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2025 - 2028

# COMMUNITY HEALTH NEEDS ASSESSMENT IMPLEMENTATION STRATEGY

**Temple University Hospital  
& Chestnut Hill Hospital**

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# OVERVIEW OF COMMUNITY HEALTH NEEDS

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# Temple Health Community Commitment

## About Temple University Hospital (TUH) and Chestnut Hill Hospital (CHH)

As the chief clinical training site for the Lewis Katz School of Medicine at Temple University, Temple University Hospital is an 879-bed non-profit acute care hospital and academic medical center that trains the next generation of healthcare professionals. We are an indispensable provider of healthcare for America's largest city without a public hospital.

Temple University Hospital is designated as a Level 1 Trauma Center, is verified by the American Burn Association as a Burn Center and has a Neonatal Intensive Care Unit. Together with its affiliated Chestnut Hill Hospital and other campuses serving North, Northwest, and Northeast Philadelphia, it offers primary and tertiary care services to the surrounding communities.

Temple's Episcopal Campus offers behavioral health services, including a Crisis Response Center, an Emergency Department, a Substance Use Disorder Clinic and adult psychiatric care.

Temple's Hospital for Women and Families provides Labor and Delivery, Maternal and Neonatal Intensive Care units. Outpatient services offered include family medicine, pediatrics, mammography, ultrasound, nuclear medicine, and radiology. These services support the Philadelphia Department of Public Health's initiatives to reduce waiting times for doctor appointments, diagnostic imaging, radiologic treatments, and pediatric vaccinations.

Temple University Hospital's Jeanes Campus in Northeast Philadelphia provides inpatient and outpatient care, emergency services, and specialties including heart and vascular, neurology, orthopedics, pulmonology, and more. Chestnut Hill Hospital serves Northwest Philadelphia and Eastern Montgomery County with similar offerings: emergency care, minimally invasive surgery, cardiology, gynecology, oncology, orthopedics, primary care, women's health, and physical therapy. Both hospitals combine community hospital services with advanced academic medical center capabilities.

### Temple Health–Chestnut Hill

**Hospital** is a 148-bed freestanding, licensed acute care community hospital under a not-for-profit company owned and led by an alliance comprising Temple Health (which has 60 percent ownership of CHH), and Redeemer Health and Philadelphia College of Osteopathic Medicine—each with 20 percent ownership. This cooperative relationship strengthens the community hospital while bringing additional expertise, networks and academic support to its employees, physicians and patients.

Serving its community for more than 100 years, CHH has more than 350 board-certified physicians offering inpatient and outpatient services including emergency care, minimally invasive laparoscopic and robotic-assisted surgery, cardiology, gynecology, oncology, pulmonology, orthopedics, primary care practices, two Women's Centers, and an off-site physical therapy center.

Temple Health continues to add new academic-level specialty services to CHH, strengthening access to the world-class care of a university health system in a community setting close to home.

## Our Mission

Temple University Hospital provides access to the highest quality of healthcare in both community and academic settings. In furtherance of this mission, the hospital supports Temple University and its Health Sciences Center's academic programs by providing the clinical environment and service to support the highest-quality teaching and training programs for healthcare students and professionals and supports the highest-quality research programs. We embrace our values of Respect, Service and Quality.

The mission of Chestnut Hill Hospital is to provide compassionate, accessible, highest-quality, cost-effective healthcare to the community, to promote health, to educate healthcare professionals; and to participate in appropriate clinical research.



# Temple Health Premier Medical Services

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## Primary and Specialty Physician Practices

*Temple Physicians, Inc.* is a network offering primary care at over 40 locations. *Temple Faculty Practice Plan* provides specialty services such as emergency medicine, oncology, gastroenterology, obstetrics, orthopedics, neurosurgery, neurology, surgery, and psychiatry.

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### Temple Heart & Vascular Institute

The Heart & Vascular Institute provides clinical care, research, and education. The Institute includes 27 specialized programs and more than 100 cardiovascular staff members, some of whom have national recognition. Patients have access to minimally invasive procedures, mechanical assist devices, artificial hearts, and a range of surgeries, including complex hybrid procedures and multi-organ transplantation.

### Temple Lung Center

Temple is recognized internationally for its advancement of innovative therapies targeting lung diseases, including COPD and interstitial lung disease. With the nation's most extensive portfolio of clinical trials dedicated to non-cancer pulmonary conditions, Temple offers access to pioneering treatments.

### Transplant Program

Temple provides successful transplant programs for lungs, livers, kidneys, pancreases, and bone marrow. Our teams have developed advanced methods to enhance donor health and reduce complications.

### Digestive Disease Center

The Digestive Disease Center integrates advanced clinical practice with ongoing research initiatives, allowing for the implementation of cutting-edge techniques in managing complex conditions affecting the esophagus, stomach, small intestine, gallbladder, colon, and liver. The center's areas of expertise encompass colorectal surgery, esophageal disorders, bariatric surgery, gastrointestinal oncology, inflammatory bowel disease, motility disorders, and therapeutic endoscopy.

### Neurosciences Center

The Temple Neurosciences Center provides care for conditions affecting the brain, spine, and nerves. The center offers neurological programs focused on stroke, multiple sclerosis, epilepsy, movement disorders, neuromuscular disease, and amyotrophic lateral sclerosis (ALS). It includes the Muscular Dystrophy Association/ALS Center of Hope and a stroke program that has received national recognition.

### Orthopaedics & Sports Medicine

Temple's Orthopaedics and Sports Medicine team offers treatment for various injuries and conditions, including orthopaedics trauma, joint replacement, sports medicine, and physical therapy. The team utilizes current technology and minimally invasive techniques in combination with clinical experience and research to address a range of patient needs.

### Fox Chase Cancer Center

Temple Health's Fox Chase Cancer Center is a 100-bed hospital focused solely on cancer care, research, and prevention. Founded in 1904 and one of the nation's first cancer hospitals, it became an NCI-designated Comprehensive Cancer Center in 1974. FCCC treats all types of cancer and draws patients from the region, the U.S., and internationally. Its physicians also provide advanced cancer treatments at Temple University Hospital and Chestnut Hill Hospital.



# Temple Health Programs to Advance Community Health

## Providing Critical Resources

Each year, we connect thousands of individuals with free social supports such as transportation, legal services, and clothing. For those with financial constraints, assistance is available for co-pays and medical supplies during the transition to home after treatment.

## Connecting Patients with Financial Resources

Our Financial Services Department offers free or reduced-price care to qualifying patients as well as assistance obtaining government-funded and subsidized health insurance.

## Promoting Multi-Cultural Services

Our 400 bilingual staff perform thousands of interpretations each year for non-English-speaking patients and families.

## Reaching Out to Communities

We interact with local residents through outreach efforts, support groups, and educational programs covering topics such as substance use disorders, behavioral health, cancer, diabetes care, childbirth, and burn prevention. The **Community Health Worker Team** (CHW) provides home visits, helps schedule and attend doctor appointments, coordinates transportation, and links individuals to social support services.

Temple Health – Chestnut Hill Hospital sponsors the **Pastorius Park Summer Concert Series**, a 75-year tradition in Northwest Philadelphia. The concerts feature various music genres, and each event includes a medical talk with time for audience questions.



## Temple Women & Families Hospital

Temple Women & Families Hospital is Philadelphia's only hospital dedicated entirely to women's health and family care. Located at Wyoming and Castor Avenues, the hospital provides comprehensive services—including obstetrics, gynecology, maternity care, pediatrics, family medicine, and women's health specialties—all in one convenient location. With leading experts, a Baby-Friendly designation, and a Level III Neonatal Intensive Care Unit (NICU), Temple Women & Families Hospital delivers exceptional, accessible care for women and families across the Greater Philadelphia region.

## Responding to Community Behavioral Health Needs.

We provide free support groups for individuals and families affected by mental health or substance use issues. Our experts offer community training on crisis response, depression, suicide prevention, and more. Specialized virtual resources are available for anxiety, burnout, social isolation, and related concerns.

## Addressing the Opioid Epidemic

Our institution plays a pivotal role in confronting this significant public health challenge: 25% of our inpatient population is affected by substance-use disorders, and the drug overdose mortality rate within our service area is seven times higher than the national average, representing the highest opioid mortality rate in the City of Philadelphia. The **Temple Recovery Using Scientific Treatment** (TRUST) **Clinic** delivers accessible substance use disorder treatment, complemented by on-site peer recovery support and comprehensive case management services.

Our licensed outpatient **Substance Use Disorder Clinic** provides services to individuals with addiction and behavioral health diagnoses. The clinic includes support from Certified Recovery Specialists and offers walk-in appointments to facilitate coordinated care.

Temple Health partners with Project Home in the **Estadt-Lubert Collaborative**, focusing on helping individuals experiencing homelessness and opioid use disorder transition from hospital to housing.

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# Temple Health Programs to Advance Community Health

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## Advancing Maternal Health Outcomes

We provide expectant mothers with comprehensive education and support throughout pregnancy and beyond. Along with prenatal care information and classes on childbirth, breastfeeding, nutrition, postnatal recovery, and newborn care, Temple offers innovative tools and programs to promote maternal health. The LENA app keeps patients connected to their care plans through reminders, education, and milestones; **Perinatal Community Health Workers** (pCHWs) help high-risk patients navigate care and access needed resources; and integrated behavioral health services provide screening and support for prenatal and postpartum depression and anxiety. Free yoga classes, evidence-based lactation education as a Baby-Friendly USA designated facility, and our **SAFE@Temple program** on safe infant sleep practices further promote wellness for mothers and families.

## Prevailing Over Cancer

We provide free breast, prostate, and other cancer screenings both on-site and in local neighborhoods. Through our partnership with the Fox Chase Mobile Screening Unit, we make screenings accessible to North Philadelphia residents and beyond. We also deliver community education on cancer risks, symptoms, screening, and treatment for at-risk groups.

## Reimagining Patient Care

Our **Multi-Visit Patient Clinic** delivers comprehensive care for patients frequently using emergency and inpatient services. After discharge, we arrange follow-up care and offer meals, transport, home visits, and social support.

## Addressing Public Health Impact of Violence

Our **Healing Through Work** program, a partnership with the Pennsylvania Commission on Crime and Delinquency, links gun violence victims to employment to reduce recurring violence. **Cradle to Grave** partners with local agencies to reach at-risk youth and prevent violence. **Fighting Chance** trains community members in basic first aid for gunshot wounds. Our **Trauma Victim Advocate Program** supports trauma patients and their families from hospital admission to discharge. Advocates connect victims with services for relocation, wage recovery, medical bills, mental health, and other post-trauma needs.

## Engaging Patients & Families

The **Patient Family and Community Advisory Councils** address community health needs, including access to primary and specialty care as well as chronic disease management. These councils involve patients, families, and community members in the evaluation of patient satisfaction across different clinical areas.

## Responding to Food Insecurity

Our **Farm to Families** initiative delivers affordable, fresh produce to North Philadelphia families, aiming to reduce obesity, food insecurity, heart disease, and diabetes. Families can use SNAP and a Temple doctor's "prescription" to buy local fruits and vegetables. Jeanes Campus hosts a seasonal farm market, while Episcopal Campus offers a weekly free pantry with produce, dairy, meats, and canned goods.

## Developing Tomorrow's Frontline Workforce

Our support for the 1199C Training and Upgrade Fund's **Community Health Workforce Program** equips community members with skills in nursing, behavioral health, childcare, Information Technology and related fields.

The **Technical Education and Careers in Healthcare** (TEACH) program, in collaboration with the Philadelphia School District, provides paid internship opportunities for high school seniors. We actively recruit from local schools and offer students exposure to positions in outpatient rehabilitation, supply chain management, dietary services, patient transport, environmental services and more.

The **Nursing Scholars Program** provides loan sponsorship for students who are applying to or are currently enrolled in an RN or CRNA program, contingent upon a commitment to employment with Temple Health following graduation.

During **Temple Health Career Exploration Days**, we encourage 5th to 8th graders from Bethune and Kenderton schools to explore future careers through hands-on workshops covering CPR, DNA, ultrasound, airway management, surgical skills, vital signs, patient transport, hospital environmental science, and pharmacy.

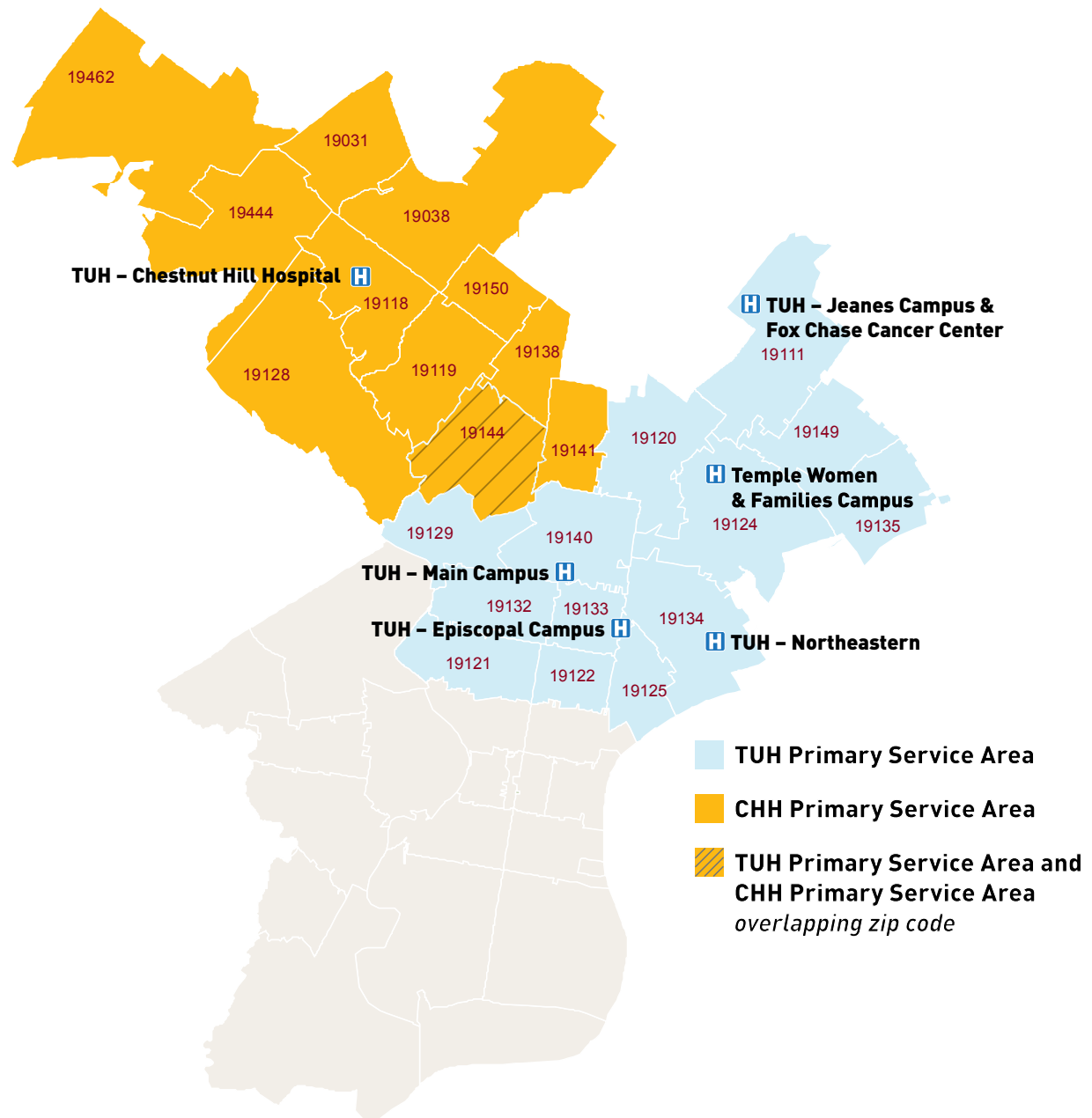


# Community Health Needs Assessment for TUH and CHH

## Community Definition for TUH and CHH

**Temple University Hospital's** targeted service area for community health improvement is comprised of 14 zip codes: 19111, 19120, 19121, 19122, 19124, 19125, 19129, 19132, 19133, 19134, 19135, 19140, 19144, and 19149. **Chestnut Hill Hospital's** targeted service area is comprised of 11 zip codes: 19031, 19038, 19118, 19119, 19128, 19138, 19141, 19144, 19150, 19444, and 19462. These are the zip codes from which about 70% of our patients are seen on an inpatient and observation basis. See below maps for these contiguous service areas.

Below is a map of service the **Temple University Hospital** and **Chestnut Hill Hospital** targeted service area for community health improvement (service area), including a list of zip codes that comprise these service areas. The Community Health Needs Assessment (CHNA) generally breaks down this service area into six sections: Far North Philadelphia, Lower Northeast Philadelphia, North Philadelphia East, North Philadelphia West, Northwest Philadelphia and Riverwards.





# Community Health Needs Assessment for TUH and CHH

In planning for the Community Health Needs Assessment, we considered input from people who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health.

In completing our CHNAs, we engaged in a regional collaborative effort led by the **Health Care Improvement Foundation (HCIF)**, which is a representative of Temple Health serves. HCIF works with organizations to improve quality of care, patient safety, and population health issues such as: COVID-19, maternal child health, re-admissions, cancer, workplace violence, food security, trauma-informed practices, health literacy and other health challenges. HCIF is led by key stakeholders in Southeastern Pennsylvania's healthcare delivery system including representatives of Temple Health, Penn Medicine, Main Line Health, Redeemer Health, Geisinger, the Health Federation of Philadelphia, the Institute of Healthcare Improvement, Independence Blue Cross, Philadelphia Corporation of Aging, the School District of Philadelphia and others.

To ensure that the concerns of those living in the immediate neighborhoods served by each of our hospital campuses are reflected in the CHNA, we invited our partnering community organizations to participate in the focus group sessions led by HCIF. These focus groups centered on certain "spotlight" topics guided by previous CHNA priorities and input from community partners. Topics of discussion included care for the uninsured, providing

culturally appropriate mental health care, housing needs, maternal health, care for older adults, primary care access, and the integration of health and social services.

For more details, view the  
**Community Health Needs Assessment.**

**Temple University  
Hospital**



[templehealth.org/  
community-health-needs](https://templehealth.org/community-health-needs)

**Chestnut Hill  
Hospital**



[templehealth.org/CHH-  
community-health-needs](https://templehealth.org/CHH-community-health-needs)

## Findings and Community Feedback

A survey of community members within the TUH service area identified the most significant adult health concerns as diabetes and high blood sugar, mental health issues, age-related illnesses, chronic pain and pain management, heart conditions, drug use, alcohol use, anxiety, depression, substance use disorder, and violence. Supporting data for the Community Health Needs Assessment indicate that the primary causes of death in the TUH service area are heart disease, cancer, accidental poisoning—including unintentional drug or alcohol fatalities—and cerebrovascular disease.



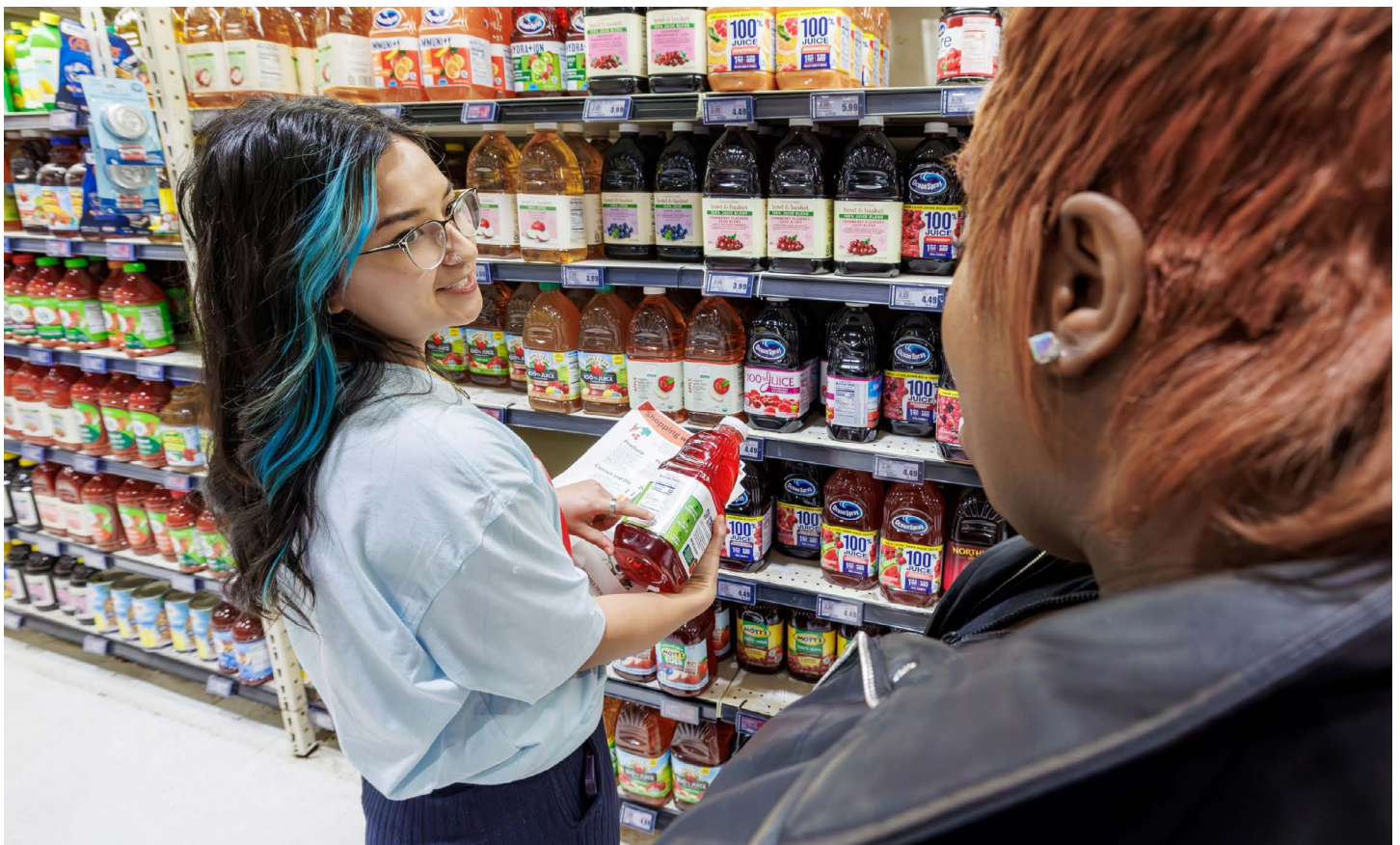


# Implementation Strategy Process for TUH and CHH

Upon completion of our 2025 Community Health Needs Assessment (CHNA), TUH and CHH's leadership formed an Implementation Strategy Team (Team) to guide development of our 2025-2028 Implementation Strategy. The Team began by reviewing needs identified by the 2025 CHNA. Using a consensus-building process, the Team identified health priorities based on the following factors:

| Root Cause                   | Internal Capacity                                                                          | Strategic Alignment                                                                           | Community Capacity                                                  | Community Importance                                                     |
|------------------------------|--------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------|
| Root cause of priority issue | Our capacity to respond, including Temple Lewis Katz School of Medicine academic resources | Alignment with our mission and strategic priorities to improve healthcare access and outcomes | External resources of TUH and CHH community and capacity to respond | Importance to community and public health consequences of not responding |

The Team collaborated with internal and external partners to create implementation plans detailing goals, actions, and TUH and CHH resources for each priority. Over the next three years, alongside Temple's Center for Population Health and Lewis Katz School of Medicine, we will pursue shared public health objectives, track results, make adjustments as needed, and provide annual updates.



# IMPLEMENTATION PLANS ADDRESSING HEALTH PRIORITIES

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## Health Priorities

Our Implementation Strategy focuses on the six below priority areas that are interrelated with the health needs identified in our 2025 Community Health Needs Assessment. Our latest CHNA builds upon previously identified health needs using more recent data and community input. Our priorities were selected through our implementation strategy process. Over the next three years, we will continue to review and expand programs and interventions based on the findings of our CHNA.

As shown on the map on page 6 of this document, TUH and CHH serve contiguous service areas. As a small community hospital, CHH has limited resources to address all of the identified health priorities. To ensure needs are met, Chestnut Hill Hospital is collaborating closely with its academic medical center partner Temple University Hospital and its affiliated Temple Center for Population Health and Fox Chase Cancer Center.



### Access to Primary and Specialty Care



### Mental Health Access



### Substance Use and Related Disorders



### Chronic Disease Prevention and Management



### Maternal, Infant and Child Health



### Violence Prevention and Intervention



# Expand Access to Community-Embedded Primary Care for TUH

**Plan Rationale:** Philadelphia communities continue to experience significant barriers to timely, high-quality primary care. Residents face disproportionate rates of chronic disease, maternal health disparities, and barriers related to transportation, insurance coverage, and other health-related social needs. To address these challenges, Temple Faculty Physicians (TFP) and Temple Health are expanding primary care access into community-anchored and patient-centered locations. The first is a partnership with Zion Baptist Church to build a state-of-the-art family medicine practice inside the Rev. Leon H. Sullivan Community Impact Center. This partnership will integrate health services with broader programs in education, workforce, and community empowerment. The second is at Temple Health's new Women & Families Hospital where we can serve parents and infants to ensure access to comprehensive family-centered care.

## Health Improvement Goals

1. Increase access to comprehensive, community-based primary care
2. Improve maternal and child health outcomes through integration of family-focused primary care
3. Reduce reliance on emergency departments for non-emergent needs
4. Advance community health by embedding care in trusted community institutions

## Action Plans

1. Launch new primary care practice within the Rev. Leon H Sullivan Community Impact Center, including construction of space
2. Conduct community focus groups and interviews to inform care design for family medicine services in the Impact Center
3. Open primary care services at the Women & Families Hospital
4. Embed community health workers and social workers to address transportation, insurance enrollment, and social support barriers

## Metrics

1. Number of patients seen at new Zion and Women & Families sites
2. Average wait time for new patient appointments
3. No-show rates across both new practices
4. Number of patients referred to a CHW or social worker to address health-related social needs

## Objectives Tied to Metrics

1. Expand the number of patients connected to primary care through the new Impact Center and Women & Families sites
2. Improve appointment availability and reduce wait times for new patients
3. Strengthen parental and child health by increasing linked patient care
4. Enhance continuity of care and patient experience through integration with community partners

### Executive Sponsors:

Claire Raab, MD, President and Chief Executive Officer, Temple Faculty Physicians  
Nina O'Connor, MD, Chair, Department of Family & Community Medicine, Interim Chair, Department of Pediatrics

### Internal Implementation Team:

Department of Family & Community Medicine  
Department of Pediatrics  
Community Health Worker Team  
Ambulatory Operations Teams  
Marketing Department

### Community Participants:

Zion Baptist Church and Called to Serve Community Development Corporation  
Pennsylvania Department of Human Services (Medicaid enrollment and coverage support)



## Expand Access to Community-Embedded Primary Care for TUH

### Communication Plan

- Internal communication through provider town halls, staff meetings, and digital announcements
- External communication through press releases and community meetings at Zion Baptist Church
- Engagement of faith-based organizations and neighborhood associations to ensure awareness and trust
- Digital and social media campaigns highlighting the availability of new services

### Resources Committed

- Hiring of eight new primary care physicians
- Hiring of an additional two primary care physicians
- Dedicated nursing, medical assistant, and community health worker support staff
- Budget allocation for facility construction at Rev. Leon H. Sullivan Impact Center and clinic space at the Women & Families Hospital
- Grant funding as available
- Other departmental budgets



# Appointment Redesign and Coordination to Improve Access to Care for TUH and CHH

**Plan Rationale:** One of the most significant health barriers our patients face is the inconsistent way they must schedule appointments across primary and specialty care. These challenges stem from variable, non-integrated scheduling logic—often referred to as “decision trees”—within the electronic health record (EHR). Our goal is to redesign these decision trees into a unified scheduling structure across Temple University Health System (TUHS). This new framework will support multiple points of entry for scheduling—such as online self-scheduling—while providing consistent and coordinated workflows across sites. By creating standardized and integrated scheduling templates, we can make the process easier for patients, reduce wait times, and improve appointment availability.

## Health Improvement Goal

The goal of this initiative is to build a unified, patient-centered scheduling system across TUHS that improves access, reduces barriers to care, and enhances the overall patient experience. In the short term, the plan aims to standardize scheduling logic across primary and specialty care, expand digital self-scheduling options, reduce unnecessary call transfers, and streamline the efficiency and consistency of appointment booking. Over the longer term, this work is designed to achieve sustained reductions in wait times, establish multiple equitable entry points for scheduling, and improve continuity of care through higher appointment completion and lower no-show rates. Ultimately, these changes will strengthen patient satisfaction and loyalty while also improving organizational performance by minimizing referral leakage and optimizing capacity across the system.

## Action Plans

1. Develop a TUHS-wide digital self-scheduling platform that is mobile-friendly, available in multiple languages, and accessible for patients with disabilities (ADA-compliant design)
2. Introduce targeted outreach campaigns such as text reminders and nurse and/or community health worker navigation for patients with higher risk of missed appointments
3. Use existing patient navigator and social work programs to assist high-risk patients (e.g., older adults, Medicaid patients, those with multiple chronic conditions) in securing timely appointments

## Metrics

1. Average wait time to next available appointment by department
2. Percentage of appointments booked online/self-scheduled
3. Call transfer percentage
4. Percent of booked appointments that convert to completed
5. Appointment completion rate by scheduling pathway
6. Patient satisfaction score on access/scheduling

## Objectives Tied to Metrics

1. Improve access and reduce barriers to timely care
2. Expand convenient entry points for patients
3. Ensuring patients are connected to the correct destination on their first call
4. Ensure ease of scheduling is resulting in actual visits
5. Evaluate equity and performance of each channel (phone, online, in-clinic)
6. Enhance patient experience and build loyalty

### Executive Sponsors:

Claire Raab, MD, President  
and Chief Executive Officer,  
Temple Faculty Physicians  
Abhi Rastogi, Executive Vice  
President of Temple University  
Health System and President and  
Chief Executive Officer Temple  
University Hospital, Inc.

### Internal Implementation Team:

Information Technology  
Temple Faculty Physicians  
Temple University Hospital  
Temple Physicians, Inc.  
Chestnut Hill Hospital  
Fox Chase Medical Group  
Fox Chase Cancer Center  
Marketing Department



## **Appointment Redesign and Coordination to Improve Access to Care for TUH and CHH**

### **Communication Plan**

- Feedback loop via patient experience survey and call center staff, patient schedulers, and care navigators
- Patient-facing campaigns (website banners, MyTempleHealth portal messages, clinic posters, SMS reminders) to announce new self-scheduling tools
- Develop tip sheets, FAQs, and short video tutorials for patients on how to use online/self-scheduling
- Use patient advisory councils to gather feedback on barriers and satisfaction

### **Resources Committed**

- Temple Faculty Physicians and Information Technology budgets



# Improve Access to Incidental Finding Follow-up and Cancer Care for TUH

**Plan Rationale:** Patients in our community often receive radiology imaging for reasons unrelated to cancer, and some studies reveal incidental findings for possible cancer. For many of our patients—particularly those with significant health-related social needs, limited or no insurance, and high no-show risks—these findings frequently fall through the cracks. Without coordinated follow-up, delays in diagnosis and treatment worsen outcomes and exacerbate gaps in healthcare. Indeed, patients in the communities that Temple Health serves present in the later stages of cancer when compared to the national average. This initiative creates a structured pathway to rapidly connect patients with an internal medicine physician and/or advanced practice provider (APP) who will function as the navigator and central point of contact. By consolidating communication and coordination, the program minimizes the number of encounters required from the patient to ensure expedited movement to appropriate specialty care and improve cooperation with care.

## Health Improvement Goal

1. Increase the proportion of patients with concerning incidental findings who receive diagnostic evaluation
2. Improve access and continuity of care for patients facing significant health-related social needs, limited/no insurance, and high no-show risk
3. Increase patient adherence to follow-up appointments by reducing system complexity and addressing barriers

## Action Plans

1. Pathway for emergently routing to a designated internal medicine physician/ APP “navigator” for incidental findings concerning for cancer
2. Pathways for physician and APP to have case collaboration with subspecialties
3. Coordinate directly with specialty teams to reserve “fast-track” slots for expedited appointments
4. Integrate community health workers to address barriers such as transportation and insurance enrollment

## Metrics

1. Average time to contact with physician or APP
2. No-show percentage
3. Average time from incidental findings to diagnosis
4. Percent of patients with cancer diagnosis
5. Average time to first treatment

## Objectives Tied to Metrics

1. Ensure rapid engagement of patients with incidental findings by reducing the time between imaging and first navigator/clinician contact
2. Improve appointment adherence for high-risk patients by reducing no-show rates through navigation, social support, and flexible scheduling
3. Expedite diagnostic workup for patients with concerning findings to shorten time to confirmed diagnosis
4. Accurately identify and link patients with true malignancies to appropriate care while minimizing drop-off for benign cases
5. Reduce treatment delays and improve equity in cancer care initiation by ensuring patients move quickly from diagnosis to first treatment

### Executive Sponsors:

Claire Raab, MD, President  
and Chief Executive Officer,  
Temple Faculty Physicians

### Internal Implementation Team:

Temple Faculty Physicians  
Community Health Worker  
Program  
Patient Financial Counseling

### Community Participants:

Local Federally Qualified Health  
Centers (FQHCs)  
Health Federation of Philadelphia  
Local independent physician  
groups  
Community organizations  
addressing health-related  
social needs



## **Improve Access to Incidental Finding Follow-up and Cancer Care for TUH**

### **Communication Plan**

- Direct outreach to both internal and external providers during meetings with Temple Health departments, FQHC providers, and other community physician groups
- Written communication will be provided with one-page flyers describing the program and regular updates with “success” cases

### **Resources Committed**

- Departmental budgets



# Expand Access to Care Through Healthy Together Initiatives for TUH and CHH

**Plan Rationale:** Improving access to health care through our Healthy Together initiatives, located at the local supermarket and delivered through the mobile health van, is essential to supporting our uninsured and underinsured community members. Our goal is to build trusted relationships that promote routine screenings, early detection, and appropriate follow-up care. This approach helps individuals receive the medical services they need to live healthier, more productive lives.

## Health Improvement Goal

1. Strategically position Temple Health to accurately identify the health-related social needs that contribute to disparities among uninsured and underinsured community members. This will be achieved through the Healthy Together initiatives at the supermarket hub located in CHH and TUH's community and mobile health unit
2. Expand and improve staff continuing education on trauma-informed approaches for assessing health-related social needs
3. Staff confidence and competence in collecting comprehensive data related to health-related social factors to better understand and meet the needs of the community served by Health Together
4. Identify and address non-medical barriers such as poverty, transportation and food insecurity which prevent our community from accessing screenings and follow-up care through the Healthy Together initiatives

## Action Plans

1. Lead and participate in culturally appropriate community events, connecting community members with the resources they need. Utilize a model involving nurses and community health workers to actively engage community members in meaningful discussions about healthy lifestyle choices. This approach should include conducting screenings to identify unmanaged chronic conditions such as hypertension, diabetes, and obesity
2. Develop a referral protocol that links patients with positive screenings to Temple clinics or partner providers for follow-up care
3. Consult trusted community advisors to design and implement nurse and community health worker services specifically for the Healthy Together initiatives, maximizing community participation and benefits
4. Leverage the expertise of Temple Health's ecosystem to engage credible messengers who can provide education in a trauma-informed manner
5. Collaborate with trusted local health systems, managed care organizations, social service providers, and faith-based or community-based organizations that offer resources such as housing, food, transportation, and internet access
6. Promote the use of the Temple Community Health Connect (Findhelp) community resource directory among both internal staff and external stakeholders

## Metrics

1. Number of community events participated in
2. Number of community members engaged
3. Number of community members screened
4. Number of community members requiring follow-up
5. Number of individuals referred to primary care
6. Patient satisfaction rating

(continued on next page)

### Executive Sponsors:

Steve Carson, MHA, BSN, RN,  
Senior Vice President, Temple  
Center for Population Health  
Lakisha Sturgis, MPH, BSN, RN,  
CPHQ, Director, Community Care  
Management, Temple Center for  
Population Health

### Internal Implementation Team:

Temple Center for Population  
Health  
Marketing Department  
Lewis Katz School of Medicine  
School of Public Health  
Fox Chase Cancer Center

### Community & Government Partners:

Shoprite of Fox Street  
Philadelphia Partnership for  
Nutrition and Health (PPNH)  
Regional health insurance plans  
Local Social Service & Other  
Community Organizations



## Expand Access to Care Through Healthy Together Initiatives for TUH and CHH

### Objectives Tied to Metrics

1. Increase outreach by participating in community events aligning with community-based organizations and stakeholders
2. Maintain community engagement through meaningful interactions promoting health
3. Identify undiagnosed conditions by screening 10% of the community at Healthy Together–ShopRite
4. Identify 100% of community members with potential health risks early and ensure timely follow-up for continued care
5. Facilitate seamless access to healthcare by increasing appropriate referrals from screenings to primary care providers, improving continuity of care for at least 50 individuals
6. Maintain or improve patient satisfaction by delivering quality, respectful and efficient services during community events and screenings

### Communication Plan

- Actively distribute eye-catching flyers promoting our disease-specific program at Healthy Together–ShopRite to engage the community
- Collaborate with the marketing department to enhance our web page and HUB, ensuring they prominently feature all participating community events
- Energize our internal staff by sharing the impactful details of our Healthy Together initiative to foster awareness and participation

### Resources Committed

- Funds and staffing from the budgets of the Temple Center for Population Health and grant funding as available



# Increase Availability and Ease of Access to Behavioral Health Services for TUH and CHH

**Plan Rationale:** This plan addresses community concerns identified through the recent and comprehensive Community Health Needs Assessment (CHNA) specific to the availability of and access to behavioral health services. The CHNA notes a shortage of mental health providers and persistent stigma, especially in ethnic minority groups. Concerns include the overlap of mental illness, substance use, and homelessness. Participants recommend integrating mental and physical health care at clinical sites.

## Health Improvement Goal

1. Implement effective strategies that increase availability, knowledge of and ease of access to behavioral health services

## Action Plans

1. Open newly expanded and renovated Crisis Response Center
2. Execute new payor contracts with insurance companies
3. Develop outpatient behavioral health clinic on the Episcopal Campus to serve chronically mentally ill patient population
4. Strengthen psychiatry consultation and liaison services throughout Temple University Health System (TUHS)
5. Strengthen referral systems within hospitals and social service agencies to ensure linkage to care
6. Obtain regulatory approval for provision of opioid treatment program
7. Explore opportunities to stand up services and additional levels of care in the behavioral health services continuum (ex: intensive outpatient program, partial hospitalization program) both within TUHS and via collaborations with community partner organizations

## Metrics

1. Number of individuals receiving behavioral health services
2. Readmission rates
3. Provider capacity for new and follow-up appointments

## Objectives Tied to Metrics

1. Improve awareness of available behavioral health services as evidenced by number of newly registered behavioral health patients
2. Increase number of individuals receiving behavioral health services as evidenced by total behavioral health encounters at all levels of care
3. Monitor ease of access as evidenced by wait times for new and follow-up appointments, hours on diversion
4. Improve individual reported perceptions of care as evidenced by patient satisfaction survey data
5. Reduce hours of divert status with Crisis Response Center

### Executive Sponsors:

Kevin Caputo, MD, Chief Medical Officer, Temple University Hospital (TUH)—Episcopal Campus  
John Robison, Executive Director, TUH—Episcopal Campus

### Internal Implementation Team:

Leadership team of TUH Episcopal Campus, TUH Main Campus and CHH  
Departments of Psychiatry and Addiction Medicine

### Community & Government Partners:

Various community-based behavioral health providers  
City of Philadelphia Department of Behavioral Health & Intellectual Disabilities Services  
PA Department of Health



## **Increase Availability and Ease of Access to Behavioral Health Services for TUH and CHH**

### **Communication Plan**

- Share updates during leadership and departmental meetings to reinforce accountability and celebrate milestones
- Post progress metrics, program updates, and success stories on the intranet and visual dashboards accessible to leadership and staff
- Maintain an updated website dedicated to promotion of and education about accessing behavioral health services
- Disseminate information specific to promotion of and education about accessing behavioral health services through community partners
- Share progress publicly through stories that highlight impact, build trust, normalize help-seeking behavior and inform about pathways to access behavioral health services

### **Resources Committed**

- Departmental budgets and grants as available



# Address Substance Use Disorder in the TUH and CHH Communities

**Plan Rationale:** This plan addresses the community's persistent concerns about substance use, particularly the opioid epidemic, and its close association with co-occurring mental illness, youth vulnerability, and perceptions of poor neighborhood safety. The Community Health Needs Assessment highlights that overdose rates remain high, yet community-based treatment and recovery services are viewed as insufficient, difficult to access, and not well-publicized. Barriers include limited awareness of existing services, fragmented care for co-occurring disorders, and a lack of prevention and early intervention efforts targeting youth.

## Health Improvement Goal

### Short-Term Goals:

1. Develop and implement a community outreach strategy to increase awareness of available substance use and mental health services
2. Strengthen referral pathways between healthcare providers and community-based organizations (CBOs) to improve access to treatment
3. Pilot integrated care approaches addressing co-occurring substance use and mental health disorders

### Long-Term Goals:

1. Reduce community overdose rates through expanded prevention, treatment and recovery supports
2. Improve perceptions of neighborhood safety by reducing substance use-related harms and strengthening community partnerships
3. Increase utilization and visibility of recovery services so they are recognized, trusted and accessible across the community

## Action Plans

### Leverage Existing Programs and Services

- Expand visibility of current substance use and mental health services through culturally tailored outreach campaigns in high-need neighborhoods
- Train frontline staff in trauma-informed care practices to reduce stigma and barriers in underserved populations
- Strengthen referral systems within hospitals and social service agencies to ensure underserved populations are linked to timely care

### Develop New Programs and Services

- Increase utilization and presence of integrated care teams that address co-occurring substance use and mental health conditions in community-based settings
- Increase integration of services into low-barrier access points for treatment and recovery services in underserved areas
- Create new services to treat patients with addiction

### Strengthen Community Partnerships

- Partner with CBOs to reach populations disproportionately impacted by substance use and poor neighborhood safety
- Collaborate with law enforcement and community safety coalitions to align harm reduction efforts with public safety strategies
- Engage people with lived experience in advisory roles to guide program development and ensure services reflect community needs

### Executive Sponsors:

John Robison, Executive Director,  
TUH—Episcopal Campus  
Daniel DelPortal, SVP, Chief  
Clinical Officer, Temple Health

### Internal Implementation Team:

Addiction Medicine Service Line  
Temple Marketing Department

### Community &

### Government Partners:

Various community-based  
organizations (addiction  
providers, housing providers)  
Medicaid Managed Care  
Organizations  
City of Philadelphia (DBHIDS,  
Office of Addiction Services,  
SUPHER, Office of Homeless  
Services)

Commonwealth of Pennsylvania  
(DDAP, DOH, OHMSAS)



# Address Substance Use Disorder in the TUH and CHH Communities

## Metrics

### 1. Access & Awareness

- a. Number of community members reached through marketing campaigns
- b. Increase in awareness of available services as measured by community survey data
- c. Number of referrals made to substance use and mental health programs

### 2. Service Utilization & Capacity

- a. Increase in enrollment in community-based treatment and recovery programs
- b. Utilization rates of new or expanded services

### 3. Health Outcomes

- a. Increase in best-practice treatment of substance use disorders
- b. Increase in participants placed in housing programs

### 4. Community Impact

- a. Increase in services located in or accessible to underserved neighborhoods
- b. Improvement in community perceptions of neighborhood safety

## Objectives Tied to Metrics

### 1. Access & Awareness

- a. Improve awareness of available substance use and mental health services by 20%

### 2. Service Utilization & Capacity

- a. Increase enrollment in treatment and recovery programs by 10% annually
- b. Reduce average wait times for treatment services to fewer than seven days

### 3. Health Outcomes

- a. Increase successful warm handoffs by 10% annually
- b. Increase participants in housing program by 10% annually

### 4. Community Impact

- a. Engage at least 500 individuals from underserved or high-risk populations annually in treatment, prevention or recovery services
- b. Improve community-reported perceptions of neighborhood safety by 15% within five years

## Communication Plan

### Internal Communication

- Staff Briefings & Training: Provide regular updates to clinical staff, case managers and outreach workers through training sessions to ensure alignment with program goals and referral processes
- Intranet & Dashboards: Post progress metrics, program updates and success stories on the internal intranet and visual dashboards accessible to leadership and staff
- Leadership Engagement: Share updates during leadership and departmental meetings to reinforce accountability and celebrate milestones

### External Communication

- Community Outreach: Launch multilingual, culturally relevant campaigns via marketing channels to increase awareness of services
- Public Website & Hotline: Maintain an updated website and dedicated phone line that clearly lists available services, locations, eligibility and referral information
- Partnership Channels: Disseminate information through community partners to reach high-risk populations
- Success Stories & Transparency: Share progress publicly through stories that highlight impact, build trust and normalize help-seeking behavior

## Resources Committed

- Departmental budgets and grant funding as available



# Enhance Patient & Family Engagement Through the Diabetes Prevention Program (DPP) for TUH and CHH

**Plan Rationale:** Diabetes and poorly managed chronic conditions contribute significantly to preventable hospitalizations, reduced quality of life, and increased healthcare costs. The DPP provides evidence-based lifestyle interventions to prevent or delay the onset of type 2 diabetes, while the Nurse Navigation Program ensures coordinated, patient-centered care transitions across inpatient, outpatient, and post-acute settings. By embedding nurses within the hospital, primary care practices, and post-acute facilities, and by engaging patients and families in program design and evaluation, these initiatives aim to improve access to care, enhance chronic disease management, and promote sustained lifestyle changes.

## Health Improvement Goal

### Short-Term Goals:

1. Develop and implement a comprehensive outreach strategy to increase awareness of the Diabetes Prevention Program (DPP) and Nurse Navigation services among patients, families, and community members
2. Standardize processes and workflows for Nurse Navigation across inpatient, primary care, and post-acute settings to ensure consistent patient and family engagement
3. Establish structured feedback mechanisms with the Patient, Family, and Community Advisory Councils to inform program enhancements

### Long-Term Goals:

1. Expand access to preventive and chronic disease management services, reducing barriers such as transportation, language, and technology access
2. Improve patient outcomes by reducing avoidable readmissions and emergency department visits for patients with or at risk for chronic conditions
3. Strengthen partnerships between healthcare providers, patients, families, and community organizations to sustain engagement and support ongoing population health improvements

## Action Plans

### DPP:

1. Expand outreach to patients at risk for type 2 diabetes through provider referrals, community events, and patient portal messaging
2. Incorporate patient and family feedback into program delivery and scheduling to improve participation and retention
3. Launch a Peer Ambassador Program by recruiting and training past DPP graduates to serve as mentors and advocates

### Nurse Navigation:

1. Create a care transition road map for patients and families that includes timelines for each stage (e.g., inpatient stay, discharge process, follow-up calls, outpatient visits) and identify who the patient/family can contact at each step
2. Standardize Nurse Navigator workflows across hospital, primary care, and post-acute settings to ensure continuity of care
3. Develop patient-friendly educational materials on chronic disease management and available community resources
4. Create a patient satisfaction survey specifically for navigated patients

### Executive Sponsors:

Steven Carson,  
SVP Population Health  
Meaghan Kim,  
AVP Population Health

### Internal Implementation Team:

Community Health Workers Team  
Primary Care Providers  
Marketing  
Diabetes Education Team  
Quality Improvement Team

### Community &

### Government Partners:

Frazier Family Coalition  
American Diabetes Association  
Local Federally Qualified  
Health Centers (FQHCs)  
Managed care organizations  
(e.g., Medicaid, Medicare  
Advantage plans)



# Enhance Patient & Family Engagement Through the Diabetes Prevention Program (DPP) for TUH and CHH

## Metrics

### DPP:

1. Number of patients enrolled per quarter
2. Program completion/graduation rate (%)
3. Average weight loss (%) and physical activity minutes per week
4. Number of active cohorts

### Nurse Navigation:

1. 30-day readmission rate (overall and for chronic conditions)
2. ED utilization rate for navigated patients
3. Percentage of navigated patients completing all recommended follow-up appointments within 30 days of discharge
4. Patient satisfaction scores

## Objectives Tied to Metrics

1. Achieve at least a **7% increase in DPP enrollment** compared to the previous year
2. Attain a **65% DPP completion rate** among enrolled participants
3. Reduce **30-day readmissions by 5%** for navigated patients within 12 months
4. Establish baseline for patient satisfaction scores for navigated patients.
  - Improve patient satisfaction scores related to care coordination by **10%** year-over-year

## Communication Plan

- Quarterly progress updates shared at Patient, Family, and Community Advisory Council meetings
- Regular feedback loops with patients and families to incorporate suggestions into program design
- Internal dashboards for leadership and staff to track metrics
- Success stories featured in hospital newsletters, website, and community forums

## Resources Committed

- Dedicated Nurse Navigators embedded in hospital, primary care, and post-acute settings
- Certified Lifestyle Coaches for DPP delivery
- Data analytics for metric tracking and reporting
- Departmental budgets and grant funding as available



# Enhance Access, Outcomes and Engagement Through the Multi-Visit Patient (MVP) Clinic at TUH

**Plan Rationale:** The MVP Clinic addresses the needs of high-utilization patients with frequent emergency department visits or recent hospitalizations by providing coordinated, multidisciplinary, and patient-centered outpatient care. The program reduces avoidable acute care utilization, improves chronic disease management, and strengthens care transitions. Given policy changes, rising chronic disease burden, and continued disparities in access for uninsured patients, this plan focuses on expanding reach, accelerating post-discharge follow-up, enhancing patient/family engagement, and integrating value-based care strategies.

## Health Improvement Goal

### Short-Term Goals

1. Increase enrollment of high-utilization patients through targeted outreach and inpatient care team integration
2. Improve post-discharge continuity by ensuring timely outpatient follow-up
3. Expand educational resources for patients and families on managing chronic conditions

### Long-Term Goals

1. Reduce acute care utilization among enrolled patients by addressing medical, social, and behavioral health needs
2. Strengthen PCP continuity for MVP Clinic graduates to support long-term health management
3. Integrate MVP Clinic workflows into system-wide value-based care pathways

## Action Plans

### Expand High-Risk Patient Enrollment

- Collaborate with inpatient care teams to identify eligible patients ( $\geq 2$  ED visits or  $\geq 1$  inpatient stay in past 90 days)
- Conduct real-time bedside engagement for eligible patients before discharge

### Accelerate Post-Discharge Follow-Up

- Prioritize scheduling MVP Clinic visits within seven days of discharge for all referrals
- Implement reminder calls/texts to patients and caregivers to increase attendance

### Strengthen PCP Conversion

- Standardize handoff workflows for MVP graduates transitioning to primary care
- Use shared care plans and co-management templates between MVP Clinic and PCPs

### Enhance Patient & Family Education

- Launch condition-specific education protocols (CHF, COPD, diabetes) with visual and plain-language materials
- Engage family members in education sessions to support self-management

### Executive Sponsors:

Daniel DelPortal, MD,  
Chief Clinical Officer  
Dharmini Shah Pandya, MD,  
Vice Chair, Quality, Safety  
and Innovation, Department  
of Medicine  
Steven Carson,  
SVP Population Health  
Meaghan Kim,  
AVP Population Health

### Internal Implementation Team:

Community Health Workers  
(CHW) Team  
MVP Care Providers  
Social Workers (SW)  
Population Health Data

### Community & Government Partners:

Local food banks  
and housing support  
Local Federally Qualified Health  
Centers (FQHCs)  
Managed care organizations  
(e.g., Medicaid, Medicare  
Advantage plans)



# Enhance Access, Outcomes and Engagement Through the Multi-Visit Patient (MVP) Clinic at TUH

## Boost Multidisciplinary Communication

- Conduct monthly case reviews with CHWs, SWs, and medical providers to coordinate care plans
- Implement shared documentation templates to streamline communication

## Integrate Value-Based Care Pathways

- Implement a CHF readmission reduction pathway aligned with value-based contracts
- Track pathway outcomes for reporting to payers and leadership

## Metrics

1. Number of patients served by MVP Clinic
2. ED utilization (90 days post-enrollment vs. 90 days pre-enrollment)
3. Inpatient utilization (90 days post-enrollment vs. 90 days pre-enrollment)
4. Percentage of outpatient follow-up visits completed within seven days of discharge
5. PCP conversion rate for MVP graduates
6. Education protocol utilization rate during visits

## Objectives Tied to Metrics

1. Increase MVP Clinic patient volume by 25% this year
2. Reduce ED and inpatient utilization by 10% within 90 days of enrollment
3. Achieve >80% completion rate for seven-day follow-up visits
4. Improve PCP conversion rate by 20% for MVP Clinic graduates
5. Ensure 85% of MVP Clinic visits include standardized chronic disease education

## Communication Plan

- Quarterly progress updates shared at Patient, Family, and Community Advisory Council meetings
- Monthly performance dashboard shared with clinic staff and leadership
- Regular feedback sessions with patients and caregivers to guide program adjustments
- Highlight patient success stories in hospital newsletters and community forums

## Resources Committed

- Full-time MVP Clinic physician coverage
- Dedicated nursing, social work, and CHW staff
- Patient education materials and translation services
- Data analytics metric tracking
- Departmental budgets



# Improve Maternal and Child Health Outcomes and Access for TUH

**Plan Rationale:** Maternal and child health outcomes within Temple University Health System's community fall below those of the surround region and the nation as a whole. Community conversations highlighted barriers to maternal and child health including: lack of access to consistent prenatal and postpartum care, especially in underserved neighborhoods; transportation challenges that limit appointment attendance; gaps in mental health and substance use support for mothers; financial and insurance barriers to accessing timely care; and concerns about maternal mortality and disparities in birth outcomes among Black and Hispanic mothers. These challenges impact families' ability to achieve healthy pregnancies, safe deliveries, and positive child health outcomes. Addressing them will reduce health gaps, strengthen community trust, and build healthier communities.

## Health Improvement Goal

1. Increase community access to best-practice maternal and infant health care and other interventions to advance maternal and child health outcomes, including a reduction in maternal morbidity and mortality
2. Expand education and support programs that reflect community needs and cultures
3. Increase timely access to prenatal, postpartum, and mid-age care

## Action Plans

1. Expand community access to care by opening Temple Women & Families Hospital
2. Provide culturally relevant education and support on breastfeeding, safe sleep, nutrition, prenatal care, and postpartum wellness
3. Integrate behavioral health into prenatal visits and expand referrals to follow-up treatment
4. Build trust through community partnerships with organizations rooted in the local community to co-design programs
5. Further evaluate and implement programs that reflect community needs related to maternal and child health and wellness

## Metrics

1. Percentage of women receiving prenatal care at Temple and subsequently delivering at Temple Women and Families Hospital
2. Maternal mortality and morbidity rates
3. Infant mortality and preterm birth rates
4. Number of women bring screened for perinatal mental health conditions
5. Increase in number of community education/outreach initiatives focused on maternal/child health outcomes

## Objectives tied to Metrics

1. Increase percentage of women receiving prenatal care and subsequently delivering at Temple Women and Families Hospital by 20%
2. Reduce maternal morbidity rates by 5% within three years
3. Lower preterm birth rates by 3% within three years
4. Screen at least 80% of mothers for perinatal depression and substance use within two years
5. Increase number of community education/outreach initiatives to four per year annually for next three years

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### Executive Sponsors:

Sharon Kurfuerst, Executive Director,  
Women & Families Campus  
Kimberly Hanson, CNO, Women  
& Families Campus  
John Kissko, M.D., Medical Director,  
Women & Families Campus  
Tanise Branche, M.D., Medical  
Director, Labor & Delivery Services  
Heidi Taylor, M.D., Neonatologist

### Internal Implementation Team:

Temple Department of OBGYN  
Temple Department of Pediatrics  
Temple Community Health Workers  
Temple Clinical and Support  
Departments, as needed

### Community &

### Government Partners:

Philadelphia Department of Public  
Health  
WIC Programs  
Head Start  
Local FQHCs  
March of Dimes  
Community-Based Organizations  
such as: YMCA Maternal Care  
Coalition, Today is a Good Day and  
faith-based partners



# Improve Maternal and Child Health Outcomes and Access for TUH

## Communication Plan

- Internal: Regular updates through department meetings, clinical dashboards, and leadership forums
- External: Outreach through social media, community forums, physician offices, patient discharge information, community events, and community partnership meetings. Information will be available in multiple languages to maximize reach

## Resources Committed

- Funds and staffing from the Women and Families Campus budget
- Marketing & Communications Department budget
- Grant funding as available



# Strengthen Trauma-Informed Victim Services at TUH

**Plan Rationale:** Gun violence continues to impact Philadelphia communities, with survivors often facing multiple barriers to recovery including trauma, housing instability, unemployment, and limited access to counseling. As Philadelphia's busiest trauma center, Temple University Hospital (TUH) sees a disproportionate number of violently injured patients. Survivors need advocacy and support that extend beyond medical care. TUH's Trauma Victim Advocacy Program addresses these needs by providing 24/7 bedside support, linking patients and families to resources, and helping them navigate the complex systems of care and justice.

## Health Improvement Goal

1. Expand access to trauma-informed behavioral health supports for survivors of violence
2. Strengthen the Trauma Victim Advocacy Program as a 24/7 service addressing social determinants of health
3. Improve patient and family access to crime victim services, housing, and legal supports
4. Advance job readiness and reintegration for survivors with limited employment options

## Action Plans

1. Provide 24/7 bedside advocacy and safety planning
2. Train all staff in trauma-informed, survivor-centered approaches
3. Implement and use the QuesGen case management database to track services and patient progress
4. Standardize program policies and procedures through a new program manual
5. Expand behavioral health referrals and support for patients and families
6. Enroll survivors in workforce development and mentorship programming
7. Strengthen partnerships with victim service agencies to increase access to housing, legal, and financial support
8. Partner with external evaluators to measure outcomes and inform program improvements

## Metrics

1. Number of violently injured patients served
2. Hours of counseling provided and behavioral health referrals completed
3. Number of patients linked to victim service agencies. Number of survivors participating in workforce development programming
4. Patient and family satisfaction with advocacy services

## Objectives Tied to Metrics

1. Increase the proportion of patients who receive counseling support pre- and post-discharge
2. Improve collaboration with community victim service agencies to expand available supports
3. Increase survivor participation in job readiness and workforce programs
4. Reduce barriers to care and support at the time of discharge

### Executive Sponsors:

Scott P. Charles, MAPP, FCPP,  
Trauma Outreach Manager,  
Temple University Hospital  
Jill Volgraf, MSN, RN, Director,  
Trauma and Burn Operations,  
Temple University Hospital

### Internal Implementation Team:

Trauma Victim Advocacy Team  
Case Management Staff  
Behavioral Health Support Team  
Workforce Development/Violence  
Recovery Staff

### Community & Government Partners:

Local victim service agencies  
Non-profit employment  
organizations  
Community-based behavioral  
health organizations



## Strengthen Trauma-Informed Victim Services at TUH

### Communication Plan

- Disseminate brochures and provide program updates through TUH's SafetyNet website and social media
- Share patient stories and outcomes with community partners and report progress and metrics to hospital leadership and funders regularly

### Resources Committed

- Staffing: 24/7 victim advocate team, Violence Recovery Coordinator, case management staff
- Technology: QuesGen case management database
- Budget: Departmental budgets and grant support from Pennsylvania Commission on Crime & Delinquency, Philadelphia Department of Public Health, Pew Charitable Trusts, Everytown for Gun Safety, and additional funders
- Institutional Support: TUH commitment to integrate victim services into standard trauma care



# Improve Access for Physical and Behavioral Healthcare at Chestnut Hill Hospital

**Plan Rationale:** The 2025 CHNA highlights ongoing challenges with healthcare access, including long waits, limited providers, appointment shortages, and location barriers. For behavioral health, there is a shortage of providers—especially in geriatric psychiatry, and support for grief, loneliness, and isolation among older adults.

## Health Improvement Goal

1. Improve access to and continuity of cancer care for patients facing transportation barriers by expanding services offered at Chestnut Hill Hospital, reducing the need long travel times
2. Increase the availability of outpatient women's health services
3. Expand access to behavioral healthcare for seniors experiencing mental health crises

## Action Plans

1. Expand physician workforce in oncologic surgery, breast surgery, plastic surgery urology, radiology and psychiatry
2. Expand and enhance clinical office facilities
3. Expand Positron Emission Tomography (PET) capabilities to detect and diagnose cancer and other disorders
4. Develop radiation oncology services
5. Expand and enhance the Women's Health Center to meet growing community demand
6. Hire a full-time psychiatrist for the Senior Behavioral Health Unit (SBHU)
7. Develop relationships with the Philadelphia Department of Behavioral Health and Intellectual Disability Services and the Montgomery County Department of Health and Human Services to enable Chestnut Hill Hospital to expand access to behavioral health services for senior citizens experiencing mental health crisis

## Metrics

- Number of oncologic surgeries
- Number of infusions
- Number of mammograms
- Number of biopsies performed
- Trends in average daily census (ADC) for the Senior Behavioral Health unit

## Objectives Tied to Metrics

- Increase oncologic surgeries by 5%
- Increase infusions by 10%
- Increase mammographies by 10%
- Increase breast biopsies by 10%
- Increase SBHU ADC to 14 patients

### Executive Sponsor:

Rich Newell, CEO Temple Health - Chestnut Hill Hospital

### Internal Implementation Team:

Joel Helmke and Brian Burke—FCCC

Dr. Kevin Caputo and

Dr. Jeff Simon—Behavioral Health

Caryn Karff and Tenisha

Scutching—Imaging Services

### Community & Government Partners:

Mobile Community Screening unit of Fox Chase Cancer Center

Healthy Together program of the Temple Center for Population Health

State and local health and human service agencies



## **Improve Access for Physical and Behavioral Healthcare at Chestnut Hill Hospital**

### **Communication Plan**

- Work with communications team to educate community members of services available at Chestnut Hill Hospital, such as through local newspapers, social media and community health events

### **Resources Committed**

- Departmental budgets and grant funding as available



## Approach to Other Needs

### Access to Health Insurance

Our financial counselors screen uninsured and underinsured patients for Medicaid, CHIP, and other government insurance. Eligible patients are connected to coverage resources. We offer free or discounted care through our Emergency Care, Charity Care, Financial Assistance, and Uninsured Discount Policy. Counselors are certified in federal and Pennsylvania marketplace enrollment and help patients enroll during open and special periods. We also host on-site enrollment events, partner with community organizations, and assist Medicare recipients in evaluating Medicare Advantage options.

### Access to Dental Care

Temple University Kornberg School of Dentistry partners with Community Health Centers to provide dental care—including adult, pediatric, and emergency services—to underserved residents in Philadelphia.

### Enhancing Neighborhood Conditions

Temple University Health System maintains robust collaborations with numerous community-based organizations dedicated to advancing safety, cleanliness, and overall quality of life within our neighborhood. These partnerships include members of the North Philadelphia Collective, the Kensington Friday Collaborative, and the Anna T. Jeanes Foundation. In addition, we coordinate with various city agencies such as the Departments of Education, Health, Recreation, Planning, Safety, and Homeless Services.

### Building Housing Supports

We partner with the City of Philadelphia, HACE Community Development Corporation, and Prevention Point on the operation of an opioid respite center on our Episcopal Campus, offering shelter and essential services to individuals experiencing homelessness and substance use disorder. In addition, we work alongside Project Home and the Philadelphia Housing Authority to develop long-term recovery residences on our Episcopal Campus, serving those who are homeless, at risk of becoming homeless, or recovering from SUD. Our support also extends to several public and subsidized housing projects through providing rental space for physician offices and community outreach programs, which helps these organizations address funding gaps and offer enhanced services to their residents.

 Temple Health