

# 2025 - 2028 Hospital Implementation Strategy Plan

Yale  
NewHaven  
**Health**  
Yale New Haven  
Hospital



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## INTRODUCTION

Yale New Haven Hospital (YNHH) is dedicated to improving the health and well-being of patients and community members. As a not-for-profit hospital, YNHH conducts a Community Health Needs Assessment (CHNA) every three years, as required by Section 501(r)(3) of the Internal Revenue Code. This assessment identifies the region’s most pressing health challenges and helps guide the hospital’s efforts to address them.

The CHNA process included input from a range of community members and leaders including public health experts, community organizations, and representatives of under-resourced populations. This approach ensures that the assessment and its findings reflect the diverse health needs and experiences of the community.

The findings in the CHNA report informed this Implementation Strategy Plan (ISP), which outlines specific steps YNHH will take to address the identified health priorities of Behavioral Health, Food Insecurity and Culturally Competent Care. The CHNA report was approved by the Yale New Haven Hospital Board of Trustees on September 29, 2025, and the ISP on February 12, 2026. The documents will be made publicly available to ensure transparency and accountability.

## About Yale New Haven Hospital

**Yale New Haven Hospital (YNHH)**, with two campuses in downtown New Haven, is a nationally recognized, not-for-profit academic medical center located in New Haven, Connecticut. It serves as the flagship hospital of Yale New Haven Health (YNHHS) and is affiliated with the Yale School of Medicine, providing advanced medical care, research, and education.

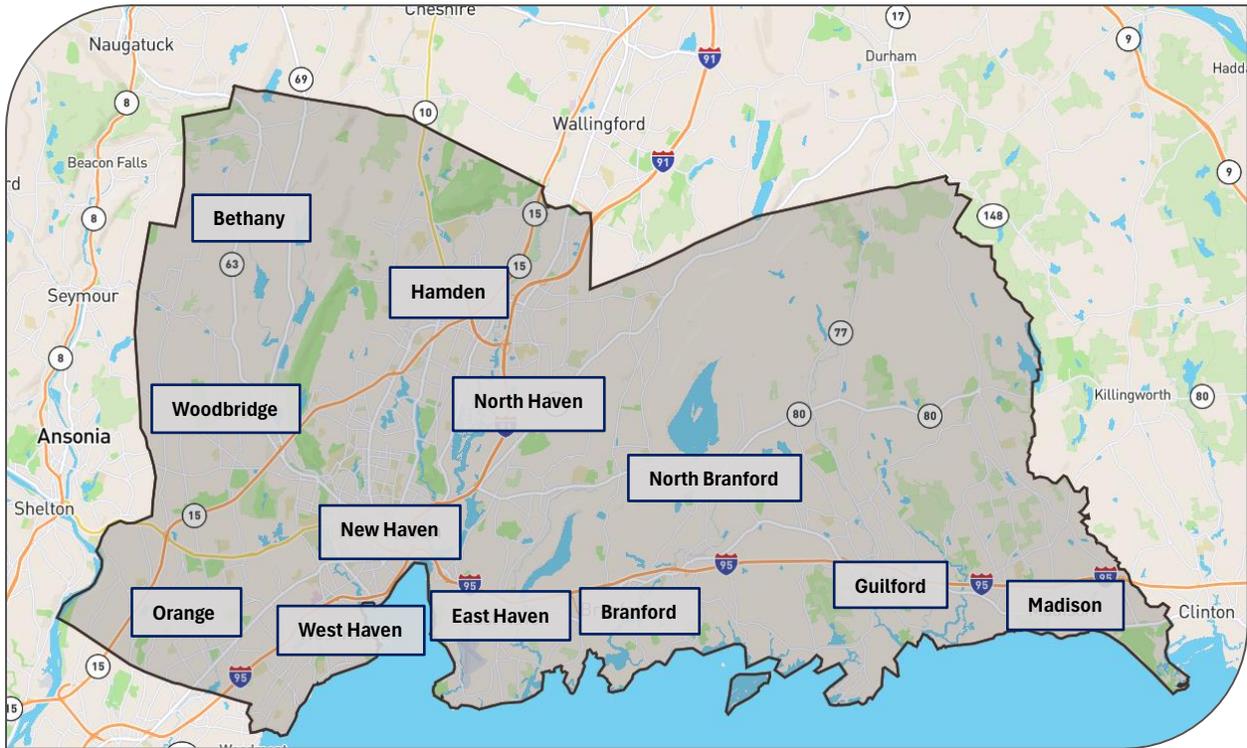
YNHH also includes several specialized hospitals, ensuring comprehensive, patient-centered care. **Yale New Haven Children's Hospital** offers specialized pediatric services, including neonatal and pediatric intensive care. **Yale New Haven Psychiatric Hospital** provides inpatient and outpatient mental health services for adolescents and adults. **Smilow Cancer Hospital**, part of the Yale Cancer Center, is a nationally recognized leader in cancer treatment and research.

As a major referral center for Connecticut and beyond, YNHH offers specialized services in cardiology, neurology, transplant surgery, trauma care, and more. The hospital is committed to improving community health through outreach programs, research, and partnerships aimed at addressing health disparities and expanding access to care.

For more information, visit Yale New Haven Hospital’s website at [www.ynhh.org](http://www.ynhh.org).

## Service Area

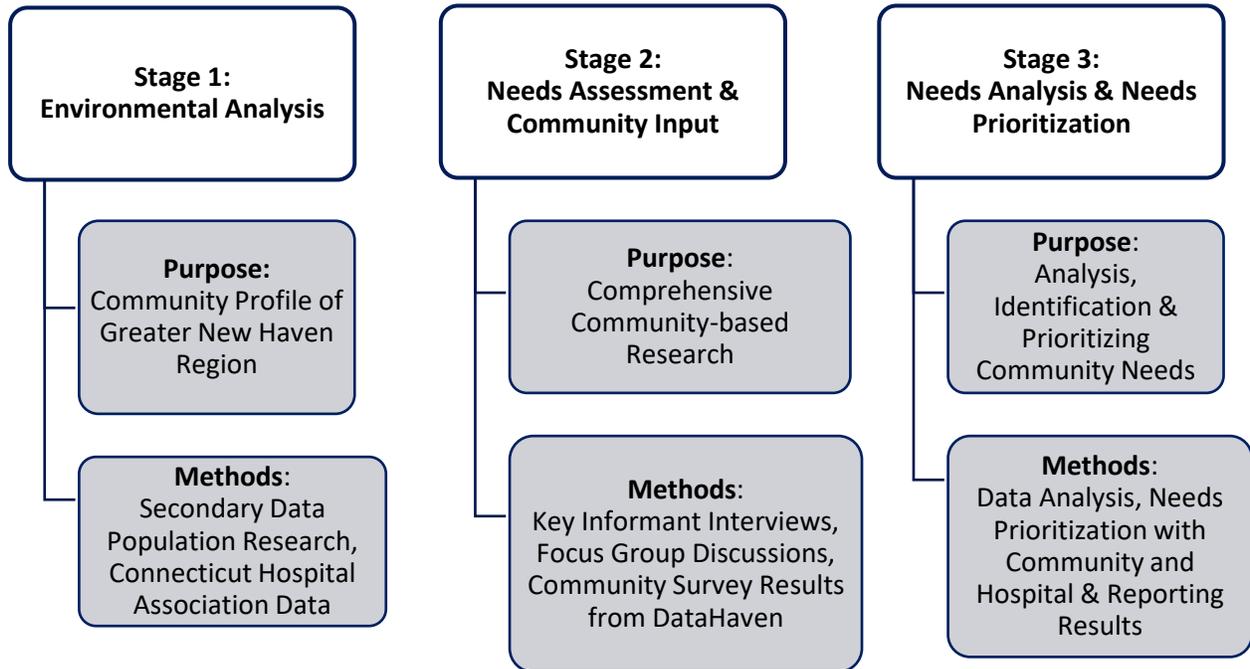
The municipalities in the Greater New Haven region served by YNHH include the cities of New Haven and West Haven, and the towns of Bethany, Branford, East Haven, Guilford, Hamden, Madison, North Branford, North Haven, Orange, and Woodbridge. These municipalities are all located within New Haven County, Connecticut.



## COMMUNITY HEALTH NEEDS ASSESSMENT OVERVIEW

The 2025 CHNA followed a three-stage methodology designed to capture a wide range of perspectives and data sources. The process included insights and input from a range of community members and leaders representing diverse backgrounds across the 12-town Greater New Haven region.

This inclusive approach is outlined in the graphic below, which summarizes the core components of each stage: environmental analysis, community input, and needs prioritization.



**Data Collection:** Our robust data collection process included qualitative and quantitative data collection which provided critical insights into demographics of the region, access and experience of care and services and how social drivers impact health outcomes.

 <p><b>Environmental Analysis &amp; Collection of Secondary Data:</b> 30 + secondary sources and 60 + Health Indicators including the American Community Survey (Census), Centers for Disease Control and Prevention, United Way of Connecticut, U.S. Department of Housing and Urban Development, County Health Rankings and Connecticut Hospital Association, among others, with information on demographics insurance status, health outcomes and more.</p>	 <p><b>DataHaven Community Wellbeing Survey:</b> 1,060 telephonic surveys completed by Greater New Haven community members as part of the probability sampling process conducted by DataHaven. The survey is used to evaluate local health and wellbeing opportunities spanning health care, housing, employment, and community needs, gaps and resources.</p>
 <p><b>Key Informant Interviews:</b> 30 one-on-one (Virtual and Telephonic) key informant interviews with 27 key informants and three Community Advocates.</p>	 <p><b>Focus Groups:</b> Nine focus groups, two in Spanish; seven in English speaking with and learning from over 82 community members.</p>
 <p><b>Access Audit:</b> Mystery shopper calls to evaluate how easily community members can access health care, social services, and resources in the Greater New Haven region.</p>	

# COMMUNITY NEEDS

## List of Identified Community Health Needs

The following list highlights the full community needs identified through the 2025 Community Health Needs Assessment data analysis process for Greater New Haven. These health needs are categorized into high-level focus areas and are presented without prioritization.



### Healthcare Needs

- Better access to specialty care services, including orthopedics and cardiology, to address extended wait times.
- Enhanced access to affordable medications to address high out-of-pocket costs for individuals on state insurance.
- Establishment of culturally competent health navigators to assist patients in navigating healthcare systems.
- Expanded maternal and prenatal care for underserved populations to improve birth outcomes.
- Expansion of community health clinics to provide preventive care and manage acute care needs.
- Increased availability of affordable dental care services, particularly for Medicaid recipients.
- Increased availability of primary care providers to reduce wait times and improve access.

### Behavioral Health Needs

- Development of crisis intervention services to provide immediate support for individuals experiencing behavioral health crises.

- Expanded access to affordable substance use treatment programs, including recovery resources.
- Greater investment in school-based behavioral health programs to address youth mental health challenges.
- Implementation of integrated care models that combine behavioral health and physical health services.
- Increased availability of mental health services for youth and adults to address long wait times for care.
- Stigma reduction programs to encourage individuals to seek behavioral health care and substance use treatment.

### **Culturally Competent Care Needs**

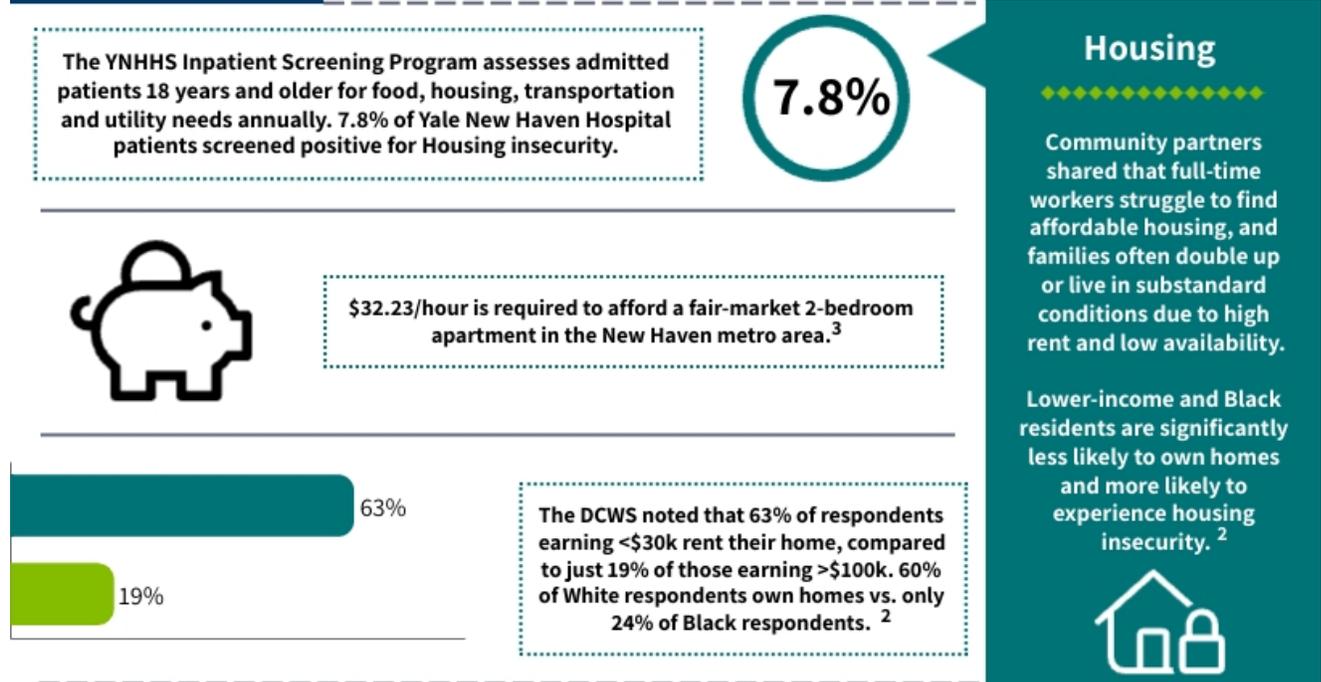
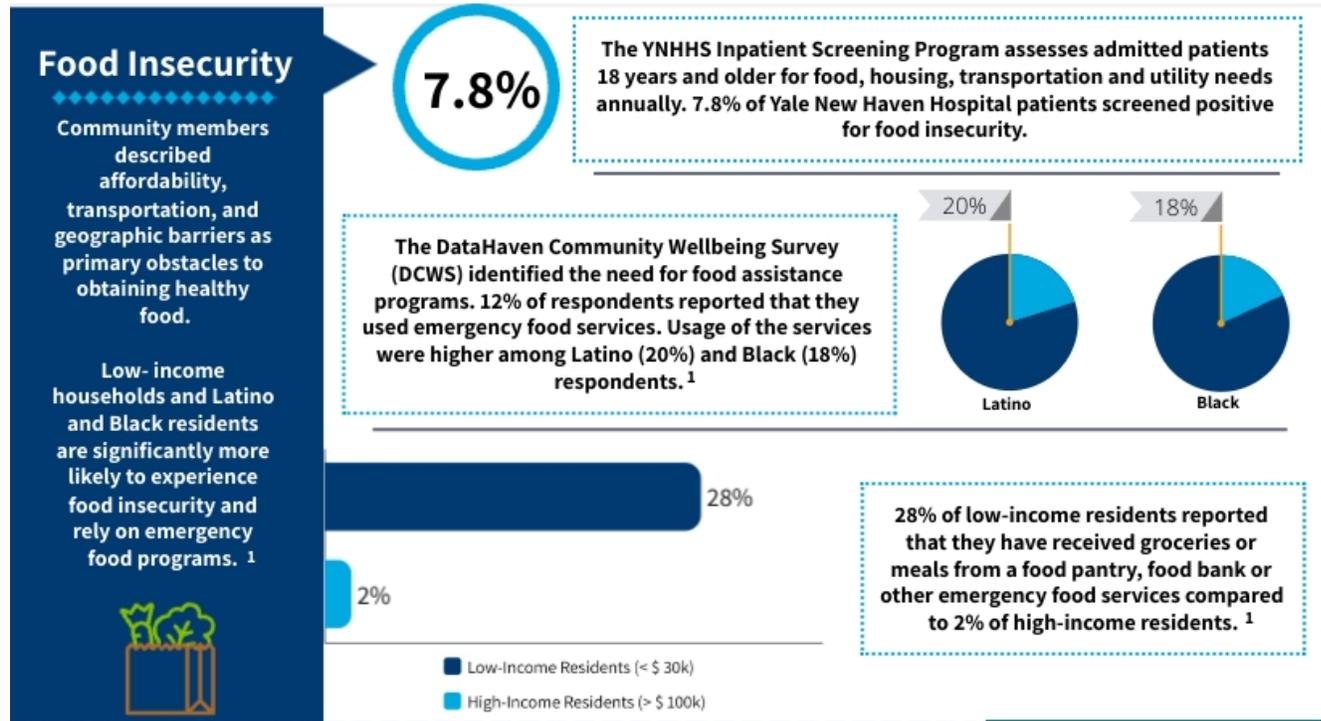
- Broader initiatives focused on addressing socioeconomic and demographic disparities in healthcare delivery and resource distribution.
- Enhanced training programs for healthcare providers to promote cultural competence and reduce implicit bias.
- Expansion of equitable resource distribution to underserved neighborhoods to reduce health disparities.
- Improved language accessibility in healthcare services through bilingual providers and interpreter services.
- Increased outreach and tailored programs for immigrant populations to reduce barriers to care.

### **Social Drivers of Health Needs**

- Development of affordable childcare programs to support working families and improve economic stability.
- Enhanced access to fresh and affordable food options to address food insecurity.
- Expansion of youth programs, including recreational and educational opportunities, to promote well-being.
- Improved environmental health initiatives to address air and noise pollution, water quality, and exposure to environmental hazards in underserved neighborhoods.
- Improved transportation services to ensure reliable access to medical appointments and community resources.
- Increased access to affordable housing to improve stability for low-income families.
- Strengthened support services for seniors, including transportation and affordable healthcare, to reduce isolation.

A summary of the data highlights that speak to these needs, and informed the hospital prioritization process, are detailed in the infographics in the three pages that follow.

## Data Highlights



<sup>1</sup> DataHaven Community Wellbeing Survey, 2024

<sup>2</sup> Community Health Profiles, Hospital utilization rates for key health indicators. Provided by Connecticut Hospital Association

<sup>3</sup> National Low Income Housing Coalition, Out of Reach 2023

## Transportation



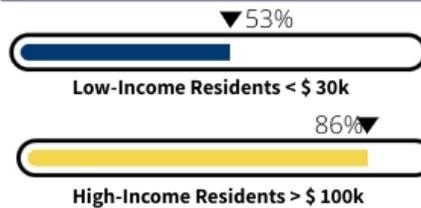
Key Informants emphasized that public transportation is expensive, unreliable, and does not adequately serve all neighborhoods—making access to healthcare and jobs difficult for low-income residents.



Low-income residents are less likely to have reliable transportation, which restricts access to healthcare, employment, and other essential services. <sup>4</sup>



The YNHHS Inpatient Screening Program assesses admitted patients 18 years and older for food, housing, transportation and utility needs annually. 3.1% of Yale New Haven Hospital patients screened positive for Transportation insecurity.



DCWS revealed residents only 53% of residents earning <\$30k had regular access to a car, compared to 86% of residents earning > \$100K. <sup>4</sup>

## Childcare

Community members and stakeholders described cost, limited availability, long waitlists, and trust issues as major barriers to accessing childcare, particularly for low-income families.

Lower-income families and single parents face the greatest difficulties finding affordable, trusted childcare, limiting their economic opportunities and family stability.

### Preterm Birth Rates



### Early Prenatal Care



Black mothers are less likely to receive early prenatal care and more likely to have preterm births compared to White mothers. Low birthweight increases risks for health complications during infancy and later life. <sup>5 & 6</sup>

## Maternal & Prenatal Care



Key Informants reported fewer providers for prenatal care, high costs for uninsured mothers, and limited culturally appropriate services.



<sup>4</sup> DataHaven Community Wellbeing Survey

<sup>5</sup> National Center for Health Statistics, final natality data.

<sup>6</sup> CDC WONDER, Natality, 2021

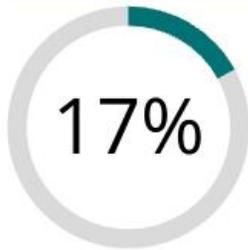
Mental health-related hospitalizations occurred at a higher rate at Yale New Haven Hospital (15.7 per 1,000) compared to the statewide rate (10.4 per 1,000).



### Behavioral Health

Community members noted a shortage of child psychiatrists, long wait times for services, and difficulty navigating fragmented mental health systems.

Black and Hispanic residents are more likely than White residents to be hospitalized for mental health and also report higher barriers to accessing outpatient care.<sup>7</sup>



The DCWS highlighted that 17% of adults could not access needed mental health care.

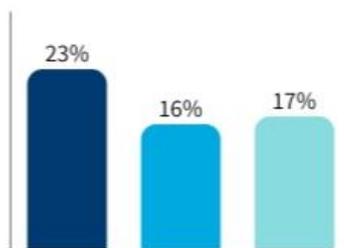
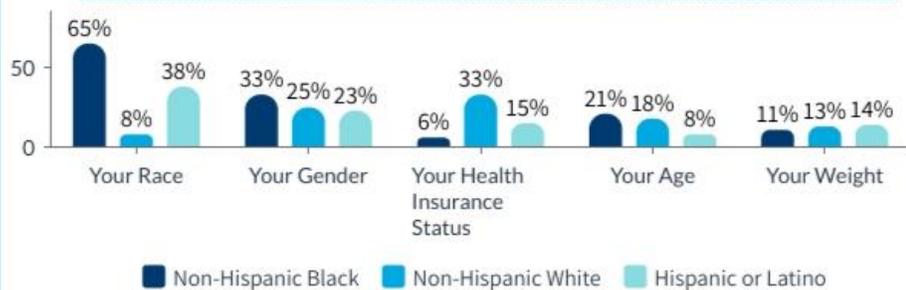
26% of Latino respondents and 20% of low-income residents reported barriers.<sup>7</sup>

### Cultural Competence

Key Informants highlighted that language access is limited. Patients often feel dismissed, and culturally appropriate care is lacking across many provider settings.

Black, Indigenous and other communities of color are more likely to experience bias and discrimination in care settings - especially in hospitals and emergency rooms.<sup>9</sup>

The DCWS highlighted that 65% of Black respondents felt their race influenced how they were treated in care settings. Community members and key informants shared that patients may receive lower-quality care or less respect in healthcare settings based on personal characteristics. Survey data from DCWS supports these concerns.<sup>10</sup>



The DCWS revealed that Black (23%) and Latino (17%) respondents were more likely than White respondents (16%) to report receiving disrespectful or poor-quality healthcare.<sup>11</sup>

<sup>7</sup> DataHaven Community Wellbeing Survey

<sup>8</sup> Community Health Profiles, Hospital utilization rates for key health indicators. Provided by Connecticut Hospital Association

<sup>9</sup> DataHaven Community Wellbeing Survey

<sup>10</sup> DataHaven Community Wellbeing Survey

<sup>11</sup> DataHaven Community Wellbeing Survey

## IMPLEMENTATION STRATEGY PLAN METHODOLOGY

To ensure that the 2025 Community Health Needs Assessment (CHNA) and Implementation Strategy Plan (ISP) reflects feedback from Greater New Haven residents, a structured prioritization process was conducted using a combination of community input and evidence-based decision-making methods.

### Regional Community Prioritization

A Community Voices Survey, available in English and Spanish, was distributed through the Healthier Greater New Haven Partnership (HGNHP) and other community partners, engaging 77 community members who ranked the most essential community needs for them and their family. Their feedback informed the regional prioritization session. The top eight needs ranked by community members were:

1. Increased access to **affordable housing** to improve stability for low-income families.
2. Enhanced access to fresh and affordable food options to address **food insecurity**.
3. Development of **affordable childcare** programs to support working families and improve economic stability.
4. Expanded **maternal and prenatal care** for underserved populations to improve birth outcomes.
5. Expansion of **youth programs**, including recreational and educational opportunities, to promote well-being.
6. Increased availability of **mental health services for youth and adults** to address long wait times for care.
7. Greater investment in school-based behavioral health programs to address **youth mental health** challenges.
8. Expansion of **equitable resource distribution** to underserved neighborhoods to reduce health disparities.

A regional community prioritization session, conducted in person with HGNHP members, Community Advocates, hospital staff and other community partners, utilized a modified Hanlon Method, an evidence-based approach approved by the National Association of County and City Health Officials (NACCHO).<sup>5</sup> Participants first completed a pre-session survey, scoring the original 25 needs from the data analysis based on magnitude, severity and feasibility which generated an initial prioritization score.

During the live session, participants used the PEARL-E framework, a modified version of the Hanlon Method's PEARL (Proprietary, Economics, Acceptability, Resources, Legality) criteria. The "E" in PEARL-E adds an Equity component to ensure that systemic disparities were considered in decision making. Needs that did not meet PEARL-E criteria were removed from

the final vote. At the end of the session, the top 10 priority needs were grouped into three priority themes with a theme addressing socioeconomic and demographic disparities.



## Hospital Priority Areas

Yale New Haven Hospital leadership engaged in a data-driven prioritization process, considering multiple inputs, including:

- Findings from the Community Voices Survey
- Outcome of the Regional Prioritization Session
- Comprehensive quantitative and qualitative data analysis

After reviewing this information, YNH leadership selected two key needs:



Behavioral health challenges and food insecurity have been ongoing community health concerns in the Greater New Haven area and were further intensified by the COVID-19 pandemic, including the effects of social isolation and economic inflation. These challenges vary across the service area, with differences observed between the city of New Haven and the surrounding 12-town region, as well as across income levels and other socioeconomic conditions.

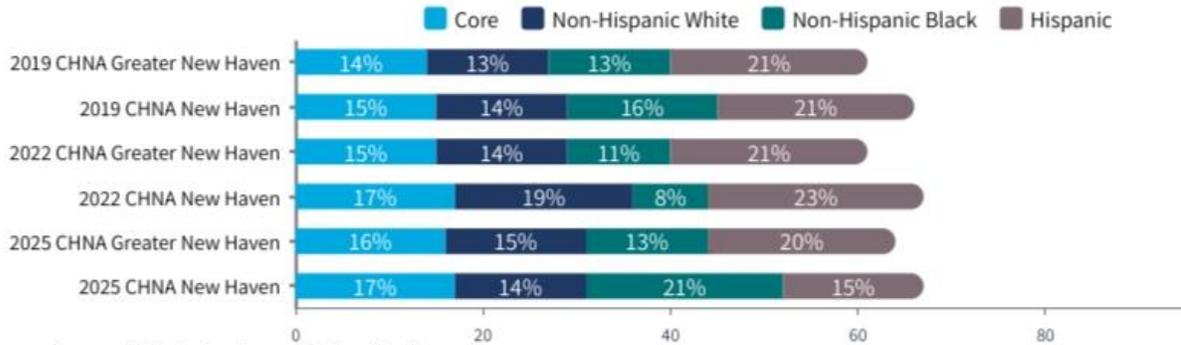
# Behavioral Health

## Greater New Haven Region vs. New Haven 2019 -2025

Source: 1. 2018 DCWS | 2. 2021 DCWS | 3. 2024 DCWS

### Anxiety 1, 2, 3

Adults who reported that they felt "Mostly" and "Completely" anxious.



\*Core represents geography Greater New Haven or the City of New Haven

### Emotional Support 1, 2, 3

Adults who indicated that they receive the emotional and social support they need.



2019 CHNA Greater New Haven



2022 CHNA Greater New Haven



2025 CHNA Greater New Haven



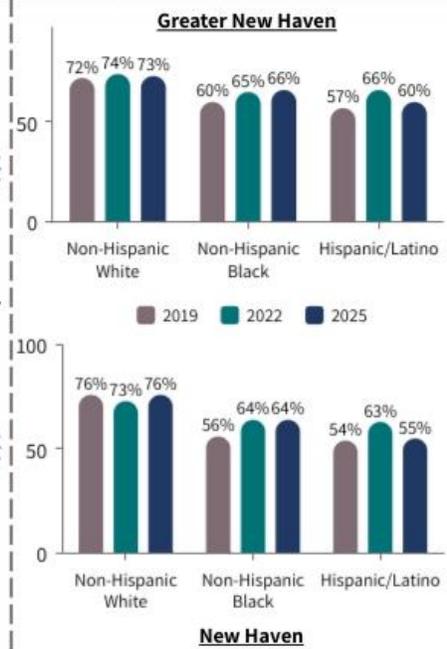
2019 CHNA New Haven



2022 CHNA New Haven



2025 CHNA New Haven



### Depression 1, 2, 3

Adults who reported feeling down, depressed or hopeless "nearly every day" " More than half the days" and "Several days".



2019 CHNA Greater New Haven



2019 CHNA New Haven



2022 CHNA Greater New Haven



2022 CHNA New Haven



2025 CHNA Greater New Haven



2025 CHNA New Haven

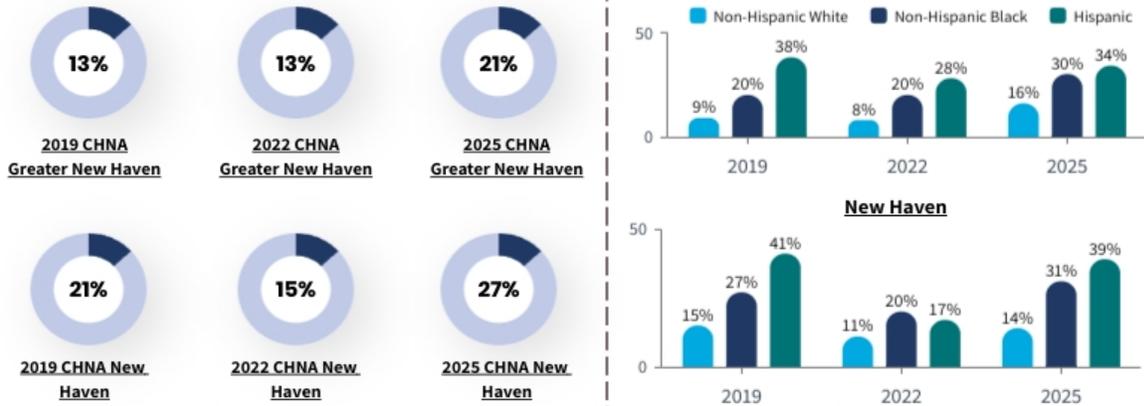
# Food Insecurity

## Greater New Haven Region vs. New Haven 2019 - 2025

Source: 1. 2018 DCWS | 2. 2021 DCWS | 3. 2024 DCWS

### Insecurity<sup>1, 2, 3</sup>

Adults who stated that they had times in the past 12 months when they did not have enough money to buy food that they or their family needed

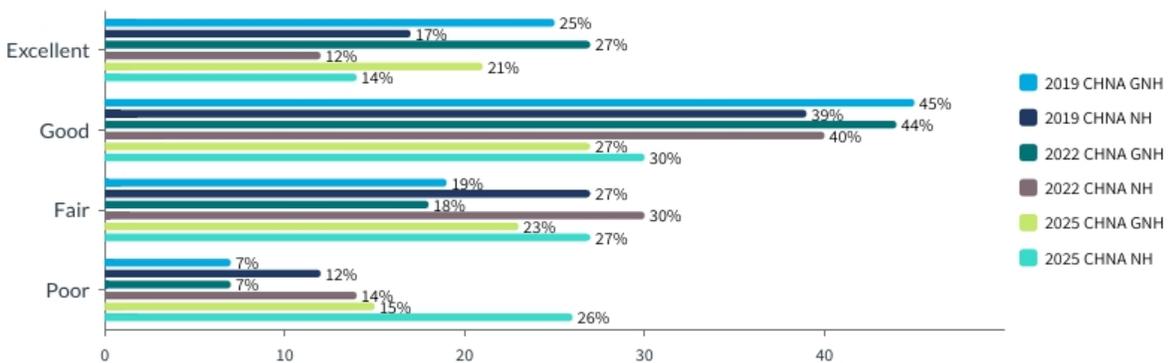


DCWS Question: How often did this happen - almost every month, some months but not every month, or in only 1 or 2 months?



### Availability<sup>1, 2, 3</sup>

Adults were asked if high-quality fruits and vegetables are readily available.

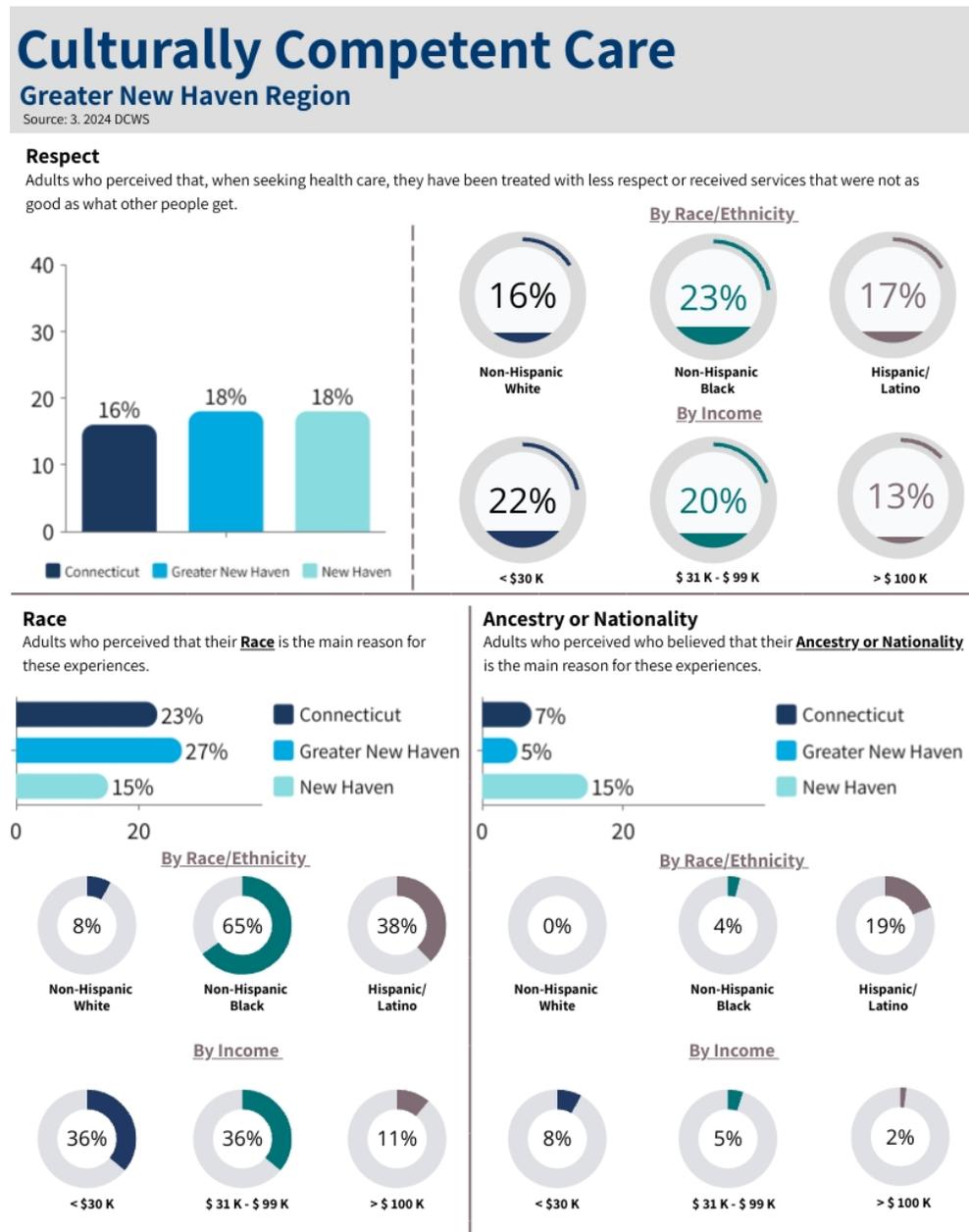


Notably, the sharp decrease in food insecurity prevalence in New Haven reported in the 2022 CHNA and 2021 DataHaven Community Wellbeing Survey is mostly attributed to the 2021 expansion of the federal child tax credit. After the federal tax credit expired, as families' budgets were stretched and with persistent economic inflation, food insecurity rose to 27% in New Haven (DCWS), considerably higher than pre-pandemic (21%) and during the tax credit period (15%).

## Health System Priority Area

Community members, from across our hospital regions, identified cultural competency as a need during the 2025 CHNA process. This valuable feedback revealed opportunities to improve patient care by expanding language access through bilingual providers and interpreter services, and cultural sensitivity training and education for staff.

In the Greater New Haven region, findings from the DataHaven Community Wellbeing Survey reveal variations in community perceptions related to quality of care and respect. These data are illustrated in the visual below.



In response, Yale New Haven Health (YNHHS) selected Culturally Competent Care as a 2025-2028 priority area and will be implementing national standards for [Culturally and Linguistically Appropriate Services \(CLAS\)](#) at each of our hospitals. These standards will enhance the existing quality of service provided to all patients, ensuring respect for every patient’s health needs and preferences. The progress of these standards will be measured with both process and outcome measures aligned with system Patient Experience metrics connected to our Press Ganey Surveys.

The Press Ganey Survey gathers patient feedback on the care and services received during their hospital stay or ambulatory visit. This valuable input helps us identify opportunities for improvement, ensure the highest quality of care, and enhance the overall patient experience. The survey addresses key aspects of patient experience, including communication with health care staff, the care environment, and overall satisfaction with treatment.



In sum, at YNHH there will be two hospital specific priorities: Behavioral Health and Food Insecurity and one YNHHS priority: Culturally Competent Care. These three focus areas align with community voice and organizational resources. The goals, strategies and action items that pertain to these three priority areas are detailed on page 23.

## Development of Strategy and Actions

To formulate effective strategies for the prioritized health needs, YNHH undertook the following steps:

- **Best Practices Literature Review:** Conducted a comprehensive review of current best practices and evidence-based interventions related to Behavioral Health and Food Insecurity.

- **Subject Matter Expert Interviews:** Engaged with internal and external experts to gather insights and recommendations on feasible and impactful strategies, including the involvement of Executive Sponsors in the areas of Behavioral Health and Food Insecurity.
- **Review of Existing Hospital Programs:** Assessed current YNHH programs and initiatives addressing the identified health needs to identify opportunities for enhancement, investment and alignment with best practices.

## Community Engagement and Strategy Refinement

YNHH and Crescendo Consulting Group facilitated two dedicated strategy sessions—one focusing on Food Insecurity and the other on Behavioral Health. These sessions, conducted through a mix of virtual and in-person meetings, included hospital leadership and subject matter experts.

Participants collaboratively discussed goals using the SMART (Specific, Measurable, Achievable, Relevant, Time-bound) framework, brainstormed potential interventions, and refined strategies. This collaborative approach ensured that the selected strategies are both evidence-based and tailored to the specific needs and capacities of the community and the hospital.

## Definition of Terms

To ensure clarity and consistency throughout the Implementation Strategy Plan, the following terms are defined. These terms describe how the hospital organized its approach to addressing community health needs, setting goals, and identifying strategies and actions for the fiscal year 2025–2028 planning cycle.

Term	Definition
<b>Priority Areas</b>	Selected community health needs for the 2025-2028 ISP.
<b>Goal</b>	Future desired result of each priority area written as a SMART goal statement.
<b>Strategy</b>	What the hospital is doing to reach the priority area goal.
<b>Action</b>	Approximately 5-10 for each strategy.

## Hospital Response to Top Regional Needs

Health Need Identified by Community in CHNA	Hospital’s Response
Affordable housing	This need is being addressed by community organizations specializing in this area.
▶ Behavioral Health	This need was selected by hospital leadership as a priority health need. See <a href="#">page 13</a> for our plan to address it.
Childcare	This need is being addressed by community organizations specializing in this area.
▲ Cultural Competence	This need (called Culturally Competent Care) was selected by Yale New Haven Health leadership as a 2025-2028 priority area and will be addressed across the system. See <a href="#">page 17</a> for our plan to address it.
▶ Food Insecurity	This need was selected by hospital leadership as a priority health need. See <a href="#">page 15</a> for our plan to address it.
Maternal/Child Health	Though not a 2025-2028 priority area, the hospital already is addressing this need through established programs.
Socioeconomic and Demographic Disparities	To improve health outcomes for the populations we serve, this need will be integrated into our work plan.
Transportation	The hospital partners with community organizations to address this need and has limited capacity to expand at this time.

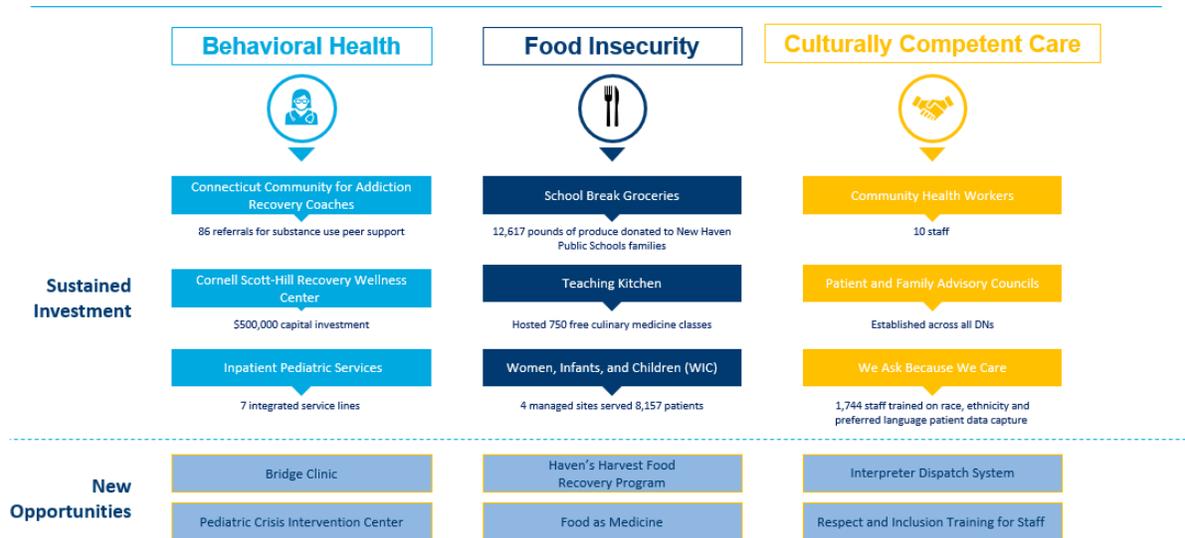
▶ Indicates hospital priority health need

▲ Indicates system priority health need

Although behavioral health, food insecurity and culturally competent care are complex challenges, they were selected as Yale New Haven Hospital priority areas for the 2025-2028 CHNA cycle because of patient and community need and desirability, organizational expertise and resources and the ability to form and build upon partnerships, research and initiatives across Yale University and with trusted community-based organizations and coalitions. The graphic below highlights Yale New Haven Hospital’s ongoing commitment to these areas and

spotlights new investments in response to the 2025 Community Health Needs Assessment. The full Implementation Strategy Plan is available on pages 18-23.

## Implementation Strategy Plan (ISP) / Fiscal Year 2024 Data



## IMPLEMENTATION STRATEGY PLAN SUMMARY

Hospital Priority Area 1: Behavioral Health	
<b>Goal</b>	<b>Increase access to behavioral health services by 3% for all in Greater New Haven by 2028.</b>
<b>Strategy 1</b>	<b>Improve and expand access to mental health and addiction services.</b> Support efforts that expand and coordinate behavioral health services across the continuum of care - including pediatric, specialty, integrated, outpatient and crisis response programs - to reduce barriers and better meet community needs.
Action 1.1	Build capacity to guide patients in need of non-emergency behavioral health services more efficiently through Yale New Haven Health CORE (Collaborations, Optimization, Resiliency, and Efficiency) initiatives.
Action 1.2	Build and operationalize the 11-bed Pediatric Crisis Intervention Care Center.
Action 1.3	Embed and integrate behavioral health services and providers in adult and pediatric primary care, specialty care, inpatient units, and ambulatory sites as applicable.
Action 1.4	Develop and operationalize a hospital-integrated ambulatory addiction medicine Bridge Clinic to support substance use related care transitions for patients post hospitalization or emergency department visit in collaboration with the Yale Program in Addiction Medicine.
Action 1.5	Enhance support of community care transitions with enhanced dialogue and advocacy between Department of Children and Families, Department of Developmental Services, Department of Mental Health and Addiction Services and Department of Social Services.
Action 1.6	Enhance access to specialty mental health services, including interventional psychiatric treatments.
Action 1.7	Provide step-down services like the Community Transitional Service, Intensive Outpatient Program, Continuing Care Clinic and Yale Child Study Center programming.
Action 1.8	Promote and enhance psychiatric and addiction medicine consultation services in inpatient settings.
Action 1.9	Develop personalized care plans for multi-visit emergency patients to address individual patient needs.

Action 1.10	Provide substance use disorder support and navigation to patients in the emergency room by embedding Department of Mental Health and Addiction Services (DMHAS) grant funded CT Community for Addiction Recovery (CCAR) Coaches.
Action 1.11	Invest in Cornell Scott Hill Health Center to address critical behavioral health needs through an integrated care model at the Recovery and Wellness Center.
<b>Strategy 2</b>	<b>Strengthen early and community-based support for behavioral health and substance use disorders.</b> Promote prevention-focused and community-anchored approaches-such as step-down services, and care navigation and screening that help individuals receive timely support before mental health needs escalate.
Action 2.1	Screen children beginning at age 12 for depression and suicidality at Yale New Haven Children’s Hospital.
Action 2.2	Expand depression screening days to community locations.
Action 2.3	Offer support groups for patients and caregivers.
Action 2.4	Provide home visiting services and depression screenings for children and families enrolled in Yale Child Study Center programming.
Action 2.5	Enhance basic needs support and promote literacy opportunities for pediatric and adult patients.
Action 2.6	Advocate for expansion of the housing shelter system, transitional beds, and skilled nursing placements for patients with mental health and/or substance use disorders.
Action 2.7	Promote and refer eligible patients to parenting support services through the Family Home Visiting Partnership of New Haven.
<b>Strategy 3</b>	<b>Provide and promote mental health, addiction and substance use disorder education and provider training.</b> Support initiatives that increase provider capacity, reduce stigma, and build mental health awareness through workforce development, community education, and provider training, particularly for those working with children and families.

Action 3.1	Provide training and education to primary care providers on how to identify and treat mental health disorders through REACH and other professional development opportunities at the Yale Child Study Center.
Action 3.2	Offer behavioral health and substance use related educational forums, grand rounds, conferences and programs through the Yale Program in Addiction Medicine for providers to reduce stigma and promote training and education.
Action 3.3	Collaborate with community-based organizations to promote mental health, substance use and harm reduction education.

<b>Hospital Priority Area 2: Food Insecurity</b>	
<b>Goal</b>	<b>Reduce food insecurity by 2% for all in Greater New Haven, as measured by the DataHaven Community Wellbeing Survey, through enhancing referrals, partnerships, and resource coordination by 2028.</b>
<b>Strategy 1</b>	
<b>Strategy 1</b>	<b>Further develop Yale New Haven Hospital referral services to food resources.</b>
Action 1.1	Optimize social drivers of health (SDoH) screening and reporting for food insecurity.
Action 1.2	Provide automatic resource recommendations for community-based supports in patients’ after visit summary for those that screen positive for food insecurity.
Action 1.3	Provide resources, navigation, and coordination for patients with food insecurity through relationships referrals and warm-handoffs between Yale New Haven Hospital, community-based organizations and Department of Social Services (DSS).
Action 1.4	Enhance referral processes to on-site Women Infants and Children (WIC) Offices for eligible patients.
<b>Strategy 2</b>	
<b>Strategy 2</b>	<b>Support nutrition and culinary education for patients and community members.</b>
Action 2.1	Provide clinical nutrition risk assessment, disease-specific nutrition education and outpatient referrals as needed for patients.
Action 2.2	Provide specialized nutrition education to patients in pediatric specialty centers, Smilow Cancer Hospital and transplant services.
Action 2.3	Enhance nutrition education in the community through participation in health fairs, community events, easy recipe development and outreach at local hunger relief organizations.
Action 2.4	Provide nutritious food, nutrition education, counseling and breast-feeding support to eligible patients and their families through on-site WIC Offices.
Action 2.5	Provide free culinary medicine classes for patients at the Irving and Alice Brown Teaching Kitchen.
Action 2.6	Expand outreach, education and community-based programming of the Irving and Alice Brown Teaching Kitchen.

Action 2.7	Explore funding opportunities to develop medically tailored meals or produce prescription pilot programs.
<b>Strategy 3</b>	<b>Collaborate with community partners to expand access to healthy food through advocacy, on-site and neighborhood-based initiatives.</b>
Action 3.1	Sustain collaboration and partnerships in the community with local hunger relief organizations, United Way of Greater New Haven, Coordinated Food Access Network (CFAN), Food As Medicine (FAM) and Racial and Ethnic Approaches to Community Health (REACH) at Community Alliance for Research and Engagement (CARE) and others.
Action 3.2	Support food security related legislative advocacy.
Action 3.3	Sponsor community organizations and initiatives that promote food security.
Action 3.4	Offer food drive opportunities for employees and medical staff to support local hunger relief efforts.
Action 3.5	Promote and endorse community-based food assistance volunteer opportunities for staff.
Action 3.6	Implement a food recovery program with Haven’s Harvest to support local procurement and reduce food waste.
Action 3.7	Support eligible caregivers with the “Parent Plate Program” at Yale New Haven Children’s Hospital.
Action 3.8	Enhance the food pantry for patients and caregivers at the Pediatric Primary Care Center.
Action 3.9	Explore funding opportunities to develop an on-site program to promote direct nutritious food access for the community, patients and/or staff.

<b>System Priority Area: Culturally Competent Care</b>	
<b>Goal</b>	<b>Support improvement of quality of service and patient experience at YNHH and its regional ambulatory sites by 5% by 2028 as measured by meeting the target goal for “Likelihood of Recommending” on Press Ganey Surveys.</b>
<b>Strategy 1</b>	<b>Implement national standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care at Yale New Haven Hospital.</b>
Action 1.1	Create a Health System / Yale New Haven Hospital CLAS Advisory Council with a focus on oversight and implementation.
Action 1.2	Centralize an interpreter dispatch system and real-time dashboards.
Action 1.3	Co-design three culturally responsive care protocols.
Action 1.4	Launch simulation training focused on respect and inclusive practices.
Action 1.5	Expand Patient Family Advisory Councils (PFACs).
Action 1.6	Identify and evaluate health disparities by examining patient needs across demographic groups.

## Evaluation Plan



Evaluation of any Implementation Strategy Plan (ISP) is just as critical as the implementation of strategies, actions, programs, and initiatives. To measure progress of goals, Yale New Haven Health (YNHHS) will utilize an adapted framework from the Center for Disease Control and Prevention (CDC) for Program Evaluation (2024). The three foundational principles of the Framework are: work collaboratively, improved health outcomes for all, and learn from and apply insights.

The Framework includes six steps to complete a successful evaluation:

1. Assess the context
2. Describe the program
3. Focus the evaluation question and design
4. Gather credible evidence
5. Generate and support conclusions
6. Act on findings

YNHHS will evaluate the progress on each goal on an annual basis. Starting at Year 0, YNHHS will determine the baseline for each goal. Each year after Year 0, the progress will be measured against the baseline. Whenever possible, YNHHS will use local, state, and national benchmarks, such as Healthy People 2030 or County Health Rankings, to measure against each year.

The evaluation of the Implementation Strategy Plan, wherever possible, will include both quantitative data and stories from staff and participants.