

COMMUNITY HEALTH NEEDS ASSESSMENT IMPLEMENTATION PLAN

Temple University Hospital and Chestnut Hill Hospital



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Expand Access to Community-Embedded Primary Care for TUH

Executive Sponsor:

Nina O'Connor, MD, Chair, Department of Family & Community Medicine, Interim Chair, Pediatrics

Health Improvement Goals:

1. Launch new primary care practice within the Rev. Leon H. Sullivan Community Impact Center, including construction of space.
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.

Objectives:

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 waiting 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.

Metrics Data Dashboard:

Data Element	Baseline	FY26	FY27- Year to Date	FY28
Number primary care visits at Impact Center	Not yet open	Not yet open	Anticipated opening Fall 2026	
Number of primary care visits at Women and Families	10,532	16,692	1,913	
Average wait for new patient appointment in family medicine (days)	13	31	40	
Average wait for new patient appointment in pediatrics (days)	5	5	5	
No show rate in family medicine		25.76%	23.72%	
No show rate in pediatrics		26.97%	24.62%	

Metric Progress Summary:

Primary care capacity continues to grow with more anticipated capacity soon. Capacity is currently excellent for children with additional needs for adults.

Action Plans Progress:

Primary care clinics in family medicine, pediatrics, and OB/GYN all opened at the new Women & Families Campus in August 2024, allowing for expanded access and co-location of care for the entire family. These clinics are expanding with additional providers in FY27. Construction continues at the Rev. Leon H. Sullivan Community Impact Center with anticipated opening in Fall 2026. With this opening, primary care for the entire family will be available within a community-owned and operated facility. The Impact Center will ring together primary care and multiple other community partners to create a trusted access point for residents. In anticipation, 6 additional family medical physicians have been hired this year to improve access and reduce wait-time for appointments.

Conclusion & Next Steps:

Progress continues towards increasing primary care access with steady hiring and addition of new locations and clinic space. The opening of the Rev. Leon H. Sullivan Community Impact Center presents a unique opportunity to embed comprehensive primary care in trusted community space.

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

Executive Sponsor:

Abhi Rastogi, President and Chief Executive Officer, Temple Health

Health Improvement Goal:

Build a unified, patient-centered scheduling system across campuses that improves access to care, reduces barriers, expands digital self-scheduling, decreases unnecessary call transfers, streamlines scheduling workflows, reduces wait times, improves appointment completion, and enhances patient satisfaction.

Objectives:

1. Improve access and reduce barriers to timely care by expanding convenient entry points for patients.
2. Ensure patients are connected to the correct destination on their first contact.
3. Improve conversion of scheduled appointments into completed visits.
4. Evaluate performance and equity across scheduling channels.
5. Enhance patient experience and patient loyalty.

Data Related to Metrics:

Data Element	Baseline	FY26	FY27	FY28
Vizient Access to Care Rating	21	20		
Percentage of appointments booked online/self-scheduled	0%	1.9%		
No Show Rate	20.8%	19.8%		
Appointment completion by scheduling pathway	NA	TBD		
Patient satisfaction with scheduling/access	NA	NA		

Metrics Progress Summary:

The project has evolved substantially since its initial design, requiring modifications that affected the relevance and utility of several of the originally proposed metrics. At present, online scheduling is available for Primary Care, Dermatology, Orthopedics, Obstetrics, Gynecology, Hepatology, Endocrinology, Nephrology, and Rheumatology. Many of these scheduling pathways have only recently been implemented and are currently concentrated within smaller departments or subspecialty sections. As a result, online scheduling presently represents a relatively small proportion of total ambulatory visits, limiting the meaningfulness of system-wide utilization metrics at this stage of implementation.

Similarly, the No-show Rate reduction intervention has thus far been implemented only within Gastroenterology and Endocrinology. Consequently, the initiative has not yet produced a measurable impact on the organization's overall completed appointment rate.

However, outcomes within the targeted populations have been highly encouraging. Among patients identified by the intervention as having a predicted no-show risk greater than 70%, the actual no-show rate decreased to 11%, demonstrating the effectiveness of the targeted approach.

We also elected to discontinue the measurements of time to next available appointment and Median Lag Time which were included in our Implementation Strategy plan. During implementation, it became clear that scheduling redesign alone cannot meaningfully improve appointment availability without a corresponding increase in provider capacity and/or clinical space. Because these metrics are primarily driven by supply rather than scheduling methodology, they were no longer considered appropriate measures of the project's impact.

Finally, patient satisfaction surveys have not yet been conducted. As implementation continues and adoption expands across additional specialties, patient experience measures will be incorporated into future program evaluations.

Action Plans Progress:

1. Expanded decision tree redesign efforts across multiple primary care and specialty service lines.
2. Continued development of a standardized enterprise scheduling framework across Temple University Health System.
3. Advanced online self-scheduling capabilities and standardized scheduling logic.
4. Engaged operational, IT, call center, clinical, and marketing stakeholders to support implementation.
5. Continued work to improve patient navigation and reduce barriers for high-risk for No-show patients through navigator and outreach initiatives.

Conclusion & Next Steps:

The development and implementation of this initiative presented significant challenges, primarily due to the complexity of standardizing scheduling decision trees across multiple Temple Health entities and addressing the associated technical and informatics requirements. As these foundational challenges have been identified and largely addressed, we anticipate accelerated progress in the coming year. Efforts will focus on expanding standardized decision-tree logic across additional Temple Health entities where appropriate and increasing online self-scheduling capabilities across more specialties. In addition, the no-show intervention has begun expanding into Neurology and Cardiology. Pending continued positive results, this intervention is expected to be implemented more broadly across the health system.

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

Executive Sponsor:

Esme F Singer, MD, MBA, FACP – Chief Medical Officer, Temple Faculty Physicians

Health Improvement Goals:

1. Increase the proportion of patients with concerning incidental findings who receive complete 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.

Objectives:

1. Reduce time from concerning feature detected to first clinician evaluation.
2. Reduce the number of patients that were lost to follow up.
3. Shorten time from incidental finding to confirmed diagnosis by pathology.
4. Reduce time from diagnosis to first treatment.

Data Related to Metrics:

Data Element	Baseline	FY26	FY27	FY28
Average time to case evaluation by physician/APP	NA	4 days		
Lost to follow-up	32%	16%		
Average time from incidental finding to diagnosis (by pathology)	NA	35 days		
Percent of patients with cancer diagnosis	NA	42.2%		
Average time to from detection to first treatment	77 days	52 days		

Metrics Progress Summary:

In FY26, the program identified 586 patients with significant barriers to care who had concerning incidental findings requiring follow-up. During the year, the lost-to-follow-up rate decreased by fifty percent to 16%, while the average time to treatment was reduced by 25 days, demonstrating meaningful improvements in timely evaluation and care coordination. Among all patients enrolled in the program, 42.2% were ultimately diagnosed with cancer. Of the total program population, 30 patients (5.2%) elected hospice care based on their diagnosis and goals of care. All remaining patients proceeded with appropriate treatment, including radiation therapy, chemotherapy, immunotherapy, surgery, and/or other indicated interventions.

As the program evolved, we refined several performance metrics to better align with its final design and operational workflow. Unlike traditional outpatient care models, this program is intentionally structured to minimize the need for in-person visits. Much of the care coordination occurs through interdisciplinary provider collaboration, chart review, and telephone outreach rather than face-to-face appointments. Because of this model, metrics such as Average Time to Contact with a Physician/APP and No-Show Rate no longer accurately reflect program performance, as they are based on traditional visit-centered workflows. Instead, we now measure Average Time to Case Evaluation by a Physician/APP, which represents the point at which a patient's diagnostic and treatment plan begins to take shape, and Lost to Follow-up, which captures patients for whom an appropriate care plan could not be established or who could not be successfully contacted despite outreach efforts.

Action Plans Progress:

1. Developed standardized incidental finding follow-up pathway using an Internal Medicine physician/APP navigator model.
2. Established multidisciplinary collaboration pathways between primary care and specialty services.
3. Worked with specialty practices to identify expedited ("fast-track") appointment processes for patients with concerning findings.
4. Integrated planning for community health worker and financial counseling support to address transportation, insurance, and other social barriers.
5. Expanded referral pathway to local Federally Qualified Health centers and other local independent physician groups.

Conclusion & Next Steps:

Overall, the MVP-Can program has been highly successful in improving care for its participants, as demonstrated by the outcomes summarized above. The program illustrates that meaningful improvements in patient outcomes can be achieved through proactive navigation, coordinated multidisciplinary care, and streamlined clinical pathways that reduce the burden of traditional, visit-based healthcare while maintaining timely evaluation and treatment. The program has also been exceptionally well received by referring physicians, who frequently face challenges engaging patients – especially those with significant psychosocial barriers- and ensuring timely access to specialty evaluation.

Looking ahead, our focus is on identifying and engaging an even greater number of patients requiring urgent diagnostic evaluation. We are expanding provider awareness of the program while leveraging Epic's artificial intelligence capabilities to improve the detection of actionable incidental findings and facilitate earlier intervention. These enhancements are expected to further improve patient access, reduce delays in care, and continue advancing the program's impact across the health system.

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

Executive Sponsors:

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

Health Improvement Goals:

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.

Objectives:

1. Increase outreach by participating in community events aligning with community-based organizations and stakeholders.
2. Maintain community engagement through meaningful interactions promoting healthy lifestyles.
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.

Data for Healthy Together Hub:

Metric	FY26	FY27		
Number of sessions at the site	162			
Number of community engagements	9,259			
Number of community screenings	1,490			
Number of community screenings requiring follow-up	432			
Number of individuals referred to primary	Not Collected			
Patient satisfaction rating	94%			

Data Healthy Together Mobile Health Vehicle:

Metric	FY26	FY27		
Number of community events participated in	49			
Number of community members engaged	4,703			
Number of community members screened	694			
Number of community members requiring follow-up	179			

Metric Progress Summary:

During FY26, Temple Health's Healthy Together initiatives demonstrated measurable progress in expanding access to preventive care and addressing health-related social needs across the communities served by Temple University Hospital (TUH) and Chestnut Hill Hospital (CHH). Through the Healthy Together Hub at Brown's ShopRite of Fox Street, the team delivered 162 community-based sessions, 9,259 community engagements, and completed 1,490 health screenings, identifying 432 screenings requiring follow-up care. These efforts created critical opportunities for early disease detection, timely intervention, and connection to clinical and community-based services. Community feedback further reinforces the program's value, with 94% of participants expressing a desire to see the Healthy Together model expanded to additional supermarkets and 90% reporting confidence in applying the health information received to improve their well-being.

The Healthy Together Mobile Health Vehicle further extended Temple Health's reach by participating in 49 community events, engaging 4,703 community members, completing 694 preventive screenings, and identifying 179 individuals requiring follow-up care. Collectively, these initiatives strengthened Temple Health's ability to proactively identify unmet medical and social needs, increase access to preventive services, and build trusted relationships within historically underserved communities. The FY26 results demonstrate meaningful progress toward advancing health equity, improving access to care, and reducing barriers that contribute to poor health outcomes.

Action Plans Progress:

During FY26, Temple Health successfully implemented a comprehensive, community-based strategy designed to reduce barriers to care, improve health equity, and expand access to preventive health services. The Healthy Together Hub and Mobile Health Vehicle served as trusted, community-centered access points for preventive screenings, health education, health-related social needs assessments, and care navigation. Strategic partnerships with community-based organizations, faith-based institutions, and local stakeholders enabled the initiatives to effectively engage uninsured, underinsured, and medically underserved populations where they live, work, shop, and gather.

Using trauma-informed, culturally responsive approaches, staff identified and addressed key social drivers of health, including food insecurity, transportation barriers, and limited access to healthcare services. Individuals identified with elevated health risks received timely follow-up, personalized care navigation, and referrals to appropriate clinical and community resources, strengthening continuity of care and reinforcing the connection between community-based outreach and Temple Health's integrated system of care. Together, these efforts advanced Temple Health's mission to improve health outcomes while building trust and long-term engagement within the communities it serves.

Conclusion:

The Healthy Together initiatives have become a cornerstone of Temple Health's population health strategy, demonstrating the value of delivering integrated, person-centered care within trusted community settings. By bringing preventive services, health education, and care navigation directly into neighborhoods, Temple Health has expanded access to care, strengthened community trust, and improved its ability to identify and address both clinical and social factors that influence health outcomes.

As Temple Health looks ahead to FY27, the organization will build upon this strong foundation by expanding community partnerships, enhancing closed-loop referral and follow-up processes, strengthening measurement of long-term outcomes, and increasing preventive screening capacity. These efforts will further position Temple Health as a regional leader in community-based population health and support sustainable improvements in health outcomes across the communities it serves.

Next Steps:

Building on the success of FY26, Temple Health will execute the following strategic priorities to further advance health equity, strengthen community partnerships, and improve population health outcomes:

- 1. Expand Community Engagement and Outreach**

Increase Temple Health's presence in high-need communities by strengthening partnerships with community-based organizations, faith-based institutions, schools, employers, and local stakeholders. In collaboration with the Marketing and

Communications team, implement targeted outreach strategies to increase awareness, participation, and utilization of Healthy Together services.

2. Strengthen Care Coordination and Referral Completion

Enhance care navigation and closed-loop referral processes to improve successful connections to primary care, specialty care, behavioral health, and community-based resources. Develop standardized follow-up workflows and performance metrics to improve continuity of care for individuals identified with medical or social needs.

3. Enhance Identification and Response to Health-Related Social Needs

Expand the integration of Social Drivers of Health (SDOH) screening across all Healthy Together initiatives while strengthening resource referral tracking and closed-loop navigation. Utilize data to identify community trends, inform resource allocation, and address barriers such as food insecurity, transportation, housing instability, and access to healthcare.

4. Enhance Data Collection Methods

Enhance data collection processes by optimizing REDCap to improve the accuracy, consistency, and efficiency of data capture, referral tracking, and outcomes reporting across community-based programs. Strengthen reporting and analytic capabilities to monitor key performance indicators, including community engagement, screening outcomes, referral completion, patient satisfaction, and health outcomes.

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

Executive Sponsor:

John Robison, Executive Director, TUH-Episcopal Campus

Health Improvement Goal:

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

Objectives:

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 perception of care as evidenced by patient satisfaction survey data
5. Reduce hours of divert status with Crisis Response Center (CRC)

Data Related to Metrics:

1. Number of inpatient behavioral health bed days across the health system
2. Number of CRC encounters
3. Patient Satisfaction Scores (overall care rating)
4. Hours of diversion in CRC

Data Element	Baseline	FY26	FY27	FY28
1	46,054	46,302		
2	10,759	10,512		
3	88.82	82.93		
4	94 hours	12 hours		

Metrics Progress Summary:

Hours spent in divert status in the Crisis Response Center decreased by 87% (94 hours to 12 hours) due to increase capacity in the newly renovated CRC.

Patient Satisfaction scores decreased by about 6.6%. Revisions to our patient satisfaction survey were completed mid-year. This included revision and layout that we believe created initial confusion and likely resulted in inaccurate scoring. We remain focused on improving survey scores in all domain measures with strategies shared among the clinical units. We monitor data monthly and adjust approach to improvement accordingly.

Inpatient behavioral health bed days and number of CRC encounters remained consistent with baseline.

Action Plans Progress:

A newly renovated and expanded Crisis Response Center was opened in September 2025. This new clinical space is more than triple the size of the old location and is complete with significant safety and aesthetic enhancements. This new location contributed significantly to the decline in diversion hours.

A credentialing application has been submitted for Chestnut Hill Hospital to join the Community Behavioral Health network. If approved, this will allow expanded access for admissions by contracting with this Medicaid payor.

This year saw expansion of patient admissions for court committed (involuntary) patients at Chestnut Hill Hospital. Previously, involuntary patients were not accepted at Chestnut Hill.

Conclusion & Next Steps:

Temple Health will continue to monitor access to care for behavioral health services and address identified barriers throughout the coming year. This fiscal year a priority focus will be on establishing a bridge clinic to serve behavioral health patients discharged from Episcopal Hospital. Provider recruitment for this initiative is underway. Once established, this clinic resource will provide invaluable and immediate medication management resources to individuals stepping down from an inpatient level of care to the community. Additionally, the service line will be implementing use of advanced practice providers to the clinical team to ensure coverage and service options for patients at all levels of care. Stronger collaboration between the Episcopal and Chestnut Hill behavioral health teams will strengthen patient access and patient outcomes.

Address Substance Use Disorder in the TUH and CHH Communities

Executive Sponsors:

John Robison, Executive Director, TUH- Episcopal Campus

Daniel del Portal, Senior Vice President, Chief Clinical Officer, Temple Health

Health Improvement Goals:

1. Develop and implement a community outreach strategy to increase awareness of available substance use disorder (SUD) 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.
4. Reduce community overdose rates through expanded prevention, treatment and recovery supports
5. Improve perceptions of neighborhood safety by reducing substance use-related harms and strengthening community partnerships.
6. Increase utilization of recovery services so they are recognized, trusted and accessible across the community.

Objectives:

1. Participate in a minimum of four community events, educating the community about addiction services at Temple Health.
2. Increase enrollment in Temple Health outpatient addiction programs by 10% annually.
3. Increase successful warm handoffs from Temple Health emergency settings to SUD Clinic by 10% annually.
4. Increase participants in housing program by 10% annually.
5. Engage at least 500 individuals from underserved or high-risk populations annually in treatment, prevention or recovery services through the Temple SUD Engagement Team.

Data Related to Metrics:

Data Element	Baseline	FY26	FY27	FY28
Number of community events	8	16		
Number of patients enrolled in outpatient addiction programs	2943	3369		
Number of warm handoffs from emergency settings to SUD Clinic	441	365		
Number of participants enrolled in housing program	33	131		
Number of individuals engaged by SUD Engagement Team	7371	12,236		

Metrics Progress Summary:

FY 26 performance demonstrates substantial expansion of Temple Health addiction services and community reach. Community events doubled, outpatient enrollment grew by 14.5%, housing program participation increased by 300% and engagement of underserved or high-risk populations increased by 66%. These four measures exceeded their established goals. Successful warm handoffs from emergency settings to the SUD Clinic declined by 17.2%, identifying this as a priority area for improvement for FY27.

Action Plans Progress:

1. Participate in a Minimum of Four Community Events Educating the Community About Addiction Services
 - a. Community outreach efforts expanded significantly during FY26, with participation in 16 community events, compared with 8 events in FY25 and a baseline of 6 events. This 100% year-over-year increase was supported by stronger coordination with community-based, faith-based, neighborhood, and healthcare partners, which improved identification of outreach opportunities and expanded the settings in which Temple Health addiction services were promoted. The Addiction Medicine and SUD Engagement teams also coordinated internal participation, prioritized high-impact events, provided education on prevention, treatment, recovery support, and available Temple Health services, and created opportunities for direct referral and follow-up. Together, these actions increased community awareness and extended the program's reach without relying solely on event attendance as the outcome measure.
2. Increase enrollment in Temple Health outpatient addiction programs by 10% annually.
 - a. Outpatient addiction program enrollment increased from 2,943 participants in FY25 to 3,369 participants in FY26, a 14.5% increase that exceeded the annual growth target. Since baseline measurement, enrollment has increased by 64.3%. FY26 actions supporting this growth included strengthening referral pathways from emergency departments, inpatient units, primary care, and community partners; increasing outreach to underserved populations; coordinating follow-up and linkage to outpatient services; and monitoring access and treatment capacity. These efforts improved identification of patients who could benefit from treatment and supported their transition into Temple Health outpatient addiction programs.
3. Increase successful warm handoffs from Temple Health emergency settings to the SUD Clinic.
 - a. Successful warm handoffs decreased from 441 in FY25 to 365 in FY26, a 17.2% decline; therefore, the annual growth objective was not achieved. During FY26, referral pathways from emergency settings to the SUD Clinic continued through Certified Recovery Specialists, care navigation, and clinical referral workflows, but the decrease indicates inconsistent conversion from referral to completed handoff. This result identifies the need

to analyze emergency department, inpatient, and Crisis Response Center workflows; clarify staff roles and referral criteria; standardize appointment scheduling, confirmation, and post-discharge follow-up; and monitor referral-to-appointment conversion by campus and care setting. Warm handoffs will remain the primary FY27 improvement priority.

4. Increase participants in housing programs by 10% annually.
 - a. A key contributor to FY26 success was the continued growth of the HomeBASE Program, which demonstrated strong outcomes in housing stabilization and care coordination. During FY26, HomeBASE enrolled 131 participants, completed more than 5,700 engagements, scheduled 451 appointments, achieved a 95% connection rate to services, and helped 95% of participants achieve housing stability. These results highlight the value of addressing housing as a social determinant of health and reinforce the importance of integrated addiction treatment, recovery support, and housing-focused interventions.
5. Engage at least 500 individuals from underserved or high-risk populations annually in treatment, prevention or recovery services through the SUD Engagement Team.
 - a. The SUD Engagement Team engaged 12,236 individuals in FY26, exceeding both the annual objective and the FY25 total of 7,371. This represents a 66.0% increase from FY25 and a 158.0% increase from baseline. The increase was supported by broader utilization of the team across hospital and community settings, stronger referral relationships with healthcare and community partners, targeted outreach to underserved and high-risk populations, and more consistent connection of individuals to prevention, treatment, and recovery resources. The available performance data demonstrates expanded team reach and service utilization as well as a more stable workforce.

Conclusion & Next Steps:

Substance Use Disorder programing grew notably in FY26 particularly in the areas of community outreach, patient encounters via the SUD Engagement Team and enrollment in SUD-related housing programs. To ensure services meet the significant needs of our community, the following next steps are planned:

1. Participate in a minimum of four community events educating the community about addiction services.
 - a. Continue participation in high-impact community outreach events.
 - b. Expand partnerships with community-based, faith-based, and neighborhood organizations.
 - c. Implement enhanced tracking of outreach contacts, referrals, and service utilization resulting from events.
2. Increase enrollment in Temple Health outpatient addiction programs by 10% annually.

- a. Continue strengthening referral pathways from emergency departments, inpatient units, primary care, and community partners.
 - b. Expand outreach and engagement efforts targeting underserved populations.
 - c. Monitor appointment access and treatment capacity to sustain continued growth.
- 3. Increase successful warm handoffs from Temple Health emergency settings to the SUD clinic by 10% annually.
 - a. Conduct workflow analysis of emergency department, inpatient, and CRC referral processes.
 - b. Expand involvement of Certified Recovery Specialists and care navigators in transition planning.
 - c. Standardize follow-up and appointment confirmation processes.
 - d. Monitor referral conversion rates monthly and implement corrective actions when performance gaps are identified.
- 4. Increase participation in housing programs by 10% annually.
 - a. Expand identification and referral of housing-insecure patients across care settings.
 - b. Strengthen partnerships with housing providers and community organizations.
 - c. Increase capacity for housing navigation and case management services.
 - d. Enhance outcome tracking related to housing placement and housing retention.
- 5. Engage at least 500 individuals from underserved or high-risk populations annually in treatment, prevention or recovery services through the SUD Engagement Team.
 - a. Continue targeted outreach in communities with high rates of substance use and overdose.
 - b. Expand partnerships with community-based organizations and healthcare providers.
 - c. Increase linkage-to-care efforts for individuals identified through engagement activities.
 - d. Monitor engagement outcomes, including referrals, treatment initiation, and recovery support utilization.

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

Executive Sponsors:

Steve Carson, Senior Vice President, Temple Center for Population Health

Meaghan Kim, Assistant Vice President, Temple Center for Population Health

Health Improvement Goals:

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 setting 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 readmission and emergency department visits for patients with or at risk for chronic conditions.
3. Strengthen partnership between healthcare providers, patients, families, and community organizations to sustain engagement and support ongoing population health improvements.

Objectives:

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.
5. Improve patient satisfaction scores related to care coordination by 10% year-over-year.

Data Related to Metrics:

Data Element	Baseline	FY26	FY27	FY28
Number of patients enrolled	492	540		
Program completion/graduation rate (%)	28%	61%		
Average Weight Loss (%); physical activity (min)	4%; 172 min	5%; 190 min		
Number of active cohorts	19	18		

Metrics Progress Summary:

Patient enrollment: Increased from 492 (FY25 baseline) to 540 in FY26, a gain of 48 patients (+9.8%).

Program completion/graduation rate: Increased from 28% (FY25 baseline) to 61% in FY26, a gain of 33 percentage points, more than doubling the program's completion rate year over year.

Average weight loss: Increased from 4% (FY25 baseline) to 5% in FY26, a gain of 1 percentage point (+25% relative improvement), reaching the CDC's target threshold for meaningful weight loss.

Average physical activity: Increased from 172 minutes per week (FY25 baseline) to 190 minutes per week in FY26, a gain of 18 minutes (+10.5%), continuing to exceed the CDC's 150-minute weekly benchmark.

Number of active cohorts: Decreased slightly from 19 (FY25 baseline) to 18 in FY26. Despite one fewer cohort, both enrollment and completion rates rose substantially, indicating a more efficient delivery model with stronger outcomes per cohort rather than growth driven simply by adding more groups.

Action Plans Progress:

Rounding at primary care office locations: Established a recurring rounding schedule with primary care practices to introduce DPP directly to providers and staff, including brief in-office education sessions and distribution of referral materials. This direct engagement has strengthened the provider referral pipeline, which participants have identified as a key motivator for enrollment and continued participation.

Community event attendance to market the program: Represented DPP at community health fairs and local events to reach residents outside the existing patient base, staffing tables with program materials and enrollment information.

Expansion of external community partnerships: Built on existing partnerships by adding new delivery sites, including ShopRite, Frazier Family Coalition, faith-based organizations, community centers, and the Law Enforcement Health Benefits group, each selected to reach populations and geographic areas not previously served by hospital-based programming.

Certification of additional lifestyle coaches: Certified additional lifestyle coaches, including Spanish-speaking coaches, to expand cohort capacity and language accessibility.

Conclusion & Next Steps:

For this CHNA cycle, Nurse Navigation data will not be added to the progress report. Although Nurse Navigation was included in the original published objectives, the team transitioned its documentation workflows in Epic, which limits the ability to compare Nurse Navigation activity consistently year over year. In addition, the Nurse Navigation program is currently being redesigned to separate Transition of Care (TOC) assignments from longitudinal care management assignments, requiring updated workflows and reporting definitions before reliable measurement can occur. A patient satisfaction survey for navigated patients has also not yet been implemented; however, development of this feedback mechanism is planned for this fiscal year. Moving forward, progress reporting for this CHNA cycle will continue to focus on the Diabetes Prevention Program (DPP).

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

Executive Sponsors:

Daniel Del Portal, MD, MBA, Senior Vice President, Chief Clinical Officer, TUHS

Dharmini Shah Pandya, MD, Vice Chair, Quality, Safety and Innovation, Department of Medicine

Steven Carson, MHA, BSN, RN, Senior Vice President, Temple Center for Population Health

Meaghan Kim, MHA, BSN, RN, Assistant Vice President, Population Health, Temple Center for Population Health

Health Improvement 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. Reduce acute care utilization among enrolled patients by addressing medical, social, and behavioral health needs.
4. Strengthen PCP continuity for MVP clinic graduates to support long-term health management.

Objectives:

1. Increase the number of community members enrolled in disease management programs.
2. Increase number of patients served by Multi-Visit Patient (MVP) Clinic.
3. Decrease MVP Clinic patient acute care hospital utilization.
4. Improve PCP establishment for patients to improve access to care and reduce ED utilization.

Data Related to Metrics:

Data Element	Baseline	FY26	FY27	FY28
Number of patients served by Temple Multi-Visit Clinic	909	1140		
Temple Multi-Visit Clinic Patient Emergency Department (ED) utilization after Multi-Visit	-56.4%	-55.2%		

Clinic enrollment) (for 90 days post-enrollment compared to the 90 days prior to first clinic visit)				
Temple Multi-Visit Clinic patient inpatient utilization after Multi-Visit Clinic enrollment (for 90 days post-enrollment compared to the 90 days prior to first clinic visit)	-56.3%	-50.5%		
PCP establishment for patients enrolled in MVP clinic	696 (76%)	890 (78%)		

Metrics Progress Summary:

Temple's Multi-Visit Patient (MVP) Clinic was established to improve care for high-utilization patients through a multidisciplinary model focused on increasing access to care, strengthening care coordination, and supporting self-management of chronic disease. The program addresses the growing burden of conditions such as heart failure, diabetes, and COPD while helping reduce disparities in healthcare access and outcomes.

Patients are referred to the MVP Clinic following an emergency department visit or inpatient hospitalization for timely post-discharge follow-up. The clinic aims to ensure a safe transition home by providing medication reconciliation, disease management, and connection to needed resources to reduce avoidable readmissions. Although follow-up visits are targeted within 7–10 days of discharge, consistent measurement remains limited by variability in the referral process. Patients receive reminder calls before appointment, and those who miss appointments receive proactive outreach to re-engage them in care.

The MVP Clinic provides intensive, individualized management for patients with complex chronic conditions through a multidisciplinary team that addresses medical, behavioral health, and social needs. Patients remain enrolled until their conditions are stabilized, and they have successfully re-established care with a primary care provider, graduating from the program after completing their first PCP follow-up visit.

During this reporting period, the clinic strengthened patient identification and referral processes, enhanced coordination between inpatient and outpatient teams, and expanded multidisciplinary care for patients with complex needs. Performance measures, including patient enrollment, emergency department and inpatient utilization, and successful linkage to primary care, continue to be monitored through program dashboards and annual evaluations to assess long-term impact.

Action Plans Progress:

The MVP Clinic has made meaningful progress across each of the major action plan priorities outlined in the implementation strategy.

Expand High-Risk Patient Enrollment

1. Continued collaboration with inpatient care teams to identify patients with frequent ED utilization or hospital readmissions.
2. Maintained bedside engagement and referral processes to connect eligible patients with MVP Clinic services prior to discharge.

Accelerate Post-Discharge Follow-Up

1. Prioritized scheduling of outpatient appointments following hospital discharge to improve continuity of care.
2. Maintain schedule flexibility to accommodate patients and maintain the goal of post-discharge follow up to within 7-10 days.
3. Continued patient outreach through reminder calls and care coordination to improve appointment attendance.

Strengthen PCP Conversion

1. Continued standardized transition planning for patients graduating from the MVP Clinic to establish ongoing care with a primary care provider.
2. Due to a change in location of the MVP clinic in August 2025, we have now been able to further streamline PCP capitation and referral process and provide patients with appointments in real time, which has in turn improved patient engagement.
3. Strengthened communication and care coordination between MVP Clinic providers and PCP practices to support long-term disease management.

Enhance Patient and Family Education

1. Continued delivery of disease-specific education focused on chronic disease self-management, medication adherence, and recognizing early signs of disease exacerbation.
2. Incorporated caregivers and family members into education whenever appropriate to reinforce treatment plans.

Improve Multidisciplinary Care Coordination

1. Continue to maintain regular collaboration among physicians, nurses, social workers, community health workers, and care management staff to address medical, behavioral health, and social determinants of health.
2. Continued use of shared care planning and documentation to improve communication across disciplines.

Conclusion & Next Steps:

The MVP Clinic remains well positioned to achieve its long-term goals of improving access to coordinated outpatient care while reducing avoidable emergency department visits and hospitalizations among high-risk patients.

The clinic continues to serve both insured and uninsured patients who face significant barriers to accessing care and navigating a complex healthcare system. By providing a

dedicated multidisciplinary team, the MVP Clinic offers ongoing support for chronic disease management, medication questions, care coordination, and social needs. This approach helps patients address concerns early, reducing reliance on the emergency department while promoting greater confidence in managing their health.

During the next reporting period, the program will focus on:

1. Expanding enrollment through continued collaboration with inpatient teams and targeted outreach to high-utilization patients.
2. Improving the timeliness of post-discharge follow-up appointments and increasing visit completion rates.
3. Strengthening successful transitions from the MVP Clinic to established primary care providers.
4. Enhancing patient education and self-management strategies for chronic diseases.
5. Continuing to monitor healthcare utilization, patient outcomes, and program performance to guide quality improvement efforts.

These ongoing efforts support Temple Health's commitment to improving population health, advancing health equity, and reducing preventable acute care utilization through coordinated, patient-centered care.

Improve Maternal and Child Health Outcomes and Access for Temple University Hospital

Executive Sponsors:

Sharon Kurfuerst, Executive Director, Temple Women & Families Campus
Colleen Moran, AVP Nursing, Temple Women & Families Campus
Tanise Branche, MD, Medical Director, Labor & Delivery Services
Heidi Taylor, MD, Chair, Department of Pediatrics

Health Improvement Goals:

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.

Objectives:

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

Data Related to Metrics:

Data Element	Baseline	FY26	FY27	FY28
Percentage of women receiving prenatal care at Temple and subsequently delivering at TWF.	62%	82%	Goal = 87%	
Severe Maternal Mortality Rate	4%	2%	Goal = 1%	

Preterm birth Rate	Preterm Birth = 17%	Preterm Birth = 14%	Goal = 12%	
Percentage of patients being screened for perinatal mental health conditions	Prenatal/Postpartum Average = 86%	Prenatal/Postpartum Average = 86%	Goal = 90%	
Number of community education/outreach initiatives focused on maternal/child health outcomes	2	5	Goal = 8	

Metrics Progress Summary:

Temple Women & Families Hospital successfully opened in September 2025, significantly expanding access to comprehensive obstetric, neonatal, gynecologic, and women's health services for North Philadelphia residents.

Increased coordination between prenatal providers and labor and delivery services has improved continuity of care and increased the percentage of patients receiving both prenatal care and delivery services within the Temple Health system. The number of patients receiving prenatal care and subsequently delivering at Temple Women & Families increased by 32%.

Standardized maternal safety initiatives continue to support reductions in preventable maternal complications while ongoing quality monitoring tracks severe maternal morbidity outcomes.

Universal screening for perinatal depression and substance use has been incorporated into prenatal and postpartum care workflows, increasing identification and referral of patients requiring behavioral health services.

Community outreach efforts expanded through partnerships focused on parenting education, safe sleep, prenatal education, nutrition, postpartum support, and maternal wellness.

Action Plans Progress:

1. Expand community access to care by opening Temple Women & Families Hospital:
 - a. Successfully opened Temple Women & Families Hospital, increasing capacity for obstetric, neonatal, gynecologic, and women's specialty services.
 - b. Expanded labor and delivery, NICU, outpatient specialty care, and surgical services.
 - c. Increased access to coordinated prenatal through postpartum care within one integrated location.
2. Provide culturally relevant education and support:
 - a. Expanded patient education on parenting, infant safe sleep, prenatal nutrition, postpartum recovery, and newborn care.

- b. Patient education materials are provided in English and Spanish.
 - c. In-person education is provided across points of care and in preferred languages via interpreter as needed.
 - d. Partnered with community organizations to deliver culturally appropriate educational programming and access to healthcare resources.
- 3. Integrate behavioral health into prenatal care:
 - a. Implemented standardized screening for perinatal depression and substance use.
 - b. Strengthened referral pathways between obstetrics, behavioral health providers, and community resources.
 - c. Increased provider education regarding early identification of maternal mental health conditions.
- 4. Build trust through community partnerships:
 - a. Strengthened collaborations with local community organizations serving and/or supporting women and families.
 - b. Participated in community health events focused on maternal and infant wellness.
 - c. Worked with trusted community partners to improve engagement among historically underserved populations.
- 5. Evaluate and implement community-informed programs:
 - a. Continued assessment of maternal and infant outcome data to identify community needs.
 - b. Used patient and community feedback to refine programming and support services.
 - c. Evaluated opportunities to expand services addressing social determinants of health affecting maternal and infant outcomes.

Conclusion & Next Steps:

The opening of Temple Women & Families Hospital represents a transformational investment in maternal and child health for the communities Temple serves. During the reporting period, significant progress was made in expanding access to comprehensive women's healthcare services, strengthening behavioral health integration, and increasing community engagement. Continued focus will be placed on improving prenatal care utilization, reducing maternal morbidity and preterm births, expanding behavioral health screening and follow-up, and strengthening partnerships with community organizations to address health disparities. Future efforts will emphasize ongoing performance measurement, quality improvement initiatives, and expansion of evidence-based programs that improve outcomes for mothers, infants, and families.

Strengthening Trauma-Informed Victim Services at Temple University Hospital

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

Health Improvement Goals:

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

Objectives:

1. Increase the proportion of patients who receive counseling support pre- and post-discharge.
2. Improve collaboration with community victim services 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.

Data Related to Metrics:

Data Element	Baseline	FY26	FY27	FY28
Number of violently injured patients served		1,235		
Behavioral Health referrals completed		49		
Number of patients linked to victim service agencies	237	283		
Number of survivors participating in workforce development programming	123	144		
Patient and family satisfaction with advocacy services		TBD		

Metrics Progress Summary:

1. Increased the number of patients linked to victim service agencies by more than 19%.
2. Increased the number of survivors participating in workforce development programming by more than 17%.
3. We are in the process of finalizing an assessment tool that will allow us to track and manage patient and family satisfaction scores using the QuesGen database and expect this tool to be fully implemented in the coming months.

Action Plans Progress:

1. Secured funding through the Pennsylvania Commission on Crime and Delinquency to expand the Trauma Victim Advocacy Program through 2027.
2. Expanded TVAP's behavioral health capacity by hiring a dedicated trauma psychologist.
3. Added a Visiting Nurse Practitioner to the program to address the barriers patients face following discharge.
4. Hired a Spinal Cord Injury Advocate to provide specialized support for survivors of SCI and other complex trauma.
5. Continued to provide emergency food and clothing to program participants.
6. Hosted the Temple University Hospital's third Violence Survivor's Day to celebrate the resilience of program participants.
7. Began a collaborative effort with the REACH program at the Lewis Katz School of Medicine which will enable our highest risk patients to receive ongoing community-based support from their program's violence intervention specialists.

Conclusion & Next Steps:

One of the primary lessons from the past year has been the need to strengthen support available to patients after discharge, particularly around behavioral health, medical follow-up, and other barriers that can affect recovery. PCCD funding for the WRAPS project has allowed TVAP to begin addressing several of these gaps by adding behavioral health, clinical, and specialized peer support to the program.

During the coming year, TVAP will focus on integrating these new services into existing workflows, strengthening connections with community partners, and improving outcome tracking through QuesGen, including implementation of a patient and family satisfaction measure.

Improve Access for Physical and Behavioral Healthcare at Chestnut Hill Hospital

Executive Sponsor:

Rich Newell, Chief Executive Officer, Temple Health – Chestnut Hill Hospital

Health Improvement Goals:

1. Improve access to and continuity of cancer care for patients facing barriers to care by expanding services offered at Chestnut Hill Hospital (CHH), reducing the need for 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.

Objectives:

1. Increase the number of community members receiving oncology surgical care.
2. Increase the number of patients accessing infusion therapy services.
3. Increase the number of community members receiving breast cancer screening (mammography).
4. Increase the number of patients accessing diagnostic breast health services (breast biopsies).
5. Increase the number of seniors in the community accessing behavioral health services in the SBHU.

Data Related to Metrics:

Data Element	Baseline	FY26	FY27	FY28
# of oncologic surgeries	713	751		
# of infusions	939	2809		
# of mammograms	10844	11566		
# of biopsies performed in women's center	248	480		
Average daily census (ADC) for SBHU	12	16		

Metrics Progress Summary:

CHH's infusion center opened early FY25. Hiring a third oncologist in FY26 increased infusion center capacity resulting in a higher volume of infusions. Similarly, additional staffing in the Women's Center led to a dramatic increase in breast biopsy and mammography volume. Breast biopsies increased by 94% (248 in FY25 to 480 in FY26). The number of screening mammograms remained relatively stable (8312 in FY25 to 8231 in FY26) but the number of diagnostic mammograms increased by 31% (2532 in FY25 to 3335 in FY26) indicating availability of mammography services has increased. The Average Daily Census in the SBHU has increased by 33% (12 to 16). We expect this trend will continue to increase as we expand the capabilities of the SBHU.

Action Plans Progress:**Improve access to cancer care**

1. To reduce barriers to cancer care, CHH opened a brand-new infusion center in FY25 where patients can receive advanced cancer care from Fox Chase Cancer Center specialists without the need to travel. In FY26 an additional oncologist was hired, allowing for more patients to be seen at this site.
2. A new infusion scheduling template generator within Epic is now being utilized to match patients based on their treatment needs with an available appointment to reduce wait times for an appointment and once they arrive.
3. CHH added a mobile Positron Emission Tomography (PET) unit in FY25, operating 2 days/ week. In FY26, operation was increased to 3 days/ week, resulting in a 56% increase in PET scan volume.
4. In-house staff were hired for the PET unit, ending its reliance on agency staff. This has improved continuity of care and allowed patients to build rapport with their clinical providers.

Increase availability of women's health services

1. Hired two radiologists specializing in breast health to increase availability of breast health services and meet community needs.
2. Funding was secured to provide significant renovations to the interior and exterior of the Women's Center to ensure a comfortable and welcoming environment for patients.

Expand access to behavioral healthcare for seniors

1. Two full-time behavioral health specialists were hired for the SBHU in FY26; a full-time psychiatrist and an additional nurse practitioner. There are now 3 providers covering the 20-bed unit and inpatient behavioral health consults.
2. CHH began accepting involuntary psychiatric admissions in the SBHU. This allowed greater access to psychiatric services for those living in Philadelphia and Montgomery Counties. The SBHU occasionally accepted patients from Cumberland and Lackawanna counties as well.

Conclusion & Next Steps:

The opening of the infusion center at CHH has helped provide seamless care to CHH cancer patients while reducing their need to travel to FCCC for care. Expanding PET unit operation to a 4th and eventual 5th day per week is in progress. CHH will revisit the goal of bringing back radiation oncology services in the future.

Through the SBHU, CHH has expanded its ability to offer critically needed behavioral health services to community. CHH is in the final stages of approval to join the Community Behavioral Health network. Contracting with CBH (a Medicaid payor) will increase access for behavioral health admissions.

Notable progress has been made to increase access for women's health, particularly in breast health, through the hiring of two specialists. This has increased CHH's capacity to provide breast biopsies and mammograms. Upon completion of the Women's Center renovations, CHH will work towards adding plastic and vascular surgery service lines.

CHH continues to increase community access to quality and academic levels of care. Work has begun to improve surgical offices and make them more comfortable for patients. New, much-needed health care services have been added to CHH including ophthalmology, Rheumatology and Endocrinology. In FY27, construction of a new pulmonary office will begin.

 Temple Health