Uber Health to provide rides to appointments for patients who lack access to reliable transportation.
        - Temple partners with Philadelphia Legal Assistance to embed a legal aid program in high-risk primary care practices.
        - Temple partners with a local internet provider to provide low-cost internet as part of our Digital Equity Program that also includes computer training.
    - Temple partnered with Health Partners Plans to address SDOH and has received funding for SDOH programming including a new Community Health Worker position in the Emergency Department at Temple Main, as well as urgent food deliveries, home remediation, and pest control for patients in need who are referred to the Community Health Worker program.
    - Temple has partnered with Project Home to provide a healing ecosystem for people who are experiencing homeless and opioid use disorder. Through this partnership patients will be provided housing with integrated healthcare.
    - Together, Temple and Jefferson Health Systems lead the Frazier Family Coalition (FFC). The goal of the FFC is to reduce the instances of stroke in North Philadelphia. To address food insecurity and reduce the risk of chronic conditions, the FFC delivers fresh produce with recipes on a weekly basis to community members in the FFC target zip codes.

5. Collaborate with the community relations team to develop educational materials to increase staff and community partners' participation in SDOH training and other efforts.
    - Temple participates in a city-wide collaborative effort led by the Philadelphia Department of Public Health and FindHelp to promote city-wide education and training around SDOH, including education of community partners.

6. Promote the use of the Temple Community Health Connect resource directory (FindHelp) among internal and external stakeholders.
    - Temple Community Health Connect (aka FindHelp) is widely promoted throughout Temple via strategically placed posters. Additionally, the QR code for the site is printed on After Visit Summaries in outpatient clinics whenever a patient screens positive for SDOH. In the Emergency Department, flyers including the same QR code are given to patients.
    - Temple Community Health Connect is also promoted at community events including health screenings and programs offered by Healthy Together, our mobile health van.
    - Temple Health signed a contract with Health Share Exchange to add PA Navigate to its resources. This program will add SDOH data that may have been collected at other organizations related to a deficit in a SDOH. This new program is slated to go live in 2025 and will help improve the coordination of community-based resources.
    - For FY25, Temple Community Connect will be added to key care management staff workflows in the EPIC EMR to facilitate the referral process.

7. Lead and participate in culturally appropriate community events that connect community members with needed resources.
    - In FY23, Temple's Healthy Together mobile health van participated in 29 events, engaging with 2,737 community members at various retail establishments, community and faith-based locations in the North Philadelphia corridor and surrounding areas.
    - In FY24, Temple Health launched the "Healthy Together" site at Brown's Shoprite of Fox Street. Our Mobile Health Van and site at Brown's Shoprite of Fox Street allow us to reach out and address undiagnosed chronic conditions like hypertension and diabetes. We also provide essential resources for social drivers of health such as transportation, food, and housing. Through both programs, we engaged with over 10,000 community members.

Conclusion & Next Steps:
Temple continues to make steady progress in SDOH screening with significant year-over-year increases in screening rates. Quality improvement projects also successfully increased screening rates in primary care and the TUH-Main Campus Emergency Department. A monthly dashboard detailing screening completion, positivity rates, and referrals to CHWs and social work is circulated monthly to stakeholders. This has been an effective monitoring strategy and will be continued in FY25.

As screening is added in additional locations, the HealthStream module will remain a key tool for ensuring staff training in trauma-informed approaches to screening. We will continue to assess the need for additional training strategies.

- With the new partnership and funding from Highmark, during FY24 several new FTE's will be added to the team:
    - A Community Health Worker will be placed in Episcopal Hospital's Emergency Department to address SDOH.
    - In February 2024, a Social Worker was placed in the Multi-Visit Patient Clinic to address the complex needs for patients that present with behavioral health and substance use disorder.

The Community Health Worker team connected patients with SDOH-related resources across multiple settings. To continue to improve SDOH response, CHW documentation and tracking in EPIC was recently redesigned to 1) increase visibility to referring clinicians and 2) allow weekly tracking of referrals, interventions, and response time. We anticipate that this additional data will facilitate continued optimization of SDOH response as well as evaluation for any additional needed resources. In FY24, the CHW program focused on closed-loop communication and their goal of achieving a 3-business day response rate.

CHNA Progress Report
Template – Plan to Address Specific Priority Area

Review instructions and complete metric definition, goals and action plan worksheet prior to completing template.

Plan Title:
Addressing the Public Health Crisis of Gun Violence

Executive Sponsor(s):
Abhijit Pathak, MD; Jill Volgraf, RN

Health Equity Goal(s):

1. Establish a behavioral health program for violently injured patients and families entering the hospital to support trauma recovery.
2. Strenghten underserved populations' access to crime victim services to address social determinants of health.
3. Increase job readiness among violently injured patients living in communities with chronic unemployment rates as a means to break the cycle of violence.

Objectives:

1. Improve Temple Victim Advocacy Program's collaboration with victim service agencies and increase the number of patients referred to these programs.
2. Increase the number of violently injured patients referred to behavioral health counseling pre- and post-discharge.
3. Improve violence survivors' access to job training and employment opportunities.

Metrics Data Dashboard:

Data Element	Baseline	FY23	FY24	FY25
Patients receiving case management services	0	557	770	
Patients referred to crime victim service agencies	226	411	483	
Patients referred to outside behavioral health services	0	155	184	
Patients engaged through workforce development programs	0	348	0	
Number of job readiness hosted	0	9	0	

Metric Progress Summary:

- Increased the number of violently injured patients receiving wraparound case management services by 38%.
- Increased the number of patients referred to crime victim services by 18%.
- Increased the number of patients receiving counseling through community-based mental health providers by 19%.

Action Plans Implementation Summary:

- Recruited hired, and trained a program therapist.
- Established a partnership with Temple Univesity's School of Social Work to place a clinical social work intern on the team to
- Recruited, hired, and trained a second case manager to increase the program's service capacity.
- Secured funding to provide emergency relocation services to survivors of gun violence.
- Secured funding to provide emergency food and clothing to program participants.
- Secured funding to maintain 24/7 victim advocate coverage within the hospital through June 2027.
- Hosted the Temple Univesity Hospital's inaugural Violence Survivor's Day to celebrate the resilience of program participants.
- Entered into contract with QuesGen System Inc. to implement their case management platform to improve data collection, evaluation, and reporting.
- Began work with the Genoa Group, an independent research firm, to evaluate the program's effectiveness.

Conclusion & Next Steps:

Due to staffing challenges, we were unable to meet our workforce development objectives and those efforts were temporarily put on hold. However, we were able to receive a one-year no-cost extension on the grant that funds this initiative and will continue our workforce development efforts through FY25. We have also received additional funding that will allow us to continue providing emergency food, clothing, transportation, and housing to patients post-discharge, as well as provide meal cards for their families while they are hospitalized.