Jefferson Health.

HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

NOVEMBER 2022

COMMUNITY HEALTH NEEDS ASSESSMENT

2022-2025 IMPLEMENTATION PLAN

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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.

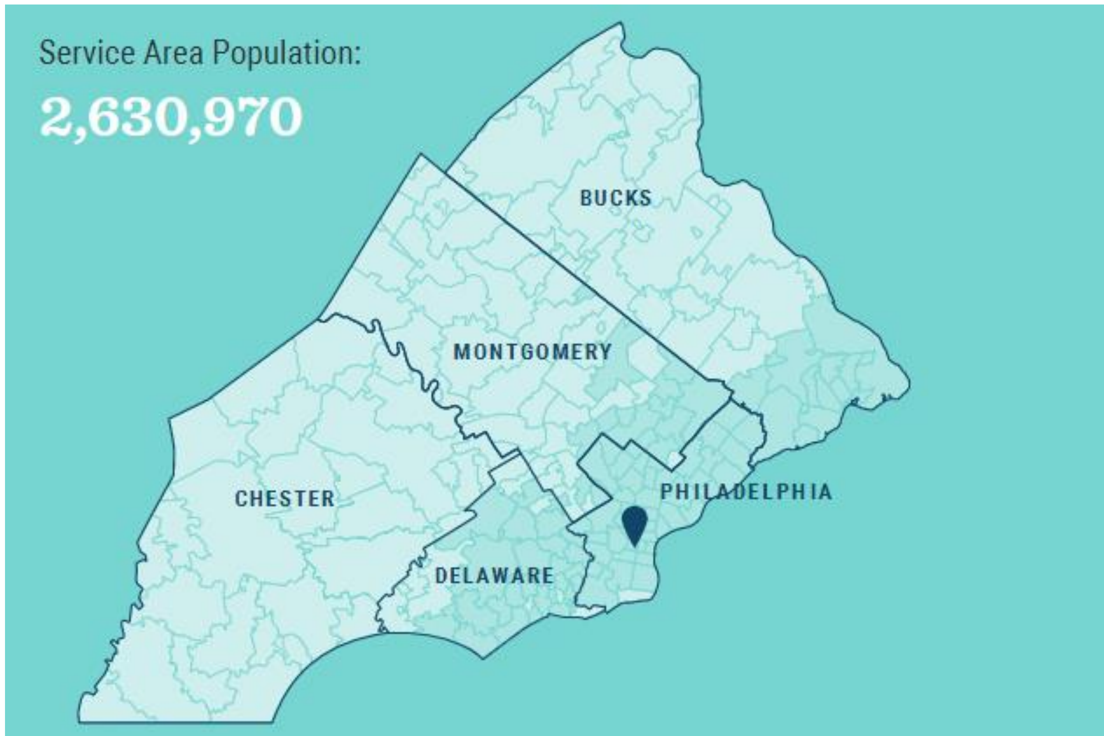
Geographic Regions & Zip Coded Services by Jefferson Health

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

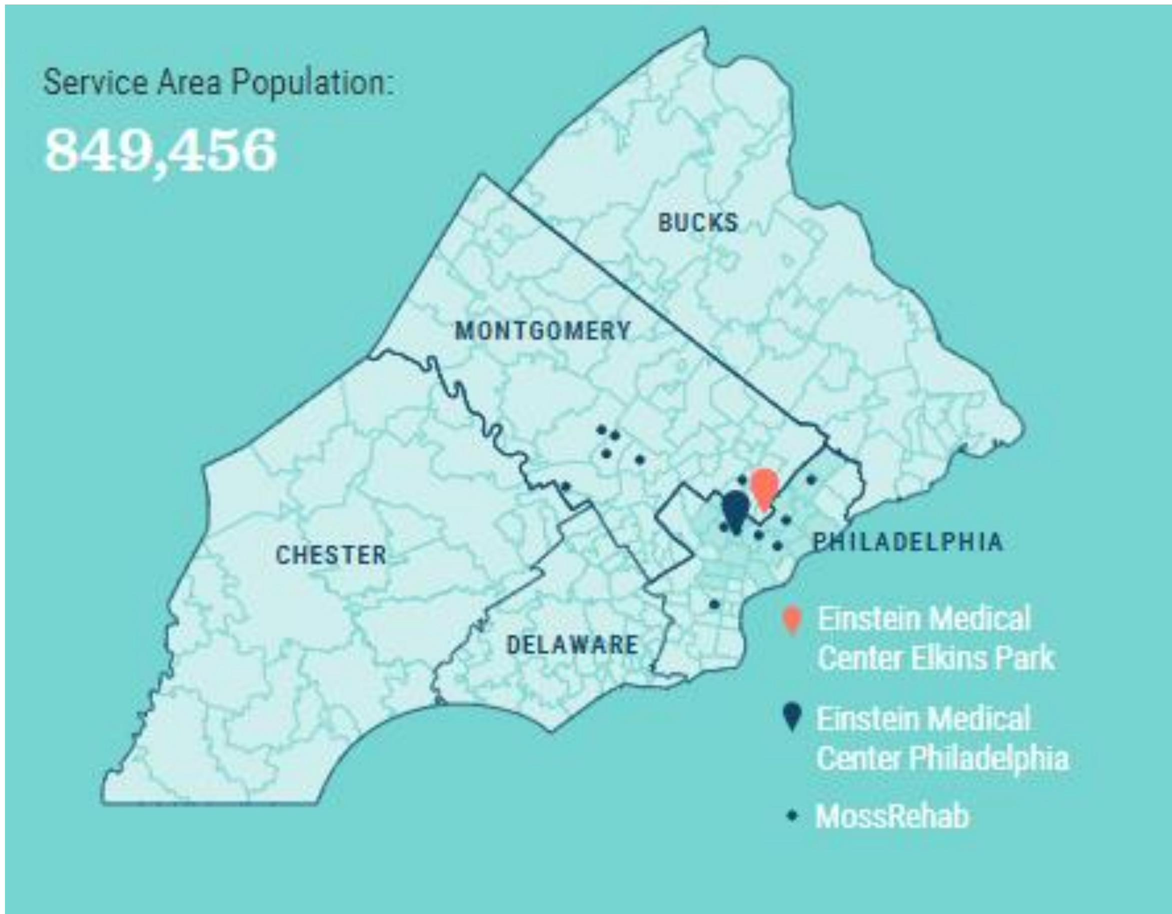


Bucks County: 19007, 19020, 19021, 19030, 19047, 19053, 19054, 19055, 19056, 19057, 19067Delaware County: 19008, 19010, 19013, 19014, 19015, 19018, 19022, 19023, 19026, 19029, 19032, 19036, 19050, 19060, 19061, 19063, 19064, 19070, 19073, 19076, 19078, 19079, 19081, 19082, 19083, 19086, 19087, 19094

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

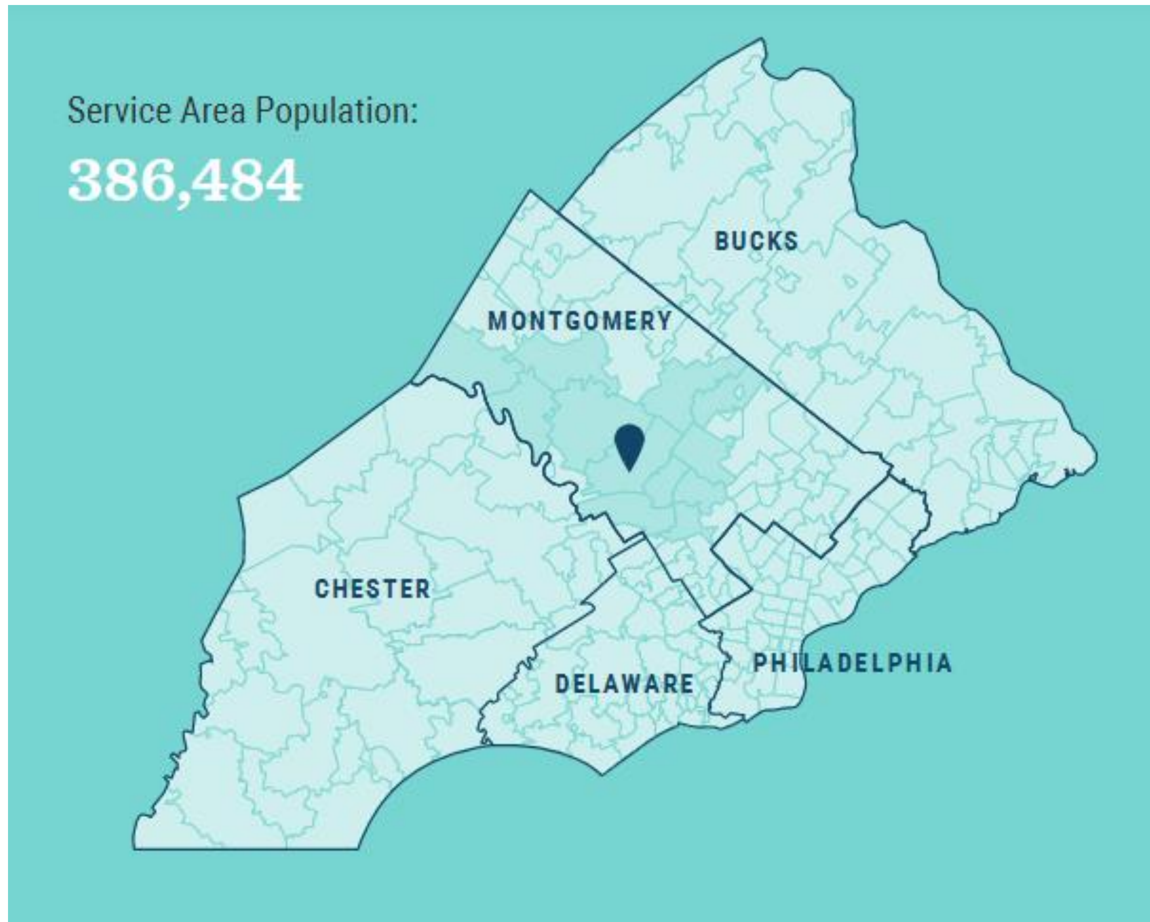
Jefferson Health – Einstein Medical Center Philadelphia



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

Montgomery County: 19027

Jefferson Health – Einstein Montgomery



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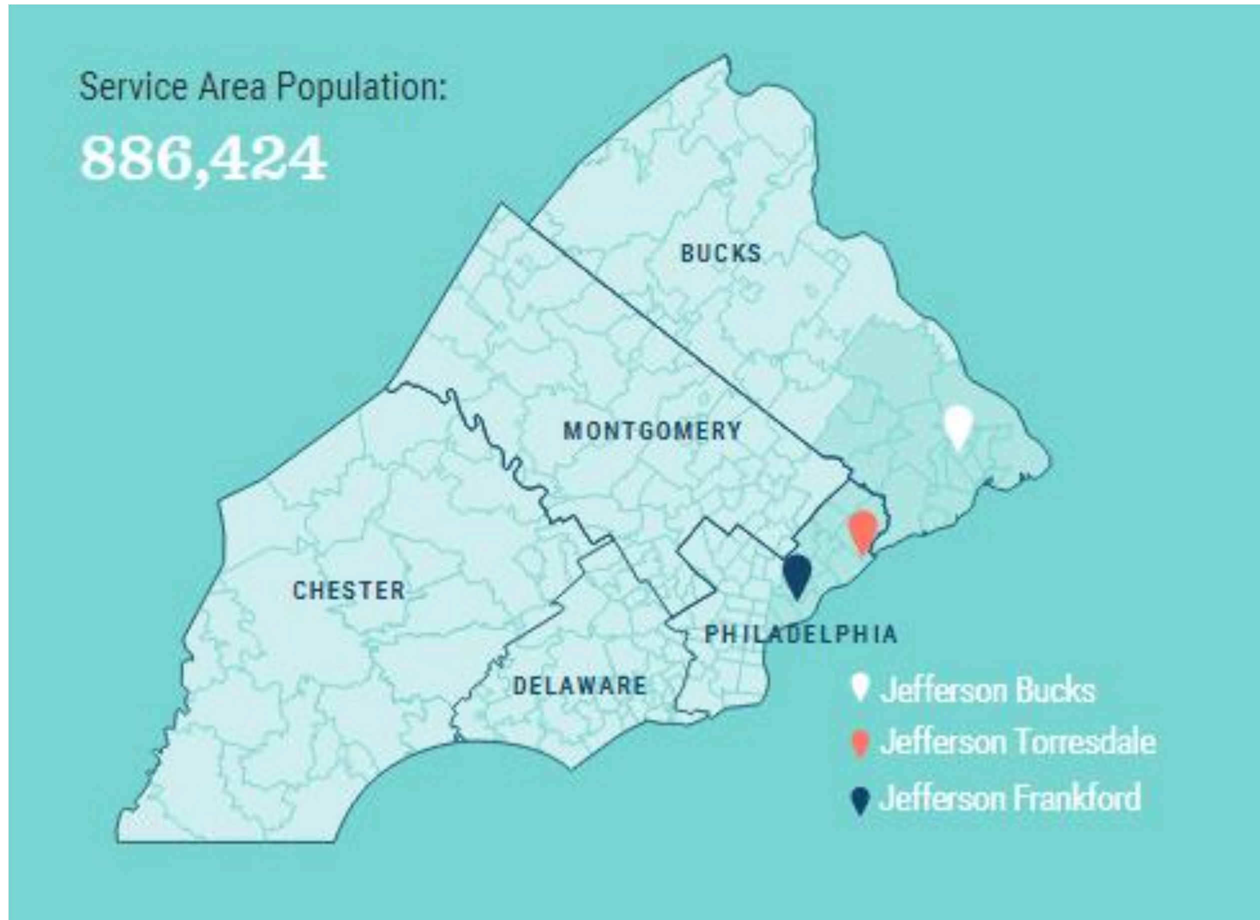
Jefferson Health – Northeast



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

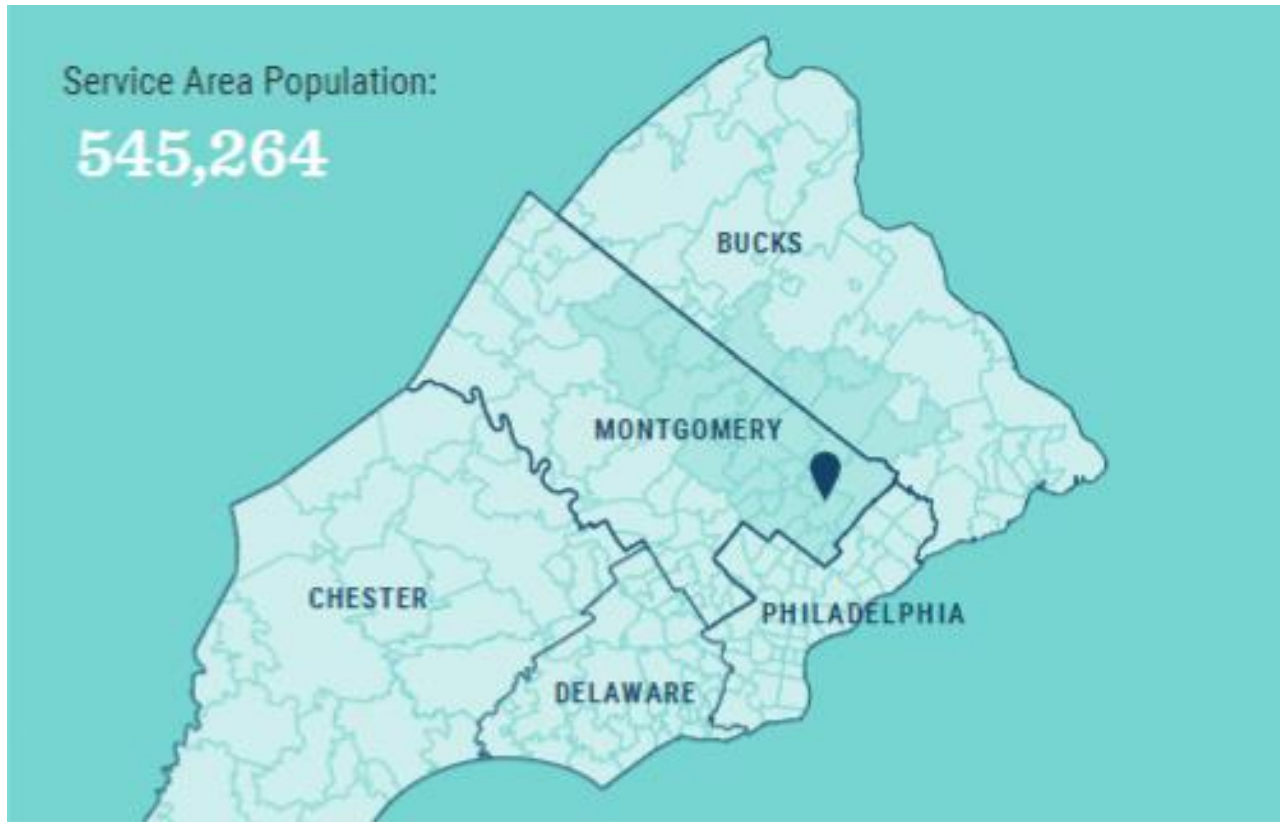
Jefferson Health – Rothman Orthopaedic Specialty Hospital

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



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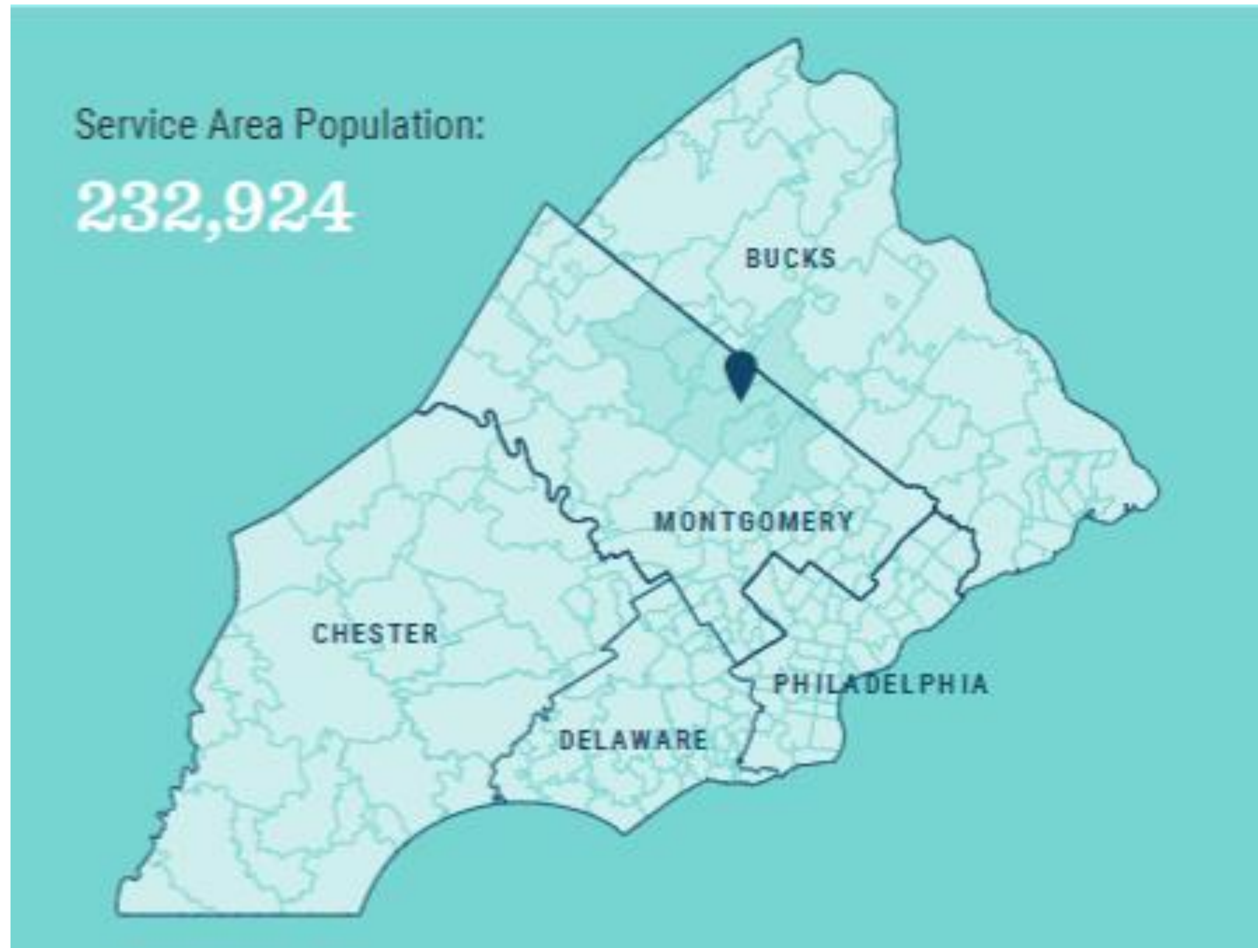
Bucks County: 18914, 18929, 18932, 18966, 18974, 18976

Jefferson Health – Lansdale



Bucks County: 18914, 18932

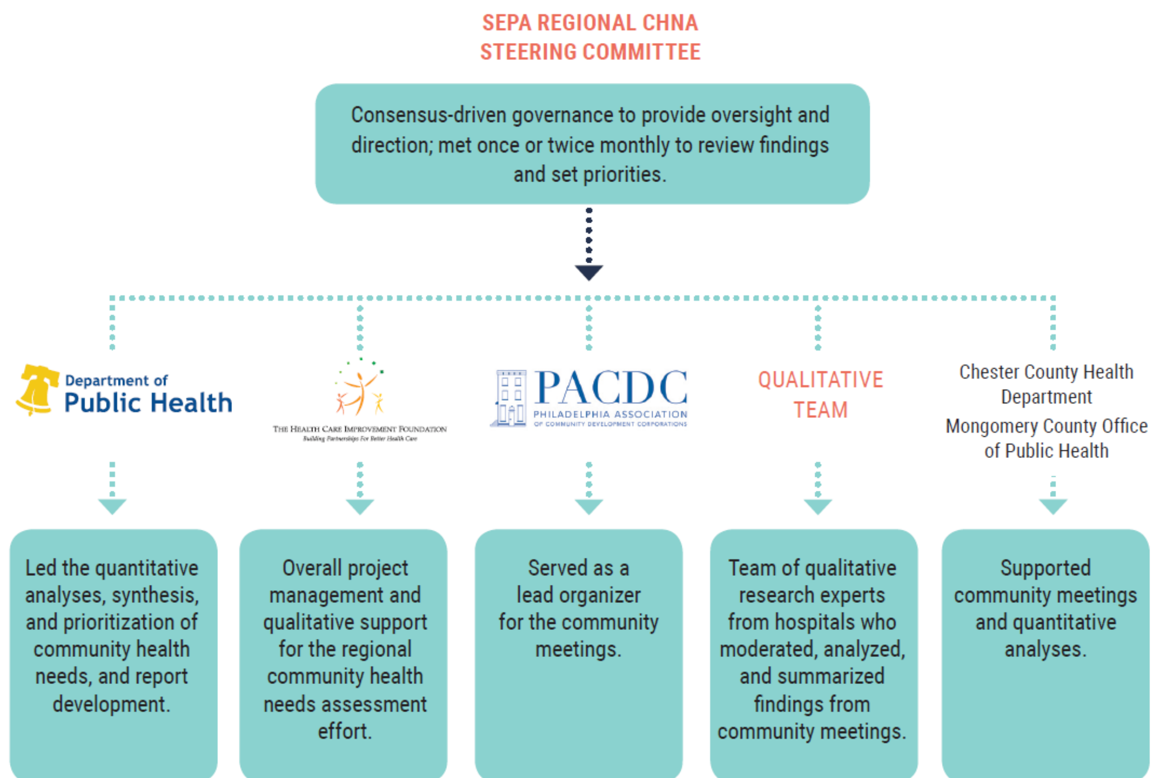
Montgomery County: 18915, 18936, 18964, 18969, 19002, 19422, 19438, 19440, 19446, 19454

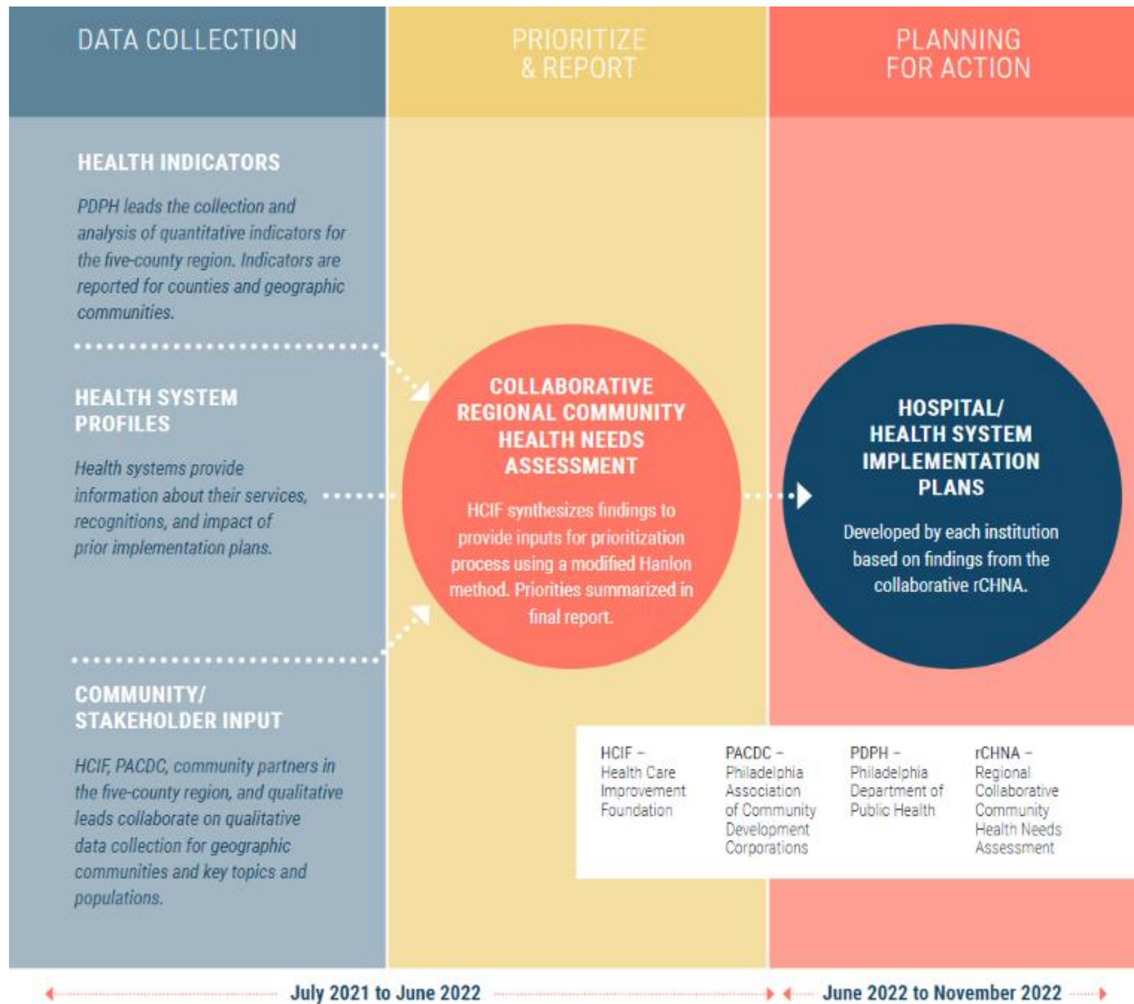
Overview of the Community Health Needs Assessment and Prioritization Process

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 a 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).**

Thomas Jefferson University Hospitals offer trusted, compassionate care to our community – from center city to the suburbs. We are committed to improving the lives of the people we interact within our hospitals, clinics and in our neighborhoods.

TJUH – Center City Community Health Implementation Plan

Jefferson Health - Center City has major programs in a wide range of growing clinical specialties that have been offered to the community for nearly 200 years. Services are provided at Thomas Jefferson University Hospital, Inc., which includes Thomas Jefferson University Hospital, Jefferson Hospital for Neuroscience, Magee Rehabilitation Center, and Jefferson Methodist Hospital.

Thomas Jefferson University Hospitals (TJUH) defines its greatest achievements by working beyond the bedside and contributing to community benefit and services.

At Jefferson, community benefit is delivered in three distinct ways:

1. Charity care and financial aid for individuals and families who cannot afford the cost of hospital services
2. Contribution toward healthcare providers
3. A variety of programs and services offered to the community including support groups, health screenings, wellness education and programs that address social determinants of health

TJUH COMMUNITY BENEFIT AREA

Lower North Philadelphia: 19121, 19122, 19132, 19133, 19134, 19140, 19124

Transitional Neighborhoods: 19123, 19125, 19130

Center City:

19102, 19103, 19106, 19107

South Philadelphia:

19145, 19146, 19147, 19148

Jefferson Health – Center City defines its **community benefit area** as the geographic area encompassing 18 zip codes in:

- North Philadelphia-East
- North Philadelphia-West
- River Wards
- Center City
- South Philadelphia-East
- South Philadelphia-West

These zip codes are the most geographically proximate to TJUH, JHN and JMH campuses. The focus within these zip codes is on communities with a poverty rate greater than 20 percent and where health disparities are more prevalent. Historically, this community benefit area represents more than one-third of all Philadelphia residents.

This catchment area experiences relatively high underlying economic and structural barriers that affect overall health, such as income, education, insurance, and housing. Racial, ethnic, and income disparities exist, and for most indicators, people of color and or Hispanic origin face the greatest barriers to access.

The **Jefferson - Center City 2022-2025 Community Health Implementation Plan (CHIP)** is a comprehensive strategic plan aiming to address the needs identified within the 2022 Community Health Needs Assessment (CHNA). The Center City CHIP was developed on the principles of health equity and cultural responsiveness in collaboration with key community stakeholders, administrative, and clinical leaders.

The CHIP plan serves as a guiding tool for the development of Jefferson Health - Center City community benefit policies, programs, and engagement. The plan will be reviewed annually and revised based on changing community needs, best practices, and analysis of outcomes. Approval for the 2022-2025 CHIP was obtained by the TJUH Board of Trustees on September 20th 2022.

The proposed strategies and activities were considered based on their alignment with national, Pennsylvania, and Philadelphia 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 2030
- American Medical Association
- National Council on Aging
- National Prevention Strategy
- Guide to Community Preventive Services
- Guide to Clinical Preventive Services

Strategies and activities were also included that can impact health issues at multiple levels of the Social Ecological Model. The model integrates:

1. **Individual factors**: sometimes called *intrapersonal* factors, like genetics and individual behaviors, attitudes, and beliefs.
2. **Interpersonal factors**: social support, social networks, family characteristics, peers.
3. **Organizational factors**: work sites, professional networks, schools, service systems, and transportation.
4. **Community factors:** community based organizations, support groups, coalitions, and media.
5. **Political factors:** Federal government agencies, local, state, and national legislatures, national advocacy groups.

The Table below compares the rankings of the priority health issues of the region to how these were ranked by senior leaders at Jefferson Health –Center City.

Comparative Rankings:

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

HEALTH ISSUES:

Mental Health

The terms mental and behavioral health are often used interchangeably. According to the Centers for Medicare and Medicaid Services, behavioral health is defined as the emotional, psychological, and social facets of overall health; it encompasses traditional mental health and substance use disorders, as well as

overall psychological well-being. This definition of behavioral health is used throughout this strategy plan.

At some point during their lifetime, almost half of all people in the U.S. will be diagnosed with a mental health disorder. According to the National Institute of Mental Health:

- Nationally, nearly 1 in 5 adults live with a mental illness, but less than half (46.2%) received care for their condition in the past year.

According to the Center for Disease Control's Youth Risk Behavior Surveillance Data Summary and Trends Report for 2009-2019:

- One in six youth reported making a suicide plan in the past year a 44 percent increase from 2009.
- These data show that almost half of youth identifying as LGBTQ+ had seriously considered suicide, and the number of Black students reporting a suicide attempt increased by almost 50 percent.

Many adolescents with depression or other behavioral health challenges do not always get necessary treatment. According to the National Survey on Drug Use and Health and the National Health Interview Survey:

- 26.7 percent with mental health problems (aged 4 to 17 years) did not receive treatment.
- Among adolescents with a diagnosis of depression (aged 12-17 years), 58.6 percent had not received treatment.
- Compared to a national rate of 8.9 percent, 14.6 percent of Philadelphia students had attempted suicide. Among those identifying as LGBTQ+, this rate was 25.7 percent.

Access to care for behavioral health services was lacking prior to the pandemic and remains extremely problematic.

- One in four older adults (aged 65 and older) are socially isolated, according to the CDC.
- Lack of social connectedness (arising from social isolation and leading to feelings of loneliness) has been linked to depression, anxiety, cognitive decline, Alzheimer's disease, and higher rates of chronic diseases like high blood pressure, heart disease, and obesity. While drug overdose rates across the U.S. have been declining, rates of substance-related hospitalizations and overdoses have increased among older adults.

MENTAL CONDITIONS	
Goal: Increase patient access to culturally responsive, patient-centered, Behavioral health services	
Objective: Increase access to mental health services through collaborative partnerships	
Strategy/Action	• Collaborate with the State Health Improvement Plan, Philadelphia Department of Health, Department of Behavioral Health and Intellectual disAbility (**DBHIDS**) and Collaborative Opportunities to Advance Community Health (**COACH**) partners to increase access to

	mental health services by raising awareness of providers and the community about available mental health resources and services • Continue to offer support groups and peer mentor programs for persons with disabilities (Magee Rehabilitation Center) • Expand the reach of the Jefferson Opiate Taskforce • Build capacity between behavioral health providers and primary care providers • Increase screening for depression, anxiety, and suicide in primary care, OB post-partum patients and the emergency department • Co-locate behavioral health services in primary care practices, emergency departments, and other venues such as supportive housing sites • Continue to explore telehealth as a means to increase access to behavioral health services. • Provide school-based healing-centered practice support • Train CHWs as peer specialists/recovery specialists and behavioral health specialists • Free Bereavement program (Methodist Hospital)
Target Population	Youth, adults in TJUH service area, health care providers, insurance companies, Philadelphia and Pennsylvania Department of Health, Department of Behavioral Health and Intellectual disAbility (DBHIDS), COACH, Prison system/Reentry
Outputs	• Develop a centralized repository of behavioral health resources and services • Improved communication between behavioral health and health care providers • Increased referrals to and utilization of behavioral health services
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, continue intentional partnership development.
FY 25 Updates	Implement community suggestions, continual documentation of process, re-assess community priority needs.
Potential Partners	**Internal Partners:** Jefferson Collaborative for Health Equity (The Collaborative),Magee Rehabilitation Center, Methodist Hospital ED, College of Nursing, Pharmacy, College of Health Professions, Institute for Emerging Health Professions, Sidney Kimmel Medical College, Psychiatry Department, TJU Counseling and Behavioral Health Department, JTEN, Population Health, Social Work, Center forIntegrative Medicine, Trauma Center at Jefferson, Jefferson primary care providers, Jefferson ED **External Partners:** NKCDC, Department of Behavioral Health and Intellectual disAbility (DBHIDS), school partners, community partners, Federation of Neighborhood Centers, ACES Taskforce, Stephen Klein Wellness Center, faith-based organizations), ALLCOVE, COACH, Concilio, senior centers
Objective: Address behavioral health/mental health access for members of the community. Increase access and referral to behavioral health services through selected Jefferson Primary Care Service Line practices	
Strategy/Action	• Continue to provide access with Behavioral Health Consultants (BHCs) in primary care and specialty practices
Target Population	Adults and children who are or become Jefferson Medical Group (JMG) patients
Outputs	• Maintain or increase current level of BHCs within practices Track # of patients served [if data reports permit] and # of practices with embedded BHCs

	• Increase # of referrals to external psychiatric providers
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, continue intentional partnership development.
FY 25 Updates	Implement community suggestions, continual documentation of process, re-assess community priority needs.
Potential Partners	**Internal Partners:** TJUH Behavioral Health Leadership, Jefferson Medical Group (JMG), Wyss Wellness Center, JTEN **External Partners:** The Health Federation of Philadelphia, N.O.R.T.H., Inc. W.I.C., PSDC (Philadelphia Suburban Development Corp), Health Promotion Unit, Department of Behavioral Health and Intellectual disability Services (DBHIDS)
Objective: Increase awareness of the Myrna Brind Center for Mindfulness is Philadelphia region's leading provider of mindfulness-based stress reduction programs	
Strategy/Action	**The Myrna Brind Center for Mindfulness** The Myrna Brind Center for Mindfulness is Philadelphia region's leading provider of mindfulness-based stress reduction programs. The Center has offered free online mindfulness sessions to support the public. The program continues to offer on-going guided mindfulness meditation practices for the community **Online Programs:** • Free Online Introduction to Mindfulness-Based Stress Reduction • Online Mindfulness-Based Stress Reduction Program
Target Population	**Philadelphia County:** 19102, 19103, 19106, 19107, 19121, 19122, 19123, 19124, 19125, 19130, 19132, 19133, 19134, 19140, 19145, 19146, 19147, 19148
Outputs	• Continue/Increase programming –online classes • Move patients through a continuum of mindfulness 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, continue intentional partnership development.
FY 25 Updates	Implement community suggestions, continual documentation of process, re-assess community priority needs.
Potential Partners	**Internal Partners:** Jefferson Collaborative for Health Equity (The Collaborative), Magee Rehabilitation Center, Methodist Hospital ED, College of Nursing, Pharmacy, College of Health Professions, Institute for Emerging Health Professions, Sidney Kimmel Medical College, Psychiatry Department, TJU Counseling and Behavioral Health Department, JTEN, Population Health, Social Work, Center for Integrative Medicine, Trauma Center at Jefferson, Jefferson primary care providers **External Partners:** PCDC, NKCDC, Department of Behavioral Health and Intellectual disAbility (DBHIDS), Philadelphia School District, community Center, United Communities, Federation of Neighborhood Centers, ACES Taskforce, Stephen Klein Wellness Center, faith-based organizations, ALLCOVE, COACH, Concilio, senior centers

Objective: Continue offering Maternal Addiction Treatment, Education, and Research (MATER) - Using a mindfulness-based, trauma-responsive, and person-centered approach as the foundation of our care to support women and their children in their recovery process	
Strategy/Action	**Maternal Addiction Treatment, Education and Research (MATER) at Jefferson Health is a mindfulness-based substance-use disorder program for pregnant or parenting women.** **Person-Centered** • Women in this program, and their families, partner with the team every step of the decision-making process, from planning initial steps to managing ongoing care. **Trauma-Responsive** • We recognize that many who struggle with substance use disorder have a history of trauma, such as violence and homelessness. With MATER's trauma-responsive approach, recovery efforts focus on more than stopping the problematic substance use by addressing each person's unique history of trauma. **Mindfulness-Based** • MATER is the first substance use disorder treatment program in the nation to integrate mindfulness into our approach and many aspects of our care. Mindfulness has been shown to help reduce stress and anxiety, promote self-compassion and improve mother-child relationships and parenting behavior. **Mental Health Care** • Mental health check-ups with our staff psychiatrist • Continued therapy, including any needed prescriptions from our staff psychiatrist **Mindfulness Training** • Mindfulness-Based Parenting (MBP) • Mindfulness-Based Family Support (MBFS) • Mindfulness-Based individual therapy **Group Therapy** • Yoga • Anger Management
Target Population	**Philadelphia County:** 19102, 19103, 19106, 19107, 19121, 19122, 19123, 19124, 19125, 19130, 19132, 19133, 19134, 19140, 19145, 19146, 19147, 19148
Outputs	• Continue/Increase programming –online classes • Move patients through a continuum of mindfulness-based substance-use disorder 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, continue intentional partnership development.
FY 25 Updates	Implement community suggestions, continual documentation of process, re-assess community priority needs.
Potential Partners	**Internal Partners:** Jefferson Collaborative for Health Equity (The Collaborative), Magee Rehabilitation Center, Methodist Hospital ED, College of Nursing, Pharmacy, College of Health Professions, Institute for Emerging Health Professions, Sidney Kimmel Medical College, Psychiatry

	Department, TJU Counseling and Behavioral Health Department, JTEN, Population Health, Social Work, Center for Integrative Medicine, Trauma Center at Jefferson, Jefferson primary care providers **External Partners:** NKCDC, Department of Behavioral Health and Intellectual disAbility (DBHIDS), school partners, community partners (Nationalities Services Center, United Communities, Federation of Neighborhood Centers, ACES Taskforce, Stephen Klein Wellness Center, faith-based organizations), ALLCOVE, COACH, Concilio, senior centers
Objective: Provide healing-centered practice workshops to promote mental health, mindfulness, and wellness	
Strategy/Action	• Partner with internal teams and community-based organizations centered on trauma-informed care and healing practices to develop free workshops offered to the community. • Increase bi-directional dialogue between Jefferson Health and community when meeting the needs of mental health, mindfulness, and wellness. • Engage youth in intentional and innovative ways and allow for youth to drive community-centered practice.
Target Population	**Philadelphia County:** 19102, 19103, 19106, 19107, 19121, 19122, 19123, 19124, 19125, 19130, 19132, 19133, 19134, 19140, 19145, 19146, 19147, 19148
Outputs	• Increase # of robust workshop series to be offered in-person and zoom • Increase # of rotated workshop speakers from internal Jefferson teams and community-based organizations.
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 Collaborative for Health Equity (The Collaborative), Magee Rehabilitation Center, Methodist Hospital ED, College of Nursing, Pharmacy, College of Health Professions, Institute for Emerging Health Professions, Sidney Kimmel Medical College, Psychiatry Department, TJU Counseling and Behavioral Health Department, JTEN, Population Health, Social Work, Center for Integrative Medicine, Trauma Center at Jefferson, Jefferson primary care providers **External Partners:** PCDC, NKCDC, Department of Behavioral Health and Intellectual disAbility (DBHIDS), Philadelphia School District, community centers, Federation of Neighborhood Centers, ACES Taskforce, Stephen Klein Wellness Center, faith-based organizations, ALLCOVE, COACH, Concilio, senior centers

Substance Use & Abuse

Substance use can include the use of illegal drugs; improper use of prescription and over-the- counter drugs; unhealthy use of alcohol, tobacco and vaping; and the continued use of drugs to alter mood, relieve stress and/or avoid reality. Many people will use substances at some point in their lives without any issues; substance use only becomes a problem when it starts to have harmful effects on someone's life. Substance use disorder (SUD) is the recurring use of a substance (legal or illegal) to the point that it interferes with the user's physical health and/or responsibilities at home, work, or school.

According to the National Institute on Drug Abuse, people with a mental health disorder, such as anxiety, depression, or post-traumatic stress disorder, may use drugs or alcohol as a form of self-medication. Multiple national population surveys have found that about half of individuals who experience an SUD during their lives will also experience a co-occurring mental health disorder and vice versa. Similarly, research suggests that adolescents with SUD also have high rates of mental health conditions.

SUBSTANCE USE & ABUSE	
Goal: To better engage and educate individuals affected by Substance Abuse Disorders (SUD)	
Objective: Reduce the number of people who are affected by Substance Abuse Disorders (SUD)	
Strategy/Action	• Reduce access to opiates and other addictive pain medications by educating healthcare providers and patients/caregivers prescribed pain medications about drug take-back programs through social media, email updates to employees, flyers, and the "Opioid Matters" newsletter • Distribute the "Opioid Matters" newsletter throughout the Jefferson Enterprise • Increase awareness among patients taking prescribed painkillers about youth and others who may take pain medication that is not prescribed for them but accessible in the home • Reduce prescribed painkillers through provider education and adherence to prescribing guidelines/ regulations • Provide X-Waiver training to increase the number of prescribers that can prescribe Medically-Assisted Treatment (MAT), particularly in primary care • Provide Chronic Pain Self-Management Programs to patients • Implement Jefferson and City opiate taskforces/work groups plans/strategies

Target Population	Patients who are prescribed painkillers and their caregivers, providers who prescribe pain medication, TJUH ED/inpatient departments, individuals suffering from Opioid Use Disorder (OUD) or Substance Use Disorder (SUD), youth in zip codes and specific groups with higher SUD rates particularly in North and South Philadelphia
Outputs	Educational/ promotional materials about drug take-back programs developed and disseminated to healthcare providers, patients prescribed painkillers, youth, and the general public. • Increased utilization of drug take-back programs in the community benefit area • Reduced youth access to prescription drugs that impact SUD and OUD rates • Reduced # of prescribed narcotic painkillers • Increased access to Medically-Assisted Treat (MAT) • Improved chronic pain management • Reduced overdoses
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 process, re-assess community priority needs.
Potential Partners	**Internal Partners:** Jefferson Collaborative for Health Equity (The Collaborative), primary care, surgery, emergency department, hospital discharge, pharmacy, psychiatry, primary care, Thomas Jefferson Narcotic Addictions Rehab Program (NARP), MATER, Myrna Brind Center, OB/GYN, College of Pharmacy **External Partners:** Police Department, lock box programs, Philadelphia Department of Health; Department of Behavioral Health and Intellectual disAbility (DBHIDS); COACH, Prison system/Reentry Coalition, community pharmacies

Objective: Reduce access to opiate pain killers and raising public awareness about addiction enterprise-wide	
Strategy/Action	**Jefferson Opiate Task Force** • Focuses on reducing access to opiate pain killers and raising public awareness about addiction enterprise-wide. One hundred percent of primary care clinicians are certified on medication-assisted treatment. Jefferson's onsite pharmacy continued to provide a drug take-back program that is open to all community members.
Target Population	Emergency patients and Primary Care patients with Opioid Use Disorder
Outputs	• Increase/standardize warm handoffs • Refer patients to community resource partners • Establish electronic methods to impact prescribing behavior • Provide real-time feedback on guideline adherence • Patient education material • Drug take- back 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, continue intentional partnership development.

FY 25 Updates	Implement community suggestions, continual documentation of process, re-assess community priority needs.
Potential Partners	**Internal partners:** Care Coordination, Case Management, Social Workers, Primary Care Providers, OB/GYN Providers, Psychiatry, CHWs **External Partners:** Police Department, Philadelphia Department of Health; Department of Behavioral Health and Intellectual disAbility (DBHIDS); COACH, Prison system/Reentry Coalition
Objective: Increase access of Medically-Assisted Training (MAT) and NARCAN distribution	
Strategy/Action	• Increase warm-hand-off referrals to Thomas Jefferson Narcotic Addictions Rehab Program (NARP) and other Medical-Assistance Programs (MAT) • Increase MAT in primary care sites • Increase access to NARCAN training and distribution. • Refer individuals with OUD to community-based support groups (NA; AA) and refer friends and family of loved ones with SUD (Methodist Hospital) • Support pregnant women with substance use disorder through the MATER program (education, therapy, housing assistance; centering pregnancy) • Expand capacity of MATER to reach more women
Target Population	Individuals with substance use disorder or opiate use disorder, health professional students and providers, community based-organizations, youth
Outputs	• Increased referrals to and utilization of MAT programs • Reduced opioid overdose • Improved maternal and infant birth outcomes
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, continue intentional partnership development.
FY 25 Updates	Implement community suggestions, continual documentation of process, re-assess community priority needs.
Potential Partners	**Internal Partners:** Jefferson Collaborative for Health Equity (The Collaborative), primary care, surgery, emergency department, hospital discharge, pharmacy, College of Pharmacy, Thomas Jefferson Narcotic Addictions Rehab Program (NARP), MATER, Thomas Jefferson University **External Partners:** Police Department, Philadelphia Department of Health, Department of Behavioral Health and Intellectual disAbility (DBHIDS), COACH, community and faith-based organizations
Objective: Reduce youth access to and utilization of alcohol, tobacco, marijuana and vaping products	
Strategy/Action	• Continue to participate in the South Philadelphia Prevention Coalition and other Drug Free Communities Coalition activities • Educate youth about the dangers of vaping tobacco and marijuana • Support policy changes that reduce youth access to alcohol, tobacco (flavored) and vaping products
Target Population	North and South Philadelphia youth and community members
Outputs	• Increase the # community members reached through programs • Increase the # youth reached

	• Increase % of youth who believe substance use is a health problem • Reduce % of youth who report using tobacco, alcohol, marijuana, vaping and other drugs
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, continue intentional partnership development.
FY 25 Updates	Implement community suggestions, continual documentation of process, re-assess community priority needs.
Potential Partners	**Internal Partners:** Methodist Hospital, Jefferson Collaborative for Health Equity (The Collaborative), Frazier Family Coalition for Stroke Education and Prevention, Wyss Wellness Center **External Partners:** Youth Serving Organizations, Town Watch, Southeast Philadelphia Collaborative (SEPC), Trinity United Methodist Church, Philly Rising Collaborative, Friends of Mifflin Square Park ***School Partners:*** students at Universal Audenried, South Philadelphia High School, Furness High School, Sharswood School, and McDaniel School, Prevention Partners, United Communities, Mural Arts Program, Business Partners, Parents, Philadelphia Department of Public Health – SMOKFREE Philly, Department of Behavioral Health and Intellectual disAbility (DBHIDS), COACH
Objective: Increase substance use screening, brief intervention and referral to treatment (SBIRT) by health care providers	
Strategy/Action	Provide SBIRT training (Screening, Brief Intervention, referral to treatment) to health professional students and health care providers
Target Population	Sidney Kimmel Medical College, Pharmacy, and Physician Assistant students and health care providers
Outputs	• 90% of first, second and third year Jefferson Medical, Physician Assistants and Pharmacy students trained • Increase # of current practicing healthcare providers trained • Increase # patients screened and referred
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, continue intentional partnership development.
FY 25 Updates	Implement community suggestions, continual documentation of process, re-assess community priority needs.
Potential Partners	**Internal Partners**: Primary Care providers, ED, Nursing, College of Pharmacy, Physician Assistants, Sidney Kimmel Medical College faculty, Jefferson Collaborative for Health Equity (The Collaborative), Frazier Family Coalition **External Partners:** SAMSHA SBIRT, Department of Behavioral Health and Intellectual disAbility (DBHIDS)

Objective: Expand access to medical treatment of opioid use disorder in Jefferson Family Medicine Associates offices to 2 additional residency practices	
Strategy/Action	Provide clinician education and establish care workflows for Medications for Opioid Use Disorder (MOUD) in 2 residency clinical practices
Target Population	Persons seeking primary care and MOUD at Jefferson Family Medicine Associates, Family Medicine residency
Outputs	• Increase # of educational sessions provided for FM residents and office staff; Policies and workflows to assessment of persons using opioids and treatment • Increase # clinicians prescribing MOUD • Increase # patients enrolled
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, continue intentional partnership development.
FY 25 Updates	Implement community suggestions, continual documentation of process, re-assess community priority needs.
Potential Partners	**Internal Partners:** Greg Jaffe, MD physician champion at JFMA MOUD clinic **External Partners:** Provider Clinical Support System (PCSS)

Objective: Continue offering ASPIRE (Advocates for Stigma Prevention and Innovation in Recovery Engagement) program	
Strategy/Action	Multidisciplinary group of clinicians and public health experts working to improve the care of patients inside and outside the hospital who are afflicted with SUD and reduce incidence of patient directed discharges
Target Population	Patients with SUD and SUD associated conditions who are treated in the ED and Inpatient (IP) units
Outputs	• Current programs include: Novel Fentanyl/Xylazine withdrawal protocols/order sets, Naloxone to go dispensing, Fentanyl Test Strip dispensing and now Safe Injection Supplies to those who are not amenable to recovery at time of service. • Two separate symposiums (one for enterprise nurses, one for emergency department providers) provided education on trauma informed care, practical advice on caring for patients with SUD and updates on withdrawal management.
FY 23 Updates	Safe injection supply provision is now live in the TJUH ED with plans to expand to the IP units and then to other hospitals across the enterprise.
FY 24 Updates	Goal to publish new withdrawal protocols to spread understanding of the need for revisions to common withdrawal management strategies.
FY 25 Updates	Goal to make harm reduction services available at all Jefferson hospitals to allow providers to make health positive interventions for patients who are not amenable at time of service
Potential Partners	**Internal Partners:** Enterprise Opioid Taskforce, Social Work, Case Management, Internal Medicine, Psychiatry, Pharmacy and Nursing Leadership **External Partners:** Prevention Point Philadelphia (supplier of harm reduction supplies), City of Philadelphia (provided grant funding supporting development)

<table>
<tr><th colspan="2">Objective: Remove Access barriers to for care for pregnant and parenting women affected by substance abuse disorders</th></tr>
<tr><td>Strategy/Action</td><td>Continue offering Maternal Addiction Treatment, Education and Research (MATER), one of the oldest, largest and most comprehensive substance use disorder (SUD) programs for pregnant and parenting women in the country

Care Coordination and Case Management
Insurance coverage
Government identification
Welfare benefits, including WIC (Women, Infants & Children), SNAP (Supplemental Nutrition Assistance Program) and transportation
Medical Care
Prenatal care from Jefferson Health
Delivery care from Jefferson/Nemours Children's Health pediatrics and neonatology
Coordination of specialist and general medical care for you and your child(ren)
Mental Health Care
Mental health check-ups with Jefferson staff psychiatrist
Continued therapy, including any needed prescriptions from our staff psychiatrist
Mindfulness Training
Mindfulness-Based Parenting (MBP)
Mindfulness-Based Family Support (MBFS)
Mindfulness-Based individual therapy Individual
Therapy & Peer Support
Strength-based treatment planning to meet your recovery needs
One-on-one sessions with an experienced therapist
One-on-one and group support with a certified peer specialist
Group Therapy
Yoga
Smoking cessation
Anger management
Life skills, like cooking and money management
12-step meetings and support groups
Child Care
Safe environment for your child(ren) ages three months to six years while you attend therapy appointments
Parenting education
Child development assessment and referrals to services
Support navigating DHS (Department of Human Services) or Family Court
Medications for Opioid Use Disorder
Our team of experienced professionals will help find the right medication and dose for you
Methadone and buprenorphine (Subutex or Suboxone) can reduce cravings and prevent withdrawal</td></tr>
<tr><td>Target Population</td><td>Pregnant and Parenting Women in TJUH's service area</td></tr>
<tr><td>Outputs</td><td>Increase # of women referred to programs</td></tr>
</table>

	• Increase # of women participating in 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, continue intentional partnership development.
FY 25 Updates	Implement community suggestions, continual documentation of process, re-assess community priority needs.
Potential Partners	**Internal Partners:** Enterprise Opioid Taskforce, Social Work, Case Management, Internal Medicine, Psychiatry, Pharmacy and Nursing Leadership. **External Partners:** WIC (Women, Infants & Children), SNAP (Supplemental Nutrition Assistance Program
Objective: JEFFQUIT is the area's leading hospital-based smoking cessation program. Based on a proven method, JeffQuit maximizes success by gradually decreasing the amount of nicotine over a three-week period – providing the greatest reduction of withdrawal symptoms	
Strategy/Action	JeffQuit is a three-week program with one group session each week. The program begins with sessions on the second Tuesday of every month. **JeffQuit combines the following elements to maximize success during the treatment process:** • Three powerful sessions with a stop-smoking expert • Stop-smoking aids • Hypnosis • Individual support and coaching **We also offer:** • Discounted acupuncture and stress-reduction programs • Individual and group fitness • Yoga • Diet, nutrition support and more
Target Population	LGBTQ+ community (Smoking rates in the LGBTQ+ community are higher than those of the U.S. population as a whole), young adults, and individuals in Philadelphia County: 19102, 19103, 19106, 19107, 19121, 19122, 19123, 19124, 19125, 19130, 19132, 19133, 19134, 19140, 19145, 19146, 19147, and 19148
Outputs	• Increase # of collaborative events with community-focused internal departments (Sidney Kimmel Cancer Center, Jefferson Collaborative for Health Equity (The collaborative), Frazier Family Coalition for Stroke Education and Prevention • Increase # of vulnerable populations participating in 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:** SKCC Cancer Center, Jefferson Collaborative for Health Equity (The Collaborative), Frazier Family Coalition for Stroke Education and Prevention, Pulmonary Medicine **External Partners:** Community-based organizations that provide health education programs, Faith-based community

Chronic Disease

Chronic diseases are a leading cause of disability and death nationwide and statewide.

In Pennsylvania, five of the ten leading causes of death are chronic diseases, including:

- Heart disease
- Cancer
- Stroke
- Chronic lower respiratory disease
- Diabetes

As Pennsylvania's aging population grows and longevity increases, the burden of chronic diseases and associated costs are expected to rise.

Across the five counties and within them, striking inequities in chronic disease burden correlate with poverty, a key determinant of poor health outcomes, which disproportionately affects communities of color. In Philadelphia, for example, Hispanic/Latino communities have some of the highest rates of chronic conditions, such as asthma and obesity, and the city's non-Hispanic Black population has disproportionately high rates of chronic conditions such as hypertension and diabetes.

CHRONIC DISEASE PREVENTION & MANAGEMENT
Goal: Decrease the prevalence of chronic disease and improve disease self-management through primary and secondary prevention efforts
Objective: Increase awareness of programs and services that support healthy eating, physical activity and chronic disease management

Strategy/Action	• Implement a centralized system/database (Find Help) that links to patient electronic health records to promote awareness about and access to nutrition, physical activity, weight management, and other wellness programs. • Engage the Jefferson Physician Relations Managers to provide information to community physicians about community based healthy lifestyle programs. Encourage Jefferson physicians to "prescribe" and refer to healthy lifestyle programs.
Target Population	Community residents, health care providers, community based organizations
Outputs	• Database implemented and promoted to targeted audiences • Increase # physicians who "prescribe" and refer patients to healthy lifestyle and chronic disease management programs • Increased number of referrals to resources and program participant
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, continue intentional partnership development.
FY 25 Updates	Implement community suggestions, continual documentation of process, re-assess community priority needs.
Potential Partners	**Internal Partners:** Jefferson Collaborative for Health Equity (The Collaborative), Frazier Family Coalition for Stroke Education and Prevention, Primary Care, Jefferson Neurosciences and Endocrinology, IS&T, Jefferson Physician Relations Managers, Care Managers **External Partners**: Find Help (resource platform), COACH, United Way 211, Philadelphia Department of Public Health, BenePhilly, community based organizations that address food security, housing, and other SDOH, PHMC, Health Promotion Council
Strategy/Action	• Raise Awareness of **"Food as Medicine"** among health care providers. Integrate routine food security screening into primary care practices, during determination of Medicaid eligibility, and hospital discharge (ED and inpatient). • Refer to and promote food cupboards and other food assistance programs such as MANNA, SHARE, Meals on Wheels, Philabundance and the Coalition Against Hunger
Target Population	**Philadelphia County:** 19102, 19103, 19106, 19107, 19121, 19122, 19123, 19124, 19125, 19130, 19132, 19133, 19134, 19140, 19145, 19146, 19147, 19148
Outputs	• Food Screening tool integrated into EPIC • Increase # of patients screened • Increase the # of patients referred • Increase the # of people referred who received assistance • Decrease # readmissions for patients with food insecurity
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, continue intentional partnership development.
FY 25 Updates	Implement community suggestions, continual documentation of process, re-assess community priority needs.

Potential Partners	**Internal Partners:** Jefferson Collaborative for Health Equity (The Collaborative), Frazier Family Coalition for Stroke Education and Prevention, Primary Care, ED, Nursing, Social Work, Discharge Planners, Admissions, Care Managers, Health Partners Plan (HPP) **External Partners:** COACH, MANNA, SHARE, Philabundance, Coalition Against Hunger
Objective: Raise awareness and understanding about chronic disease risk factors, healthy lifestyles, and chronic disease prevention	
Strategy/Action	• Provide in-person and telehealth Diabetes Prevention Program in partnership with the Philadelphia Department of Public Health, AMA, ADA, CDC, and Cities Changing Diabetes; Develop and implement strategies to enhance communication between Jefferson's DPP program and primary care providers (referral to program and follow-up) • Provide screening for hypertension and associated risk factors to detect and manage high blood pressure. Support the Philadelphia Department of Public Health's Get Healthy Philly and Philly Difference Initiatives by continuing to provide Heart Smarts/Blood Pressure Plus programs • Develop and implement strategies to enhance communication between Jefferson's community-based hypertension screening program and primary care providers (referral to program and follow-up)
Target Population	Adults in the Jefferson community benefit area, low-income neighborhoods with high rates of overweight and obesity, preschool children, families including pregnant women, Jefferson employees, parents, veterans.
Outputs	• At least one monthly program reaching at least 20 people per program provided (in-person or via zoom sessions) • Increase # of people screened monthly; % return screening rate • Assist with the health navigation needs of community members: health insurance enrollment, established a primary care provider, scheduling appointments, completed care • Increase # of food insecurity screenings • Increase the # of care referrals • Increase the # Improved healthy lifestyle behaviors • Increase the # of people referred to QUIT Line; the # of people who have successfully quit smoking • Improved communication with primary care doctors • Improved blood pressure control • Reduced maternal morbidity and mortality due to hypertension
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 Primary Care, Methodist and Jefferson ED, care managers, Jefferson Collaborative for Health Equity (The Collaborative), Jefferson Endocrinology, Dietitians, College of Pharmacy, Jefferson students **External Partners:** Food Trust, Stephen Klein Wellness Center, faith-based institutions, public library, schools, community gardens, Philadelphia Housing Authority, PACDC, Veterans Multi-Services Center, senior centers, NKCDC, Philadelphia Dept. of Public Health, Healthcare Improvement Foundation (HCIF), Philadelphia Library, senior centers, YMCA, Cities Changing Diabetes, CDC, American Medical Association (AMA), American Diabetes Association (ADA), and other community based organizations including community development corporations.
Objective: Raise awareness about prevention, early detection and management of strokes	
Strategy/Action	The Frazier Family Coalition for Stroke Education and Prevention aims to wholly integrated health education and community navigation program that connects at risk members in the community with the information, resources, and clinical care they need to prevent stroke and connect patients who have had a stroke with the information, resources, and support services they need to prevent a reoccurrence. The core tenets of our program include: **Awareness Campaign** • Increasing knowledge about risk factors and screening opportunities through comprehensive health education programs **Health Education** • Developing community sites to deliver targeted interventions that improve knowledge about healthy behaviors and puts community members on a path to living healthier lifestyles **Program highlights:** • Diabetes Prevention and Management • Diabetes Self-Management Education and Support • Hypertension Self-Management Education and Support • Tobacco Treatment Program • Farm to Family • Computer Literacy Program
Target Population	TJUH – patient population, High-Risk zip codes 19121, 19132, 19133, and 19140
Outputs	• Program participants that report increased awareness of (education, resources, services, and information) • Increase # of participants who attend and complete educational programs • Increase % of participants who meet at least one behavior goals (e.g., healthy eating, taking medications, being active) • 90% participants who saw or made an appointment to see PCP, ophthalmologist, dentist, foot doctor
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 Collaborative for Health Equity (The Collaborative), Wyss Wellness Center, Primary Care Practices, Family and Community Medicine, Methodist and Jefferson ED, care managers, Jefferson Endocrinology **External Partners:** Mayor's Office of Civic Engagement and Volunteer Services, The Health Federation of Philadelphia, Self-Inc. Strawberry Mansion Action Center, N.O.R.T.H., Inc., Director W.I.C., PSDC (Philadelphia Suburban Development Corp), Outreach Director for the PA State Senator Sharif Street, North Central Philadelphia CDC, DaVita Kidney Care, The Philadelphia Black Women's Health Alliance, The Urban League of Philadelphia, Mental Health First Aid, Health Promotion Unit, Department of Behavioral Health and Intellectual Disability Services (DBHIDS)

Objective: Raise awareness about early detection and management of hypertension and reduce cardiovascular disease prevalence	
Strategy/Action	The Nicoletti Family Hypertension Prevention program seeks to address hypertension as a predominant precursor to cardiovascular disease through education, outreach and screening, as well as health coaching and navigation.
Target Population	Patients at risk for cardiovascular disease in TJUH's service area particularly high risk zip codes 19121,19132, 19133, 19140, 19148
Outputs	• Imagine A healthier You: Blood Pressure management and Healthy Living Program, a comprehensive Health Education Program adapted from the American Heart Association – Life's Essential 8 and CDC (Center for Disease Control) • # Blood Pressure Screenings • # high-risk patients referred to PCP for further evaluation • # referrals to Jefferson Collaborative for Health Equity's Hypertension Education Programs • #referrals to smoking cessation classes • # of participants in educational programs-in person and online • 1:1 Counseling with Nurse Navigator, Nutritionist, CHWs and Pharmacist
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 Enterprise – Family Medicine, Internal Medicine, Population Health, Clinical Care Coordinators, Primary Care Practices, Jefferson Collaborative for Health Equity, Frazier Family Coalition for Stroke Prevention, Wyss Wellness Center, SKCC, Health Partners Plan, Cardiovascular Service line

	External Partners: Health Partner Plans; Community Based Organizations, Faith Based Organization, Wyss Wellness Center, Esperanza, Temple TCIN Practices, Frazier Family Coalition, Senior Centers, American Heart Association, American Diabetes Association
Objective: Provide chronic disease community health screenings	
Strategy/Action	• Engage community organizations, grassroots organizations, local health providers, and communities of faith to initiate conversations about cardiovascular health and education surrounding heart health • Promote wellness and lifestyle change through health screenings and community engagement • Provide clinical navigation and support for persons who are screened
Target Population	TJUH – patient population, High-Risk zip codes 19121, 19132, 19133, and 19140
Outputs	• 80% of high-risk patients are referred to a primary care provider for further evaluation • 75% of those referred to a primary care provider are evaluated by a primary care provider
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, Methodist and Jefferson ED, care managers, Jefferson Endocrinology, nutrition services, OB-GYN staff, MATER, Population Health, Jefferson Collaborative for Health Equity, Frazier Family Coalition for Stroke Prevention, Wyss Wellness Center, SKCC, Health Partners Plan, Cardiovascular Service line **External Partners:** Philadelphia Dept. of Public Health, Healthcare Improvement Foundation, Philadelphia Library; senior centers, YMCA; Cities Changing Diabetes, Food Trust, Stephen Klein Wellness Center, faith-based institutions, public library, head start/ preschool, schools, community gardens, Philadelphia Housing Authority, PACDC, Veterans Multi-Services Center, senior centers, NKCDC
Objective: Hold Wellness Wednesday Programs at Frazier Family Coalition for Stroke Education and Prevention	
Strategy/Action	Provide regular health screenings with partners in the community
Target Population	Heart Smart Program at local Corner Stores (zip code 19133); Libraries: Widener Branch/ Lillian Marrero library/ Nicetown- Tioga branch near Frazier site Department of Corrections/ Parole office located at 100 West Lehigh
Outputs	• Increase awareness and knowledge about metabolic syndrome (cardiovascular disease and diabetes) for disease prevention and reduction in prevalence • Raise awareness about early detection and to improve disease management • Track # Screenings • Increase # high-risk patients referred to PCP for further evaluation • Track # referrals to Jefferson Collaborative for Health Equity's Hypertension and Diabetes Education Programs • Increase #referrals to smoking cessation classes • Increase # of participants in educational programs-in person and online

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 Collaborative for Health Equity (The Collaborative), JeffPEERS, Primary Care Practices, Jefferson Latina's Clinic, Wyss Wellness Center, MATER, Social Workers, Population Health, Health Partners Plan (HPP) **External Partners:** Department of Corrections, Philadelphia Libraries, Philabundance, community based organizations, COACH, Philadelphia Dept. of Public Health, Healthcare Improvement Foundation, Philadelphia Library; senior centers, YMCA; Cities Changing Diabetes, Food Trust, Stephen Klein Wellness Center, faith-based institutions, public library, head start/ preschool, schools, community gardens, Philadelphia Housing Authority, PACDC, Veterans Multi-Services Center, senior centers, NKCDC
Objective: To provide chronic disease management support and program evaluation at Jefferson Family Medicine Associates (JFMA)	
Strategy/Action	Implementing and evaluating a prediabetes order set
Target Population	Adult patients at JFMA meeting criteria for prediabetes
Outputs	Creation of an Epic prediabetes order set with patient education materials, instructions for metformin prescribing, and referrals to the Diabetes Prevention Program and other educational 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 process, re-assess community priority needs.
Potential Partners	**Internal Partners**: JFMA, Jefferson Collaborative for Health Equity, Frazier Family Coalition, pharmacists, diabetes educators **External Partners:** Potentially other prediabetes education providers, Regional Diabetes HUB
Objective: Continue to promote Chronic Disease Prevention and Management, Cancer Early Detection and Treatment	
Strategy/Action	• Provide colorectal cancer education programs in community venues to increase knowledge about the risk factors for colon cancer and the importance of early detection through screening
Target Population	TJUH service areas
Outputs	• 2-3 educational programs conducted annually reaching 25 individuals per program • Increase # of persons served by the SKCC screening van • Track # of patients serviced in community • Increase # of patients moving through a referral pipeline
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:** GI Physicians and staff, Jefferson Collaborative for Health Equity (The Collaborative), Jefferson Primary Care Practices, Sidney Kimmel Cancer Center External Partners: American Cancer Society, Senior Centers, Faith-based organizations, community based organizations, serving older adults, Philadelphia Corporation on Aging, Philadelphia Dept. of Public Health, Stephen Klein Wellness Center, library
Objective: Increase colonoscopies in the targeted areas	
Strategy/Action	• Identify Jefferson Internal Medicine Associates and Jefferson Family Medicine Associates patients in South Philadelphia, Center City and Lower North Philadelphia who have not had a screening or follow-up colonoscopy based on the recommended guidelines
Target Population	Jefferson Internal Medicine Associates and Jefferson Family Medicine Associates' patients in South Philadelphia, Lower North Philadelphia and Center City
Outputs	• Reach 20% of patients from Center City, Lower North and South Philadelphia identified as needing a colonoscopy receive a screening or follow-up colonoscopy • Increase # of persons served by the SKCC screening van • Track # of patients serviced in community • Increase # of patients moving through a referral pipeline
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 Internal Medicine physicians, Jefferson Internal Medicine Associates, Jefferson Family Medicine Associates, Sidney Kimmel Cancer Center **External Partners**: Recreation centers, community-based organizations, community gardens, community parks, School District of Philadelphia, Stephen Klein Wellness Center, Project Home
Objective: Raise public awareness about the SKCC Screening Van and its committed mission to provide screening and early detection of breast and cervical cancer	
Strategy/Action	• Raise community and TJUH health care provider awareness about the Pennsylvania Breast and Cervical Cancer Prevention and Treatment program by publicizing the Pennsylvania Breast and Cervical Cancer Early Detection Program (PA-BCCEDP) and the SKCC mobile van screening services on Jefferson Breast Care Web Page, promote breast and cervical cancer programs at the SKCC Welcome Center and across the Jefferson Health Enterprise

	• Provide community-based breast and cervical cancer education programs (Methodist community day taking place during breast cancer awareness month. (Employee screening day in Center city location). • Continue to provide breast and cervical screening to uninsured/underinsured women through partnerships/resources such as NBCFF, and the Pennsylvania Healthy Women 40+ program for breast and cervical cancer screening.
Target Population	Uninsured, underinsured and underserved women in Jefferson's community benefit area and the greater Philadelphia area
Outputs	• Expand Pennsylvania's Healthy Women program and screening services promoted on Jefferson Breast Care Web Page • Increase # programs provided • Increase # of participants • Increase # of physician referrals to breast and cervical cancer programs/screenings • Increase # of persons screened for cervical cancer • Increase # of people receiving mammography
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:** Radiology, Surgery, Ob-Gyn, Sidney Kimmel Cancer Center, Patient Support Services, Breast Cancer Center, Jefferson Family Medicine Associates **External Partners:** Community Based Organization (SEAMACC, Bebashi, Mazzoni, Stephen Klein Wellness Center, Project Home, etc.)
Objective: Raise awareness of the human papillomavirus (HPV) prevention including the HPV vaccine	
Strategy/Action	• Promote the human papillomavirus (HPV) vaccine as a cancer prevention method for HPV-related cancers, including cervical cancer
Target Population	Parents of children ages 9-17 who are recommended to be vaccinated; providers who care for children ages 9-17. Philadelphia County: 19102, 19103, 19106, 19107, 19121, 19122, 19123, 19124, 19125, 19130, 19132, 19133, 19134, 19140, 19145, 19146, 19147, 19148
Outputs	• Increase the % of males and females ages 13-17 who are vaccinated against HPV—within Jefferson (health system), Philadelphia County
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:** Sidney Kimmel Cancer Center, Jefferson Family Medicine Associates, Nemours Pediatric Practices, Jefferson Internal Medicine, Primary Care Service Lines

	External: American Cancer Society, Philadelphia Department of Public Health, Philadelphia Immunization Coalition, FQHC's, community based organizations
Objective: Increase public awareness about lung cancer prevention and the importance of early detection	
Strategy/Action	• Provide lung cancer screening education programs in community venues to increase knowledge about the risk factors for lung cancer and the importance of early detection through screening
Target Population	Asian, African American, LGBTQ+, Veteran, Refugee/immigrant communities
Outputs	• 3-4 educational programs conducted annually reaching 25 individuals per program • Increase # of persons served by the SKCC screening van • Track # of patients serviced in community • Increase # of patients moving through a referral pipeline
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:** Sidney Kimmel Cancer Center, Jefferson Internal Medicine Associates, Jefferson Family Medicine Associates, Pulmonology, Jefferson Collaborative for Health Equity (The Collaborative) **External Partners**: SEAMAAC, BAOP, Philadelphia FIGHT, Mazzoni Center, Veterans Multi-Service Center, Impact Services, Stephen Klein Wellness Center, Philadelphia Dept. of Public Health, senior centers, faith-based, community-based organizations serving older adults, and refugee/immigrant communities
Objective: Increase public awareness about prostate cancer prevention and the importance of early detection	
Strategy/Action	• Provide prostate cancer screening education programs in community venues to increase knowledge about the risk factors for prostate cancer and the importance of early detection through screening
Target Population	African American, LGBTQ, and Veteran communities
Outputs	• Develop and promote 3-4 educational programs conducted annually reaching 25 individuals per 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:** Sidney Kimmel Cancer Center, Jefferson Department of Urology, Internal Medicine Associates, Jefferson Family Medicine Associates **External Partners:** American Cancer Society, Prostate Cancer Foundation, Veterans Affairs, LGBTQ+ community advocacy organizations, faith-based programs serving African Americans, Philadelphia Health Department, PHMC.

Goal: Provide supportive care services and cancer-related information for patients, their families and caregivers	
Strategy/Action	Provide supportive care services and cancer-related information/education at the Welcoming Center including: • Nutritional counseling and seminars • Workshops for patients and families • Exercise classes • Clinical trial and research information • Appointment assistance • Buddy Support Program resources and support group information
Target Population	Cancer patients, families and caregivers
Outputs	• Increased access to information Improved ability to understand and manage disease Increased support through group and individual counseling/assistance
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, continue intentional partnership development.
FY 25 Updates	Implement community suggestions, continual documentation of process, re-assess community priority needs.
Potential Partners	**Internal Partners:** Sidney Kimmel Cancer Center, Welcoming Center **External Partners:** American Cancer Society, Philadelphia Health Department, community based organizations

Access and Quality of Healthcare and Health Resources

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

At Jefferson Health, we are reimagining diversity and inclusion to promote and cultivate an inclusive environment that celebrates the diversity of our patients, families, students, workforce and the communities we serve. We believe that a diverse and inclusive environment is fundamental to our mission for the advancement of education and health and the achievement of health equity.

We use the following definitions:

Diversity – the richness of human similarities and differences that make up One Jefferson Family.

Inclusion – the ability to provide outstanding health care to all people and all communities while giving everyone voice and the opportunity to be valued, respected and supported.

Equity – choosing to provide fairness in the way people are treated when seeking healthcare services, employment, development and community engagement.

The Office of Diversity, Inclusion and Community Engagement is responsible for ensuring the social, cultural and linguistic needs in the care we provide to the diverse communities we serve.

This includes ensuring compliance with all laws, regulations and mandates to provide medically qualified interpreters for Limited English Proficient (LEP) patients and their families, as well as ASL interpreters for deaf patients and family members.

In an effort to improve health outcomes and quality of care while also increasing patient safety and satisfaction, the Enterprise Office of Diversity, Inclusion and Community Engagement hosts cultural competency training sessions to enhance the ability of hospital staff and students to deliver health care effectively.

Diversity, Inclusion *and* Community Engagement Blueprint *for* Action

MISSION: **WE IMPROVE LIVES**

STRATEGY: *Jefferson holds itself accountable, at every level of the organization, to nurture an environment of inclusion and respect, by valuing the uniqueness of every individual, celebrating and reflecting the rich diversity of its communities, and taking meaningful action to cultivate an environment of fairness, belonging & opportunity.*

DIMENSIONS	LEADERSHIP *and* GOVERNANCE	MARKETING *and* COMMUNICATIONS	PEOPLE	EXPERIENCE	EXTERNAL STAKEHOLDERS
KEY FOCUS AREAS	• Develop Board/Corporate Objectives • Enterprise Accountability of Behaviors • Alignment of DEI Goals	• External Communication Plan • Internal Communication Plan • Inclusive Marketing & Advertising	• Learning & Development • Diversity Councils • Equity in Managing Talent (includes Talent Acquisition & Student Admissions, Annual Performance & Leadership Continuity)	• Key Stakeholders (Learners, Patients, Employees) • Cultural Competence & Language Services • Health Equity	• Economic Inclusion (Supplier Diversity & Vendor Development) • Enterprise Sponsorships • Strategic Partners (Community & Civic Orgs, Elected & Public Officials, Benefactors)

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

VALUES: **Put People First | Be Bold & Think Differently | Do the Right Thing**

Jefferson | HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

Jefferson Health is recognized by the Human Rights Campaign as an "LGBTQ+ Healthcare Equality Leader." Jefferson Health is one of less than 500 healthcare facilities across the

nation to be honored for exceptional commitment to inclusive care for LGBTQ+ patients and their families.

Linguistically and Culturally Appropriate Services & Racism and Discrimination in Healthcare Settings	
Goal: : Improve patient-provider communication through expansion of cultural competence and cultural humility training for healthcare providers related to special populations such as: **Immigrants and refugees populations, the LGBTQ+ community, older adults, returning citizens, neurodiverse populations, and people experiencing trauma, and the homeless**	
Objective: Provide on-site language interpreter services for diverse populations	
Strategy/Action	Align and expand interpreter services across the Jefferson Enterprise • **Standardized Language Interpreter Service –** now standardized to one service vendor (Globo), ability to leverage audio and video interpreter services in addition to the translation. The contract includes new equipment and a democratized app process allowing staff to access interpreting service via a smartphone, pin number, and medical Record number.
Target Population	TJUH patient population, primary care practices, Emergency Departments
Outputs	• Increased Interpreter services • Track # Interpreter Minutes used • Increase # of languages offered • Ability to test staff language competencies
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, continue intentional partnership development.
FY 25 Updates	Implement community suggestions, continual documentation of process, re-assess community priority needs.
Potential Partners	**Internal Partners:** Language Service directors, ED staff, primary Care staff social work teams **External Partners:** Language interpretation vendors -Globo, patients and family members, Community based organizations serving non-English speaking/immigrant populations, Medical Interpreter certification programs, Healthcare Improvement Foundation (HCIF)
Objective: Improve Health Literacy materials and delivery models	
Strategy/Action	• Adopt health literacy universal precautions and teach-back methods throughout Jefferson. • Review and revise patient education materials, discharge instructions, informed consent, and web-site for readability ease and usability

	• Translate written materials/forms into foreign languages where 5% or 1,000 individuals have limited English proficiency • Provide health literacy training, including language access regulations (language line use and use of interpreters), for Jefferson health care providers, staff and students
Target Population	TJUH Patients and families, TJUH employees, health care providers and staff, TJU health professional students
Outputs	• Patient education materials/discharge instructions and website usability reviewed and recommendations made for improvement • Healthstream module developed and implemented to address language access regulations related to translation and interpretation. All new employees completed Healthstream module • A tool to measure satisfaction with communication and adherence to regulations regarding interpretation/translation requirements developed and implemented with patients with Limited English Proficiency and/ or those serving these patients
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, continue intentional partnership development.
FY 25 Updates	Implement community suggestions, continual documentation of process, re-assess community priority needs.
Potential Partners	**Internal Partners**: Frazier Family Coalition for Stroke Education and Prevention, TJUH Patient Education, Marketing, TJUH Hospital employees, TJUH Health care providers and staff, TJU students, Patient Services, Office of Diversity and Inclusion, EPIC, IS+T, Patient & Family Advisory Council, Jefferson Collaborative for Health Equity (The Collaborative), TJU Colleges, Neuro Center **External Partners**: Patients and Family Members, Community based organizations serving non-English speaking/immigrant populations, Language interpretation vendor –Globo, Medical Interpreter certification programs, Healthcare Improvement Foundation (HCIF)
Objective: Enhance and further develop Chinese Health Clinic programming	
Strategy/Action	Continue to provide weekly free access to medical and specialty care to the community population
Target Population	Underserved, disadvantaged, uninsured, undocumented population of Philadelphia
Outputs	Track patients served by the Jefferson Chinatown Clinic
FY 23 Updates	• Began consistent relationship with psychiatry at Jefferson to provide mental health care regularly • Worked with Manna to provide meals to a significantly disadvantaged patient • Continued to recruit patient navigators of all cultures and primary languages • Continue to work with Community Legal Services to help patients obtain emergency medical assistance
FY 24 Updates	• Increase specialty care possibilities through personal relationships • Continue to help patients facing large medical bills • Continue to provide chronic disease management
FY 25 Updates	• Increase specialty care possibilities through personal relationships • Continue to help patients facing large medical bills • Continue to provide chronic disease management

Potential Partners	**Internal Partners:** Chinese Health Information Center staff, Methodist Hospital staff, Jefferson Collaborative for Health Equity (The Collaborative), Patient Services, Jefferson Dept. of Psychiatry, Jefferson Department of Emergency Medicine (Ultrasound), Jefferson Rheumatology **External Partners:** Nationalities Services Center; Health Federation, Community Legal Services of Philadelphia
Objective: Create a diverse, equitable and inclusive workforce	
Strategy/Action	• Increase diversity and inclusion of healthcare workforce leadership through recruitment, mentorship and training • Partner with Jefferson Health's Diversity, Inclusion and Community Engagement team to develop staff training centered on effective cultural humility and cultural competence. • Partner with the Clinical Health Equity and Patient Experience teams to enhance the patient experience: o Advance Patient, Family and Staff Partnership - Leverage human centered design principles and optimize the Jefferson digital experience strategies. o Social justice movement and community focus o Increased adoption of telehealth services • In partnership with Health Care Improvement Foundation (HCIF), continue to provide health literacy training, including the Teach-Back Method and motivational Interviewing, in Southeastern Pennsylvania and across the Commonwealth. • Continue to advocate for and support policies/system changes that mandate health literacy competence in all written and oral communication through participation in the Pennsylvania Health Literacy Coalition.
Target Population	TJUH and Enterprise staff, Home Health Agencies, Community based organizations, insurers, patients within the Philadelphia Region: special emphasis on the zips of 19121, 19132, 19133, 19140, and 19148
Outputs	• Increase the # of trained staff/# of on-going trainings • Design and deploy Patient & Family Centered Care (PFCC) model for Enterprise-wide • Develop on-line training modules and in-person training sessions that focus on empathy effective communication, and ground-setting on cultural humility and cultural competence • Diversify the pool of training facilitators –with emphasis on those with lived experience (ex. Community Health Workers, Social Workers, Primary Care support staff) • Continue to grow robust DEI councils within the Jefferson Enterprise and continue promote support services colleagues into leading roles within the DEI strategy space • Encourage dialogue centered in awareness, respect, and advocacy • Build capacity for participation in community driven events and continual partnership with grassroots organizations • Leverage human centered design principles and optimize the Jefferson digital experience strategies • Engage the diverse community as strategic advisors to understand community priorities • Actively engage patients ("activate patients") and families as co-equal stakeholders • Listen/incorporate understanding of the patient journey into our patient care structures • Ensure all team members attend the Jefferson Experience "It Starts with Me" sessions • Enhanced service delivery resources in telehealth and virtual visit environment

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:** Diversity and Inclusion steering committee, DEI councils ; LGBT and Allies Committee **External Partners:** - Nationalities Services Center, the Welcoming Center and other Community –based organizations serving non-English speaking refugees and immigrants, Mazzoni Health Center (LGBTQ+), LGBT-Elder Initiative; Philadelphia Corporation on Aging (older adults), Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), Mental Health First Aid, Project HOME, Women Against Abuse (Trauma Informed Care), Urban League, NAACP
Objective: Caring for the LGBTQ+ Community	
Strategy/Action	**Provide gender affirming care:** **Child, Adolescent, and Adult Psychiatry** • LGBTQ+ youth and adults can see Jefferson psychotherapists and psychiatrists for a variety of services, including psychiatric evaluations and medication management. **Center for Healthy Aging** • Healthcare for LGBTQ+ patients 55 years and older, as well as support for caregivers. **Gender-Affirming Hormone Therapy** • Subcutaneous injection – under the skin of the abdomen • Intramuscular injection – in the muscle of the glutes or thigh • Patch • Topical gel • Implanted pellet • Pill **Menstrual Suppression and Post-Operative Care** • Vaginal dilation **Otolaryngology Head & Neck Surgery** • Treatment and care for head and neck cancer, including HPV associated oropharyngeal cancer and thyroid cancer. **Pre-exposure prophylaxis** • (PrEP) evaluation for those with increased risk of HIV **Psychology** • Therapy provided by Jefferson counselors, therapists and psychologists can help with various mental health-related issues, including family building. **Reproductive Endocrinology & Infertility** • Helping LGBTQ+ families with family planning and building with fertility/fertility preservation. **Ryan White Program**

	• The federally sponsored program allows people – with or without health insurance – access to ongoing HIV treatment and access to other valuable social services **Top Surgery** • Female to male (FTM) top surgery is a gender affirming surgical procedure that alters characteristics of the chest, typically through the removal of breast tissue, allowing for a more masculine appearance **Urogynecology & Female Pelvic Medicine** • Treatments for LGBTQ+ patients (including integrative medicine) with urinary concerns, pelvic floor problems, pelvic pain and vaginal pain **Urology** • LGBTQ+ patients can be treated for genital reconstruction, prosthetics, orchiectomy, penile implants, testicular implants and urethral stricture/fistula repair and other complications from vaginoplasty/phalloplasty/metoidioplasty
Target Population	LGBTQ+ population, High-risk patient populations, Philadelphia County: 19102, 19103, 19106, 19107, 19121, 19122, 19123, 19124, 19125, 19130, 19132, 19133, 19134, 19140, 19145, 19146, 19147, 19148
Outputs	• Increase # of program participants • Increase program awareness with internal and external partners • Engage the diverse community as strategic advisors to understand community priorities. • Listen/incorporate understanding of the patient journey into our patient care structures. • Enhance, and promote gender-affirming care: expand self-identifiers, hormone therapy • Cultural competency, cultural humility, & Implicit bias training Embed the LGBTQ+ population as a core population the collaborative will be serving -Provide screenings -Assistance with accessing resources -More intentionally partner with CBOs and grassroots organizations that provide resources, programming, and support to the LGBTQ+ 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:** Center for Aging, Diversity and Inclusion steering committee ; LGBTQ+ and Allies Committee **External Partners:** - Nationalities Services Center, the Welcoming Center and other CBOs serving non-English speaking refugees and immigrants, Mazzoni Health Center (LGBTQ+), LGBT-Elder Initiative; Philadelphia Corporation on Aging (older adults), Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), Mental Health First Aid, Project HOME, Women Against Abuse (Trauma Informed Care)
Strategy/Action	**Promote preventive Care for Trans Adults** • Counseling to prevent sexually transmitted infections

	• Depression screenings • HIV screening • Immunizations, including those for the flu, hepatitis and human papillomavirus (HPV) • Pap tests and breast cancer screenings for patients born female • Screenings for blood pressure, cholesterol, Type 2 diabetes and obesity • Screenings for tobacco and alcohol use
Target Population	Trans adults, LGBTQ+ populations, supporting family, caregivers
Outputs	• Increase # of program participants • Increase program awareness with internal and external partners • Engage the diverse community as strategic advisors to understand community priorities. • Listen/incorporate an understanding of the patient journey into our patient care structures. • Enhance, and promote gender-affirming care: expand self-identifiers, hormone therapy • Cultural competency, cultural humility, & Implicit bias training • Embed the LGBTQ+ population as a core population the collaborative will be serving -Provide screenings -Assistance with accessing resources -More intentionally partner with CBOS & grassroots organizations that provide resources, programming, and support to the LGBTQ+ 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:** Diversity and Inclusion steering committee, LGBTQ+ and Allies Committee, Primary Care, Jefferson Medical Group **External Partners:** - Gender Wellness Program at Nemours, Nationalities Services Center, the Welcoming Center and other CBOs serving non-English speaking refugees and immigrants, Mazzoni Health Center (LGBTQ+), LGBT-Elder Initiative; Philadelphia Corporation on Aging (older adults), Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), Mental Health First Aid, Project HOME, Women Against Abuse (Trauma Informed Care)
Objective: Providing education opportunities for the LGBTQ+ Community	
Strategy/Action	**Q-mUNITY - An Edu-Port Group** LGBTQ+ Health Program provided every third Tuesday of the month for a group based, collaborative discussion with providers on what's new in the LGBTQ+ community regarding language, healthcare needs and overall wellness.
Target Population	LGBTQ+ population, **Philadelphia County:** 19102, 19103, 19106, 19107, 19121, 19122, 19123, 19124, 19125, 19130, 19132, 19133, 19134, 19140, 19145, 19146, 19147, 19148
Outputs	• Increase # of program participants

	• Increase program awareness with internal and external partners • Engage the diverse community as strategic advisors to understand community priorities. • Listen/incorporate understanding of the patient journey into our patient care structures. • Enhance, and promote gender-affirming care: expand self-identifiers, hormone therapy • Cultural competency, cultural humility, & Implicit bias training • Embed the LGBTQ+ population as a core population the collaborative will be serving -Provide screenings -Assistance with accessing resources -More intentionally partner with CBOS & grassroots organizations that provide resources, programming, and support to the LGBTQ+ 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:** Diversity and Inclusion steering committee, LGBTQ+ and Allies Committee **External Partners:** - Nationalities Services Center, the Welcoming Center and other CBOs serving non-English speaking refugees and immigrants, Mazzoni Health Center (LGBTQ+), LGBT-Elder Initiative; Philadelphia Corporation on Aging (older adults), Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), Mental Health First Aid, Project HOME, Women Against Abuse (Trauma Informed Care/Healing Centered practices)
Strategy/Action	**Marc David LGBTQ Endowed Scholarship** Awarded to undergraduate students who demonstrate active leadership and advocacy for LGBTQ+ causes. Students are eligible to receive the scholarship beginning in their sophomore year and continues by maintaining a GPA above a 3.0. The scholarship will be awarded to deserving students who demonstrate financial need as determined by the University's Office of Financial Aid, but leadership and advocacy for the LGBTQ+ community is paramount.
Target Population	Graduating high school seniors and current undergraduate students
Outputs	• Increase awareness of scholarship opportunity with graduating high school seniors and current undergraduate students
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:** Thomas Jefferson University, Sidney Kimmel Cancer Center, Jefferson Collaborative for Health Equity (The Collaborative)

	External Partners: Nationalities Services Center, the Welcoming Center and other Community-based organizations serving non-English speaking refugees and immigrants, Mazzoni Health Center (LGBTQ+), LGBT-Elder Initiative, Philadelphia Corporation on Aging (older adults), Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), Mental Health First Aid, Project HOME, Women Against Abuse (Trauma Informed Care), local high schools
Strategy/Action	**Mark L. Zwanger, MD ’82 and Malcolm A. Kram, DVM, LGBT Scholarship at SKMC** This is the first LGBTQ+ scholarship established at Thomas Jefferson University and is provided to need-based SKMC students with preference given to first-year, LGBTQ+ students. For more information, please contact Larry Slagle, Director of Development, at 215-955-6658 or larry.slagle@jefferson.edu.
Target Population	Graduating high school seniors and current undergraduate students
Outputs	• Increase awareness of scholarship opportunity with graduating high school seniors and current undergraduate students
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:** Thomas Jefferson University, Sidney Kimmel Cancer Center, Jefferson Collaborative for Health Equity (The Collaborative) **External Partners:** Nationalities Services Center, the Welcoming Center and other CBOs serving non-English speaking refugees and immigrants, Mazzoni Health Center (LGBTQ+), LGBT-Elder Initiative; Philadelphia Corporation on Aging (older adults), Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), Mental Health First Aid, Project HOME, Women Against Abuse (Trauma Informed Care), local high schools
Strategy/Action	**Professional Development Program for Sexual and Gender Minority Education and Training (SG-MET)** Jefferson College of Rehab Sciences offers an innovative professional development program on understanding, educating, and advocating for the LGBTQ+ population as a faculty (clinical or non-clinical), staff, or healthcare provider. This 7-month program sponsored by Jefferson's Office of Diversity, Inclusion & Community Engagement includes structured learning sessions that encompass structured learning sessions on various topics, from cultural competence and humility to tackling health disparities, as well as mentoring sessions with SG-MET faculty and much more.
Target Population	Clinical or non-clinical, staff, or healthcare provider
Outputs	• Increase the awareness of this program both internally and externally • Increase the # of participants of development 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:** Primary Care Practices, Specialized practices, Emergency Department staff, social workers, Community Health Workers (CHWS), behavioral health/trauma-healing departments **External Partners:** The Mazzoni Center and The William Way Center
Objective: Increase access to care for vulnerable populations including immigrants, refugees, homeless, individuals in Reentry, and individuals with disabilities	
Strategy/Action	**Wyss Wellness Center** The Wyss Wellness Center serves as a hub for clinical and educational outreach activities with a focus on the immigrant population in addition to the surrounding South Philadelphia community. The center provides a platform to deliver full-spectrum primary care, social services, wellness activities, and other community focused programming. **Clinical Services** • Primary care • Reproductive Health • Pediatrics • Labs and Radiology **Supportive Services** • Social Services to assist with health care insurance coverage, public benefits, access to community resources, and other needs • Community workshops, classes, and other group programming • Health & Nutrition Education • Community Engagement • Language Interpretation & Translation
Target Population	Immigrants, refugees, homeless, individuals with disabilities, incarcerated and individuals in reentry, low income
Outputs	• Increase # of patients moving through a continuum of care/access to services of care • Enhance internal and external promotion of services • Collaborate with local community led organizations to identify patients' needs/gaps in care • Engage the diverse community as strategic advisors to understand community priorities • Listen/incorporate understanding of the patient journey into our patient care structures • Increase the # of Community Health Workers (CHWs) that represent the communities served • Conduct trainings for bilingual Community Health Workers (CHWs) to provide health education in immigrant communities on variety of topics such as healthy eating, physical activity, and signs and symptoms of stroke, heart attack, diabetes prevention program, smoking cessation programs, and how to use 911

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**: Health care providers, health professional students, University health professional faculty, Jeff HOPE, Refugee Health Partners, Magee Rehab Hospital, Jefferson Collaborative for Health Equity (The Collaborative), primary care providers, Emergency Department **External Partners:** SEAMAAC, Department of Behavioral Health and Intellectual disAbility (DBHIDS), Nationalities Services Center, Philadelphia Refugee Health Collaborative, Mural Arts Storefront; Cambodian Association, BAOP, Vietnamese community based organizations, Project HOME, Broad Street Ministry, Pathways to Housing, Reentry Coalition
Strategy/Action	**Jefferson Latina Women's Clinic** Jefferson Latina Women's Clinic is committed to providing quality, compassionate health care to the most vulnerable and teaching the next generation of providers to do the same. While the clinic is deeply entrenched in the migrant community, it serves anyone and everyone who does not have access to care. For the Jefferson Latina Women's Clinic, caring for the disenfranchised is a moral and ethical responsibility. Every patient deserves to be treated with dignity and respect. • Comprehensive prenatal and postnatal care • High-risk prenatal and postnatal care • 24/7 access to care • Medical-legal guidance • Behavioral health counseling • Patient education and advocacy
Target Population	Immigrants, refugees, homeless, individuals with disabilities, incarcerated and individuals in reentry, low income
Outputs	• Increase # of patients moving through a continuum of care/access to services of care • Enhance internal and external promotion of services • Collaborate with local community led organizations to identify patients' needs/gaps in care • Engage the diverse community as strategic advisors to understand community priorities • Listen/incorporate understanding of the patient journey into our patient care structures
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**: Health care providers, primary care providers, Emergency Department health professional students, University Health professional faculty, Jeff HOPE, Refugee Health Partners, Magee Rehab Hospital, Jefferson Collaborative for Health Equity (The Collaborative), primary care providers, Emergency Department **External Partners:** SEAMAAC, Department of Behavioral Health and Intellectual disAbility (DBHIDS), Nationalities Services Center, Philadelphia Refugee Health Collaborative, Mural Arts Storefront, Cambodian Association, BAOP, Vietnamese community-based organizations, Project HOME, Broad Street Ministry, Pathways to Housing, Reentry Coalition
Strategy/Action	**Midwifery Health Clinic Program** As part of a long-standing partnership with the City of Philadelphia, Jefferson's team of midwives volunteers at health centers across Philadelphia with the goal of reducing maternal health disparities in our local communities and promotion of quality and equitable prenatal care.
Target Population	Pregnant persons, vulnerable populations, Philadelphia County: 19102, 19103, 19106, 19107, 19121, 19122, 19123, 19124, 19125, 19130, 19132, 19133, 19134, 19140, 19145, 19146, 19147, 19148
Outputs	• Increase # of pregnant patients moving through a continuum of care/access to services of care • Enhance internal and external promotion of services • Collaborate with local community led organizations to identify patients' needs/gaps in care • Engage the diverse community as strategic advisors to understand community priorities • Listen/incorporate understanding of the patient journey into our patient care structures
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**: Health care providers, health professional students, university health professional faculty, Jeff HOPE, Refugee Health Partners, Magee Rehab Hospital, Jefferson Collaborative for Health Equity (The Collaborative), Frazier Family Coalition for Stroke Education and Prevention, primary care providers, Emergency Department, Social workers **External Partners:** SEAMAAC, Department of Behavioral Health and Intellectual disAbility (DBHIDS), Nationalities Services Center, Philadelphia, Refugee Health Collaborative, Mural Arts Storefront, Cambodian Association, BAOP, Vietnamese community based organizations, Project HOME, Broad Street Ministry, Pathways to Housing, Reentry Coalition
Objective: Raise awareness on the Center for Autism & Neurodiversity (JeffCAN)	
Strategy/Action	The Center for Autism and Neurodiversity is recognized for improving the lives of children, adolescents and adults through clinical practice, research, and community-oriented programming that fosters opportunities for those with neurodiversity.

	Our clinical practice assesses and integrates medical, educational, and therapeutic services for children with potential neurodiverse diagnoses, including: • Autism • Developmental delay • Intellectual and developmental disorders • ADHD • Learning disabilities 1 in 44 children in the U.S. is diagnosed with autism. Community programs offer an interdisciplinary approach of inclusion for individuals with neurodiversity across the lifespan. The center consults with businesses, healthcare organizations, and community stakeholders to create awareness and accessibility in the environment. • **"Safety on the Spectrum": Situational Awareness in Public Spaces, (SoS)**
Target Population	Neurodiverse children, adolescents and adults, supporting families, and caregivers.
Outputs	• SOS Project: In two years, involve police, individuals, and families identifying and preparing for the most common situations and creating district/personalized plans for safe actions in public places or at community and family gatherings • Increase # of patients moving through a continuum of care/access to services of care • Enhance internal and external promotion of services • Collaborate with local community led organizations to identify patients' needs/gaps in care • Engage the diverse community as strategic advisors to understand community priorities • Listen/incorporate understanding of the patient journey into our patient care structures • Connecting persons with disabilities to Legal Clinic
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**: Health care providers; health professional students, university health professional faculty, Jeff HOPE, Refugee Health Partners, Magee Rehab Hospital, Jefferson Collaborative for Health Equity (The Collaborative), Frazier Family Coalition for Stroke Education and Prevention, primary care providers, Emergency Department, Social Workers **External Partners:** Philadelphia School District, Community Based Organizations focused of the needs of the neurodivergent population
Objective: Further the awareness of programs offered through The Jefferson Center for Connected Care	
Strategy/Action	**The Jefferson Center for Connected Care**

	The Jefferson Center for Connected Care develops and tests innovative approaches for a patient-responsive care delivery system. Our goal is to create replicable and sustainable models of care to reduce, and ultimately eliminate, health disparities. **Digital Health Readiness** • Focused on ensuring digital health equity across vulnerable populations by addressing digital literacy limitations **Patient Uncertainty** • Patient uncertainty related to experiencing symptoms is a primary driver of decisions to seek care and a primary unmet need at the end of emergency department (ED) visits • A Model of Uncertainty and Care Seeking was developed to explain patients' decisions to seek care, the Jefferson Uncertainty Scale to measure patient uncertainty during an acute care visit, and the Uncertainty Communication Checklist to improve communication with patients who are discharged with ongoing uncertainty. **Vaccine Confidence** • Data suggest that rates of confidence are lower among minority and other underserved populations, thus threatening to worsen already significant health disparities. Work in this portfolio focused on better understanding and addressing barriers to vaccine confidence among underserved populations. **Impact of Telehealth on Patient and System Outcomes** • Our team continues to conduct multi-methods evaluations of various telehealth care models, and to incorporate telehealth as a care delivery model in prospective trials. **Patient Centered System Design** • For this work, we focus on applying qualitative and mixed methods to elicit the patient perspective regarding needs related to seeking acute care, with a goal of informing decision of a care delivery system more responsive to individual patient needs. In addition, we are testing novel approaches to delivering improve system capacity to deliver patient-centered care. **Harm Reduction** • Our harm reduction portfolio of research seeks to mitigate harms associated with drug use, especially as it relates to the overdose crisis. We conduct mixed-methods research related to overdose prevention, drug checking, and treatment outcomes both in and out of clinical settings. Through our harm reduction research, we hope to advance policy and other efforts to benefit the health of people who use drugs. **VaxConnect Taskforce:**

	• The Jefferson VaxConnect Taskforce is an interprofessional team dedicated to conducting widespread outreach to patients across the enterprise to ensure equitable access to COVID-19 vaccines. • Outreach is focused specifically on ensuring inclusion of populations in underserved zip codes and communities of color and is designed to overcome potential barriers to individual self-scheduling such as lack of internet access or MyChart use, low health literacy and vaccine confidence, and logistical challenges getting to vaccine appointments (e.g., lack of transportation). **Digital Outreach Taskforce (DOT):** • Taskforce primarily comprised of Jefferson Masters in Public Health (MPH) students who conduct outreach to Jefferson patients to provide assistance with setting up and using digital devices to engage in telehealth services.
Target Population	**Philadelphia County:** 19102, 19103, 19106, 19107, 19121, 19122, 19123, 19124, 19125, 19130, 19132, 19133, 19134, 19140, 19145, 19146, 19147, 19148
Outputs	• Increase # of patients moving through a continuum of care/access to services of care • Enhance internal and external promotion of services • Collaborate with local community led organizations to identify patients' needs/gaps in care • Engage the diverse community as strategic advisors to understand community priorities • Listen/incorporate understanding of the patient journey into our patient care structures
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**: Health care providers, health professional students, University health professional faculty, Jeff HOPE, Refugee Health Partners, Magee Rehab Hospital, Jefferson Collaborative for Health Equity (The Collaborative), Frazier Family Coalition for Stroke Education and Prevention, primary care providers, Emergency Department, Social Workers **External Partners:** Philadelphia School District, Community Based Organizations focused of the needs of the neurodivergent population

FOOD ACCESS

Issues of food access focus primarily on food security, defined as having reliable access to a sufficient quantity of affordable, nutritious food. Many community members experience challenges with obtaining sufficient food of any kind, as well as report issues with accessing healthy food more specifically.

The financial challenges brought on by the COVID-19 pandemic has led to an increase in rates of food insecurity across all counties and sharply rising demand for emergency food assistance. Nearly a quarter of Philadelphia households are receiving Supplemental Nutrition Assistance Program (SNAP) benefits.

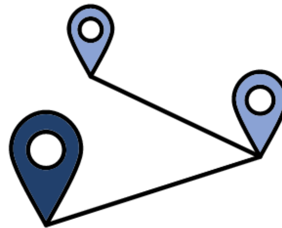
Black and Hispanic/Latino communities are disproportionately impacted by food insecurity, as are older adults and immigrant communities.

Food Access	
Goal: Reduce access barriers to healthy food and nutrition related services	
Objective: Increase awareness of 'Food as Medicine' initiative among health care providers	
Strategy/Action	• Improved screening and intervention for food insecurity among TJUH Emergency Department (TJUH ED) patients and Jefferson Methodist Emergency Department (MHD ED) patients • As part of the pre-clerkship SKMC program, Clinical Experience (CE), medical students screen ED patients for social determinants of health (SDOH), including food insecurity. Any identified needs are connected to community resources, with the facilitation of community health workers.
Target Population	Emergency Department and Inpatients at Methodist and TJUH; Primary care providers
Outputs	• Track # of patients screened • Track # of patients with reported food insecurity, types and count of social interventions
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:** Academic Affairs (funds SDOH screening program), SKMC, ED leadership, case management and social work **External:** SNAP (Department of Public Welfare), MANNA, MOM's meals, FAST, local food banks

Objective: Reduce access barriers to healthy, affordable food	
Strategy/Action	In partnership with Head Start and PreK programs develop food buying clubs and nutrition education programs to support access to and consumption of healthy affordable food
Target Population	Low income preschoolers and their families; Head Start Staff
Outputs	• Continue food buying club at Mercy Neighborhood Ministries of Philadelphia (North Philadelphia) and expand to at least one additional preschool program (Acelero Learning). • 6 nutrition education related programs provided annually for staff and Head Start families (20 families participate per program) • 6 nutrition education programs provided for 3 to 5 year olds attending the Head Start reaching 100 children annually • Improved dietary habits among 80% 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:** Jefferson Collaborative for Health Equity (The Collaborative), Frazier Family Coalition for Stroke Education, Primary Care Practices, Wyss Wellness, Latina's Clinic **External Partners:** Acelero Learning, Mercy Neighborhood Ministries of Philadelphia, Norris Square Community Alliance, PreK programs, Common Market, APM, SHARE, Philabundance, and other food distributors, Food Trust
Objective: Continue Partnership with Collaborative Opportunities to Advance Community Health (COACH)	
Strategy/Action	COACH • Leverages a multi-stakeholder collaborative by planning, implementing, and evaluating coordinated strategies to address key community health and social needs • Current priority focal areas for COACH's shared implementation strategies include addressing food insecurity and advancing trauma-informed care and organizational practices • Create strategy plans to minimize hospital cafeteria food waste.
Target Population	Philadelphia Region: special emphasis on the zips of 19121, 19132, 19133, 19140, 19148, High-Risk zip codes 19121, 19132, 19133, 19140
Outputs	• Increase # of partnerships in the food insecurity space. • Increase the food distribution efforts/publically served events (1x a month minimum) • Host monthly nutrition classes, on-line and in-person • Develop and service 3-4 community fridges
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 Collaborative for Health Equity, TJUH and Methodist Emergency departments providers, EPIC teams, Discharge Planners, Pastoral Care, Care Coordinators, Volunteer Services, Sidney Kimmel Medical College clinical experience **External Partners:** COACH, Food Policy Advisory Council Hunger Subcommittee, Coalition against Hunger, MANNA, SHARE, Philabundance, Means Database, MedStar Union Memorial Hospital, Hub of Hope, SEPTA

Healthcare and Health Resource Navigation Services



Jefferson Health aims to improve care coordination as part of an integrated care model that assesses the whole person, addresses both physical and behavioral health, and coordinates care across hospitals and community-based service providers.

The Jefferson Collaborative for Health Equity's **CHW Academy Program** will improve the health of vulnerable community members by strengthening and expanding the CHW workforce in multiple ways. CHW are a vital part of the health care and social systems workforce since CHWs are trusted members of and/or has an unusually close understanding of the communities they serve that enables them to help community members navigate complex systems, provide information and resources, and support strength-based behavior change. CHWs work in a multiple of locations (health systems, FQHCs, schools, community-based organizations).

Healthcare and Health Resource Navigation Services	
Goal: Expand warm handoffs between hospitals, emergency departments, primary care practices, community behavioral health service providers and community-based organizations	
Objective: Build patient service capacity by expanding the Community Health Worker workforce	
Strategy/Action	**The Jefferson Collaborative for Health Equity's CHW Academy** The CHW Program includes the following components:

	CHW Training • **The Jefferson Collaborative for Health Equity** –The Collaborative is an accredited (by the Pennsylvania Certification Board) CHW trainer. The Collaborative provides CHW training to Jefferson staff, community partners, and community members. Depending on the need, the CHW training may focus only on the CHW Core Training or it may include professionalism, specialty topics, coaching and work experience. • Once trained, the CHWs will engage with community members, offer SDOH screening, connect community members to resources, and provide support and education. **CHW Training for Currently Employed CHWs** • The Collaborative offers CHW training to currently employed CHWs that have not received their Pennsylvania Certification Board CHW Certification. Participants are individuals employed as CHWs or CHW type jobs that have not been formally trained as CHWs. Attending this training enables the participants to further develop their skills, learn about the CHW movement and how it connects to their work, and be eligible to receive certification. **CHW Academy** • The CHW Academy is a workforce development program for individuals that are new to the CHW workforce and may have limited or no work experience and share some of the same experiences as the communities they will serve (i.e., recruitment may focus on returning citizens, individuals in recovery, young adults, and others). • The CHW Academy will include personal growth and job readiness, CHW Core Training, specialty topics, work experience and coaching. Being part of this program will provide community members with training, work experience, and support to enter into a growing profession that includes career ladders and links to other educational programs. **NKCDC Health Empowerment Zone Partnership** • Workforce development program that recruits community members (12 to 18 per cohort) to attend in an expanded CHW training. • The training includes foundational CHW training, professionalism, computers, and additional topics and is usually 160 hours. • Once the training is completed, NKCDC hires some of the trainees as part-time CHWs for the remainder of the program year (6 to 9 months) and are mentored and /coached throughout the year on skill building and their job search. • The Collaborative developed the program model and curriculum, provides training and coaching/mentoring for the program participants and is involved in program oversight and implementation **CHW Training for Partners** • The Collaborative offers CHW training to community partners as needed. **Professional Development** • To maintain your PA Certification Board CHW Certification, CHWs must attend 30 hours of professional development every two years. • The collaborative offers these trainings plus other trainings to ensure continuous learning. **Jefferson CHW Community of Practice** • The Jefferson CHW Community of Practice (CHW CofP) members meet throughout the year and is an opportunity for the Community Health Workers and those that supervise CHWs throughout Jefferson Health to share resources, discuss their work, attend professional development programs, and generally connect with one another.

	Community Health Worker Advocacy and Support • The Collaborative's CHW Program collaborates with other CHW programs in the Philadelphia area, statewide and nationally, to support the CHW profession through research and advocacy
Target Population	Community from high-risk zip codes 19121, 19132, 19133, 19140, Immigrant and Refugee communities.
Outputs	• Successfully employ and deploy multiple cohorts • Increase internal and external partnerships for CHW building and capacity building • Hire 2-3 bilingual CHWs per cohort • Recruit CHWS with specialized areas of public health interest (e.g., Maternal Health, Behavioral Health, LBGTQ+ Health)
FY 23 Updates	**CHW Training** CHW Academy • Implement the CHW Academy model **Train and support one cohort in FY23 and one in FY24 CHW Training for Currently Employed CHWs** • Train one cohort a year of currently employed CHWs to provide them with the training they need so they can apply for certification and to improve their skills. • **NKCDC Health Empowerment Zone Partnership:** • Collaborate with NKCDC on Year 4 & 5 (FY23) & FY24) of the HEZ Grant. • Train CHW Cohorts for Years 4 & 5 • Provide coaching and support to all CHW Trainees (all cohorts) to support them as they work as CHWs and in their job searches. • Collaborate with NKCDC to extend the program past the HEZ grant • Identify one community partner a year for whom to provide CHW training • Offer professional development to CHWs throughout the year to improve knowledge and increase skills.
FY 24 Updates	**CHW Academy** • Train and support one cohort in FY24 • The CHW Trainees will obtain jobs that provide them with family sustaining wages, health benefits, and career advancement • CHWs will work in the community and at Jefferson Health and will have a positive impact on community members' health status by connecting them to services, helping them navigate complex systems, providing them with information and resources, and providing strength based behavior change support • CHW trainees will receive the PA Certification Board CCHW
FY 25 Updates	**CHW Academy** • Train and support two cohorts in FY25 • The CHW Trainees will obtain jobs that provide them with family sustaining wages, health benefits, and career advancement

	• CHWs will work in the community and at Jefferson Health and will have a positive impact on community members' health status by connecting them to services, helping them navigate complex systems, providing them with information and resources, and providing strength based behavior change support. • CHW trainees will receive the PA Certification Board CCHW
Potential Partners	**Internal Partners:** Sidney Kimmel Medical College Clinical Experience Program, Einstein Complex Care Program, Jefferson Northeast, Family and Community Medicine, Infectious Disease, Center for Center for Neurorestoration, the Vickie & Jack Farber Institute for Neuroscience, Jefferson University Public Health Program, College of Population Health, Jefferson Center for Connected Care, Health Partners Plan **External Partners:** NKCDC, BEBASHI, Impact Services, Esperanza Health , Health Federation, PA AHEC, PA CHW Task Force, PA CHW Association
Strategy/Action	**Housing Smart Program Pilot** Multidisciplinary care team to help individuals with co-occurring diagnoses (physical and behavioral) navigate the health system and improve health outcomes. **Phase 1: Team Arrive -Partnership with Resources for Human Development (RHD) and Community Behavioral Health (CBH)** • Program goals include reducing avoidable healthcare utilization; linking members to primary care and behavioral health services; and addressing SDoH • Population Served: 30 individuals who are CBH members, insured by Keystone or Health Partners Plan, have chronic medical conditions and behavioral health concerns (including substance use disorder), experience housing instability, and frequent the Jefferson ED • CBH Funded Team: Tenant Services Coordinator, Certified Peer Support Specialist, Psych Rehab Specialist, Case Manager or Care Coordinator • Jefferson Funded Team: RN or LPN **Phase 2: Housing Smart** • A collaboration between RHD, Temple University Hospital, Keystone First, and Health Partners Plans. • The program has reduced Emergency Department visits by 72% and increased the utilization of primary care providers by 93%. • Overall, the program leads to more appropriate healthcare usage, decreased health care costs, and better health outcomes for consumers. • Subsidized housing vouchers for participants.
Target Population	Individuals who are Community Behavioral Health members, insured by Keystone or Health Parnters Plan (HPP), have chronic medical conditions and behavioral health concerns (including substance use disorder), experience housing instability, and frequent the Jefferson Emergency Department
Outputs	• Under pilot program, serve 30 persons

	• Track program efficiencies, potential gaps in service. • Replicate model and expand
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:** TJUH & Methodist Emergency rooms, Social Services, HPP, Jefferson Collaborative for Health Equity (The Collaborative), Frazier Family Coalition for Stroke Education and Prevention **External Partners:** Human Development (RHD), Community Behavioral Health (CBH)

Community Factors

The CDC describes health equity as achieved when every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances." Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment.

Jefferson Health is striving to center to address structural drivers of health inequity through deep partnership with community and faith-based organizations, businesses, entrepreneurs, and a broad base of advocates to address upstream causes of health inequity

Three pillars of health equity

WORKFORCE

Creating and supporting a diverse and inclusive workforce that reflects the demographic characteristics of the community through all levels of the organization. Leaders and staff create a culture where underrepresented staff feel safe and valued, and core talent management processes serve underrepresented employees more equitably.

PATIENT OUTCOMES

Ensuring equitable outcomes for patients by guaranteeing that all of their individual physical, behavioral, and social needs are met. In addition to point-of-care solutions, leaders must tackle specific non-clinical needs that ultimately influence long-term outcomes.

COMMUNITY EFFORTS

Addressing community-wide social determinants of health by focusing on their root causes, including structural racism and intergenerational poverty. This approach will improve health equity among workers and individual patients, as well as long-term, population-level outcomes.

Social Determinants of Health (SDOH) Socioeconomic Disadvantages, Community Violence, Neighborhood Conditions, Housing	
Goal: Screen patients for Social Determinants of Health (SDOH) and connect those with needs to corresponding community resources	
Objective: Screen Emergency Department patients for Social Determinants of Health (SDOH) and connect those with needs to corresponding community resources	
Strategy/Action	• As part of the pre-clerkship SKMC program, Clinical Experience (CE), medical students screen Emergency Department patients for SDOH, including health insurance, transportation needs, medication affordability, utilities, food insecurity, and housing instability. Any identified needs are connected to community resources, with the facilitation of community health workers.
Target Population	Patients presenting to the TJUH Emergency Department and Methodist Hospital Emergency Department.
Outputs	• Track # of patients screened • Track # of patients with reported housing instability, types and count of social interventions.
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:** Academic Affairs (funds SDOH screening program), SKMC, ED leadership, case management and social work **External:** Government-based support (social security, SNAP, Medicaid) and social determinant-specific community resources (including, but not limited to): *Health insurance*: PATHS, BenePhilly *Transportation*: Insurance-based benefits, Modivcare, Septa *Medications*: PACE, PACENET, GoodRx *Utilities*: PECO, PGW *Food*: SNAP (Department of Public Welfare), MANNA, MOM's meals, FAST, local food banks *Housing*: Project HOME, Office of Homeless Services, Philly House, Homeless Advocacy Project, Community Legal Services, Prevention Point
Strategy/Action	**"Closing the Gap" Initiative** In 2021, Jefferson and Novartis Pharmaceuticals Corporation in partnership with the Jefferson Collaborative for Health Equity initiated a program called "Closing the Gap" to focus on reducing cardiac health disparities across 5 vulnerable zip codes in Philadelphia. 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.
Target Population	High-Risk zip codes 19121, 19132, 19133, 19140
Outputs	• Increase amount of individuals screened for CVD risk factors • Establish care for patients deemed high risk for CVD • Increase amount of active partners making patient referrals to Wyss and Frazier • Increase % of patients aware of BP numbers • Increase % of patients able to self-measure BP numbers • Increase % of patients aware of lifestyle risk factors for CVD and ways to improve them • Increase access to digital health tools to support care and treatment adherence • Decrease amount of patients lost to follow-up after initial contact • Increase amount of patients with severe risk factors who attend specialist visits
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 Collaborative for Health Equity (The Collaborative), Frazier Family Coalition for Stroke Education and Prevention, Wyss Wellness Center, SK Cancer Health Partners Plan, Population Health **External Partners:** Novartis Pharmaceuticals Corporation, WHYY
Objective: Identify methods/tools or technology/techniques that support the ability to engage, track and measure patient and participant progress over time	
Strategy/Action	• Ability to carry client information across platforms and databases • Identify platforms for Information dissemination to clients – text, robo-call, etc. • Ability to auto-connect participants to resources (SDOH E-script) • Platforms for text message reminders and robo-call for appointments, prevention classes and wellness activities • Technological support which allows CHWs to maximize navigation and follow up support to patients and clients
Target Population	Philadelphia County: 19102, 19103, 19106, 19107, 19121, 19122, 19123, 19124, 19125, 19130, 19132, 19133, 19134, 19140, 19145, 19146, 19147, 19148
Outputs	• Development of platforms and databases that provide information and reminders to patients and clients • Development of auto-connections to resources • Development of technological support for CHWs to maximize navigation and follow up support to patients and clients
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 Collaborative Health Equity, Wyss Wellness Center, Einstein, Family and Community Medicine, Infectious Disease, Emergency Department, Care Managers, Jefferson University Public Health Program, College of Population Health, Jefferson Center for Connected Care, Health Partners Plan **External Partners**: Microsoft, Community-based organizations
Objective: Identify methods/tools or technology/techniques that support the ability to engage, track and measure patient and participant progress over time.	

Objective: Address housing as a community need that impacts overall health	
Strategy/Action	**Better Together @Home** • Through Better Together @ Home (BT@H), Jefferson's Collaborative for Health Equity (The Collaborative), aims to provide 25 eligible participants living in zip codes 19121, 19132, 19133, 19140 housing structural and/or safety repairs. The goal of the housing structural and/or safety repairs is to improve food access and alleviate barriers to care preventing individuals from focusing on their physical health and well-being.
Target Population	Households at high Safety/Structural Risk in the 19121, 19132, 19133, and 19140 zip codes
Outputs	• 25 Projects to be completed, high-risk families identified • Track # of patients referred to internal and external partners • Build infrastructure to be replicated long-term
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:** Frazier Family Coalition for Stroke Education and Prevention, Primary Care Teams, Wyss Wellness Center, Health Partners Plans (HPP) **External Partners:** Manna, Habitat for Humanity, Philabundance
Strategy/Action	**JeffHOPE** • The JeffHOPE (Health Opportunities, Prevention & Education) program supports four homeless shelters and one needle exchange harm reduction program in Philadelphia every week. • The team provides acute and basic medical care and helps individuals and families experiencing homelessness access other health and social resources and healthcare providers who are better equipped to care for them long-term.
Target Population	Homeless and displaced persons, persons affected by substance abuse disorders, Philadelphia County: 19102, 19103, 19106, 19107, 19121, 19122, 19123, 19124, 19125, 19130, 19132, 19133, 19134, 19140, 19145, 19146, 19147, 19148
Outputs	• Increase # of patients moving through a continuum of care. • Actively engage patients ("activate patients") and families as co-equal stakeholders. • Listen/incorporate understanding of the patient journey into our patient care structures.
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 Departments at TJUH and Methodist Hospitals, Frazier Family Coalition for Stroke Education and Prevention, Jefferson Collaborative for Health Equity (The Collaborative)

	External Partners: Project Home, community based and grassroots organizations centered on mitigating homelessness
Objective: Promote recruitment/retention of Underrepresented in Medicine (UIM) and Advance Health Equity Research and Implementation	
Strategy/Action	**Mamie Polite Peace Equity Scholar** • Mamie Polite Peace Equity Scholar Award for Early Career Faculty Development is named in honor of the first African American director of the operating room at Thomas Jefferson University Hospitals. • Awards ranging from $15,000 to $25,000 for early career Jefferson faculty are provided for up to two years to select recipients in support of multidisciplinary pilot research across a range of disciplines, including medicine, nursing, allied health, pharmacy, behavioral health, and health information technology. • Priority is given to projects designed to promote health equity by addressing key areas: Mental Health, Trauma, Safety and Violence, Housing and the Built Environment, Food insecurity and Access, and Cardiovascular Disease Risk. Current Project: **Project Title:** "Safety on the Spectrum": Situational Awareness in Public Spaces (SoS) Wendy Ross, MD, FAAP, Associate Professor of Psychiatry and Director of Jefferson's Center for Autism and Neurodiversity (JeffCAN) with Collaborator Sabra Townsend, Director of Operations for Jefferson's Center for Autism and Neurodiversity (JeffCAN)
Target Population	TJUH and TJU faculty working to mitigate health inequities
Outputs	• Develop a brief project description, outlining clear goals, objectives and outcomes, as well as community engagement and evaluation approach and research strategy • Devise a community health impact statement, clearly stating how their project addresses social determinants of health and promotes health equity as a result of their intervention. • Develop a plan outlining community engagement strategy and plans for partnering with community-based organization for duration of project • Report project goals and outcomes annually
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:** Thomas Jefferson University Schools of medicine, Jefferson College of Population Health **External Partners:** community-based and grassroots organizations, faith based organizations, social services groups, parks and recreation centers, neighborhood corridors teams

Strategy/Action	**The Carl Mansfield, MD, Equity Scholar Faculty Development Award** • Enables the forward-thinking, community-focused Jefferson faculty to pursue high-impact projects focused on addressing health disparities in Philadelphia. Designed for physicians considered underrepresented in academic medicine (UIM), this unique program provides faculty members within the first seven years after their first appointment with $50,000 to launch targeted interventions and research focused on health equity. • In 1974, Carl Mansfield, MD history by becoming the first full-time African American professor at Jefferson. Dr. Mansfield went on to successfully lead three departments as chair over a nearly three-decade span. • This award provides developmental research funding, thereby increasing opportunities for UIM Jefferson faculty to engage in collaborative research and seek senior positions in academic medicine at Jefferson. In doing so, the Carl Mansfield, MD, Award further strengthens Jefferson's diversity and inclusion efforts, helps retain more UIM physicians, elevates the voices of our early-career faculty, and makes a true impact in the health and well-being of Philadelphia's underserved communities.
Target Population	Full-time, UIM physician faculty interested in clinical medicine, population health, and health services/implementation science
Outputs	• Devise scope of research/activity focused on health disparities, implementation science, patient-centered outcomes, health services research, population and/or community health, or another health equity focus • Develop a brief project description, outlining clear goals, objectives and outcomes, as well as community engagement and evaluation approach and research strategy • Devise a community health impact statement, clearly stating how their project addresses social determinants of health and promotes health equity as a result of their intervention Current Projects: **Project Title**: Jefferson Training Healthcare Residents in Equity & Addressing Disparities (**JeffTHREAD**) • **Project Description:** Conceptualization and Implementation of Graduate Medical Education Health Disparities Curriculum at TJU **Project Title:** "Eat With Me" • **Project Description:** Leverage social media to increase awareness and knowledge about heart healthy eating and, specifically, healthy options individuals can find in their local environment, with a focus on engaging high school students
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:** Enterprise-wide departments focused on Mental Health, Trauma, Safety and Violence, Housing and the Built Environment, Food insecurity and Access, and Cardiovascular Disease Risk, Thomas Jefferson University, Health Partners Plans (HPP), Thomas Jefferson University School of Medicine, Jefferson College of Population Health **External Partners:** community-based and grassroots organizations, faith based organizations, social services groups, parks and recreation centers, neighborhood corridors teams
Objective: Enhancing the Built Environment cultivating green space	
Strategy/Action	**Park-in-a-Truck** Park-in-a-Truck –Jefferson's Landscape Architecture program has launched this simple, fast and cost-effective park system that not only provides green spaces for neighborhoods in need but also battles climate change, one lot at a time.
Target Population	Philadelphia County: 19102, 19103, 19106, 19107, 19121, 19122, 19123, 19124, 19125, 19130, 19132, 19133, 19134, 19140, 19145, 19146, 19147, 19148
Outputs	• Increase # of green spaces • Promote the health benefits of a green environment • Continue to develop and distribute toolkits • Increase # of Community events
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:** Thomas Jefferson University, Jefferson Collaborative for Health Equity (The Collaborative) **External Partners:** PHS, local gardens, students, City of Philadelphia, Commercial Corridors
Objective: Continuing engaging youth populations	
Strategy/Action	Athlete Health Organization of Thomas Jefferson University. Providing free comprehensive sports physicals to middle and high school age children
Target Population	Middle School and High School in Socioeconomic Disadvantaged areas
Outputs	• Encourage safe/healthy participation in physical activity. • Engage students with healthcare providers. • Promote overall wellness through education. (E.g. nutrition/mental health)
FY 23 Updates	• Continue to expand on number of events. (50-100 students per event) • Engage with new community partners • Establish new board
FY 24 Updates	• Continue growth • Expanded services offered at each event to aide needed gaps in Primary Care in this population • New partners for expanded services
FY 25 Updates	• Continue growth • Mobile unit to reach schools with appropriate supplies

	• Electronic solutions for data capture
Potential Partners	Internal Partners: Jefferson Family Medicine, Cardiology, Pulmonary, Psychiatry, Nutrition External Partners: Philadelphia School District, UPenn Sports Med, Simons Heart
Objective: Build programming that aims to address community violence	
Strategy/Action	**Catalyst Grants** • Catalyst Grants capacity-building partnership between the Jefferson Collaborative for Health Equity and local Community-Based Organizations that demonstrate positive community impact and work to mitigate drivers of community violence • 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	TJUH – patient population, priority high-risk zip codes 19121, 19132, 19133, 19140
Outputs	• Increase # youth events hosted • Increase # of program participants • Gather community feedback • Employ trust-building programs • Cultivate CHW career pipelines • Develop paid ambassador 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:** Jefferson Collaborative for Health Equity (The Collaborative) Magee Rehab, Einstein, Jefferson Northeast, Wyss Wellness Center **External Partners:** MOMs Demand Action, Think First, Unity in the community, the Lighthouse, Jackson Core, Black Men Run, Philadelphia School District, PHMC
Strategy/Action	**THINK FIRST** Think First is a free program through Magee Rehabilitation Center that stresses prevention by “thinking first” in order to avoid permanent brain and spinal cord injuries. The main message of the Think First program is that young people can have a fun, exciting life while taking precautions to avoid injury. To schedule a Think First presentation at your school or organization, contact Magee’s Think First Coordinator at knewerla@mageerehab.org or (215) 587-3412.
Target Population	Philadelphia County: 19102, 19103, 19106, 19107, 19121, 19122, 19123, 19124, 19125, 19130, 19132, 19133, 19134, 19140, 19145, 19146, 19147, 19148
Outputs	• Increase # presentations offered to youth

	• Increase # of internal and external partners
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 Collaborative for Health Equity (The Collaborative) Magee Rehab, Einstein, Jefferson Northeast, Wyss Wellness Center **External Partners:** MOMs Demand Action, Think First, Unity in the community, the Lighthouse, Jackson Core, Black Men Run, Philadelphia School District, PHMC

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