Redeemer Health
Holy Redeemer Hospital
2022 Community Needs Assessment Implementation Plan

Holy Redeemer Hospital's (HRH) Implementation Plan explains how HRH will address health needs identified in their 2022 Community Health Needs Assessment (CHNA). The action plans for the identified health needs will include both existing programs as well as new strategies, with a focus on collaborating with other organizations. This document will also explain why HRH cannot address all the needs identified in the CHNA. It is expected that this document will be subject to ongoing revision and enhancement as appropriate and needed.

I. Prioritizing Identified Needs

Holy Redeemer Hospital participated in a collaborative to complete the 2022 CHNA, participating with local non-profit hospitals and health systems, the Philadelphia Department of Public Health (PDPH), other health departments, and the Health Care Improvement Foundation (HCIF) for the Southeastern PA (SEPA) region, with specific focus on Bucks, Chester, Delaware, Montgomery, and Philadelphia counties. The completed CHNA can be found on Redeemer Health's website.

Similar to its prioritization process with the 2013, 2016 and 2019 CHNAs, HRH's CHNA Steering Committee met and discussed each identified need from the collaborative CHNA, including the impact of this need on the community, what it will take to make an impact on the need, the ability of Redeemer Health to make an impact, and what resources and collaboratives are already available in the community. Committee members again used three criteria on which to base prioritization of the identified needs. These criteria included: 1) magnitude of the problem, 2) alignment with Redeemer Health's strategic direction, and 3) availability of resources to make an impact.

The prioritization process resulted in the identification of the following needs which will be addressed in Holy Redeemer Hospital's Implementation Plan for 2022-2025.

- Mental Health Conditions
- Substance Use & Related Disorders
- Food Access
- Access to Care (Primary & Specialty)
- Chronic Conditions (Prevention & Management)
- Racism and Discrimination in the Healthcare Setting
- Housing

This document will also list the situation, activities, resources, collaborations, project lead and metrics for each of the identified priorities.

II. Needs Not Identified as Priorities

There were needs identified in the collaborative CHNA document that Holy Redeemer Hospital is choosing not to address as priorities based upon the prioritization process noted above. While important to the community and the hospital, they were not chosen based on HRH's prioritization process which included the limited availability of resources. These identified needs include the following.

- Healthcare & Health Resources Navigation
- Linguistically & Culturally Appropriate Services
- Community Violence
- Socioeconomic Disadvantage
- Neighborhood Conditions

Redeemer Health and Holy Redeemer Hospital do still perform many activities that meet the identified needs of the community which were not chosen as priorities during this CHNA process. Some of those activities include adding nurse navigators to complex areas, increasing transportation accessibility, partnering with a local school district to provide work study hours and information on health care careers, having a language line and translated surveys for patients who do not speak English, as well as other initiatives. In addition, some of these needs are already provided by other community organizations who have the expertise to provide these services. Redeemer Health will partner with those organizations and continue to provide appropriate services as able.

III. Action Plans

In addition to current activities being performed, the following details some initiatives that HRH will implement with the goal of making improvements to the health of its community.

Mental Health Conditions					
Situation	**Activities**	**Inputs/Resources**	**Collaborations**	**Lead**	**Metrics**
	What are the main things the project will do/provide?	*What resources will be used to support the project?*	*Who will we work with on implementing the project?*	*Person responsible*	*What results should follow?*
Youth and adult community members and community partners prioritize mental health as their top health need. Significant mental health needs across the region are indicated by: – High rates of depression among youth and adults (1 in 5 adults report diagnosed depressive disorders, and many more are undiagnosed) – Across the 5 counties, 15 percent of residents report frequent mental distress. – Suicide mortality and suicide attempts/ideation rates among youth (particularly among those who identify as LGBTQ+) that persist and are likely to show increases when more recent data is made available. These concerning trends were exacerbated by the social isolation, stress, and fear experienced due to the COVID-19 pandemic. Pandemic-related trauma is particularly compounded for those communities also contending with trauma associated with high levels of poverty, community violence, and racism. If left undiagnosed or untreated, there is increased likelihood of serious issues that result in increased health care (especially emergency department) utilization and co-occurring substance use disorders. Populations particularly affected include youth, older adults, immigrant communities, LGBTQ+ communities, those experiencing homelessness and housing insecurity.	Training all staff in trauma informed practices beginning with the staff in the Obstetric practices and on the LDR/OB/NICU units. Continue training in all other areas of the hospital.	Staff time and salary cost Organization to provide training	Community organization Funding organizations	Chief Nursing Officer	No. of staff trained Pre & post knowledge tests
	Continue collaboration with the COACH Collaborative, implementing the trauma informed approach throughout the health system.	Staff time and travel expenses to attend meetings, provide information and develop initiatives	Includes hospitals, behavioral health hospitals, health department and other community organization representatives	Director of Planning Chief Nursing Officer Behavioral Health	Participation in the COACH Collaborative
	Provide de-escalation training throughout the health system utilizing a train the trainer approach.	Staff time De-escalation program	Program organization	AVP, Emergency Management	No. of staff trained
	Continue to add therapists to current physician offices with co-located behavioral health specialists. Expand to new physician office locations and add additional appointment hours as able.	Staff time to develop and implement the program Office space and materials Behavioral Health specialists Training of staff to utilize specialists	Primary care physician practices Philmont Guidance Center	VP, Care Coordination & Transitions of Care	No. of physician practices with a co-located behavioral health specialist No. of patients assisted

There continues to be a significant lack of community-based, integrated mental health treatment options and a particular dearth of resources for youth with mental health needs and their families.	Activities	Inputs/Resources	Collaborations	Lead	Metrics
	Evaluate program decision elements for an imbedded behavioral health specialists model in the physician practices and implement.	Staff time to evaluate and implement the program Office space and materials Behavioral Health specialists Provider training	Primary care physician practices Philmont Guidance Center	VP, Care Coordination & Transitions of Care	No. of physician practices with an imbedded behavioral health specialist No. of patients assisted
	Investigate the future options of telehealth and/or teletherapy options.	Staff time Cost of product	Telehealth and/or Teletherapy companies Providers	VP, Care Coordination & Transitions of Care	Implementation of product Others TBD
	Lecture or lecture series for the community on potential behavioral health topics. (For example, depression, anxiety, suicide) Make available for future viewings.	Staff time Cost of production Zoom resources Website space	Providers Community resources	VP, Care Coordination & Transitions of Care	No. of lectures No. of attendees and clicks on saved lecture
	Investigate adding behavioral health information to employee facing newsletters and employee portal app.	Staff time	EAP program Providers Information resources	VP, Care Coordination & Transitions of Care Sr. Director, Enterprise Design & Improvement	No. of articles
	Develop and implement an employee wellness at work initiative.	Staff time Locations Zoom and website resources Supplies & materials	CORA Community organizations Providers Funding organizations	Sr. Director, Enterprise Design & Improvement	No. of employees participating
	Utilize Redeemer Health public relations publications and social media outlets to educate community members about the offerings available.	Staff time Printing costs Website & social media sites Email lists	Various organizations, clinicians and providers who can contribute information to the publications and posts	Marketing Department – Public Relations	No. of articles and social media posts

Food Access					
Situation	**Activities**	**Inputs/Resources**	**Collaborations**	**Lead**	**Metrics**
	What are the main things the project will do/provide?	*What resources will be used to support the project?*	*Who will we work with on implementing the project?*	*Person responsible*	*What results should follow?*
Issues of food access focus primarily on food security, defined as having reliable access to a sufficient quantity of affordable, nutritious food. Many community members experience challenges with obtaining sufficient food of any kind, as well as report issues with accessing healthy food more specifically. The financial challenges brought on by the COVID-19 pandemic has led to an increase in rates of food insecurity across all counties and sharply rising demand for emergency food assistance. Nearly a quarter of Philadelphia households are receiving Supplemental Nutrition Assistance Program (SNAP) benefits. Black and Hispanic/Latino communities are disproportionately impacted by food insecurity, as are older adults and immigrant communities. Redeemer Health has three food pantries which are located in Northeast Philadelphia, Cape May County, NJ and a Green Light food pantry at the Drueding Center, North Philadelphia. There is also a food closet located at Holy Redeemer Hospital's Cancer Center. Redeemer participates with the FAST App as a provider of food resources.	Continue partnership with the COACH collaborative to address food access in vulnerable populations which includes food insecurity screening, referral process development and a menu of other interventions. Advocate for legislation that supports access to food and supports.	Staff time to participate on the collaborative, attending meetings and participating in follow up activities	COACH which includes hospitals and other community and government organizations	Director of Planning	Implementation of new and improved food insecurity projects
	Investigate the implementation of food insecurity screening and referral in various areas of HRH including the Emergency Department, physician practices and Cancer Center.	Staff time in the development of the program and education of staff on the process. Potential IT staff time for the addition of a tracking measurement. Materials needed for the program	COACH, Physician practices, Community and government organizations (referral process)	Chief Nursing Officer Director of Planning	No. of people/families identified No. of people referred
	Investigate providing more self-choice options at the food pantries.	Staff time to develop and implement program Space	Community and government organizations	Director of Community Program and Engagement	No. of people/families who use self-choice
	Investigate implementing an electronic intake system at the Townsend Rd. food pantry for better tracking of demographics and needs of clients.	Staff time including IT to research, implement and train Intake System		Director of Community Program and Engagement	Implementation of system
	Investigate adding wrap around health services at the pantries such as flu shots, etc.	Staff time to develop and implement program Clinical staff time to staff the wrap around services Equipment Space	Community organizations, Physician practices	Director of Community Program and Engagement	No. of people who obtain wrap around services

	Activities	Inputs/Resources	Collaborations	Lead	Metrics
	Investigate the addition of a micro pantry at the hospital with food for patients needing immediate assistance.	Staff time to develop and implement program Location Supplies	Community organizations	Director of Community Program and Engagement	No. of people given food from the micro pantry
	Investigate additional delivery or transportation options for clients who cannot get to the Townsend Rd. food pantry.	Staff time to develop and implement program Volunteers or training on FAST App Depending on method – cost of transportation	Community organizations, FAST APP, Food Connect	Director of Community Program and Engagement	No. of deliveries by method

Access to Care (Primary & Specialty)					
Situation	**Activities**	**Inputs/Resources**	**Collaborations**	**Lead**	**Metrics**
	What are the main things the project will do/provide?	*What resources will be used to support the project?*	*Who will we work with on implementing the project?*	*Person responsible*	*What results should follow?*
The supply of primary care providers across the region compares favorably to national data and trends with uninsured rates are improving regionally, but challenges remain with increasing provider acceptance of new patients with Medicaid coverage. Barriers to access to primary care for communities are due to: – Lack of providers in neighborhoods (especially in NE/SW Philadelphia, rural areas in suburban counties) – Affordability (particularly among those who are uninsured, those with lower incomes unable to afford co-payments/ deductibles) – Language/cultural barriers (notably among immigrant communities and English language learners) The above issues are exacerbated with specialty care, with added challenges posed by even more limited availability of appointments, high cost, and lack of care coordination/linkage with primary care. Impacts of the COVID-19 pandemic include: – Increased enrollment in Medicaid (increases ranging from 11% to 20% in 5 counties, 2020-2021) – Longer wait times for appointments, especially for specialty care – Gaps in access to preventive services, including immunizations for children/youth, health screenings/ diagnostic testing for adults (e.g., chronic diseases, breast/ colon/prostate cancer)	With the Chestnut Hill Hospital Alliance (and pending final approvals), provide women's health, home care and other services as collaborative efforts may determine, to the service area which include west and north west Philadelphia. Alliance will also ensure emergency room services.	Staff time Providers Office location Materials & Supplies	Chestnut Hill Alliance which also includes Temple Health & Philadelphia College of Osteopathic Medicine (PCOM)	EVP/CAO HRPAS SVP/CMO Home Care & Pop Health	No. of office locations No. of patients
	Investigate expanding partnership with Medicaid insurers. Screen patients for Medicaid eligibility, assisting them with enrolling, particularly Obstetrics patients.	Staff time Training time	Insurers Community organizations Providers	EVP/CAO HRPAS SVP/CMO Home Care & Pop Health	No. of patients assist Coverage of service area
	Provide screenings, programs or health fair at the northeast Philadelphia and/or Cardone locations. Could include mammograms, blood pressure screenings, diabetes screenings, etc.	Staff time Providers Location Materials & Supplies	Community organizations Providers Insurers PCOM Students	EVP/CAO HRPAS SVP/CMO Home Care & Pop Health	No. of people screened, attended programs or fairs No. of tests run
	Provide educational programs for church and other organizations on topics relevant to primary, specialty and palliative care. Investigate recording the sessions for increased access to information.	Staff time Providers Materials & Supplies Video equipment & editing Website space	Community organizations Religious organizations Providers Insurers	EVP/CAO HRPAS SVP/CMO Home Care & Pop Health	No. of locations provide programs No. of people attend
	Expand the House Calls program, a program providing physician visits in the home.	Staff time Providers Materials & Supplies	Families	EVP/CAO HRPAS SVP/CMO Home Care & Pop Health	No. of visits No. of patients
	Formalize resource referral lists and process for SDOH screenings in the physician practices.	Staff time Printing Website space	Community organizations Providers	EVP/CAO HRPAS SVP/CMO Home Care & Pop Health	Completion of referral lists and process No. of referrals

	Activities	Inputs/Resources	Collaborations	Lead	Metrics
	Explore developing a formal medication review program in the primary care offices.	Staff time Providers IT support	Pharmacies Providers	EVP/CAO HRPAS SVP/CMO Home Care & Pop Health	No. of patients screened
	Continue to promote and increase ease of telehealth visits especially for patients who have access issues.	Staff time Providers Possibly information materials for patients	Insurers	EVP/CAO HRPAS SVP/CMO Home Care & Pop Health	No. of telehealth visits
	Continue to translate documents and forms for prevalent languages in the service area.	Staff time Interpreter services Printing	Community organizations Interpreter services	EVP/CAO HRPAS SVP/CMO Home Care & Pop Health	No. of documents translated
	Explore developing a mobile medical clinic program.	Staff time	Community organizations Providers Funding Agencies	EVP/CAO HRPAS SVP/CMO Home Care & Pop Health	Implementation of program
	Explore opening a Federally Qualified Healthcare Center.	Staff time	Providers Funding Agencies Federal Government	EVP/CAO HRPAS SVP/CMO Home Care & Pop Health	Implementation of program
	Utilize Redeemer Health public relations publications and social media outlets to educate community members about the offerings available.	Staff time Printing costs Website & social media sites Email lists	Various organizations, clinicians and providers who can contribute information to the publications and posts	Marketing Department – Public Relations	No. of articles and social media posts

Chronic Conditions (Prevention & Management)					
Situation	**Activities**	**Inputs/Resources**	**Collaborations**	**Lead**	**Metrics**
	What are the main things the project will do/provide?	*What resources will be used to support the project?*	*Who will we work with on implementing the project?*	*Person responsible*	*What results should follow?*
Conditions like heart disease, cancer, stroke, and chronic lower respiratory diseases continue to constitute the majority of the top 5 leading causes of death for all counties. Notable differences between counties in southeastern Pennsylvania: – Rate of premature cardiovascular deaths significantly higher in Philadelphia County – Cancer mortality rates highest in Delaware and Philadelphia Counties – Hypertension-related hospitalization rates highest in Bucks, Delaware, and Philadelphia Counties Across and within 5 counties, disparities in burden of chronic disease correlate with poverty, which disproportionately affects communities of color. In Philadelphia, for example, Hispanic/ Latino communities have some of the highest rates of chronic conditions, such as asthma and obesity, and the city's non Hispanic Black population has disproportionately high rates of chronic conditions such as hypertension and diabetes. The COVID-19 pandemic has negatively impacted chronic disease prevention and management. Notably, there have been delays in seeking care, as found in qualitative reports and indicated by lower health care utilization in 2020 as compared to previous years. The full impacts will be clearer with data from 2021 and beyond.	Nutrition & diabetes education to outpatients (both group and one-on-one) and employees. Nutrition care to inpatients and St. Joseph's Manor residents. Attendance at health fairs.	Staff time to provide education Materials Location to hold events	Organizations with Health Fairs Divisions within health system Physicians	Clinical Nutrition Manager	No. of people counseled
	Investigate restarting the Trim-a-Weigh or similar program as a Zoom class which will combine fitness and food counseling for people who want to lose weight.	Staff time to provide services Materials Location to hold exercise and nutrition classes	Providers Weight loss and food counseling program	Fitness Center Clinical Nutrition Manager	No. of people who participate
	Continue to provide programs which benefit employees and community members to eat better, exercise and improve mental well-being.	Staff time to provide the program Location to hold programs Materials	Simplex Nutrition Fitness Center Various partners to provide classes	Various Departments	No. of people who participate No. of programs
	Smoking Cessation – Train new staff members to be certified in smoking cessation classes. Implement free smoking cessation classes 2 to 4 times a year. Participate in the Great American Smoke out. Continue with lung screening program for at risk community members.	Staff time to develop and market programs Staff time to counsel Marketing materials Smoking class materials Lung screening diagnostics	American Cancer Society Physicians	Smoking Cessation Coord Cancer Center Director	No. of people who attend classes and participate in programs No. of community members screened for lung cancer

	Activities	Inputs/Resources	Collaborations	Lead	Metrics
	Health Screenings – Provide screenings for at risk populations, collaborating with organizations and community groups. Going out into the community with screenings as often as feasible. Uninsured breast cancer screenings for eligible women without insurance.	Staff time to organize screenings Staff and physician time Screening cost for people with no insurance	Potential partners include community groups, insurance co, businesses, schools, churches, Healthy Women program, American Cancer Society, S. Firehouse event, among others	Cancer Center Director	No. of screenings performed No. of people screened
	Community events and walks – Hold events and walks with a focus on education about healthy living including obtaining screenings and prevention of diseases, targeted to at risk populations and conditions.	Staff time to organize community events Staff time participating at community events Cost of materials Marketing efforts	Potential partners include community groups, businesses, schools, churches, American Cancer Society, Ladies of Port Richmond, among others	Cancer Center Director Marketing Department	No. of community members who participated No. of events
	Hold disease specific zoom webinars throughout the year to educate the community on disease conditions, screening tools and/or prevention mechanisms.	Staff time to develop the webinar Zoom & IT resources Provider time Marketing efforts	Providers Community organizations as relevant	Various Department Heads Marketing Department	No. of webinars No. of attendees
	Utilize Redeemer Health public relations publications and social media outlets to educate community members about the offerings available.	Staff time Printing costs Website & social media sites Email lists	Various organizations, clinicians and providers who can contribute information to the publications and posts	Marketing Department	No. of articles and social media posts

Substance Use and Related Disorders					
Situation	**Activities**	**Inputs/Resources**	**Collaborations**	**Lead**	**Metrics**
	What are the main things the project will do/provide?	*What resources will be used to support the project?*	*Who will we work with on implementing the project?*	*Person responsible*	*What results should follow?*
Substance use disorders often co-occur with mental health conditions. Substance use is associated with community violence and homelessness. Drug overdose rates continue to be high due to the opioid epidemic. The drug overdose rates in Bucks, Delaware, and Philadelphia Counties exceed the overall Pennsylvania rate. It is the leading cause of death for young adults. The opioid epidemic is associated with increases in other health conditions including HIV, Hepatitis C, and Neonatal Abstinence Syndrome (NAS). Use of other substances, especially during the COVID-19 pandemic, was of pressing concern to community members and partners. Binge drinking among adults and youth, as well as cigarette, marijuana, and vape use among youth, were raised as increasingly prevalent. High rates of marijuana vaping among youth in the four suburban counties.	Substance Use Disorder (SUD) program for pregnant through post-partum patients and their babies. Program to include a SUB OB Navigator and Behavioral Health counselor. Assessment beginning in the OB office, with screening tool, resources, suboxone prescription and referral process through post-partum follow up. Documents provided in seven different languages.	Staff time Materials for education and training IT resources Other resources as needed	Providers Community Organizations to provide supportive services and resources Opioid and substance abuse organizations	Chief Nursing Officer	No. of positive screens No. of referrals No. of women in program initially, 3, 6, and 9 months post-partum
	Training of all staff in the Obstetric practices and on the LDR/OB/NICU unit in trauma informed practices. Continue training in all other areas of the hospital.	Staff time and salary cost Organization to provide training	Community organization Funding organizations	Chief Nursing Officer	No of staff trained Pre & post knowledge tests
	Provide Narcan to all identified moms in the SUD program upon discharge.	Staff time Narcan	Narcan supplier	Chief Nursing Officer	No. of Narcan handed out
	Investigate adding a certified addiction counselor at OB visits in all practices for those patients who screen positive.	Staff time Salary	Providers	Chief Nursing Officer	No. patients who visit the counselor
	Continue to institute a warm handoff program in the Emergency Department, using a care manager to provide a connection for people with addictions to treatment.	Staff time Materials for print publications & cost of obtaining mailing lists	Hospital Association of Pennsylvania Treatment facilities Community organizations Health Department	Chief Nursing Officer Director of Nursing, ER	No. patients referred No. of patients connected to treatment
	Continue to have Emergency Department staff go out to health fairs, etc. to educate the community about substance use issues	Staff time Materials	Community organizations including schools, churches, etc.	Chief Nursing Officer Director of Nursing, ER	No. of community connections
	Investigate holding a take back prescription drug event. Educate community about the current location of drop off boxes.	Staff time Location Materials	Community organizations	Chief Nursing Officer	No. of prescription drugs in drop off boxes
	Utilize Redeemer Health public relations publications and social media outlets to educate community members about the offerings available.	Staff time Printing costs Website & social media sites Email lists	Various organizations, clinicians and providers who can contribute information to the publications and posts	Marketing Department – Public Relations	No. of articles and social media posts

Racism & Discrimination in the Healthcare Setting

Situation	Activities	Inputs/Resources	Collaborations	Lead	Metrics
	What are the main things the project will do/provide?	*What resources will be used to support the project?*	*Who will we work with on implementing the project?*	*Person responsible*	*What results should follow?*
Racism is recognized as an ongoing public health crisis in need of urgent, collective attention. The COVID-19 pandemic has unmasked and amplified longstanding health and economic disparities experienced by communities of color. Higher rates of COVID-19 infection, hospitalization, and mortality experienced by Black communities are further examples of inequities stemming from structural racism. Representatives of communities of color shared their mistrust of healthcare providers and institutions arising from seeing such disparities and personally experiencing discriminatory treatment in health care settings. Such experiences can lead to forgoing of needed care, resulting in increased morbidity and mortality. Anti-Asian hate crimes have increased during the COVID-19 pandemic. Fear of violence among Asian older adults has led to reluctance in leaving their homes, resulting in increased social isolation and adversely affecting mental and physical health.	Formalize the strategic direction of the DEI program in conjunction with the newly hired Chief Diversity & Inclusion Officer	Staff time		Chief Diversity & Inclusion Officer	Completion of strategic direction
	Develop a data collection and dissemination strategy for the DEI program.	Staff time IT resources Data analytic program		Chief Diversity & Inclusion Officer	Completion of the dashboard updated monthly
	Continue with the 5-part Diversity, Equity and Inclusion educational sessions for leadership and staff. Integrate educational opportunities into various platforms.	Staff time Zoom & IT resources Training facilitation	VIP Training	Chief Diversity & Inclusion Officer	No. of staff who complete
	Formulate a process for establishing a mentoring program.	Staff time		Chief Diversity & Inclusion Officer	No. of staff mentored
	Utilize internal and external communication mechanisms to acknowledge, educate and celebrate cultural events and holidays. Establish a Diversity Awareness week to educate and celebrate the importance of diversity.	Staff time Employee portal IT resources Social media platforms	Resources to gather information about various cultures	Chief Diversity & Inclusion Officer	No. of communications
	Continue to act as a work study location for the Cristo Rey high school students interested in the medical field throughout the system.	Staff time IT resources Materials & Supplies	Cristo Rey High School	Associate Vice President, Human Resources	No. of students who participate in the work study program
	Inventory current community partnerships, identify gaps in communities we serve, and establish additional partnerships focused on DEI efforts.	Staff time	Community organizations Businesses Not for Profit organizations	Chief Diversity & Inclusion Officer	To be determined depending on the partnership No. of partnerships

Housing					
Situation	**Activities**	**Inputs/Resources**	**Collaborations**	**Lead**	**Metrics**
	What are the main things the project will do/provide?	*What resources will be used to support the project?*	*Who will we work with on implementing the project?*	*Person responsible*	*What results should follow?*
Safe, stable housing is critical for physical and mental health and well-being. Lack of stable housing is associated with 27.3 fewer years of life expectancy. In 2018, 40 percent of Philadelphia households were costburdened (when a household spends 30 percent or more of its income on housing costs, including rent, mortgage payments, utilities, insurance, and property taxes). This figure is expected to be higher as a result of the COVID-19 pandemic. Lack of affordable housing is a major driver of homelessness. Although point-in-time counts of individuals experiencing homelessness indicate decreases in overall numbers in all five counties over the past several years, continued focus on addressing homelessness is critical, especially when the moratorium on evictions ends. Homelessness experienced by youth and older adults are of particular concern for local advocates. Drueding Center, located in North Philadelphia, offers long-term support services and transitional housing for young families (18-24) and their children.	Improve and modify the on campus transitional housing units to make them easily convertible to permanent supportive housing when/if needed.	Staff time Funding for renovations Materials & Supplies	Funders – local, state and federal Architects & Builder	VP/Executive Director of Drueding Center	Current transitional housing units renovated.
	Continue to provide rental assistance through internal rent subsidies to approved DRAPP recipients.	Staff time Funding	Landlords Local Housing Agencies Housing organizations	VP/Executive Director of Drueding Center	No. of families assisted through subsidies or discounts.
	Investigate the potential for and impact of developing additional units of permanent supportive and/or affordable housing on future operations.	Staff time Data Analytics Consultant expertise	Funders – local, state and federal Potential Partner Architects Community Members	VP/Executive Director of Drueding Center	Decision on project. If yes, number of units/housing.
	Investigate and continue to engage in partnerships for the benefits of residents and clients, providing opportunities for community building, housing, education, programming and any other relevant activity, including programs that focus on skills to decrease homelessness.	Staff time Space Facilitator/Educator Funding Materials	Landlords Non-profits For-profits Organizations Community Members	VP/Executive Director of Drueding Center	No. of increased housing opportunities No. of education or programming events
	Focus advocacy efforts for relevant topics including additional affordable housing and increase in income/wages.	Staff time Travel expense Resident or client time	Local, state and federal legislators Other community organizations with similar interests	VP/Executive Director of Drueding Center	No. of touchpoints