ACTION WELLNESS

Putting good health into motion

# Strategic Plan Fiscal Years 2024-2026

Updated September 2023

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# INTRODUCTION

Action Wellness embarked on a strategic planning process in January 2023 for Fiscal Years 2024, 2025 and 2026. We were fortunate to secure the services of Volunteer Executive Consultants (VEC) at RSVP. RSVP is a 501©(3) nonprofit with over forty-five years of program management experience and over 1,200 individual volunteers who have a mission to improve their communities. VEC consultants are skilled retired executive volunteers who assist nonprofit organizations build organizational capacity to sustain their efforts long-term, increase the efficiency and effectiveness of the nonprofit community, and extend program reach and mission impact. Action Wellness VEC Consultants included Ray Hoving, Susan Beck, Iris Drechsler, and Donald Shump. Action Wellness is grateful to the VEC Consultants for their considerable expertise, the time they invested and their expert guidance.

The Core Group and the Stakeholders Group were formed for the process. The Core Group met weekly from January 2023 through April 2023 with the consultants to move the planning process forward. The Stakeholder Group met with the Core Group for three meetings during the course of planning for the purpose of providing feedback about the work the Core Group was doing. Both groups are committed to advancing the plan during the three years of implementation.

There were three major components to the strategic planning process: Assessment, Strategy Development, and Action Planning. The team also updated the Vision, Mission, and Values statements. Assessments included Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis, Program Assessment, Competitive Assessment and Alliance Opportunities. Strategy Development included defining Core Competencies, Strategic Intent, and Goal development. Action Planning focused on how to move from Strategic Intent to measurable Goals, and developing a Change Management Plan.

As shown in the table of contents, the body of the Plan is supplemented by 3 appendices. Appendix A shows the detailed analysis done for each of the assessment areas. Appendix B describes the planning process used by the consultants and the assigned roles. Appendix C provides educational material on planning terms and the exercises used by the Core Team to develop the Plan materials.

In the following pages, we provide documentation for each area of work, with tools to help us be accountable and focused. We acknowledge the need for flexibility as we continue executing this Strategic Plan. Plans are only of value if they can be implemented effectively. We have placed great attention to linking strategy to action, assigning staff to goals, and monitoring progress. We hope to continue the enthusiasm we have generated during this planning process to achieve positive outcomes for Action Wellness' clients.

## STRATEGIC PLAN SUMMARY

The 3 Strategies on the left column of the table below guide the future of Action Wellness:

1) The quality of our existing services for our client base remains our first priority. Our staff will have the tools to efficiently gather more data for improving medical care coordination, consistency of services, and monitoring results. We will continue the unique and personal relationships we have with our clients.
2) We will leverage our expertise from 30+ years of support for the HIV community to expand our services to other chronic illnesses including substance use and Post-COVID Conditions. We will also pursue opportunities to provide onsite medical and pharmacy services. We will expand on specialized services such as perinatal care for women of color, in particular African American and Latina women.
3) Action Wellness must strengthen its financial security to support existing and new programs. Maintaining and expanding reliable funding is critical to the breadth and quality of the services we provide and to the number of clients we can assist each year. We will place more efforts on two key funding sources: 340B and fee-for-services (FFS). We will attempt to increase 340B enrollments with help from our direct services staff.

| Strategy | Strategic Intent | Goals |
|---|---|---|
| Focus on Quality of Service | 1. Provide service excellence for our current community.<br>2. Continue the unique personal relationships with our clients. | 1.1 Give attention to serving our existing HIV clients.<br>1.2 Increase data and supporting staff capacity and efficiencies.<br>2.1 Improve face to face contact for higher acuity clients. |
| Grow our Coverage of Support | 3. Support additional chronic illnesses for the underserved.<br>4. Expand the breadth of services that support our clients. | 3.1 Expand Medical Case Management for substance abuse disorders and chronic illnesses.<br>3.2 Add Post COVID Conditions to chronic illnesses we support.<br>4.1 Add Medical services for our clients.<br>4.2 Add Pharmacy services.<br>4.3 Expand perinatal medical and case management services for women of color. |

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| Ensure Solid Financial Foundation | 5. Have the operating revenue and discretionary funding to support our growing client base. | 5.1 Increase 304B revenue.<br>5.2 Create fee-for-service opportunities with insurance companies. |

## KEY UPDATES

We have updated our mission statement, vision, values and guiding principles to make them more current, concise and to better capture the range of work we are currently doing and our goals as identified in the Strategic Plan.

### Vision

*From:* No one should face chronic illness alone.

*To:* We are a caring community working collaboratively so that no one faces chronic illness alone.

### Mission Statement

*From:* Action Wellness enhances the lives of individuals living with HIV and other chronic illnesses by providing holistic and trauma-informed health, prevention, and supportive services. The agency empowers those it serves to rise beyond the barriers of disease to achieve wellness and increased stability within the community.

*To:* Action Wellness enhances the lives of individuals living with HIV and other chronic illnesses by providing a range of trauma-informed social services to help our clients achieve physical, emotional and economic wellness.

### Values

*From:* A two-and-a-half-page description of values contained in the Employee Handbook covering the following values:

- Client Centered Services
- Consumer Driven Services
- Competency
- Collaboration
- Ethics

- Innovation
- Multi-Culturalism
- Diversity
- Volunteer Involvement
- Measurable Outcomes

*To:* These seven core values that embody our culture, spirit and dedication:

- Do what is right for our clients and those who support us.
- Uphold standards of professional excellence and ethics.
- Seek solutions that benefit the overall Action Wellness community.
- Promote changes, diversity and innovation.
- Be caring and empathetic while making choices based on data, outcomes and results.
- Embrace the differences of our clients, volunteers and staff.
- Collaborate with other providers in good faith

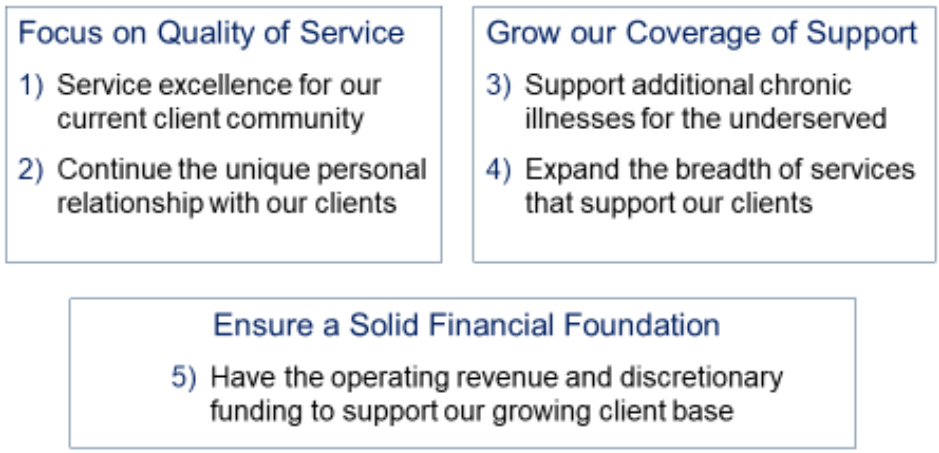
### Guiding Principles

The updated Plan adheres to the following principles:

- We will focus our support in Philadelphia and Delaware Counties to those having one or more chronic illnesses, including HIV, substance use disorders, and mental health.
- We will serve client populations with chronic illnesses who have the greatest needs and the fewest resources.
- We strive to help our clients with access to primary medical care, medical case management, housing, pharmacy services, prenatal care, food, clothing, and transportation.
- We provide emotional support and enter into a relationship with our clients so they never feel alone. We work to overcome stigma and isolation.

## STRATEGY

Our three strategies below are the pillars of our Plan. They are linked to 5 strategic intent statements, which are described in the section that follows.




## STRATEGIC INTENT

Strategic intent is the expression of an organization's strategy. It states our desired direction and the way we will chart our progress. The Core Team identified the 5 strategic intent statements below.

| We intend to… | By… |
|---|---|
| 1. Provide excellent service to our current clients, who live with chronic illnesses and have unfulfilled basic needs. | Navigating the range of services to meet varied needs:<br>• Create and maintain knowledge of available resources to meet the needs of our clients in both the management of their chronic condition, as well as meet basic needs to achieve and maintain wellness.<br>• Continue to build relationships with other providers so that our clients can access their services.<br>• Develop new services in areas of need where external service providers are not available.<br>• Commit to quality improvement initiatives and opportunities. |
| 2. Continue the unique personal relationships we have with our clients, enabling us to combine our | Showing compassion and competence:<br>• Place our offices in the neighborhoods where our clients live. |

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| knowledge of managing chronic illness, with the ability to respond to the needs of each client. | • Stay in face-to face contact with our clients through our Direct Services staff and Volunteer Buddy Program.<br>• Support clients who face stigma and isolation so that no one faces chronic illness alone. |
| 3. Provide support for additional chronic illnesses for the underserved in our community. | Expanding access for persons with Post COVID Conditions, heart disease and uncontrolled diabetes for which we provide comprehensive support:<br>• We have supported clients with HIV for over 30 years. We recently added clients with substance use disorders and other addictions. We are committed to serving people with Post COVID Conditions as the need arises and financial resources are available .<br>• Adapt our current medical case management and program development core competencies to these new client populations. |
| 4. Expand the breadth of services that support our clients. | Building service capacity through new internal capabilities and alliances with experts in the field:<br>• Enhance existing services (e.g., housing, food, clothing, and transportation) where the need is the greatest.<br>• Form alliances with organizations that provide medical care and pharmacy services.<br>• Form alliances with organizations with specializations such as perinatal care and addiction support. |
| 5. Have sufficient operating revenue and discretionary funding to support our growing client base through a solid financial foundation | Expanding program resources through fee-for-services and fundraising, and prioritizing the distribution of agency resources:<br>• Use fee-for-services model to support day-to-day operations. |

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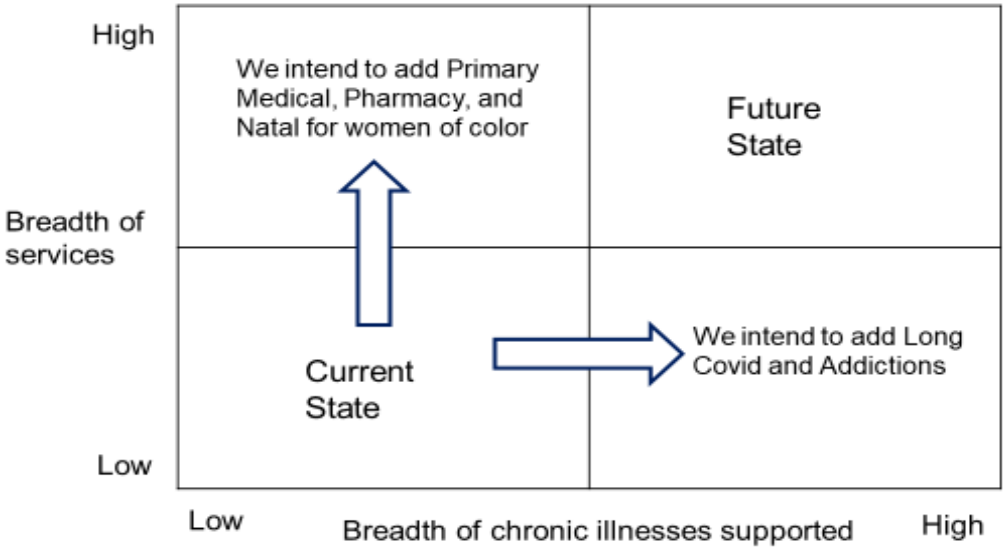
| that maximizes our various funding sources. | • Engage in creative fundraising to enable our expansion.<br>• Allocate resources to areas of greatest need the communities we serve. |

One of our strategic intents is to provide more holistic services for our clients. This chart shows the first phase of our approach. We will add other chronic illnesses and services in subsequent years as needs arise and if funding is available. Please note that women of color refers to African American and/or Latina women.



## GOALS

Goals are achievable milestones with established measures for success. Below is a summary of Goals for each Strategy and Strategic Intent Statement:

| Strategy | Strategic Intent | Goals |
|---|---|---|
| Focus on Quality of Service | 1) Provide service excellence for our current client community | 1.1 Give first attention to serving our existing HIV clients |
| | | 1.2 Increase data and supporting staff capacity and efficiencies |
| | 2) Continue the unique personal relationship with our clients | 2.1 Improve face to face contact for higher acuity clients |
| Grow our Coverage of Support | 3) Support additional chronic illnesses for the underserved | 3.1 Expand Case Mgt for addictions and other chronic illnesses |
| | | 3.2 Add Long COVID to chronic illnesses we support |
| | 4) Expand the breadth of services that support our clients | 4.1 Add medical services and medical case mgt for our clients |
| | | 4.2 Add pharmacy services for our client community |
| | | 4.3 Expand perinatal medical and case mgt for women of color |
| Ensure a Solid Financial Foundation | 5) Have the operating revenue and discretionary funding to support our growing client base | 5.1 Increase 340B revenue and apply those unrestricted funds |
| | | 5.2 Create fee for service opportunities with several sources |

Each goal has been assigned to "Goal Owners" who have accountability for the goal's success.

| Goal | Goal Owner(s) |
|---|---|
| 1.1 Prioritize serving existing and new clients with HIV. | Deputy Executive Director, Assistant Directors of Client Services, and Direct Services (DS) Coordinators |
| 1.2 Increase our data capacity to support direct service staff to collect and utilize essential data to build and expand our data warehouse. | Director of Performance Measurement and Compliance |
| 2.1 Increase face-to-face contact for higher acuity clients. | DS Coordinators |
| 3.1 Expand and strengthen Medical Case Management services for clients with substance use disorders and other chronic illnesses. | Deputy Executive Director, Assistant Directors of Client Services and DS Coordinators |
| 3.2 Add post COVID conditions to the chronic illnesses we support once funding is secured. | Executive Director and Deputy Executive Director |

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| 4.1 Expand medical services for our clients. | Executive Director and Deputy Executive Director |
| 4.2 Add pharmacy services for our clients. | Executive Director, Deputy Executive Director, Director of Performance Measurement and Compliance |
| 4.3 Expand perinatal services to pregnant women of color specifically African American and Latina women. | Executive Director, Deputy Executive Director |
| 5.1 Increase 340 B revenue and use earnings to grow our reserves and increase our ability to meet the needs of the community we serve. | Executive Director, Deputy Executive Director, Director of Performance Measurement and Compliance |
| 5.2 Create fee-for-service opportunities with several sources (e.g., securing contracts with additional Medicaid managed care organizations and private insurance companies while also pursuing additional fee-for-service opportunities. | Executive Director, Director of Finance |

## ACTION PLANS

An Action Planning Worksheet has been prepared for each Goal as shown below, including the desired outcomes and success measures with target dates, and time-sequenced action items. The goal owners will use this as a planning tool and will update documents as action items are completed or changes are made.

| Goal | Desired Outcome and Target Date | Success Measures *All dates are for fiscal year (July 1- June 30)* | Sequenced Action Items |
|---|---|---|---|
| 1.1 Prioritize serving existing and new clients with HIV. | • Improvement in client's physical and emotional wellness (Q4/CY 2024). | ○ Measure clients' satisfaction via annual survey (Q2/2024).<br>○ Increased percentage of clients with HIV who achieve viral suppression (Q4/2024). | 1. Implement Quality Improvement initiatives to:<br>a. Improve medical care coordination and documentation.<br>b. Reduce service gaps.<br>c. Better prioritize high acuity clients.<br>d. Provide more efficient and consistent coverage |

| Goal | Desired Outcome and Target Date | Success Measures *All dates are for fiscal year (July 1- June 30)* | Sequenced Action Items |
|---|---|---|---|
| | | ○ Increased retention in medical care and MCM (Q4/2024).<br>○ Increased units of service for clients receiving MCM (Q1/2025).<br>○ Reduced documentation burden for DS staff (Q1/2025).<br>○ Data that demonstrates that client's needs are being met (Q2/2025). | during high turnover periods.<br>e. Increase standardization in service delivery and supervision.<br>(Q1-Q4/2024)<br>2. Adapt client satisfaction survey to include all client services and questions related directly to the organization's mission (Q2/2024).<br>3. Increase client participation in satisfaction survey to ensure a representative sample (Q2/2024).<br>4. Align quality management (QM) with Strategic Plan (Q3/2024).<br>5. Improve linkage and retention in medical care and medical case management (Q4/2024).<br>6. Expand QM to better represent all of our services (Q1/2025).<br>7. Compare data regarding how services completion impacts client needs and medical outcomes (Q1/2025).<br>8. Track client "met needs" via reports in CaseWorthy and monitor over time (Q2/2025). |
| 1.2 Increase data and supporting staff capacity and efficiencies to | • Improved capacity to apply | ○ Service improvements via analytics (Q2/2024). | 1. Implement CaseWorthy, Planful and MIP Cloud:<br>a. Introduce and train staff on software. |

| Goal | Desired Outcome and Target Date | Success Measures *All dates are for fiscal year (July 1- June 30)* | Sequenced Action Items |
|---|---|---|---|
| provide essential data and develop a data warehouse. | for data-intensive grants (Q2/2024).<br>• Better data available for analysis (Q3/2024).<br>• Data to support operations (Q3/2024).<br>• Data entry burden reduced (Q1/2025).<br>• Sharable data for alliance transactions (Q1/2025). | ○ Positive staff feedback on staff satisfaction survey (Q2/2024).<br>○ Grant win ratio (Q1/2025). | b. Monitor staff utilization, identify challenges and opportunities for adapting software.<br>(Q1/2024)<br>2. Automate repetitive data requests for existing and new grants; design process for updating, verification, and cross-checking (Q2/2024).<br>3. Design process for data and staff involvement:<br>a. Train staff in CaseWorthy, Planful, MIP Cloud.<br>b. Develop reports to meet data requirements.<br>c. Automate data collection.<br>d. Identify data points for internal quality improvement.<br>(Q2-Q3/2024)<br>4. Study gathering more data for new grants vs easing data entry burden (Q3/2024). |
| 2.1 Increase face-to-face contact for higher acuity clients. | • Improved client access to case managers based on their needs (Q4/2024).<br>• Enhancement of Buddy/Client/ Case manager relationship. (Q3/2025). | ○ Client satisfaction with services, i.e. reduced isolation, felling stigmatized (Q2/2024).<br>○ Increased face-to face contact for Comprehensive | 1. Develop process to facilitate communication between medical case managers and Buddies to improve continuity of care for clients and to ensure Buddies know how important they are to the client and the organization (Q4/2023—Completed 5/2023). |

| Goal | Desired Outcome and Target Date | Success Measures *All dates are for fiscal year (July 1- June 30)* | Sequenced Action Items |
|---|---|---|---|
| | | Clients (Q4/2024).<br>○ Client retention in medical care and case management (Q4/2024).<br>○ Reduction in service delivery gaps (Q4/2024).<br>○ Decrease DS documentation units and increase DS service units (Q1/2025).<br>○ Improved satisfaction on Buddy Satisfaction Survey (3/2025). | 2. Educate staff about our focus on relationships with clients and importance of building trust as a foundation for clients feeling welcome, accepted, and cared for (Q2/ 2024).<br><br>3. Incorporate what we know and what we learn about the past and present stigma and trauma of clients to build relationships and help client retention in medical care and case management (Q2/2024).<br><br>4. Create survey for Buddies focusing on strengths, satisfaction, areas for growth, and feedback on motivation to become a Buddy at AW. What keeps them engaged. and if applicable why they leave. Conduct exit interviews for volunteers leaving the organization (Q3/2024).<br><br>5. Distribute satisfaction survey for Buddy volunteers about their experience in the program and incorporate findings into improvement activities (Q3/2024).<br><br>6. Conduct QI to better prioritize high acuity clients and provide more effective and consistent coverage during high turnover periods. (Q4/2024).<br><br>7. Reconfigure staff resources to enhance data capacity and |

| Goal | Desired Outcome and Target Date | Success Measures *All dates are for fiscal year (July 1- June 30)* | Sequenced Action Items |
|---|---|---|---|
| | | | reduce documentation burden on DS staff so they can focus on clients (Q1/2025). |
| 3.1 Expand and strengthen Medical Case Management for clients with substance use disorders and other chronic illnesses. | • Increased caseload and capacity for serving clients with addiction and chronic illness (Q3/2024).<br>• Provide medical case management services to 100 clients with addictions (Q4/ 2024).<br>• Increased client independence and wellness (Q4/2024).<br>• Treat clients holistically (Q1/2025).<br>• Serve 200 chronic illness clients with 400 units of service (Q1/2025).<br>• Become recognized leader in the provision of MCM services for clients with addiction and chronic illness (Q4/2025). | ○ Increased caseload and capacity serving clients with addiction and chronic illness by 50% (Q3/2024).<br>○ Increased client movement through a documented continuum of care indicating improved independence and wellness (Q1/2025).<br>○ Additional work readiness services provided (Q1/2025).<br>○ Clients receive needed services (Q1/2025). | 1. Strengthen addiction services:<br>a. Hire DA Case Manager Specialist.<br>b. Develop or utilize needs assessment tool to measure client baseline and progress for clients over time and build into CaseWorthy<br>c. Offer space at our offices for AA and NA meetings.<br>(Q2/2024-Q4/2024)<br>2. Expand Chronic Illness Case Management:<br>a. Review the diagnoses of current clients being served by Chronic Illness Case Management.<br>b. Hire additional Chronic Illness Case Manager(s)<br>c. Develop a prioritized list of additional chronic illnesses that have a high need for medical case management.<br>d. Determine criteria for which clients with chronic illness we will serve, considering: poverty, food deserts, housing insecurity, lack of insurance and under-served populations.<br>e. Develop and implement |

| Goal | Desired Outcome and Target Date | Success Measures *All dates are for fiscal year (July 1- June 30)* | Sequenced Action Items |
|---|---|---|---|
| | | | funding and marketing campaigns for the above at the appropriate phase.<br>f. Explore possible collaborations and partnerships.<br>g. Discussion with the medical providers we collaborate with for input on targeted diagnosis we should consider.<br>h. Encourage providers like HUP to support expanding fee-for-service for clients with chronic illness (MCO).<br>(Q2/2024-Q2/2025) |
| 3.2 Add Post COVID Conditions (PCC) to the base of chronic illnesses we support. | • Provide 10 people with PCC comprehensive medical case management (Q2/2025). | ○ Information and data that support the need for PCC medical case management (Q3/2024).<br>○ Performance, measures and outcomes for PCC case management (Q4/2024).<br>○ FFS Contract with 1 or more insurance companies for PCC case management (Q3/2025). | 1. Conduct research to understand Post COVID Conditions:<br>a. Who is most impacted by PCC?<br>b. What percentage of our current clients report PCC?<br>c. Contact medical providers we have established relationships with to learn what percentage of their patients report PCC.<br>d. Engage HUP to learn about their PCC Clinic.<br>(Q3/2024)<br>2. Explore whether other providers are providing social |

| Goal | Desired Outcome and Target Date | Success Measures *All dates are for fiscal year (July 1- June 30)* | Sequenced Action Items |
|---|---|---|---|
| | | | services to clients with PCC, and how they are funding the initiative: insurance, government grants, private donations? (Q3/2024)<br><br>3. Engage with online PCC groups to assess needs (Q4/2024).<br><br>4. Educate staff and volunteers about PCC and incorporate into orientations and trainings (Q4/2024).<br><br>5. Implement low-cost initiatives for PCC:<br>a. Virtual and in-person support groups.<br>b. Social media PCC campaign.<br><br>(Q1/2025)<br><br>6. Determine performance measures and goals for PCC (Q1/2025).<br><br>7. Pursue government and private funding to support PCC services (Q1/2025).<br><br>8. Expand Volunteer Buddy Program to include clients with PCC (Q2/2025).<br><br>9. Advocate on local and national levels for resources for PCC services (Q2/2025).<br><br>10. Secure FFS contract with 1 or more insurance companies for PCC services (Q3/2025). |

| Goal | Desired Outcome and Target Date | Success Measures *All dates are for fiscal year (July 1- June 30)* | Sequenced Action Items |
|---|---|---|---|
| 4.1 Add medical services for our clients. | • Explore potential small medical clinic in an underserved area (Q4/2024).<br>• Action plan to implement medical clinic (Q1/2025).<br>• Secure resources to move forward (Q4/2025).<br>• Open medical clinic (Q2/2026). | ○ A small primary care clinic in an underserved area (Q2/2026).<br>○ Expanded services to 400 clients (Q4/ 2026).<br>○ Federally Qualified Status achieved (Q4/ 2026). | 1. Develop Action Wellness General Medical Services Pilot Project and secure funding:<br>a. Begin exploratory conversations with Division of HIV Health regarding possible RW funded clinic in an underserved part of the city.<br>b. Begin exploratory conversations with small primary care practices we currently collaborate with to get their input and guidance, including Dr. Hauptman and Jefferson.<br>c. Explore relationships with addictions physician and nurse practitioners.<br>d. Explore all funding options for a small clinic in an underserved area.<br>e. Set fundraising goal to raise money for build out and equipment needed.<br>(Q4/2024-Q4/2025)<br>2. Once there is a funding commitment, begin implementation of the program:<br>a. Licensing, insurance coverage and certification requirements.<br>b. Determine caseload size for medical practice. |

| Goal | Desired Outcome and Target Date | Success Measures *All dates are for fiscal year (July 1- June 30)* | Sequenced Action Items |
|---|---|---|---|
| | | | c. Secure a location and build out as needed.<br>d. Hire physicians or nurse practitioners, nursing staff, office manager<br>e. Develop and implement funding and marketing campaigns for the above at appropriate phase.<br>(Q4/2025-Q2/2026)<br>3. Explore feasibility to qualify as an FQHC (Q2/2026).<br>4. If successful, expand services and program (Q4/2026). |
| 4.2 Add pharmacy services for our clients. | • Initial exploration (Q2/2024).<br>• Present plan to Board (Q2/2024).<br>• Secure funding and compliance with regulatory requirements, licensing etc. (Q1-Q4/2025)<br>• Open the Action Wellness 340B pharmacy (Q1/2026). | ○ Completion of pharmacy in one or more AW offices (Q4/ 2025).<br>○ Provide pharmacy services to 100 AW clients (Q1/2026).<br>○ Increased revenue from the 340B Pharmacy program (Q2/2026). | 1. Have exploratory discussion with Neff Pharmacy:<br>a. Is it possible for AW to join Neff Pharmacy Group?<br>b. If yes, what is the process and requirements?<br>(Q2/2024)<br>2. Have exploratory discussion with our consultant at Ponaman regarding process for opening our own pharmacy:<br>a. Identify barriers and strategies to overcome barriers.<br>b. Research what is required to open a pharmacy.<br>c. Review and discuss options with AW 340B |

| Goal | Desired Outcome and Target Date | Success Measures *All dates are for fiscal year (July 1- June 30)* | Sequenced Action Items |
|---|---|---|---|
| | | | staff and management team. Develop recommendations for the Board to review.<br><br>(Q2/2024)<br><br>3. Review all information and make decision about what office pharmacy should be located at and brainstorm the pros and cons of each location.<br>a. Kensington<br>b. 1216 Arch<br>c. Filbert Street<br><br>(Q3/2024)<br><br>4. Secure funding for pharmacy construction (Q1/2025).<br><br>5. Once there is funding:<br>a. Licensing, insurance coverage, and certification requirements to open the pharmacy.<br>b. Determine IT requirements.<br>c. Develop and implement funding and marketing campaigns.<br><br>(Q3/2025)<br><br>6. Hire contractor to do pharmacy build out (Q3/2025).<br><br>7. Recruit, interview and hire pharmacy staff (Q4/2025). |

| Goal | Desired Outcome and Target Date | Success Measures *All dates are for fiscal year (July 1- June 30)* | Sequenced Action Items |
|---|---|---|---|
| 4.3 Expand perinatal services to pregnant women of color. | • Improve health outcomes for pregnant women of color (Q1/ 2025).<br>• Apply for new grants (Q3/2025). | ○ Expansion of perinatal program (Q1/2025).<br>○ Engagement of perinatal clients in first trimester of pregnancy (Q1/2025).<br>○ Retention of perinatal clients in MCM. (Q1/2025). | 1. Doula Training for perinatal MCM (Q3/2024).<br>2. Leverage contract with AmeriHealth (Q3/2024).<br>3. Mimic Gilead funding resource (Q3/2024).<br>4. Link to preventative Care (Q3/2024).<br>5. Develop relationship with Association of Black Cardiologists (Q3/2024).<br>6. Connect with Cardiologist for Chronic Illness & Perinatal (Q4/2024).<br>7. Focus on postpartum care (Q4/2024).<br>8. Link expecting families who are homeless to mobile health care options (Q4/2024).<br>9. Devise strategy to encourage client interest in the agency's support groups (Q1/2025).<br>10. Implement Family Planning services (Q2/2025).<br>11. Identify grants to leverage behavioral health for pregnant women (Q3/2025).<br>12. Implement Telehealth for behavioral health services for pregnant women (Q4/2025). |
| 5.1 Increase 340B revenue and use those funds to | • Mitigate the impact of 340B revenue | ○ Implement 340B training program and new | 1. Assess current procedures for 340B client enrollments and recommend |

| Goal | Desired Outcome and Target Date | Success Measures *All dates are for fiscal year (July 1- June 30)* | Sequenced Action Items |
|---|---|---|---|
| grow our services and increase our ability to respond to the needs of the community. | disruptions (Q2/2024).<br>• Increase client participation in the 340B program (Q1/2025). | incentives for CMs (Q3/2024).<br>○ Increase 340B revenue by at least 10% in FY 2024 compared to FY 2023 (Q4/2024). | improvements in efficiency and effectiveness (Q2/2024).<br>2. Assess current procedures for 340B annual re-authorization renewals and recommend corrective procedures to avoid lapses (Q2/2024).<br>3. Develop a comprehensive understanding of the impact of 340B program participation from the client perspective (Q3/2024).<br>4. Create updated 340B training materials for rollout 340B training materials for Case Managers (Q3/2024).<br>5. Rollout training and implement recommended procedural improvements. Emphasize coordinator and CM accountability (Q3/2024).<br>6. Meet to discuss implementing 340B minimal standards in CM's performance review and annual merit bonus (Q3/2024).<br>7. Develop specific 340B minimal standards and merit bonus criteria, quantify financial impact (Q4/2024).<br>8. Communicate new performance evaluation policies to staff and |

| Goal | Desired Outcome and Target Date | Success Measures *All dates are for fiscal year (July 1- June 30)* | Sequenced Action Items |
|---|---|---|---|
| | | | implement for FY 2025 (Q4/2024).<br>9. Research potential 340B relationships with new pharmacies and engage with them to assess interest (Q1/2025).<br>10. Engage with participating pharmacies on 340B relationship and current trends (Q1/2025).<br>11. Review current 340B contracts and look for improvement opportunities in contract terms for next renewal (Q2/2025)<br>12. Renew 340B contracts with most favorable terms for Action Wellness (Q2/2025).<br>13. With each new successful grant or FFS contract secured, research opportunities to expand 340B non-HIV medications (Ongoing). |
| 5.2 Create fee-for-service opportunities with several sources e.g. securing contracts with additional MA MCO's and private insurance companies and pursuing additional fee- | • Strengthen our FFS resume using data that highlights our services and outcomes (Q4/2024).<br>• Increase FFS revenue by securing additional contracts with insurance | ○ Implement at least two significant data improvements focused on promoting our FFS capabilities and success (Q1/ 2025).<br>○ Secure at least two additional FFS contracts with Ameri- | 1. Assess current data capabilities and create a wish list identifying the most valuable data wanted to best promote our value in providing FFS (Q3/2024).<br>2. Prioritize data wish list in order of value and achievability and develop a plan to upgrade data reporting/efficiency (Q3/2024). |

| Goal | Desired Outcome and Target Date | Success Measures *All dates are for fiscal year (July 1- June 30)* | Sequenced Action Items |
|---|---|---|---|
| for-service opportunities. | companies (Q3/ 2025).<br>• Become a preferred collaborator with AmeriHealth Caritas (Q1/2026). | ○ Health or another MCO or insurance company (Q3/ 2025).<br>○ Maintain FFS compliance and minimize bad debt (Ongoing). | 3. Implement recommendations for data upgrades (Q4/2024).<br>4. Review current FFS compliance, billing, and collections processes and build on our current accomplishments and identify and implement potential improvements (Q4/2024).<br>5. Research Aetna FFS contract supporting non-HIV chronic illness and strategize about what went wrong /right in the process and how to best duplicate its success (Q4/ 2024).<br>6. Develop marketing strategy to improve "attractiveness" to target potential FFS partners (Q1/2025).<br>7. Determine market interest and logistics in packaging our case management expertise with FFS opportunities (Q1/2025).<br>8. Research peers and competitor's active FFS contracts where possible and assess if there are any opportunities for AW given our current capabilities (non-HIV) (Q1/2025).<br>9. Engage with AmeriHealth Casitas to develop strong working relationship and identify potential |

| Goal | Desired Outcome and Target Date | Success Measures *All dates are for fiscal year (July 1- June 30)* | Sequenced Action Items |
|---|---|---|---|
| | | | current/future opportunities (Q2/2025).<br>10. Identify upcoming Health Fairs and conferences that are best for Action Wellness to attend to expand exposure and develop valuable contacts with specific MCO and insurance companies (Q2/2025).<br>11. Pursue best FFS contract opportunities (Q2/2025).<br>12. Routinely follow up with any newly established MCO contacts (Ongoing). |

# ADDENDA

## Goal 6: Workforce Development

*We intend to:*

Ensure a work environment for staff that is responsive to their career goals while supporting professional development.

*By:*

Offering benefits and programs that provide training and support for their success, including:

1. Education and Training Opportunities
    a. Workplace trainings to advance professional development.
    b. Topics for training sessions are identified by Department Directors in conversation with their teams.

    c. Tuition reimbursement per Employee Handbook.
    d. Funding for conference attendance.
    e. Commitment to weekly supervision sessions for all direct services staff.
2. Maintaining work-life balance
    a. Provide paid time off that is on par with other nonprofits.
    b. Maintain flexible scheduling, including early closings on the day preceding a holiday and summer Fridays.
    c. Provide access to a robust employee assistance program.
    d. Provide a benefits package that includes high quality health insurance, short-and-long term disability benefits, life insurance coverage, dental and vision insurance.
    e. Provide opportunity to work remotely within the limits and demands of the organization and specific department.
3. Compensation
    a. Review industry specific salary survey to determine where our scale is in comparison. Review with the Personnel Committee: December 2023
    b. Offer a competitive salary
    c. Offer benefits package.
    d. Offer paid leave and medical leave.
4. Sequenced Action Items:
    a. Review time off policy at Personnel Committee: June 2023
    b. Survey staff to determine which benefits listed above staff are currently utilizing: October, 2023
5. Review health care benefits package prior to open enrollment: November 2023
    a. Support ongoing staff input.
    b. Continue ongoing work to address diversity, equity and inclusion among the workforce.
    c. Delineate desired outcomes and success measures by October 2023.

## Goal 7: Health Equity

In order to promote a health equity, it is important to have a common definition of this term as well as what is meant by health disparities, a core component of health equity.

Per the Centers for Disease Control and Prevention: "Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving this requires ongoing societal efforts to: address historical and contemporary injustices; overcome

economic, social, and other obstacles to health and health care; and eliminate preventable health disparities."

Additionally, "Health disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by populations that have been disadvantaged by their social or economic status, geographic location, and environment. Many populations experience health disparities, including people from some racial and ethnic minority groups, people with disabilities, women, people who are LGBTQI+ (lesbian, gay, bisexual, transgender, queer, intersex, or other), people with limited English proficiency, and other groups."

*We intend to:*

Create an environment that promotes health equity for our clients and staff.

*By:*

1. Addressing and incorporating health equity throughout the strategic plan.
2. Delineating desired outcomes, success measures and sequenced actions by October 2023
3. Training leadership and staff on the theoretical underpinnings of health equity.
4. Establishing health outcomes to measure, implement and track in order to identify health disparities among the different groups receiving services at the agency.
5. Creating, changing and/or implementing policies and procedures to address the identified disparities.
6. Hiring a consultant, if feasible, with a demonstrated history to guide the development and implementation of policies and procedures.
7. Getting staff buy-in by keeping them involved and/or updated from the beginning of the process.
8. Evaluating and monitoring efforts.
9. Sharing findings with staff and clients.
10. Regularly assessing efforts and adjusting as needed.

## Additional Goals Considered

While the Assessment triggered many action ideas for the Plan Goals, there were a few that stood on their own merit, either as input to a goal, or part of one of our Programs. They are listed below for consideration

| Source | Suggested Action Item | Relevant Strategic Goal or AW Program | Goal Owner or Functional Leader |
|---|---|---|---|
| SWOT | 6) FPCN increase partnership. | Goals 4.1 and 4.3 | Executive Director and Assistant Director of Client Services at Filbert Street |
| SWOT | 14) Partnership with Philadelphia Corporation for Aging and AARP. | Volunteer Program and Goal 1.1 | Director of Volunteers |
| SWOT | 15) For LEAP, obtain new source of funding (this will require increasing capacity in some departments like Compliance. | LEAP Program | Executive Director and Assistant Director for LEAP |
| Program Assessment | 6) Consider town hall with developers to support/grow housing program. | Housing Programs | Assistant Director for Housing (SV) |
| Program Assessment | 7) Share data (outcomes) with city to promote value of housing referrals. | Housing Programs | Assistant Director for Housing (SV) |
| Program Assessment | 8) Assess interest and implement flexible work schedule to better accommodate prison visits. | Prison Linkage Program and LEAP | Assistant Director (DK) |
| Program Assessment | 9) Identify specific target audience for expanded volunteer recruiting. | Volunteer Program | Director of Volunteers |
| Program Assessment | 14) Partner with Prevention Point. | Goal 3.1 | Deputy Executive Director |
| Program Assessment | 16) Add Compliance Staff (1-2 FTE) to exclusively focus on data/documentation. | Goals 1.1, 1.2 and 2.1 | Executive Director, Deputy Executive Director, Director of Performance Measurement and Compliance |

| Source | Suggested Action Item | Relevant Strategic Goal or AW Program | Goal Owner or Functional Leader |
|---|---|---|---|
| Program Assessment | 17) Reduce time spent on documentation by DS staff by 50% as an outcome goal for each RW grant. | Goals 1.1, 1.2, NS 2.1 | Executive Director, Deputy Executive Director, Director of Performance Measurement and Compliance |
| Alliances | 5) Contact and create open dialogue with Gaudenzia. | Goal 3.1 | Deputy Executive Director |
| Alliances | 6) Contact Shift Capital about current and future plans/ aspirations in Kensington. | Housing Program | Executive Director and Assistant Director of Client Services (Housing) |

## CHANGE MANAGEMENT

Change Management is a process that understands the behavioral impact of a new initiative and takes steps to ensure a positive outcome for stakeholders. It considers overcoming resistance to change as well as harnessing enthusiasm for a new initiative. The Change Statements below, as prepared by the Core Team, explain why the changes are necessary.

| Initiative | Change Statement |
|---|---|
| Quality of Current Services | As we expand to other chronic illnesses and medical services, our first priority is quality of service for our existing clients, including the HIV community. We will continue the unique and personal relationships we have with our clients. Our staff will have the tools to efficiently gather more trusted data for improving medical care coordination, consistency of services, and monitoring results. |

| Initiative | Change Statement |
|---|---|
| Grow New Service | We will leverage our expertise from 30+ years of support for the HIV community to expand our services for other chronic illnesses including substance use addictions and post COVID conditions. We will also pursue opportunities in providing onsite medical and pharmacy services. We will grow specialized services such as perinatal care for women of color. Our underserved community is in great need for chronic illness and medical support. We are prepared to work through these changes with our clients, staff, volunteers, and administrators. |
| Build a Financial Foundation | Action Wellness must maintain its financial security to support existing and new programs. Maintaining and expanding reliable funding is critical to the breadth and quality of the services we provide and to the number of clients we can help each year. We will place more efforts on our two key funding sources: 340B and FFS (fee-for-service). We will increase 340B enrollments with help from our field staff. Adding Pharmacy services will ensure future 340B funding. We will have the data needed for more FFS transactions with current providers and will seek contracts with other providers. These and other funding actions will enable us to grow our reserves while supporting new services. |

This analysis predicts how various stakeholders could react to the changes in the plan in a **positive way**. Methods to bring out the positive responses are listed.

| Impacted Groups | How they would see the change favorably | Change Management Approach |
|---|---|---|
| Clients | Improved services, better results monitoring, supports aging populations, convenience, and security, better outcomes. | Promote services and improvements, request feedback, satisfaction surveys, and follow-up discussions. |
| Direct Service Staff | More interactive time with clients, better data collection, less paperwork, provides holistic service to their clients. | Training on new data collection, chronic illness, and medical and pharmacy services, incentive system. |
| Coordinators | Data can be trusted and useful to manage line staff, participating in | Ongoing training and feedback, train with staff on data |

| | | |
|---|---|---|
| | delivering expanded client services, better support for their teams. | collection, remain open to feedback and support open communication. |
| Management Team | More data available for management of processes, more leverage with funders, better promotion of services, improved staff morale. | Use weekly team meetings to update status of goals, support each other as the organizations goes through transitions. |
| New Ed | The plan has energized the organization to impact clients in new and meaningful ways. | Help ED to absorb all of this, invite to participate in the plan leadership and to modify plan when consensus supports change in plan. |
| Board of Directors | The plan has identified numerous improvements to be implemented at an accelerated pace. The client community will benefit greatly, having a financial foundation is key. | Take the time to educate the Board on the plan objectives and intricacies. Ask for feedback and adjust accordingly. Enable the Board to be ambassadors of the plan. |
| Volunteers | Easier data collection, learning new skills to work with different clients, and medical services, better ways to support clients. | Training and awareness, buddy satisfaction survey, face-to face feedback meetings, frequent updates. |
| Current Allies | AW has more to bring to the table o make for a meaningful alliance. AW's strong client loyalty creates connections. | Promotional programs to increase public perception. Collaborative approach with alliance candidates. |
| Funders | AW has strengthened its reputation, standing out among other service providers, demonstrated fiscal integrity. | Stay in constant communication, share performance data and research results, make strong case for new services. |

This analysis predicts how various stakeholders could react to the changes in the plan in a **negative way**. Methods to deal with the expected resistance to change are listed below.

| Impacted Groups | How they might see change unfavorably | Change Management Approach |
|---|---|---|
| Clients | Too much interaction with me, made me switch pharmacies, I may get lost in the shuffle while you grow. | Balance face to face communication, promote changes to clients, stick to AW principles of client coming first. |
| Line Staff | A few staff may not want to work with chronic illness clients, feel stress about more of their caseload in 340B. | Assign cases based on MCM preferences, solid training, for new chronic illness MCM, assist with 340B, education about benefits to clients who enroll in 340B program. |
| Coordinators | Harder teaching role, more complexity, new data reports may feel burdensome or confusing, unclear about 340B program and how it impacts organization. | Provide better support and education about 340B, teaching skills development, and role definition as a leader of the organization. |
| Management | Pressure to implement the action plan, having to provide status reports to staff and Board. | Issue resolution, mutual support, be gentle with ourselves about shortfalls, respond to signals from new management. |
| New ED | Overwhelmed by the scope of the plan, worried about being on the hook. | Acknowledge the difficult role of the ED and support new ED, ask for feedback and adjust as needed. |
| Board of Directors | Concerns about expansion, pharma, medical facilities, risks, (liability, financial), possible latent loyalty to HIV over other chronic illnesses. | Well-defined plan with flexibility to manage risk, awareness of programs, communication of plan progress and ask for feedback and open communication. |

| Impacted Groups | How they might see change unfavorably | Change Management Approach |
|---|---|---|
| Volunteers | Might not want to volunteer for new services, may not feel appreciated for their work with clients. | Listen to feedback, adjust assignments, clear communication at volunteer meetings and n written communication. |
| Current allies | Possible resistance from Pharma and medical providers if seen as AW competing with them. | Frame expansion as opportunity for increased collaboration and support. |
| Funders | Possible resistance because it changes expectations and creates uncertainty. | Increased communication leading up to changes and during transition to retain trust and open communication. |

## COMMUNICATION AND MONITORING

As we move forward with exploring and implementing new programs and processes, good communication and monitoring of our progress and challenges is of vital importance to the success of the organization. Strategic Plans distinguish themselves by acting upon the plan. This requires linking the strategy to action and putting a governance structure in place to ensure execution and success. We will keep the plan in action by:

- Communicating the plan to everyone it touches, ask and be open to feedback and adjusting our plan in order to secure the support of our Board, volunteers, staff and the community.
- Implementing roles and accountability. Goal Owners will update Action Planning Worksheets and report on status for feedback, support and adjustments.
- Having the Plan Caretakers keep the plan updated, identify issues, and initiate Change Management activities.
- Sharing in the responsibility of monitoring our progress. Management Team will have the status of the Strategic Plan as a fixed agenda item at every meeting. Updates will be communicated to staff at the monthly General Staff meeting, and the Board will be updated at Quarterly Board meetings.
- Celebrating our successes, learn from our shortcomings and always hold our clients as our top priority.

# APPENDIX A: STRATEGIC PLAN ASSESSMENTS

# APPENDIX B: THE PLANNING PROCESS

# APPENDIX C: EDUCATIONAL MATERIALS AND CORE TEAM EXERCISES ON PLANNING TOPICS