Jefferson Health.

HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

NOVEMBER 2022

COMMUNITY HEALTH NEEDS ASSESSMENT

2022-2025 IMPLEMENTATION PLAN

Overview of Jefferson Health

Jefferson Health recognizes that by providing quality health care to our patients, and education and outreach to our neighbors, we are also enriching the lives and future of our surrounding communities. The work extends beyond the bedside. By partnering with the community, Jefferson Health seeks to improve the health and well-being of young and older Philadelphia and suburban residents through a variety of interventions including prevention and wellness programs, health education seminars, and screenings, as well as efforts that identify and address barriers to health, including the upstream factors (social determinants of health) that impact the health of everyone in the community.

MISSION: ***We Improve Lives***

VISION: ***Reimagining health, education, and discovery to create unparalleled value.***

VALUES: ***Jefferson Health's values define who we are as an organization, what we stand for and how we continue the work of helping others that began here nearly two centuries ago. These values are:***

- ***Put People First*: Service-Minded, Respectful & Embraces Diversity**
- ***Be Bold & Think Differently:* Innovative, Courageous & Solution-Oriented**
- ***Do the Right Thing:* Safety-Focused, Integrity & Accountability**

Jefferson Health, in partnership with Thomas Jefferson University, is dedicated to discovering new treatments and therapies that will define the future of clinical care; providing exceptional primary through complex quaternary care to patients in the communities we serve throughout the Delaware Valley; and educating tomorrow's professionals through transdisciplinary and experiential learning designed for new and emerging fields for the 21st century.

Jefferson Health includes 18 hospitals throughout southeastern Pennsylvania and southern New Jersey. They are:

- Einstein Medical Center Elkins Park
- Einstein Medical Center Montgomery
- Einstein Medical Center Philadelphia
- Jefferson Abington Hospital
- Jefferson Bucks Hospital
- Jefferson Cherry Hill Hospital
- Jefferson Frankford Hospital
- Jefferson Hospital for Neuroscience
- Jefferson Lansdale Hospital
- Jefferson Methodist Hospital
- Jefferson Stratford Hospital
- Jefferson Torresdale Hospital
- Jefferson Washington Township Hospital
- Magee Rehabilitation Hospital
- MossRehab
- Physicians Care Surgical Hospital
- Rothman Orthopaedic Specialty Hospital
- Thomas Jefferson University Hospital

In 2021, Jefferson Health finalized its ownership of Health Partners Plans (HPP), a health maintenance organization that provides CHIP, Medicare Advantage and Dual Eligible Special Needs plans, and a nationally recognized Medicaid plan. Through HPP, Jefferson can continue to advance its value-based care model while reducing costs of healthcare services, particularly among underserved patients and families of the greater Philadelphia region.

Combined, Jefferson Health and Thomas Jefferson University have more than 42,000 employees, which includes nearly 3,500 employed physicians/advanced practice professionals, 9,500 full and part-time nurses and more than 1,900 full and part-time paid faculty. Jefferson is the second largest employer in Philadelphia and the largest health system in Philadelphia based on total licensed beds. Jefferson Health includes over 50 outpatient and urgent care centers; 10 Magnet®-designated hospitals; the NCI-designated Sidney Kimmel Cancer Center; and one of the largest faculty-based telehealth networks in the country that began more than 10 years ago.

Thomas Jefferson University Hospital is one of only 14 hospitals in the country that is a **Level 1 Trauma Center** and a federally designated Regional Spinal Cord Injury Center. In 2021, Jefferson Health earned Digital Health Most Wired recognition from the College of Healthcare Information Management Executives (CHIME). Jefferson scored in the top 5% of all participating organizations, earning recognition for its technology advancements in acute care, ambulatory care and long-term care. Also in 2021, nearly 600 Jefferson physicians were named among the region's best by Castle Connolly in Philadelphia magazine's 2021 Top Docs™ issue.

COVID-19 RESPONSE

Jefferson was able to treat more than 16,000 COVID-19 inpatients — ranking it as the busiest care provider in the Philadelphia region battling this global pandemic. Jefferson was the first health system in the Philadelphia region to institute universal masking guidelines, and at the peak of COVID-19, its infection rate among frontline staff was roughly 1% — a testament to the effectiveness of its safety protocols and the relentless commitment to sourcing adequate supplies of personal protective equipment for staff. This in turn translated to protecting thousands of patients from COVID-19 exposure. Jefferson was also among the first in the region to arrange external Emergency Department triage tents and mobile-testing sites to keep patient screenings for COVID-19 outside of its hospitals.

In parallel, Jefferson, with the largest faculty-based telehealth network in the country, treated more than 500,000 patients virtually throughout the pandemic — keeping both patients and physicians safe. Jefferson Health and the City of Philadelphia also worked closely together to open a COVID-19 testing site in Northwest Philadelphia to offer free, twice-weekly testing throughout the peak of the pandemic. When the COVID-19 vaccine became available, Jefferson Health assembled a multidisciplinary COVID-19 Vaccine Task Force that worked tirelessly to develop its **Real Talk Initiative** and **Trusted Messenger program** to spread accurate and up-to-date information about the vaccine, particularly to Black and Brown communities that had concerns about the vaccine and mistrust of the medical and scientific community. In tandem, Jefferson initiated a **mobile community vaccination program** that has administered more than 5,200 vaccines in marginalized communities.

IN THE COMMUNITY

In FY20 Jefferson Health contributed more than $448 million in charitable care and community benefit. Among Jefferson's many efforts in this area is the work of the **Jefferson Collaborative for Health Equity** (the Collaborative), the community outreach and engagement arm of Jefferson Health charged with addressing the social and structural determinants of health in Philadelphia. Aligned with the CHNA and CHIP, the Collaborative partners with internal and external stakeholders to address the complex issues facing our communities by aligning resources, building partnerships, and forging trust and relationships that create sustainable change. The Collaborative builds on community strength to improve health and well-being in communities, fostering the local Ecosystem necessary to promote health equity and help every family in our targeted communities reach their full potential. In 2020, Jefferson, in partnership with Temple, launched **The Frazier Family Coalition for Stroke Education and Prevention**, which is coordinated through the Collaborative to promote the health of North Philadelphia residents through a multifaceted program aimed at reducing the number of strokes. With its office located in the lowest-income zip code in the city, the coalition is countering the lack of access to providers, unmanaged chronic disease, and limited awareness of risk factors that has allowed the rate of stroke to swell in North Philadelphia.

Jefferson and Novartis also initiated a program called "Closing the Gap" to focus on reducing cardiac health disparities across the city's most vulnerable zip codes. Addressing social determinants of health, the program heavily utilizes Community Health Workers to screen, identify, and navigate individuals at high-risk for cardiovascular disease to the care and preventative services they need. The **Jefferson Center for Connected Care** was also launched to develop and test innovative approaches for a patient-

responsive care delivery system. As part of its Reimagine fundraising campaign, Jefferson has set a goal of raising $100 million for health equity initiatives in the greater Philadelphia region.

Jefferson is one of the largest providers in Philadelphia for refugee health care and is one of only four programs in the nation recognized by the Centers for Disease Control and Prevention as a Center of Excellence. In addition to its Center for Refugee Health, Jefferson opened the **Hansjörg Wyss Wellness Center** in 2021. The Center brings free medical and social services to immigrant and refugee communities. In the fall of 2021, Jefferson and other providers supported an extensive volunteer medical operation at the airport for Afghan evacuees. They offered urgent medical care for 1,600 on site, while providing family-centered testing and vaccinations.

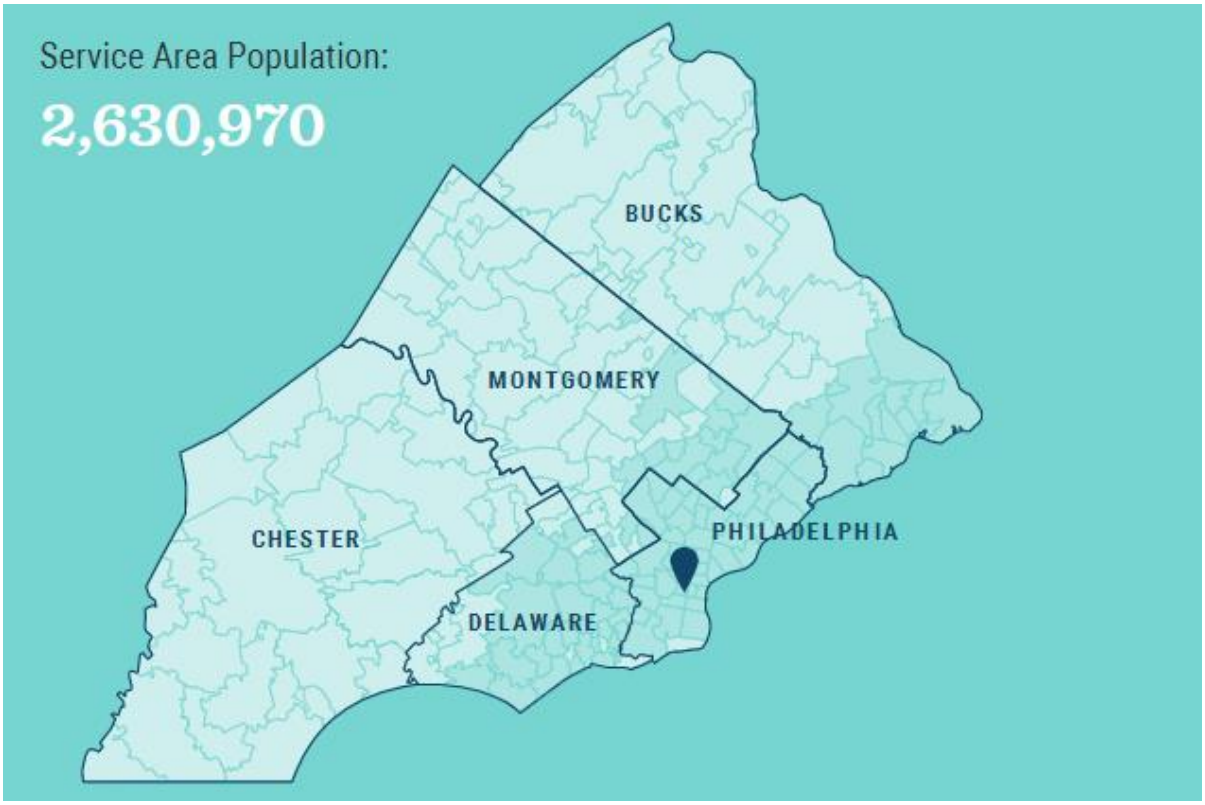
Geographic Regions & Zip Coded Services by Jefferson Health

Jefferson Health – Center City

Thomas Jefferson University Hospital, Jefferson Methodist, Jefferson Hospital for Neuroscience

Philadelphia County: 19102, 19103, 19106, 19107, 19121, 19122, 19123, 19124, 19125, 19130, 19132, 19133, 19134, 19140, 19145, 19146, 19147, 19148

Jefferson Health – Magee Rehabilitation



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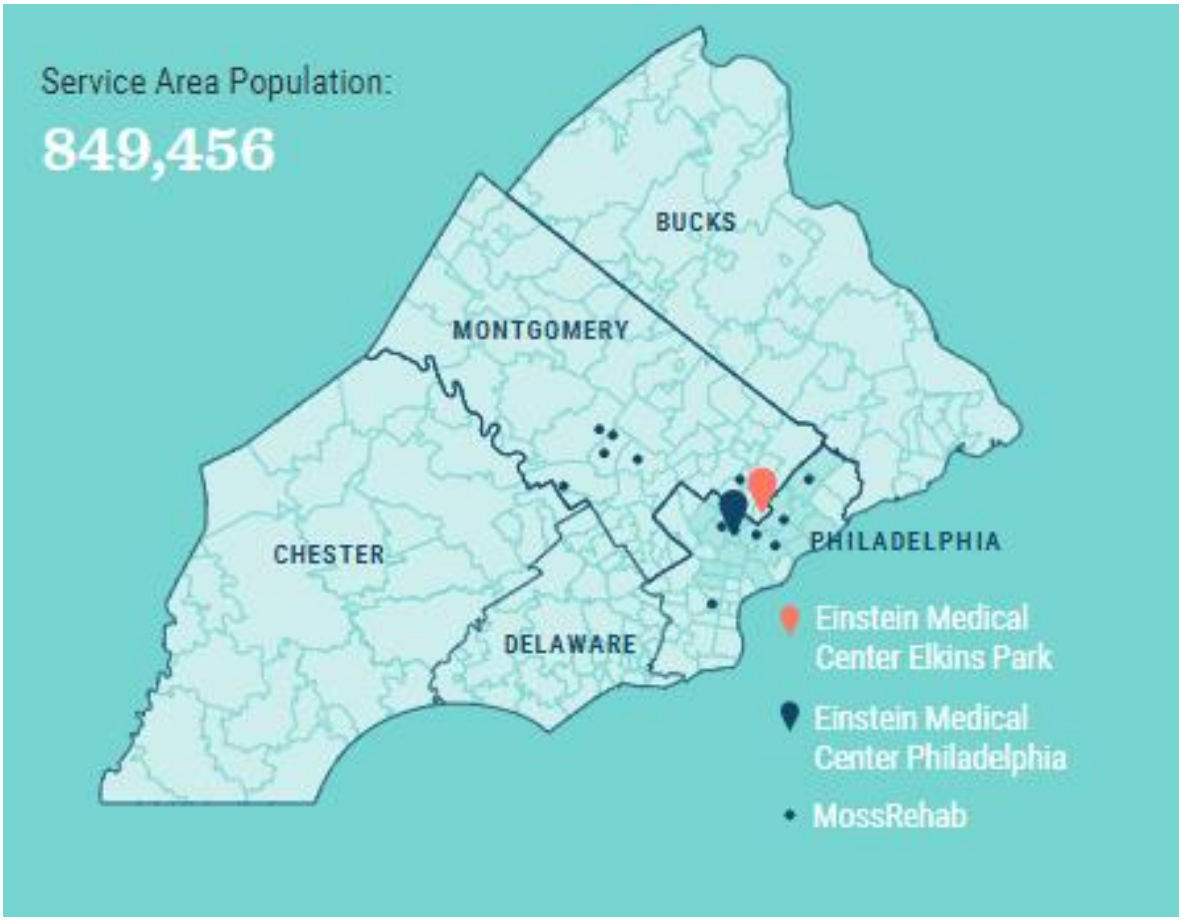
Montgomery County: 19001, 19002, 19003, 19004, 19006, 19027, 19031, 19038, 19040, 19044, 19046, 19072, 19075, 19090, 19095

Philadelphia County: 19102, 19103, 19104, 19106, 19107, 19111, 19114, 19115, 19116, 19118, 19119, 19120, 19121, 19122, 19123, 19124, 19125, 19126, 19127, 19128, 19129, 19130, 19131, 19132, 19133, 19134, 19135, 19136, 19137, 19138, 19139, 19140, 19141, 19142, 19143, 19144, 19145, 19146, 19147, 19148, 19149, 19150, 19151, 19152, 19153, 19154

Jefferson Health – Einstein Medical Center Philadelphia



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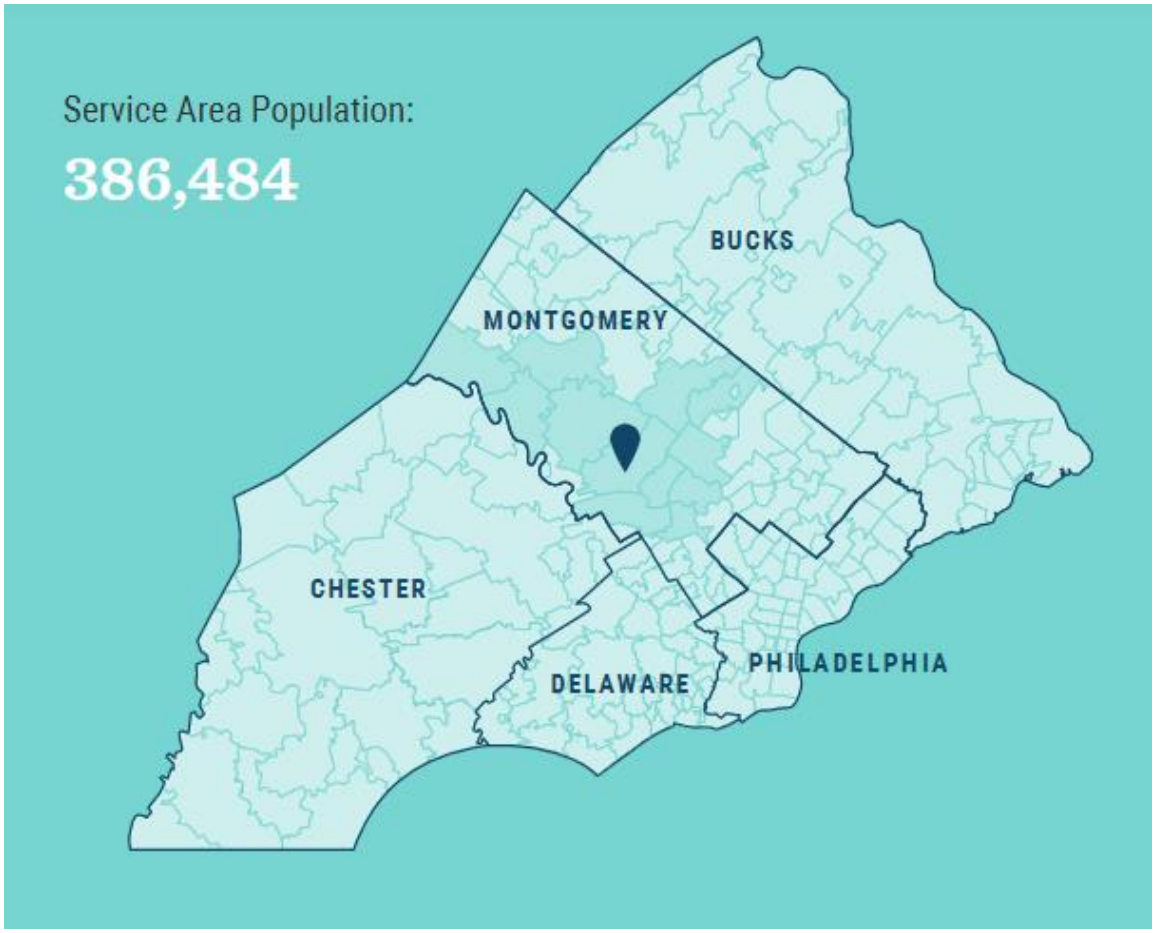
Montgomery County: 19027

Jefferson Health – Einstein Montgomery



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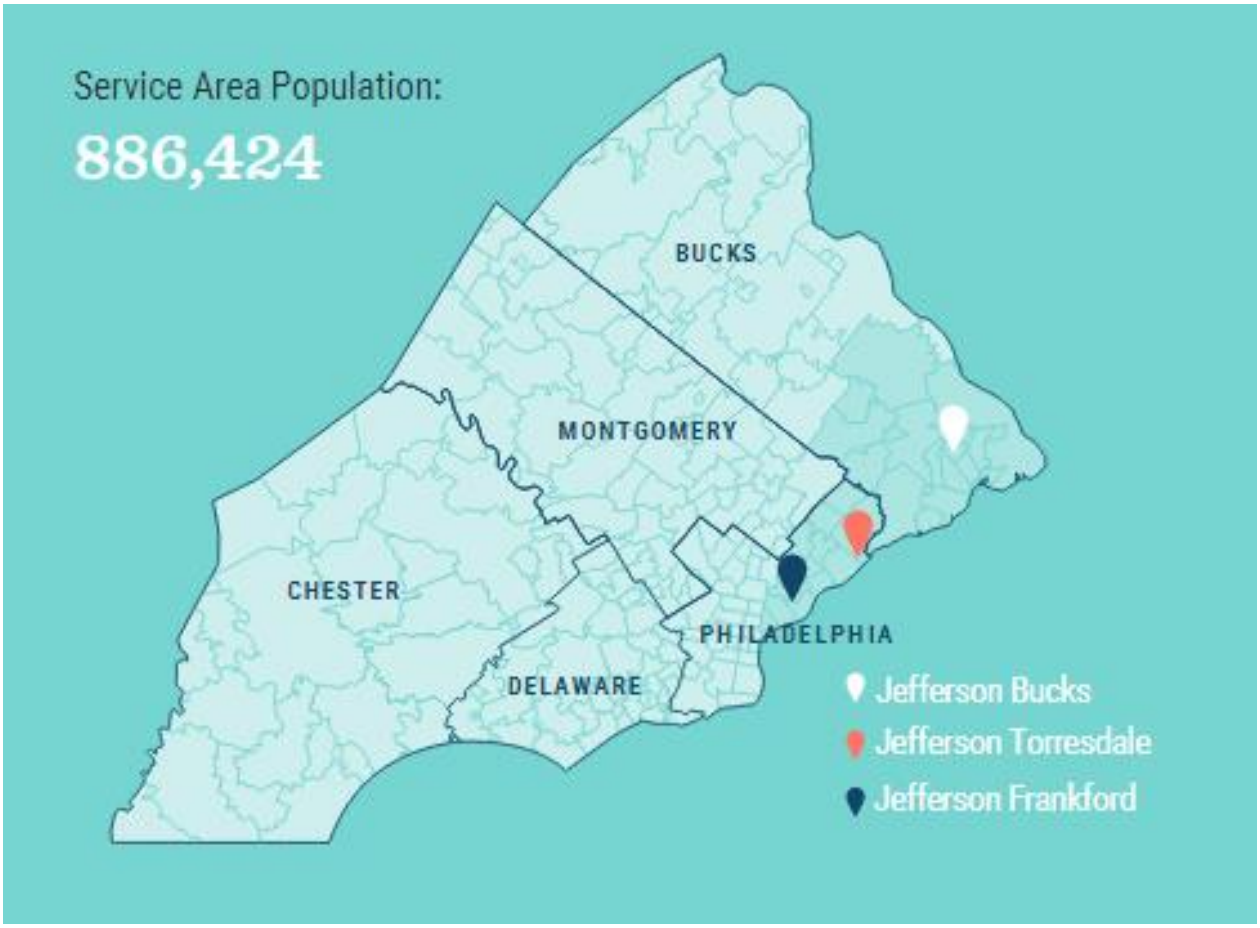
Jefferson Health – Northeast



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Philadelphia County: 19111, 19114, 19115, 19116, 19124, 19125, 19134, 19135, 19136, 19137, 19149, 19152, 19154

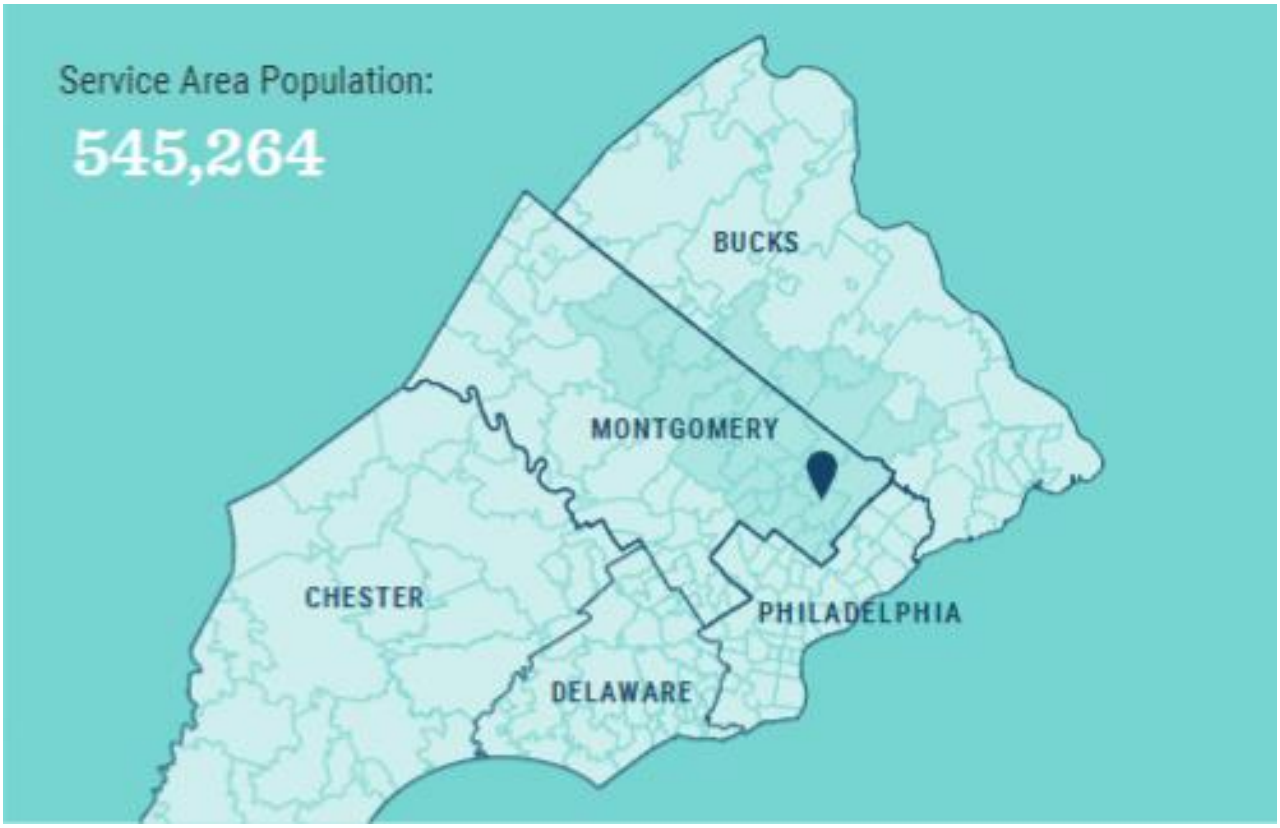
Jefferson Health – Rothman Orthopaedic Specialty Hospital

Bucks County: 18901, 18914, 18938, 18940, 18944, 18966, 18974, 18976, 19007, 19020, 19030, 19047, 19053, 19054, 19056, 19057, 19067

Montgomery County: 19002, 19006, 19038, 19040, 19046, 19403, 19422, 19446, 19454

Philadelphia County: 19111, 19114, 19115, 19116, 19119, 19124, 19128, 19135, 19136, 19145, 19146, 19147, 19148, 19149, 19152, 19154

Jefferson Health – Abington Hospital



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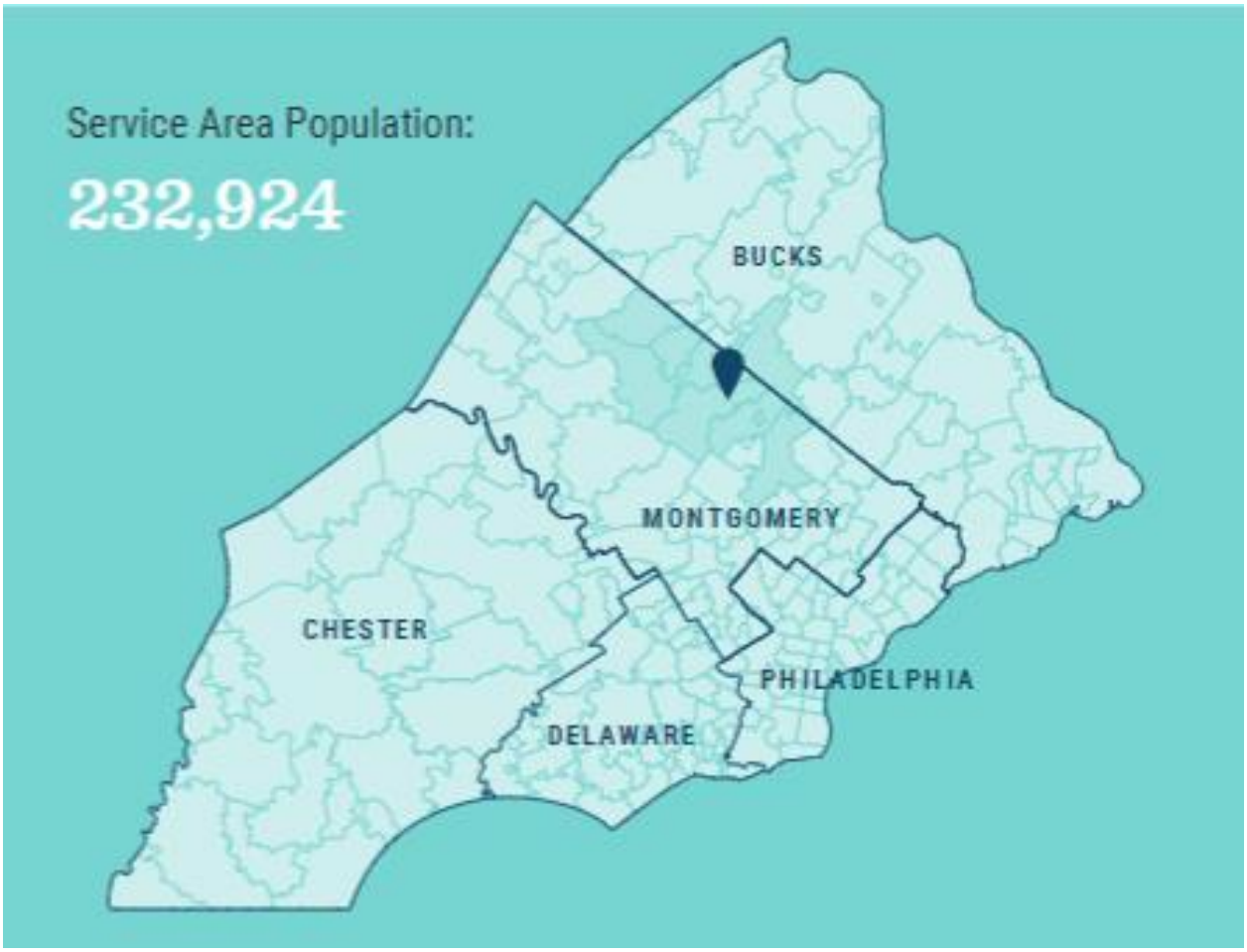
Bucks County: 18914, 18929, 18932, 18966, 18974, 18976

Jefferson Health – Lansdale Hospital



Bucks County: 18914, 18932

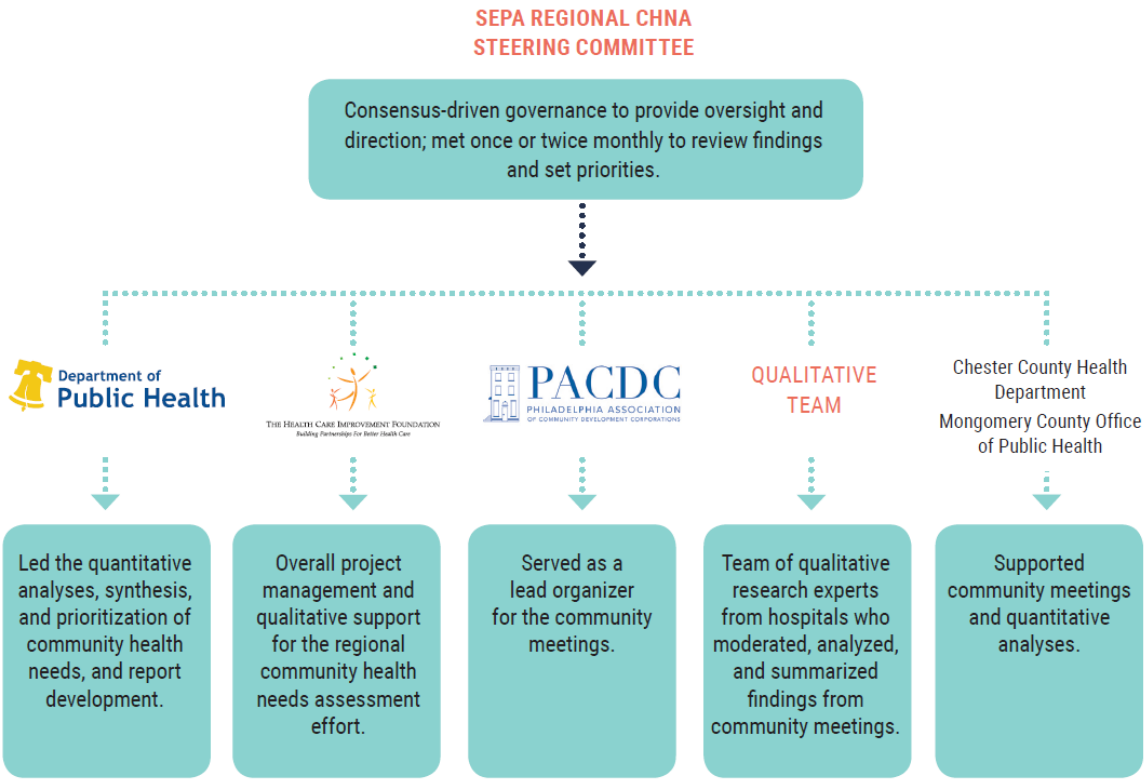
Montgomery County: 18915, 18936, 18964, 18969, 19002, 19422, 19438, 19440, 19446, 19454

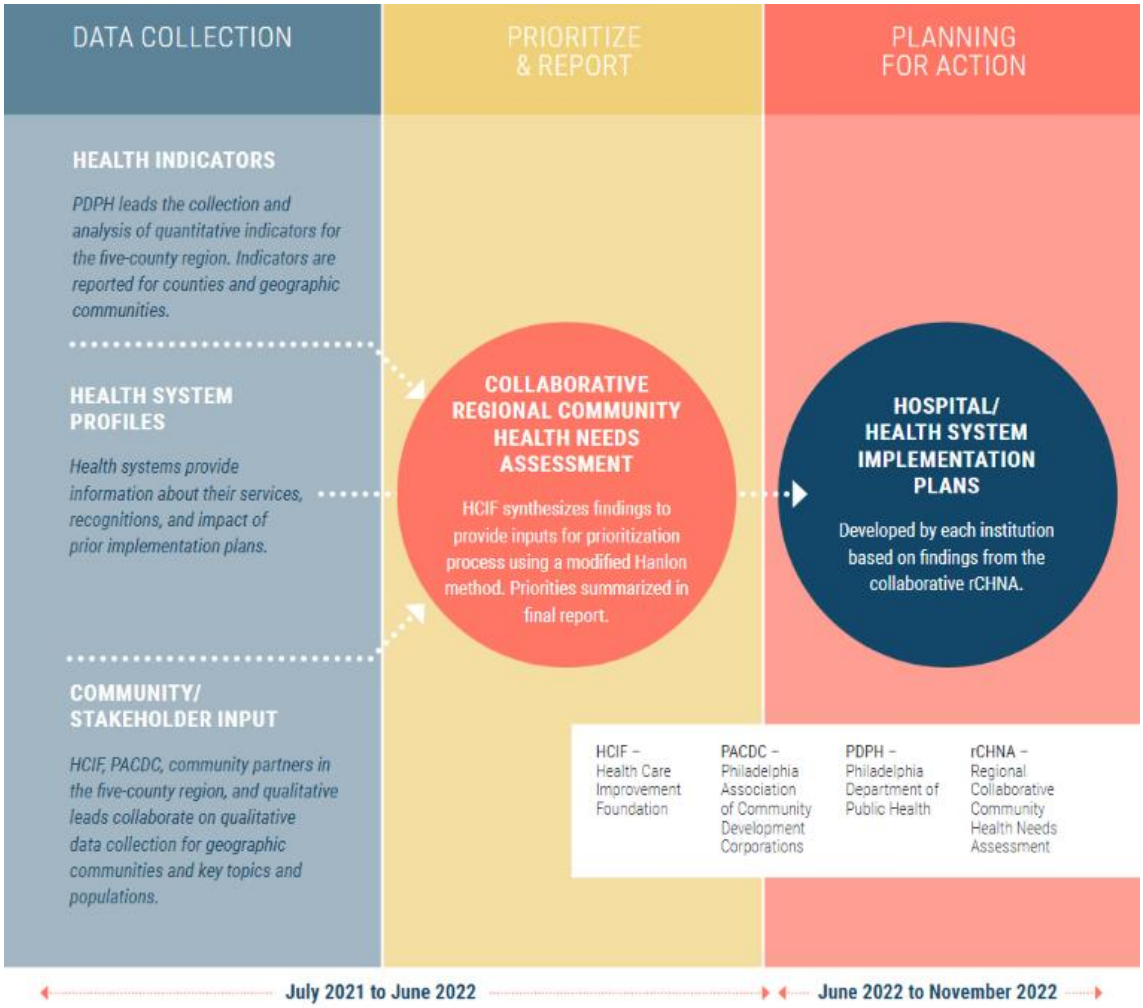
Overview of the Community Health Needs Assessment and Prioritization Process

Identifying and addressing unmet health needs of local communities is a core aspect of the care provided by hospitals and health systems across the U.S. The Affordable Care Act (ACA) formalized this role by mandating that tax-exempt hospitals conduct a Community Health Needs Assessment (CHNA) every three years and implement strategies focused on emergent priorities from the assessment. This assessment is central to not-for-profit hospitals and health systems' community benefit and social accountability planning. By better understanding the service needs and gaps in a community, an organization can develop implementation plans—also mandated by the ACA—that more effectively respond to high priority needs.

Recognizing that hospitals and health systems often mutually serve the same communities, a group of local hospitals and health systems have again collaborated on a **Southeastern Pennsylvania (SEPA) Regional CHNA (rCHNA),** with specific focus on Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties. This continued collaboration enables continuity of approach, while also providing opportunities to expand and improve upon the last assessment process.

A steering committee was formed and participants developed a collaborative, community-engaged approach as indicated below:





Participants recognize that the CHNA is an important part of how health systems, multi-sector partners, and communities work together to achieve meaningful and positive community change. In addition to the shared learning, increased efficiencies, and reduced community burden offered by the collaborative approach, participants have derived particular benefits from mutual support in the face of the COVID-19 pandemic and its cascading impacts. In response to the crises of the past several years, the 2022 rCHNA is explicitly grounded in an approach that seeks to advance health equity and authentic community engagement.

Quantitative data were acquired from local, state, and federal sources and focused on indicators that were uniformly available at the ZIP code level across the region. The Philadelphia Department of Public Health (PDPH) team, which included experts in epidemiological and geospatial analyses, compiled, analyzed, and aggregated over 60 health indicators encompassing data on community demographic characteristics, COVID-19, chronic disease and health behaviors, infant and child health, behavioral health, injuries, access to care, and social and economic conditions.

In addition, the steering committee either undertook directly or supported partners with targeted primary data collection to better understand the needs of particular communities or populations. These

focus areas and communities were either specific to a different type of facilities within participating health systems (i.e., cancer centers, rehabilitation facilities) or reflected gaps in the 2019 rCHNA:

- **Cancer**
- **Disability**
- **Immigrant, refugee, and heritage communities**
- **Youth voice**

All data were synthesized by HCIF staff and a list of **12 community health priorities** was presented to the Steering Committee. Using a modified Hanlon ranking method, each participating hospital and health system rated the priorities. An average rating was calculated, and the community health priorities were organized in priority order based on:

- **Size of health problem**
- **Importance to Community**
- **Capacity of hospitals/health systems to address**
- **Alignment with mission and strategic direction**
- **Availability of existing collaborative efforts**

Using these five criteria, an average rating was calculated for each priority area.

The community health priorities for the region are presented below in ranked order:

2022 Regional CHNA PRIORITY HEALTH ISSUES/NEEDS
1. Mental Health Conditions
2. Access to Care (Primary & Specialty)
3. Chronic Disease Prevention & Management
4. Substance Abuse and Related Disorders
5. Healthcare & Health Resources Navigation
6. Racism & Discrimination in Healthcare
7. Food Access
8. Culturally & Linguistically Appropriate Services
9. Community Violence
10. Housing
11. Socioeconomic Disadvantage
12. Neighborhood Conditions

RCHNA – Health Needs Categories

Health Issues	Access and Quality of Healthcare and Health Resources	Community Factors
• Chronic conditions (prevention and management) • Mental health conditions • Substance use and related disorders	• Access to care (primary and specialty) • Food access • Healthcare and health resources navigation (including transportation) • Linguistically- and culturally-appropriate services • Racism and discrimination in healthcare settings	• Housing • Neighborhood conditions (e.g., blight, greenspace, air and water quality, etc.) • Community violence • Socioeconomic disadvantage (e.g., poverty, unemployment)

12 high priority community health needs, representing three categories:

1. **Health Issues:** (Chronic Conditions (prevention and management), mental health conditions. Substance use and related disorders.
2. **Access & quality of healthcare & resources: Access** to care (primary & specialty), food access, healthcare and health navigation (including transportation), linguistically-and-culturally appropriate services.
3. **Community factors:** Housing, neighborhood conditions (e.g., blight, greenspace, air, and water quality, etch), community violence, socioeconomic disadvantage (e.g, poverty, unemployment).

2022 Regional CHNA Priority Health Needs

rCHNA Regionally	TJUH Center City, Methodist, & Magee	JHA Abington, & Lansdale	Einstein Philadelphia, Elkins Park, Montgomery County, & Moss Rehab	JNE Torresdale, Frankford, Bucks, & ROSH	Jefferson NJ Cherry Hill, Stratford & Washington Township
1.Mental Health Conditions	1. Mental Health Conditions	1. Mental Health Conditions	1. Mental Health Conditions	1. Healthcare & Health Resources Navigation	1. Maternal & Child Health
2. Access to Care (Primary & Specialty)	2. Access to Care (Primary & Specialty)	2. Substance Use and Related Disorders	2. Food Access	2. Substance Use and Related Disorders	2. Behavioral Health
3. Chronic Disease Prevention & Management	3. Chronic Disease Prevention & Management	3. Chronic Disease Prevention & Management	3.Substance Use and Related Disorders	3. Access to Care (Primary & Specialty)	3. Chronic Disease
4. Substance Use and Related Disorders	4. Healthcare & Health Resources Navigation	4. Access to Care (Primary & Specialty)	4. Healthcare & Health Resources Navigation	4. Mental Health Conditions	4. Youth Mental Health
5. Healthcare & Health Resources Navigation	5. Substance Use and Related Disorders	5. Healthcare & Health Resources Navigation Food Access	5. Chronic Disease Prevention & Management	5. Chronic Disease Prevention & Management	N/A

This framework serves as the foundation for the health strategies presented within the Jefferson Health Community Health Implement Plan (CHIP).

Jefferson Health – Northeast Hospitals
Community Health Implementation Plan

Overview of Jefferson Health-

Since 2015, the organization has been part of Jefferson Health, which now includes 18 hospitals and more than 40 outpatient and Urgent Care Center locations located throughout Philadelphia, Bucks and Montgomery counties in Pennsylvania and Camden and Gloucester counties in New Jersey. Outpatient and community-based services are delivered through a network of owned and affiliated physician practices, satellite medical and surgical centers, outpatient laboratories and radiology centers. Together, Jefferson Health has 126,000 inpatient admissions; 499,000 Emergency Department visits, and four million outpatient visits annually.

Jefferson Health – Northeast entities include the following:

- Jefferson Health Northeast includes Jefferson Bucks, Frankford and Torresdale Hospitals and have 464 licensed bed. In FY22, the hospital had 23,002 total admissions.
- Employed physician practices located in Philadelphia and Bucks counties with 36 locations.
- In fiscal year 2022, there were 218,906 outpatient visits across all Jefferson Health – Northeast locations.

Jefferson Health – Northeast employs nearly 4,000 employees, making it one of the largest employers in Northeast Philadelphia and Bucks County. The hospital's medical staff consists of over 1,000 physicians, including primary care, medical and surgical specialists. More than 200 volunteers give their time and talents to support this not-for-profit hospital.

In fiscal year 2022, Jefferson Health – Northeast treated more than 99,144 patients in its three Emergency Departments, with Jefferson Torresdale Hospital having the distinction of being a Level II Trauma Center.

Jefferson Torresdale Hospital is a 253-bed acute care hospital has a thrombectomy capable stroke center, as well as highly advanced programs in cancer, surgery, cardiovascular services, and neuroscience. Also located at Jefferson Torresdale Hospital is the Sidney Kimmel Cancer Center, a full service outpatient cancer center of the Sidney Kimmel Cancer Center – Jefferson Health.

Jefferson Frankford Hospital is a 115-bed, acute care general hospital providing inpatient and outpatient services, including an Emergency Department, a full range of medical and surgical programs, preventive health screenings, primary stroke services, and a Wound Care Center.

Jefferson Bucks Hospital is a 96-bed, acute care general hospital providing inpatient and outpatient services, including an Emergency Department, a full range of medical and surgical programs, comprehensive orthopaedic and neurosurgical service, preventive health screenings, primary stroke services, and a Wound Care Center.

Priority Health Issues and Needs to be Addressed

The Table listed on page 17 compares the rankings of the priority health issues of the region and Jefferson Hospitals to how these were ranked by senior leaders at Jefferson Health – Northeast.

In order to maximize the resources available, Jefferson Health – Northeast has chosen to address the following priorities listed in the 2022 Regional Community Health Needs Assessment:

Healthcare & Health Resources Navigation
Substance Use and Related Disorders
Access to Care (Primary and Specialty)
Mental Health Conditions
Chronic Disease Prevention and Management

Community Health Implementation Plans (CHIP) are written to address these specific five priorities for Jefferson Health – Northeast's Bucks, Frankford and Torresdale hospitals. Jefferson Health - Northeast administrative and clinical leaders develop and implement goals and action plans.

The next following two priorities are addressed within normal hospital operations:

- Linguistically and Culturally Appropriate Services
- Racism and Discrimination in Healthcare Settings

The following four priorities are addressed through work with local and regional collaborative and referrals to community or government resources:

- Community Violence
- Housing
- Socioeconomic Disadvantage (e.g. Poverty, Unemployment)
- Neighborhood Conditions (e.g. Blight, Greenspace, Air/Water Quality, etc.)

In addition, Jefferson Health – Northeast professionals collaborate with Jefferson colleagues to improve health status in conjunction with the hospital's partnerships. Best and promising practices are shared with the aim of enhancing infrastructure, stretching resources, and incorporating knowledge about social determinants of health and health literacy to better the population's health and well-being. Community benefit leaders will continue to monitor the changing landscape and requirements initiated through future health reform and the IRS including financial assistance requirements.

Overview of the Jefferson Health – Northeast Plan Community Health Implementation Plan (CHIP)

The Jefferson Health - Northeast CHIP was developed in collaboration with Jefferson Health – Northeast key community stakeholders, administrative and clinical leaders. The plan is reviewed annually and revised based on changing community needs, best practices and short-term/intermediate outcomes.

Using a logic model for each priority health need, the CHIP provides an overview of the objectives, proposed strategies/activities, outputs/impact measures, and potential partners.

Proposed strategies/activities were considered based on their alignment with national, state, and county health improvement plans, and national best practices cited by organizations such as the US

Department of Health and Human Services, Agency for Health Research and Quality, Healthy People 2020, the American Medical Association, National Council on Aging, the Joint Commission, the American Heart Association, the National Prevention Strategy, the Guide to Community Preventive Services, and the Guide to Clinical Preventive Services.

The following plans will be implemented by Jefferson Northeast Hospitals (Torresdale, Frankford, Bucks and Rothman Orthopedic Surgical Hospital).

Mental Health Conditions	
Goal: Improvement in the capacity of Jefferson Northeast Hospital (JNE) and community-based organizations to address behavioral health/mental health conditions within the community	
Objective: Increase access and referral to behavioral health services	
Strategy/Action	Behavioral Health Consults (Licensed Clinical Social Workers) are available to PCP practices for mental health consultation via warm hand-off or telephonic outreach. LCSWs to focus on mental health issues as well how patients' mental health affects their acute or chronic disease conditions.
Target Population	Adult patients of Jefferson Northeast Hospitals
Outputs	• # Behavioral Health Consultations within Primary Care Visit • # of practices with embedded BHCs • # warm Handoffs completed
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Primary Care Practices; JNE Behavioral Health providers External Partners: External behavioral health providers
Strategy/Action	Explore sponsoring the Grace Project's (non-profit organization) annual gala. Also provide support through conducting hygiene collections throughout the year with collaboration of our Diversity Council.
Target Population	Substance Use disorder patients, People living in poverty, homeless
Outputs	• Track collections and sponsorship donations to the Grace Project
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development

FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: JHNE CRS, Social Workers, Diversity Council External Partners: Grace Project organization
Objective: Enhance communication strategies for relevant mental health referral resources to community and workforce including Mental Health Awareness Month each May	
Strategy/Action	Communicate through hospital and community updates and social media relevant referral resources
Target Population	JNE Community and workforce
Outputs	• E-mails to key community stakeholders
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Community Health staff; Public Relations and Marketing, JHNE Employees External Partners: Community based organizations [CBOs]
Objective: Explore and enhance community partnerships for potential outreach and/or education on issues and topics relevant to behavioral health/mental health conditions	
Strategy/Action	Explore partnerships with the Muslin faith-based community and behavioral health professionals to develop a comprehensive network of care and/or education, outreach and support
Target Population	Muslim population and their families in the community served by JHNE
Outputs	• # visits from Muslim Faith pastoral care
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Behavioral Health team, Community Health leaders and Pastoral Care External Partners: NAMI, Faith-based community, Muslim pastoral care
Objective: Re-engage with hospital support and self -help groups for in-person offerings in hospital meeting space and/or share virtual groups. Promote to community and workforce	
Strategy/Action	Monitor COVID19 protocols for return of groups to hospital campus meeting space; create process for re-engagement and onboarding Work to capture virtual support groups through local, reputable organizations and communicate to stakeholders and workforce
Target Population	Former hospital support and self-help groups' facilitators; Pilot and approve potential new groups

Outputs	• Track # of groups returning to in-person • Track sharing of virtual groups
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Behavioral Health leaders and coordinators; Community Health leaders; Administration for space approval and scheduling; Public Relations and Marketing External Partners: Support and Self-help group facilitators
Objective: Provide depression and suicide screenings for specific JNE patient populations	
Strategy/Action	Promote and provide suicide screenings in JHNE Hospitals' Emergency Department
Target Population	Adults admitted to JNE Hospitals' Emergency Room
Outputs	• Track # of patients screened for suicide screening with Epic data reports
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Emergency Department Leadership; On-call Psychiatry External Partners: Friends Hospital
Objective: Integrate trauma informed practices to create a culture of healing-centered care.	
Strategy/Action	Promote practices related to providing training and awareness building, advancing healing-centered patient care, and building staff resilience and supportive resources
Target Population	JNE Workforce, patients
Outputs	• Document practices and trainings including # of persons served
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Nursing Department, Nurse Residents External Partners: Community stakeholders
Objective: Provide workplace violence training for hospital personnel	
Strategy/Action	Promote Handle with Care hands on training on advanced physical skills to targeted areas of the hospital and promote verbal de-escalation skills to additional workforce
Target Population	JHNE workforce
Outputs	• Track # of trainings • Track # of persons served

FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Trained Handle with Care colleagues; Security, Nursing Education External Partners: Handle with Care consultants

Substance Use and Related Disorders	
Goal: Decrease substance use and related disorders	
Objective: Expand prevention programs for National Drug Take Back, community education and electronic/social media communication	
Strategy/Action	In conjunction with BCHIP (Bucks County Health Improvement Partnership) and/or other community organizations, JHNE will create communication strategies [i.e., flyers/emails] on National Drug Take Back programs and disposal sites to community and workforce in an effort to reduce and remove unused or old prescriptions within the home. Increase social media presence on drug take back programs.
Target Population	JHNE community and workforce
Outputs	• National Drug Take Back Days are October and April of each year. Track communication strategies • Document social media analytics and/or communications
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Community Health leaders, Public Relations and Marketing; social media colleagues. External Partners: Community Based Organizations
Objective: Reduce access to opiate pain killers and raising public awareness about addiction	
Strategy/Action	Continue to reinforce Jefferson Health – Northeast physicians' commitment to increase compliance with patient "agreements" for chronic opioid use
Target Population	JHNE physicians
Outputs	• Track # of physicians
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact

FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: JHNE physicians External Partners: Community served
Strategy/Action	Utilize Certified Recovery Specialist (CRS) to help in the weaning of opioid/alcohol dependent patients when presenting in the Emergency Department
Target Population	Substance Use Disorder patients presenting in the Emergency Department (ED)
Outputs	• Track # of SUD patients sent to Rehab from ED and inpatient locations
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Certified Recovery Specialists External Partners: Friends Hospital, Drug and Alcohol Rehab Facilities
Strategy/Action	The Jefferson Health – Northeast Emergency Department will continue its warm handoff protocol to facilitate connecting patients with Opioid Use Disorder (OUD) to community resources that provide OUD therapy. Mothers and pregnant women with OUD will be referred to Jefferson Health's MATER program in Center City. Care Management services will be available 24/7 to facilitate these OUD referrals
Target Population	OUD patients, OUD pregnant mothers and OUD mothers
Outputs	• Track # of OUD patients, OUD pregnant women and OUD mothers with warm handoff to community resources • Track # of OUD pregnant women and mothers referred to MATER
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Social work , providers , certified recovery specialists External Partners: Friends, MATER Program
Strategy/Action	Integrate education on alcohol and opioid use issues and CDC guidelines into continuing medical education
Target Population	Medical Residents, Interns
Outputs	# staff trained in alcohol and opioid use disorders
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development

FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Medical and Family practice residents and interns External Partners: JHNE patients rendering care
Strategy/Action	Incorporate pain management curricula into Jefferson Health – Northeast's educational framework for all levels of providers starting with students
Target Population	All Levels of Providers
Outputs	• # of staff educated in pain management
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Educators, Pharmacy , Social Work, Physicians, Nurses, all students External Partners: Emergency Medical Services
Strategy/Action	Continue to support the Bucks County "Warm Handoff" Initiative which has been initiated at all three campuses. Certified Recovery Specialists are available at certain times of the day and if not available to meet face to face patients are connected via educational information to call for follow up if the patient agrees to be connected
Target Population	Emergency Department patients presenting with substance use disorder
Outputs	• # of patients connected to education information and programs • # of patients call for followed-up
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Emergency Department Team, Care Management, Certified Recovery Specialists External Partners: The Council of Southeast Pennsylvania BCARES (Bucks County Connect.Assess.Refer.Engage.Support) Certified Recovery Specialist
Objective: Continue to partner with community based organization (s) for education on substance use disorders for community and workforce	
Strategy/Action	Engage Council of Southeast PA, Inc. or other community organization for an educational series each year
Target Population	JHA Community and workforce
Outputs	• Track # of programs • Track # of participants
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact

FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Behavioral and Community Health leaders; Public Relations and Marketing; community and JHNE staff External Partners: Council of Southeast PA, Inc. or other community organization
Strategy/Action	Review sponsorship requests from school districts and other non-profit agencies to host events that educate parents, students, or professionals on alcohol and/or substance abuse
Target Population	JHNE Staff and community
Outputs	• # of events • # participants • # sponsorships
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: JHNE Staff, Physicians External Partners: Community members, local schools/students
Objective: Expand Narcan training and distribution	
Strategy/Action	In partnership with local EMS, continue holding Narcan training programs for clinicians, non-clinicians, corporate partners, and community groups. This allows availability of take home naloxone for our patients presenting to the ED after opiate overdose, and ongoing education for care providers on the scourge of OUD. The JNE Foundation also supported creating Opioid Overdose Naloxone Kits that have been distributed to local businesses and schools to keep our communities safe.
Target Population	JNE inpatients; ETC/ER/JMG patients; trainings to community and workforce
Outputs	• Track # of number of naloxone dispensed from EDs for take home program • Track # of assembled Narcan kits • Track communications to community and workforce on Narcan trainings
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: : Jefferson Northeast Foundation, Jefferson Northeast Business Council, Jefferson Opioid Task Force

	External Partners: Bensalem Public Safety, Bucks County Emergency Health Services, Philadelphia Fire Department, Delaware River Port Authority, , Bucks County Chiefs of Police Association, Council of Southeastern Pennsylvania. Philadelphia Addiction Services Medical Director Committee
Chronic Disease Prevention and Management	
Goal: Improved health behaviors including utilization of preventive screenings, improved disease management including adherence to treatment recommendations and better communications between patients, families, and providers, and elevated health status as a result of increased continuity of care	
Objective: Better Inform, educate, and engage the public regarding chronic disease prevention and management	
Strategy/Action	Mobile Stroke Program
Target Population	JHNE community
Outputs	• Track # dispatches, track # cat scan transports • Track # clot buster medication doses given
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: JeffStat, Stroke Mobile Unit External Partners: Bensalem EMS, Bucks County EMS
Strategy/Action	Offer blood pressure and risk assessments to raise awareness about prevention and early detection using BE-FAST acronym
Target Population	JHNE community members in the service area
Outputs	• # of risk assessment offering completed
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Community Education, Stroke Manager External Partners: Bensalem EMS, Bucks County EMS Agencies
Strategy/Action	Explore the potential to expand the monthly stroke support groups for community members held at the Torresdale Hospital to each campus. The focus of this group is encouragement, education, and support for stroke survivors, family members, and friends.

Target Population	Stroke Survivors and family members
Outputs	• # of stroke survivors and or family members and # of sessions
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: JNE Community Outreach Partners/Director of Volunteer Services, Diabetes Educator/ED Director or Delegate/Stroke Program Director and Thrombectomy Director External Partners: JHNE community members who experienced stroke or needs stroke support
Strategy/Action	Explore offering comprehensive diabetes education programs for the community at each hospital with support from local diabetes educators and provide glucometers to those new to insulin, and those with high A1C levels
Target Population	Newly diagnosed DM patient's identified by Inpatient Diabetes Education program especially those with high A1C levels
Outputs	• Number of inpatient patients with Diabetes Mellitus in JNE hospitals
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Providers, Endocrinologists, Pharmacies, Pharmacists, and RN's External Partners: Local Diabetes Educators, Pharmacy representatives
Strategy/Action	Include intensified insulin self-management training, nutrition counseling, pre-diabetes intervention for inpatients. Refer patients with gestational diabetes for diabetes management to Jefferson Endocrinology and Jefferson OB/GYN
Target Population	Residents of Philadelphia and Bucks Counties who are inpatients at JNE with Diabetes
Outputs	• Number of inpatient patients with Diabetes Mellitus in JNE hospitals • Number of inpatients who receive training, counseling and pre-diabetes intervention • Number of patients with gestational diabetes referred for diabetes management
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development

FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Providers:, Pharmacy, Endocrinologists, Pharmacist, and RN's External Partners: Local Diabetes Educators, Pharmacy representatives
Strategy/Action	Focus on all forms of cessation education (e.g. all tobacco products – cigarettes, vaping, chew, etc.) in the Jefferson Health – Northeast community program in partnership with Bucks County Health Improvement Partnership (BCHIP)
Target Population	Patients or community members that smoke or has desire to quit smoking
Outputs	• # classes completed • # participants
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Smoking Cessation instructors External Partners: Community members who want to quit smoking
Strategy/Action	Explore provision of education programs utilizing the expertise of Jefferson Health – Northeast respiratory therapists to reduce asthma prevalence and improve disease management at each hospital twice a year
Target Population	Community members with asthma or caring for a family member with asthma
Outputs	• # of community members in attendance # of sessions offered
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Torresdale Campus Lung Program- RN Navigators/Respiratory Technicians, Family practice Residents External Partners: American Lung Association
Strategy/Action	Offer asthma education programs in community settings to raise awareness about warning signs of asthma to promote earlier diagnosis, avoid "asthma triggers," gain better control, and understand treatments
Target Population	Community members with asthma or caring for a family member with asthma
Outputs	• # of community members in attendance • # of sessions offered
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact

FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Torresdale Campus Lung Program- RN Navigators/Respiratory Technicians/Family practice Residents External Partners: American Lung Association
Objective: Increase networking and collaboration among community organizations and health system partners	
Strategy/Action	Each JHNE hospital will host local outreach leveraging some existing community based groups. The events will focus on either general cardiology or a specific subspecialty (i.e. heart failure, heart disease)
Target Population	JHNE patients, community members
Outputs	• # sessions hosted • # participants
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Subject matter experts from the Jefferson Northeast division of cardiology (physicians and APP's) External Partners: Community group leaders and medical device/pharmaceutical companies whose products may be appropriate therapy for a particular population
Strategy/Action	Actively participate with community based collaborative organizations and health system partners
Target Population	Community based organizations and health system partners within the Jefferson Northeast Hospitals' service area.
Outputs	• Designated Community Health staff will attend 75% of community based collaborative organizations meetings annually. • Designated Community Health staff will attend 90% of Community Health/Benefit Enterprise meetings annually.
Potential Partners	Internal Partners: Community Health, Jefferson Northeast Hospitals ED, Jefferson Enterprise Health System partners External Partners: COACH Collaborative, Faith-based Community
Strategy/Action	Host at least 1 nutritional and obesity educational programs for community members at each campus each year in partnership with or support from other Jefferson Health entities and/or other community organizations.
Target Population	Patients with a BMI greater than 30
Outputs	• # of community members in attendance • # of sessions offered
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact

FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Diabetes Educator, Nutritionist & Dietitians/Family Practice Physicians External Partners: American Diabetes Association/Academy of Nutrition & Dietetics: Eatright.org, community-based organizations
Strategy/Action	Provide education, risk assessments and support programs to increase screening rates for cancer
Target Population	All adult Jefferson Northeast Hospitals and community members
Outputs	• Provide and track # of low cost mammogram and Healthy Women PA • Provide Annual Community Screening Day (Skin, Head and Neck, Prostate, Breast). • Provide Colon Cancer Community Education/Outreach
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: JNE Community Outreach, PR/Marketing/Staff, Sidney Kimmel Cancer Center, Radiology External Partners: Philadelphia County Office of Public Health, JNE affiliated dermatologists, American Cancer Society
Objective: Provide education programs requested by community	
Strategy/Action	Provide educational programs and screening for community members to increase awareness and reduce cardiovascular disease prevalence and improve disease management at each hospital at least twice a year
Target Population	High risk patient population by census tract
Outputs	• # community events hosted • # community participants • # screenings
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: SKCC at Torresdale, Volunteer Services, Cardiovascular Service Line External Partners: Klein Center, local Senior Centers, Faith - Based Communities, Community Based Organizations

Strategy/Action	Present health awareness and prevention programs and screenings at community outreach events as requested
Target Population	JHNE Community
Outputs	• # Session offered • #participants
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: JNE Community Outreach Partners/Director of Volunteer Services/Trauma Program Coordinator/Diabetes Educator/Emergency Department Director or Delegate/Stroke Program Director and Thrombectomy Manager External Partners: American Lung Assoc., American Cancer Society, American Heart Assoc. , Stroke Programs/American Diabetes Assoc./American Red Cross
Strategy/Action	Participate in local health fairs to educate community regarding stroke risk and access to the Lower Bucks County-based Jefferson Health Mobile Stroke Unit (MSU)
Target Population	JHNE Community
Outputs	• # Vendors • # attendees
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: JHNE Hospitals and Physician Practices, Jeff Stat External Partners: Vendors from Northeast and Bucks county region that support stroke care, Bensalem EMS
Strategy/Action	Provide community programs regarding how to fit healthy food choices into daily life through nutrition education
Target Population	All Jefferson Northeast Hospital and Jefferson Hospital community members
Outputs	• # sessions held • # participants
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: JNE Community Outreach, Diabetes and Nutrition Center

	External Partners: Community libraries, Community Senior Adult Centers, Philadelphia County Office of Public Health, Area YMCA's

Access to Care (Primary and Specialty)	
Goal: Create high quality free or low cost health care options to those who may be uninsured or underinsured.	
Objective: Increase access to care	
Strategy/Action	Assist patients and their families in accessing government-based insurance options (Medical Assistance, children's health insurance program [CHIP], health insurance marketplace). For patients who are over 65 or disabled options include Medicare, Medical Assistance, private insurance (Medigap, Medicare advantage plans), and supplements (PACE, PACENET, Part D providers)
Target Population	Patients in need of governmental assistance
Outputs	• # patient referrals • # community hosted events about options
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: HRSI, Care Managers, Social Workers, Einstein External Partners: Social Security Administration, Patients' employers, Friends, Drug and Alcohol Rehabs
Strategy/Action	Screen any patients presenting to JNE Hospitals with no evidence of insurance, limited insurance or insurance questions and refer them for assistance
Target Population	JHNE patients receiving care at Hospitals
Outputs	• # of patients for which new or updated insurance is obtained • # of referrals to Care Managers • # of referrals to Social Security • Educate patients and families on what insurance covers for patient's post-acute needs
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Care Managers, Social Workers

	External Partners: Social Security Administration, Patients' employers and BHSI (inpatient drug use for the city for non-insured patients)
Strategy/Action	Ensure that all staff participate in cultural diversity training.
Target Population	All staff employed by Jefferson Heath Northeast
Outputs	• # of staff that participated in mandatory cultural diversity training modules via MyJeffHub
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Members of Diversity, Inclusion and Community Engagement , Nurse Education, Human Resources External Partners: Enterprise office of Diversity, Inclusion and Community Engagement
Strategy/Action	Explore utilization of a clinic social worker and/or students to conduct outreach and provide direct assistance to patients in need at the Frankford clinic to connect them with relevant social services such as Supplemental Nutrition Assistance Program (SNAP), subsidized housing, subsidized child care, and Lifeline (free cell phone program). Cultivate relationships with local community organizations to keep abreast of available services/programs
Target Population	Any patient presenting to the Frankford Clinic who may need assistance with insurance or community referral resources
Outputs	• # of patient's community resources were secured
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Care Managers, Social Workers External Partners: Philadelphia Corporation for Aging, Area Skilled Nursing Facilities, Home Care, Welfare, Social Security. Psych and drug and ETOH resources, food pantries, Meals on Wheels, home infusion, durable medical equipment companies
Strategy/Action	Utilize JNE strong health outreach programs in underserved communities to identify individuals at risk and provide resources for clinical care
Target Population	All JNE Community Members who are uninsured or underinsured; individuals/families with low income; immigrants
Output	• Provide JNE clinic information at all community outreach programming • Provide follow up calls to all screening participants with abnormal results and ensure that they are active in a primary care home, or provide referral

	• Translate written health education materials into foreign languages where 5%, or 1,000 individuals have limited English proficiency
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: JNE Community Health Outreach, Save Your Soles Program, JNE Care Managers External Partners: Globo HQ, Community
Strategy/Action	Facilitate the provision of specialty care for uninsured/underinsured patients
Target Population	All JNE Community Members who are uninsured or underinsured; individuals/families with low income; immigrants
Output	• Track number of patients seen Track number of children who are patients in JNE Newborn and Children's Clinic who are referred to specialty children's hospitals
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: All JNE clinics staff, JNE Care Managers, Jefferson Medical Group Specialists External Partners: Children's Hospital of Philadelphia; Nemours Children's Hospital, Shriner's Children's Philadelphia
Objective: Improve patient-provider communication through expansion of cultural competence and cultural humility training for healthcare providers	
Strategy/Action	Ensure that all staff participate in cultural diversity training.
Target Population	All staff employed by Jefferson Heath Northeast
Output	• # of staff that participated in mandatory cultural diversity training modules via MyJeffHub
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Members of Diversity, Inclusion and Community Engagement , Nurse Education, Human Resources External Partners: Enterprise Office of Diversity, Inclusion and Community Engagement
Objective: Provide language interpreters and health education materials in diverse languages	

Strategy/Action	Provide language assistance to individuals with limited English proficiency and/or other communication needs to facilitate oral communication and ensure communication needs are met
Target Population	All JNE Community Members who are uninsured or underinsured; individuals/ Families with low income; immigrants; all JNE patients
Outputs	• Monitor and evaluate tracked data on use of the language services • Track use of interpreters in clinic services within Jefferson Northeast Hospitals. • Increase use of bilingual staff where appropriate • Translate written materials/forms into foreign languages where 5% or 1,000 individuals have limited English proficiency
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: JNE Interpretation Services, JNE PR/Marketing, all clinics staff External Partners: Globo HQ, language service vendors
Strategy/Action	Provide patient education materials in multiple languages
Target Population	Patients and Community members
Outputs	# education materials in Epic translated in multiple languages
Potential Partners	Internal Partners: JH-NE patients, JH-NE staff External Partners: Elsevier, Epic

Healthcare and Health Resource Navigation	
Goal: Improve navigation of health care services to link individuals to appropriate social service agencies	
Objective: Improve access to public benefits and programs	
Strategy/Action	Assist patients and their families in enrolling in public benefits and programs such as government based insurance options (Medicaid, children's health insurance program [CHIP], health insurance marketplace), SNAP benefits, housing, LIHEAP, etc.
Target Population	All JNE Community Members who are uninsured or underinsured; individuals/families with low income; immigrants.
Outputs	• Track # of insurance applications completed • Maintain or increase # of social service referrals

FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Care management, HRSI External Partners: JHNE Community
Strategy/Action	Explore utilization of a clinic social worker and/or students to conduct outreach and provide direct assistance to patients in need at the Frankford clinic to connect them with relevant social services such as Supplemental Nutrition Assistance Program (SNAP), subsidized housing, subsidized child care, and Lifeline (free cell phone program). Cultivate relationships with local community organizations to keep abreast of available services/programs
Target Population	Any patient presenting to the Frankford Clinic who may need assistance with insurance or community referral resources
Outputs	# of patient's community resources were secured
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Care Managers, Social Workers External Partners: Philadelphia Corporation for Aging, Area Skilled Nursing Facilities, Home Care, Welfare, Social Security. Psych and drug and ETOH resources, food pantries, Meals on Wheels, home infusion, durable medical equipment companies
Objective: Expand low cost transportation options	
Strategy/Action	Provide information regarding available transportation services and facilitate the process for accessing these services
Target Population	All JNE Community Members who are uninsured or underinsured; individuals/families with low income; immigrants
Outputs	• # transports provided to patients in need • # Referrals to medical assistance transportation systems
FY 23 Updates	• Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	• Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	• Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: JNE Care Managers, Social Workers,

	External Partners: Ambulanz, Bucks County Transportation
Objective: Accessible access to healthcare for persons with disabilities	
Strategy/Action	Provide access to preventive care and health education/screening for persons with disabilities
Target Population	All JNE community members with disabilities
Outputs	• # community health education programming to individuals with disabilities
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Care Managers, Social Workers, Nursing and Providers External Partners: Magee Rehabilitation Hospital
Objective: Increase public awareness of community resource directories	
Strategy/Action	Develop/maintain culturally and linguistically appropriate community resource directories, bulletins or newsletters
Target Population	All JNE community members
Outputs	• # people who access findhelp.org website
Potential Partners	Internal Partners: JNE Community Health, Hartnett Health Services, , JNE Financial Services, JNE Community Health Outreach External Partners: Local community events, Para-plus Translation Services, Inc.
Objective: Increase community resident's knowledge of Jefferson Health's Financial Assistance program	
Strategy/Action	Assist patients and families in enrolling in Jefferson Health Financial Assistance program
Target Population	All JNE Community Members who are uninsured or underinsured; individuals/families with low income; immigrants
Outputs	• Track # of referrals/applications to Jefferson Health Financial Assistance program
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development

FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: JNE Social Workers, JNE Care Management, JNE Financial Services Unit External Partners:

Food Access	
Goal: Increase community access to sufficient, nutritious food	
Objective: Identify patients and community members who are interested in food resources and programs that support access to healthy food	
Strategy/Action	Using a two question best practice method, provide food insecurity screening in JNE, Community Health Chronic Care Management and Diabetes Education Programs
Target Population	All JNE Community Members who are uninsured or underinsured; individuals/ families with low income; immigrants; those with limited access to healthy food
Outputs	• Track # of food insecurity screenings
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: JNE Community Health Outreach, Clinic, JNE Diabetes Education Program, External Partners: COACH, Philadelphia County Anti-Hunger Network, Philabundance
Strategy/Action	Explore expanding variety of vegetables harvested to increase Frankford 's demand based on community needs
Target Population	Frankford Community to include patients and residents of the area
Outputs	• Extend the harvest period of the vegetables which will produce a greater yield over a longer period of time
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Facilities, Food and Nutrition , Administration, clinical and non-clinical staff, Jefferson Collaborative for Health Equity External Partners: Shearon Landscaping, Frankford Community Development Corporation (CDC)
Objective: Connect patients and community members to resources that support food access through community-clinical partnerships, including public benefits assistance, emergency food resources, or education	

Strategy/Action	Provide food insecure patients and community members with resources for healthy food. Connect food insecure patients with JNE social workers for assistance in signing up for government benefits. Connect food insecure community members with Philadelphia County Food pantries. Maintain community partnerships to create food distribution sites for yearlong food access in underserved communities
Target Population	JNE Community Members and/or patients who have been identified as food insecure
Outputs	• Explore and maintain community partnerships to create food distribution sites for yearlong food access in underserved communities. • Track # of patients served through Food Pantry
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: JNE Community Health Outreach, JNE Diabetes Education Program, Jefferson Medical Group (JMG) Physician Practices External Partners: COACH, Philadelphia County Anti-Hunger Network, Philabundance, Women, Infant, and Children (WIC) Nutrition Program, local school districts (National School Lunch Program), Philadelphia County Office of Public Health
Strategy/Action	Increase the impact of the community garden program at Jefferson Frankford Hospital by increasing engagement of local community-based organizations and neighborhood residents in garden activities. These activities will be aided by a $20,000 grant (disbursed over a 4-year period) recently received from American Heritage Federal Credit Union.
Target Population	Frankford Community to include patients and neighborhood residents
Outputs	• # of pounds of produce distributed • # of patients produce is distributed
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Facilities, Food and Nutrition , Administration, clinical and non-clinical staff External Partners: American Heritage, Shearon Landscaping, Frankford Community Development Corporation (CDC)
Strategy/Action	Explore opportunities to pursue additional grant funding to expand the garden from such sources as the Philadelphia Water Department, Pennsylvania Horticultural Society, Home Depot, Lowes, seed companies, Gardenburger Community Garden Grants, Nature's Path Gardens for Good Grants
Target Population	Frankford Community to include patients and residents of the area

Outputs	• Provide fresh vegetables and herbs for the community utilizing a farmer's market approach to distribution within Jefferson Frankford Hospital
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Facilities, Food and Nutrition , Administration, clinical and non-clinical staff, & Jefferson's Collaborative for Health Equity Team External Partners: American Heritage, Shearon Landscaping, Frankford Community Development Corporation (CDC)
Strategy/Action	Engage civic and community-based organizations in the Frankford community to help spread the message about our garden and seek opportunities to collaborate for greater impact.
Target Population	Frankford community
Outputs	• # feedback sentiments provided • # changes made based off feedback of garden
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Frankford CDC, Philadelphia Police District Advisory Commission, Philabundance
Strategy/Action	Increase community access in Northeast/Lower Northeast Philadelphia to programs that support healthy eating such as cooking demonstrations, tasting programs, and nutrition education by exploring partnerships with community resources such as the Vetri Community Partnership (Eat360, My Daughter's Kitchen, and/or Vetri Cooking Lab). Work with our nutrition vendor to develop creative ways to educate the community to prepare fresh vegetables for healthy consumption.
Target Population	JNE community members
Outputs	• # cooking demonstrations and tasting programs for the Frankford Community
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Administration, Food and Nutrition staff External Partners: Sodexo, American Heritage
Objective: Participate with collaborating health system and community-based partners in shared learning around implementation strategies through the COACH Food Security workgroup	

Strategy/Action	Engage in discussion and capacity building to embed new practices and methodologies to increase community engagement and access to healthy food
Target Population	All JNE Community Members who are uninsured or underinsured; individuals/ families with low income; immigrants; those with limited access to healthy food
Outputs	• Designated Community Health Staff will attend bimonthly COACH Food Security workgroup meetings
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: JNE Community Health Outreach External Partners: COACH

Culturally and Linguistically Appropriate services	
Goal: To ensure safety and high quality of care and appropriate understanding and effective communication for LEP and deaf and hard of hearing population	
Objective: Enhance service to the deaf and Hard of Hearing and Limited English proficiency patients across Jefferson Health	
Strategy/Action	Align and expand interpreter services in JHNE and across Enterprise
Target Population	Jefferson Northeast Community Limited English Proficient Patient Population
Outputs	• # Interpreter Minutes used • # Languages offered
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Language Directors, Patient Experience, Volunteer Services, Patient Relations External Partners: Globo, Phoenix Language Services, Cyracom, other approved language vendors
Objective: Increase number of certified multilingual staff at Jefferson Health Northeast	
Strategy/Action	Explore partnerships with community-based organizations/language vendors that serve non-English speaking communities to expand the capacity of multi-lingual staff to provide chronic disease prevention and management education
Target Population	LEP Patients living and receiving care in the JHNE community

Outputs	• # Session offered #participants # trained staff
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Internal linguists, potential partnership with Globo (new language vendor) External Partners: JHNE community, language vendors/organizations

Racism and discrimination in healthcare settings	
Goal: Provide a venue to discuss racism and discrimination in healthcare settings	
Objective: To increase awareness of how racism and discrimination can affect the workplace setting	
Strategy/Action	Continue to partner with DEI to promote racial and ethnic diversity through awareness and education
Target Population	Community stakeholders, Jefferson Employees
Outputs	• % Compliance with mandatory education • # of Awareness Campaigns
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: JNE Community Health Outreach, Clinic, JNE Diabetes Education Program, External Partners: COACH, Philadelphia County Anti-Hunger Network, Philabundance
Strategy/Action	Include Racism/Discrimination in Healthcare into one of the scheduled Schwartz Rounds
Target Population	JHNE physicians and staff
Outputs	• # Schwartz rounds involving topics of racism and discrimination in healthcare
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partner: Schwartz Rounds administrators, JHNE staff, Schwartz Rounds panelists External Partners: Patients/Community Members

Social Determinants of Health (SDOH) Housing, Neighborhood Conditions, Community Violence, Socioeconomic Disadvantages	
Housing	
Objective: Address housing as a community need that impacts overall health	
Strategy/Action	Explore home rehabilitation programs and establish partnerships to support families in need
Target Population	High Risk families in Northeast Philadelphia
Outputs	• # Projects completed • # High risk families identified
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Social Work, Case Managers, External Partners: Habitat for Humanity, Home Depot, Lowes, American Heritage Federal Credit Union
Neighborhood Conditions	
Objective: Address neighborhood conditions that impact overall health	
Strategy/Action	Offer asthma education programs in community settings such as faith-based organizations to raise awareness about warning signs of asthma to promote earlier diagnosis, avoid "asthma triggers (e.g. neighborhood and housing conditions)," gain better control, and understand treatments
Target Population	Northeast Community members at risk for asthma and reactive airway disease issues
Outputs	• # Educational Programs • #Persons at risk for asthma attending programs •
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development

FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: JNE Physicians, Respiratory Therapist and Health Educators External Partners: Faith-based organizations, Schools, American College of Asthma

Community Violence	
Objective: Explore programming to address community violence	
Strategy/Action	Explore sponsoring structured youth programs in safe locations, such as exercise and sports, that are provided during out of school times to reduce opportunities to become involved in substance use and other negative activities
Target Population	North Philadelphia youth community
Outputs	• # Youth Events hosted • # Program participants
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Government Affairs External Partners: Local EMS, Bucks County Drug and Alcohol Commission, Philadelphia Schools, Dept. of Recreation, Area YMCA
Objective: Identify opportunities to participate in events to support the LGBTQ community	
Strategy/Action	Collaborate with the Attic Youth Center through JHNE Diversity Council to identify opportunities or education to support LGBTQ youth community
Target Population	LGBTQ Youth Community
Outputs	# events partnering with the Attic Youth Center
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 25 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Diversity Council, JHNE staff External Partners: The Attic Youth Center, other LGBTQ centers, LGBTQ community

Socioeconomic disadvantage (e.g., poverty, unemployment)

Objective: Screen Emergency Department patients for Social Determinants of Health (SDOH) and connect those with needs to corresponding community resources	
Strategy/Action	Continue screening clinic patients for SDoH and refer to resources as appropriate; expand program across inpatient and Emergency Department settings
Target Population	High risk emergency patients determined by SDoH screening
Outputs	• # of SDoH Screening in ED • # Referrals to resources
FY 23 Updates	Engage and survey internal and external community stakeholders to develop inclusive action plan initiative timelines and metrics for impact
FY 24 Updates	Report impact findings, Invite feedback from program stakeholders and continue intentional partnership development
FY 25 Updates	Implement community suggestions, continual documentation of the process, and re-assess community priority needs
Potential Partners	Internal Partners: Social Work, Case Managers External Partners: Find Help, Eat 360, Verti Cooking Lab, My Daughter's Kitchen