St. Jude Children's Research Hospital®
Finding cures. Saving children.
ALSAC • DANNY THOMAS, FOUNDER

2025-2027

COMMUNITY HEALTH NEEDS ASSESSMENT IMPLEMENTATION STRATEGY PLAN

REPORT DATE: NOVEMBER 3, 2025

ST. JUDE CHILDREN'S RESEARCH HOSPITAL
2025-2027 COMMUNITY HEALTH NEEDS ASSESSMENT
IMPLEMENTATION STRATEGY PLAN
Report Date: November 3, 2025

Executive Summary

The 2025 Community Health Needs Assessment (CHNA) was completed and approved in June 2025 and serves as the basis for the 2025-2027 CHNA Implementation Strategy Plan (ISP). This ISP provides goals, anticipated outcomes, actions, and measures to address the priority community health needs identified in the 2025 CHNA. As a not-for-profit hospital, St. Jude Children Research Hospital (St. Jude) conducts a CHNA and updates the ISP every three years to meet the requirements of the Patient Protection and Affordable Care Act and IRS for maintaining its 501(c)(3) status.

Located in Memphis, Tennessee, St. Jude specializes in research and care for some of the most catastrophic pediatric diseases—cancer, blood disorders, infectious diseases, neurological conditions and other related life-threatening illnesses—all while investing in resources and technologies for cutting-edge research. It is leading the way the world understands, treats, and cures childhood cancer, sickle cell disease, and other catastrophic diseases. St. Jude shares the breakthroughs it makes to help doctors and researchers around the world improve the quality of treatment and care for even more children.

Purpose

The purpose of the CHNA process is to identify and prioritize significant health needs within the St. Jude community. The priorities identified in the 2025 CHNA report guide the hospital's community health improvement programs, community benefit activities, and collaborative efforts with other organizations sharing the mission to improve community health. St. Jude collaborated with various community partners, members and healthcare providers to conduct the 2025 CHNA. To complete the assessment, St. Jude contracted Conduent Healthy Communities Institute (Conduent HCI) to facilitate data collection, analysis, and to prepare the CHNA report. This report was approved by the St. Jude governing body and is currently posted on stjude.org at this **link** per regulatory requirements.

Community Definition

The community assessed for the 2025 CHNA includes the patients and families served from the local community area and from St. Jude Affiliates and Satellite Clinic areas. For this report, the local community area was defined as Shelby County, where St. Jude is located, as well as 24 additional surrounding counties in Tennessee, Arkansas, and Mississippi. These 25 counties represent 80% of the patients from the local area that receive care at St. Jude. The work St. Jude pursues in global markets was not included for the CHNA process and is addressed through St. Jude Global.

2025 Priority Health Needs

In April 2025, the St. Jude CHNA Advisory Council met to review CHNA findings and discuss priority areas for future community benefit programs and services to supplement the medical research and financial assistance community benefit activities that St. Jude already provides. In reflecting upon the success of the current St. Jude community benefit activities, the Advisory Council and Steering Committee chose to build on the prior community benefit activities and data presented in the assessment to develop more targeted aims that continue to align with the mission of St. Jude – to advance cures, and means of prevention, for pediatric catastrophic diseases through research and treatment.

Following completion of a three-step process of prioritization, St. Jude identified the following significant health needs:

Cancer & Long-Term Follow-up

Creating smooth transitions for cancer patients from St. Jude to local providers and specialists for long-term follow-up

Children's Health, Access to Healthcare & Chronic Diseases

Improving access to healthcare and social services for children

Education

Enhancing patient learning during treatment to prevent post-treatment learning gaps

Infectious Diseases and Immunizations

Increasing prevention measures to reduce HIV and HPV-associated cancers

Mental Health, Wellness & Lifestyle

Addressing patient mental health challenges and access to services during and after treatment

Development Process

The ISP was developed during the summer and fall of 2025 with input from the Advisory Committee members and subject matter experts from St. Jude. The ISP provides goals, anticipated outcomes, actions, and measures to address the priority community health needs identified in the 2025 CHNA. The implementation plan will be monitored, and accomplishments reported at the end of each year, presented to St. Jude leadership, and reported through the IRS process. A complete list of participants in the development of the ISP is included in the Acknowledgements section of this report.

2025-2027 CHNA Implementation Strategy Plan Goals

The Advisory Committee members and subject matter experts discussed the various health needs and developed the following goals to guide the action planning process.

Access and Post-Treatment Follow-up	Education (Memphis Community)	Education (Patients and Families)	HPV Education and Vaccination	Infectious Diseases	Mental Health and Wellness
Goal 1: Improve access to providers, resources, and coordinated care during treatment and the transition from St. Jude and its affiliates and satellite clinic to community and/or adult care settings.	**Goal 2:** Improve health literacy and access to STEMM educational resources for greater-Memphis community and affiliates / satellite clinic	**Goal 3:** Improve health literacy and access to educational resources for St. Jude patients and families.	**Goal 4**: Lead and support evidence-based efforts to increase HPV vaccination and prevent HPV cancers locally, regionally, and nationally.	**Goal 5:** Increase awareness and education of infectious diseases (HIV/AIDS) in the community.	**Goal 6**: Address patient and caregiver mental health challenges and access to services.

2025-2027 CHNA IMPLEMENTATION STRATEGY PLAN

The 2025-2027 ISP was developed through a series of structured virtual sessions that engaged key members of St. Jude faculty and staff experts to discuss each priority health need. These initial workshop sessions were facilitated by the Conduent Healthy Community Institute, using the Technology of Participation (ToP®) consensus-building methods. From this point, goals were developed, and groups of faculty and staff subject matter experts were convened to develop the action plans for each goal. Through this process, St. Jude identified actionable strategies to address the most pressing health needs and builds on current efforts that are funded and focused on the St. Jude mission.

Access and Post-Treatment Follow-up

Goal 1: Improve access to providers, resources, and coordinated care during treatment and the transition from St. Jude and its affiliates and satellite clinic to community and/or adult care settings.

Anticipated Outcomes:

- Enhancing continuity of care from pediatric to adult services.
- Reducing dependency on centralized care (St. Jude) by enabling local systems.
- Improving post-treatment health outcomes through scalable transition protocols.
- Increased patient support through community partnerships and patient assistance.

Intended Populations: St. Jude patients and families
Resources: St. Jude; St. Jude Affiliates and Satellite Clinic
Collaboration Partners: St. Jude; St. Jude Affiliates and Satellite Clinic

Action 1	Lead Person / Department	Implementation Activities Year 1	Implementation Activities Year 2	Implementation Activities Year 3
Facilitate transition (St. Jude to community) initiatives across all oncology services.	Emily Browne, DNP, APN, RN, Director-Transition Program	Facilitate transition readiness assessment administration. Implement “Intervention Menu” of resource options for identified transition-related barriers. Explore alternative methods for distributing educational materials. Review feedback responses collected from families.	Expand transition readiness assessment administration to pre-ACT timepoint. Engage patient/family advisors in evaluating “Intervention Menu” for needed modifications. Share updates of activities with patient/family advisors. Survey staff.	Analyze aggregate transition readiness scores for trends and potential intervention opportunities. Formulate action plan to staff survey responses.
Action 1 Measures	• Transition Dashboard (rates of transition tab documentation, transition guide review, transition guide educational assignment, transition readiness assessment administration, Subspecialty transition readiness assessment scores). • Patient/family & staff surveys. • Transition readiness assessment tools.			

Action 2	Lead Person / Department	Implementation Activities Year 1	Implementation Activities Year 2	Implementation Activities Year 3
Facilitate pediatric to adult transition initiatives across all St. Jude services.	Emily Browne, DNP, APN, RN, Director-Transition Program	Finalize decision on standardized transition readiness assessment tool. Submit Epic build requests for service-specific questions. Establish regular meeting cadence to share updates & resources among service representatives.	Review existing Epic transition tab formatting for potential modifications. Facilitate transition readiness assessment administration across all services. Inventory current educational resources across services.	Analyze transition readiness assessment data for trends among ages, services. Create prioritized list of educational content needs.
Action 2 Measures	• Transition readiness assessment tools. • Pediatric to adult transition tab content documentation. • Inventory current educational resources.			

Action 3	Lead Person / Department	Implementation Activities Year 1	Implementation Activities Year 2	Implementation Activities Year 3
Improve coordination of off-therapy care between St. Jude and affiliates / satellite clinic for shared patients.	Jennifer Morgan, RN, Director-Domestic Affiliate Nursing Program	Conduct annual review of affiliate/satellite transition processes using standardized metrics. Share individualized feedback reports with each affiliate/satellite site to support continuous quality improvement. Facilitate collaborative meetings with affiliate/satellite teams to discuss best practices and address identified gaps. Update and disseminate transition process toolkit based on review findings and affiliate/satellite input.	Finalize and disseminate a protocol for transitioning shared patients off therapy, including clear roles for St. Jude and affiliate teams. Establish regular cadence for case review meetings between St. Jude and affiliate teams to discuss recent transitions and identify gaps. Provide joint training sessions for affiliate/satellite nurses and providers on survivorship care planning and community provider coordination. Launch a pilot tool or spreadsheet to track shared patients transitioning off therapy, including dates, responsible parties, and follow-up status.	Analyze data from Year 2 to assess effectiveness of transition protocols, refine based on feedback from affiliates/satellite clinic, St. Jude, and patient outcomes. Create a directory of trusted local community providers in each affiliate/satellite area for referrals.

Action 3	Lead Person / Department	Implementation Activities Year 1	Implementation Activities Year 2	Implementation Activities Year 3
Action 3 Measures	• % of patients receiving treatment summary at transition. • % of charts showing transition to community providers. • % of shared patients discussed in joint case reviews. • % of affiliate/satellite staff trained in survivorship protocols. • % of community providers engaged or contacted.			

Action 4	Lead Person / Department	Implementation Activities Year 1	Implementation Activities Year 2	Implementation Activities Year 3
Reduce barriers to accessing care in the community through formal and informal community partnerships and increase patient assistance.	Erica Sirrine, PhD, LCSW, Director-Social Work Antoinette Cooper: Patient Assistance Navigator II	Explore the current state of formal and informal community partnerships and relationships that enhance the psychosocial and medical support provided to our patients and families. Compile an updated list of current community partnerships, including scope and limitations of services. Develop an educational resource for patients eligible for disability.	Evaluate utilization of those partnerships and services. Identify gaps in patient/family needs and resources that fall within the St. Jude scope of practice Research potential resources in the Memphis community to enhance the support provided to local, international, and LEP families. Increase referrals to the Pt Assistance Coordinator for insurance, disability, and SNAP applications.	Explore potential informal and formal community partnerships to fill identified gaps and enhance mental health support for local patients and caregivers. Expand the use of Find Help within the institution, ensuring patients have access to the database of national community resources. Conduct benchmarking with other hospital systems regarding partnerships and programs to address SDOH needs, including food insecurity and housing instability.
Action 4 Measures	• Find Help usage data. • Usage data from community partnerships that address food insecurity, housing instability, legal needs, and other financial resource needs. • Patient Assistance Coordinator baseline referral data.			

Education (Memphis Community)

Goal 2: Improve health literacy and access to STEMM educational resources for greater-Memphis community and affiliates / satellite clinic.

Anticipated Outcomes:

- Increase the number of students and teachers participating in the St. Jude STEMM educational lessons that position STEMM practices as a tool of care.
- Position students as knowledge producers and health communicators in their communities.

Intended Populations: Memphis community
Resources: St. Jude STEMM Education & Outreach Program
Collaboration Partners: Local School Partners

Action 1	Lead Person / Department	Implementation Activities Year 1	Implementation Activities Year 2	Implementation Activities Year 3
Continue and expand partnerships with local education agencies to disseminate educational programs that position STEMM practices as a tool of care.	Kate Ayers, PhD, Director-STEMM Education & Outreach Robyn Pennella, Program Manager-External Quality Data	Train teachers to implement STEMM curricula in their classrooms. Host afterschool STEMM Clubs. Provide research immersion experiences. Connect schools with STEMM ambassadors.	Train teachers to implement STEMM curricula in their classrooms. Host afterschool STEMM Clubs. Provide research immersion experiences. Connect schools with STEMM ambassadors.	Train teachers to implement STEMM curricula in their classrooms. Host afterschool STEMM Clubs. Provide research immersion experiences. Connect schools with STEMM ambassadors.
Action 1 Measures	• # of teachers implementing STEMM curricula. • # of schools hosting an afterschool club. • # of students in the research immersion program. • # of applicants to the research immersion program. • # of schools reached by science ambassadors.			

Action 2	Lead Person / Department	Implementation Activities Year 1	Implementation Activities Year 2	Implementation Activities Year 3
Position students as knowledge producers and health communicators in their communities.	Kate Ayers, PhD, Director-STEMM Education & Outreach Robyn Pennella, Program Manager-External Quality Data	Host STEMM-sponsored community exhibitions and school events.	Host STEMM-sponsored community exhibitions and school events.	Host STEMM-sponsored community exhibitions and school events.
Action 2 Measures	• # of students presenting at STEMM-sponsored community exhibitions and school events.			

Education (Patients and Families)

Goal 3: Improve health literacy and access to educational resources for St. Jude patients and families.

Anticipated Outcomes:

- Increased health literacy and access to educational resources for St. Jude patients and families.
- Standardized and integrated education into care plans and after treatment.
- Support care transitions with education.

Intended Populations: St. Jude patients and families
Resources: St. Jude Patient Education (Strategic Communication, Education & Outreach); Nursing, Affiliates and Satellite Clinic; Information Services; Clinical Information Services
Collaboration Partners: St. Jude Clinical Staff; Patient Family Centered Care Program; Patient Experience

Action 1	Lead Person / Department	Implementation Activities Year 1	Implementation Activities Year 2	Implementation Activities Year 3
Enhance understanding of family planning methods and reproductive health in sickle cell population ages 16 -18.	Audrey Cole, Data & Education Coordinator, Hematology	Complete baseline health literacy survey.	Develop family planning health literacy based on survey feedback.	Implement family planning education.
Action 1 Measures	• Health literacy surveys. • Patient education engagement analytics. • Community resource utilization reports.			

Action 2	Lead Person / Department	Implementation Activities Year 1	Implementation Activities Year 2	Implementation Activities Year 3
Develop and implement strategies for patient family feedback and measurement of education outcomes.	Samantha Ransone, PhD, Director-Medical Content & Patient Outreach Nursing, Clinical Excellence	Identify key organizational stakeholders, conduct baseline surveys/focus groups, and analyze data. Evaluate current state of the Patient Education Steering Council.	Create plan to receive feedback on Patient Education Program from Patient Education Steering Council Implement a formal process for Patient Education Steering Council review of educational resources.	Evaluate engagement of patient families in review process and quality of education resources.
Action 2 Measures	• Surveys and focus groups. • Training completion and rates. • Technology usage reports. • Volume of materials reviewed by patient families.			

Action 3	Lead Person / Department	Implementation Activities Year 1	Implementation Activities Year 2	Implementation Activities Year 3
Standardize the access of education resources by patient families as part of the electronic health record.	Samantha Ransone, PhD, Director-Medical Content & Patient Outreach Nursing, Clinical Excellence Clinical Information Services	Complete resource inventory, including the technical accessibility of resources.	Identify priority content groupings (curriculum) needed for patient families and create patient family curriculum.	Launch patient family curriculum in Epic.
Action 3 Measures	• Staff and patient family feedback of Epic resources. • Electronic health record reports on utilization.			

HPV Education and Vaccination

Goal 4: Lead and support evidence-based efforts to increase HPV vaccination and prevent HPV cancers locally, regionally, and nationally.

Anticipated Outcomes:

- Reduction in HPV-associated cancer rates across multiple geographic areas.
- Increase in adolescent HPV vaccination rates from 58.6% (2020) toward 80% by 2030 across all levels.

Intended Populations: St. Jude Patients and families; Vaccine decision makers in the community

Resources: St. Jude funding and staff; Existing St. Jude Partner Organizations; St. Jude HPV Cancer Prevention Program partners such as the American Cancer Society; National HPV Vaccination Roundtable; Internal advisors (HPV Task Group); External Advisors, Established intranet-based resources targeting local, regional, rural, and national communities

Collaboration Partners: St. Jude SCEO; American Cancer Society; Centers for Disease Control and Prevention; Rural southeastern states (SE), regional, and national partners

Action 1	Lead Person / Department	Implementation Activities Year 1	Implementation Activities Year 2	Implementation Activities Year 3
Continue collaboration with the St. Jude HPV Vaccine Task Group, COE Advisory Council, and external subject matter experts through regular engagement and quarterly meetings.	Andrea Stubbs, PhD, Administrative Director-HPV Cancer Prevention Julia Brown, Manager-HPV Cancer Prevention	Conduct quarterly meetings with internal and external partners to guide and advance HPV vaccination efforts. Regularly assess partner satisfaction, track engagement, and monitor initiatives through surveys, interviews, and activity reports.	Expand rural & SE outreach to boost HPV vaccination. Strengthen partner collaboration and power-sharing. Increase provider training for strong vaccine recommendations. Support clinical practice implementation. Grow and diversify partner network implementation interventions.	Expand rural & SE outreach to boost HPV vaccination. Strengthen partner collaboration and power-sharing. Increase provider training for strong vaccine recommendations. Support clinical practice implementation. Grow and diversify partner network implementation interventions.
Action 1 Measures	• HPV vaccination and HPV cancer-related data. • Partnership surveys. • Patient education engagement analytics. • Community resource utilization report. • Number of direct (HPV Cancer Prevention Program led) implementation activities. • Number of direct or indirect (partner led, HPV Cancer Prevention Program supported) implementation activities. • Number of interventions implemented (internal, local, statewide, regional, national). • Number of internal staff or external partners reached through interventions.			

Action 2	Lead Person / Department	Implementation Activities Year 1	Implementation Activities Year 2	Implementation Activities Year 3
Actively engage with roundtables, coalitions, and organizations to support evidence-based HPV vaccination programming and increase coverage.	Andrea Stubbs, PhD, Administrative Director-HPV Cancer Prevention Julia Brown, Manager-HPV Cancer Prevention	Regularly assess partner satisfaction, track engagement, and monitor initiatives through surveys, interviews, and activity reports.	Expand rural & SE outreach to boost HPV vaccination. Strengthen partner collaboration and power-sharing. Increase provider training for strong vaccine recommendations. Support clinical practice implementation. Grow and diversify partner network, implementing interventions.	Expand rural & SE outreach to boost HPV vaccination. Strengthen partner collaboration and power-sharing. Increase provider training for strong vaccine recommendations. Support clinical practice implementation. Grow and diversify partner network, implementing interventions.
Action 2 Measures	• HPV vaccination and HPV cancer-related data. • Partnership surveys. • Patient education engagement analytics. • Community resource utilization report. • Number of direct (HPV Cancer Prevention Program led) implementation activities. • Number of direct or indirect (partner led, HPV Cancer Prevention Program supported) implementation activities. • Number of interventions implemented (internal, local, statewide, regional, national).			

Infectious Diseases

Goal 5: Increase awareness and education of infectious diseases (HIV/AIDS) in the local community.

Anticipated Outcomes:

- Increased knowledge of HIV prevention and treatments.
- Increased engagement in social media messaging led by the community initiative Ending the HIV Epidemic (End HIV 901) targeting HIV prevention and treatment.

Intended Populations: St. Jude patients and greater Memphis community
Resources: St. Jude; Shelby County Health Department; End HIV 901
Collaboration Partners: Shelby County Health Department; End HIV 901 community members

Action 1	Lead Person / Department	Implementation Activities Year 1	Implementation Activities Year 2	Implementation Activities Year 3
Establish and maintain community partnerships for youth HIV prevention education.	Karrie Reed, Program Manager, Infectious Diseases Dept.- Outreach team	Identify and establish community partners for Connect to Protect Memphis (C2P). Develop knowledge measurement tool.	Monitor and increase engagement of community partners in C2P. Capture structural change intervention established by coalition. Implement knowledge measurement tool.	Capture structural change intervention established by coalition.
Action 1 Measures	• Local health departments data on HIV testing data. • Clinic records tracking PrEP/PEP prescriptions, opt-out HIV testing uptake. • Community surveys measuring awareness, attitudes, and knowledge levels. • # of educational sessions conducted at schools, clinics, community centers and in under-resourced areas. • # of youth accessing PrEP/PEP education. • % change in knowledge scores from pre/post education surveys.			

Action 2	Lead Person / Department	Implementation Activities Year 1	Implementation Activities Year 2	Implementation Activities Year 3
Increase awareness of HIV treatment access points.	Karrie Reed, Program Manager, Infectious Diseases Dept.- Outreach team	Develop and disseminate youth-led educational video regarding treatment at St Jude.	Monitor engagement of educational video.	Monitor engagement of educational video.
Action 2 Measures	• # of individuals reached through campaigns (flyers, social media, radio). • # of youth referred to St. Jude for treatment. • # of social media posts specific to HIV treatment. • # of social media following.			

Mental Health and Wellness

Goal 6: Address patient and caregiver mental health challenges and access to services.

Anticipated Outcomes:

- Increased patient utilization of currently offered St. Jude services promoting mental health and wellness support.
- Increased caregiver utilization of currently offered St. Jude services promoting mental health and wellness support.
- Increased clinical and program staff awareness and promotion of currently offered St. Jude mental health and wellness support services to patients and caregivers.
- Increased staff knowledge and understanding of trauma-informed care practice, leading to improved patient/caregiver experience.

Intended Populations: St. Jude patients and caregivers
Resources: St. Jude
Collaboration Partners: Wellnite; St. Jude internal departments; Patient Family Centered Care Program

Action 1	Lead Person / Department	Implementation Activities Year 1	Implementation Activities Year 2	Implementation Activities Year 3
Strengthen institutional services, offerings, and programs to enhance the psychosocial care and resilience of our **patients**.	Valerie Crabtree, PhD, Member, Vice President-Psychosocial Services Lauren McCann, LMSW, Administrative Director-Psychosocial Services Carla London, DNP, APN, RN, Psychosocial Services Program Manager-APP Abby Cooley, Program Coordinator, Family Guest and Volunteer Services Kaylee Fisher, Program Manager-	Evaluate patient preferences and needs for psychoeducational information, including how they wish to receive the education. Explore current psychoeducational materials/workshops offered for patients, identify gaps or needs in programming. Implement Teen and Emerging Adults (TEA) Steering Council, with representation of youth on PFAC. Implement screening for coping needs across all patients, individualizing plans to support wellbeing throughout treatment for catastrophic disease. *(i.e. behavioral risk, universal coping, ICU assessment, nursing*	Create and implement psychoeducational materials and/or workshops to support patients that meet identified gaps or needs.	Inclusion of psychoeducational content in SW care plans.

Action 1	Lead Person / Department	Implementation Activities Year 1	Implementation Activities Year 2	Implementation Activities Year 3
	Psychology Services	*screening for depression for tailored triage and response).*		
Action 1 Measures	• Psychoeducational materials created and distributed, followed by gathering feedback from patients. • TEA Patient and Caregiver Needs assessment surveys. • TEA meeting attendance logs, agendas, feedback from participants. Number of participants. • TEA surveys to measure progress after implementing interventions. • Support group attendance logs. • Results of patient/caregiver input or feedback.			

Action 2	Lead Person / Department	Implementation Activities Year 1	Implementation Activities Year 2	Implementation Activities Year 3
Strengthen institutional services, offerings, and programs to enhance the psychosocial care and resilience of our **caregivers.**	Valerie Crabtree, PhD, Member, Vice President-Psychosocial Services Lauren McCann, LMSW, Administrative Director-Psychosocial Services Carla London, DNP, APN, RN, Psychosocial Services Program Manager-APP Abby Cooley, Program Coordinator, Family Guest and Volunteer Services Kaylee Fisher, Program Manager-Psychology Services	Evaluate caregiver preferences and needs for psychoeducational information, including how they wish to receive the education. Explore current psychoeducational materials/workshops offered for caregivers, identify gaps or needs in programming. Further promote caregiver use of telehealth for mental health services. Further implement caregiver distress screening for coping needs. Host Caregiver SHARE podcast and Caregiver Connections groups. Continue distribution of Relationship Toolkit. Provide mentors through the Mentor Program, including adviser participation in	Create and implement psychoeducational materials and/or workshops to support caregivers that meet identified gaps or needs. Strengthen institutional efforts to support bereaved caregivers. - DOR - Utilize feedback from St. Jude Voice survey for bereaved families	Develop and implement a mindfulness toolkit for caregivers. Expand efforts to formally address identified caregiver distress following screenings.

Action 2	Lead Person / Department	Implementation Activities Year 1	Implementation Activities Year 2	Implementation Activities Year 3
		Caregiver Rounding and Caregiver Support.		
Action 2 Measures	• Psychoeducational materials created and distributed, feedback from caregivers. • # of mentors. • # of mentor matches (sessions). • # of podcasts/ downloads. • 3 seasons of Caregiver SHARE podcast completed (episodes). • Existing number of downloads by FY. • Caregiver satisfaction, feedback, and awareness surveys. • Number of referrals to telehealth – Wellnite. • Number of participants in telehealth – Wellnite.			

Action 3	Lead Person / Department	Implementation Activities Year 1	Implementation Activities Year 2	Implementation Activities Year 3
Advance trauma-informed and strengths-based practices by aligning care approaches with patient needs and increasing staff awareness of existing trauma-informed care (TIC) initiatives.	Kaylee Fisher, Program Manager-Psychology Services Andrew Elliott, MD, Assistant Member, Director, Psychiatry Division Niki Jurbergs, PhD, Psychology Service Chief / Member Valerie Crabtree, PhD, Member, Vice President-Psychosocial Services	Evaluate caregiver and staff preferences and needs for trauma-informed education, including how they wish to receive the education. Explore current materials/workshops offered to staff regarding the emotional safety of patients and families to identify gaps or needs in educational offerings.	Develop ongoing educational offerings for staff and family education to highlight St. Jude's focus on trauma-informed care practice for patients and families.	Review current institutional policies and practices with the lens of trauma-informed care practice and revise as needed.
Action 3 Measures	• Validated measures of trauma-informed care practices (existing trauma-informed care practices). • Trauma-Informed Care Organizational Planning Model results.			

Acknowledgements

The groups and organizations listed in this section participated in collective and individual discussions, sharing valuable insights related to the health of the community, barriers and challenges, strengths and resources, recommendations for future planning, and development of the 2025-2027 ISP. To complete the assessment and ISP Workshops, St. Jude contracted Conduent Healthy Communities Institute (Conduent HCI).

2025 Community Health Needs Assessment Participants

Community Partner Listening Sessions

St. Jude hosted four (4) Community Partner Listening Sessions. Participating groups included:

- St. Jude Medical Executive Committee (MEC)
- Le Bonheur Childhood Advocacy Institute
- St. Jude Psychosocial Department
- St. Jude HIV and Infectious Diseases

Community Member Focus Groups

St. Jude hosted conversations with five (5) groups of community members. These groups included participants from the following patient demographics:

- Patient Survivors
- Hematology and Infectious Diseases
- Active Patients
- Affiliates and Local Families
- Patient Family Advisory Council (PFAC)

Key Partner Interviews

St. Jude hosted sixteen (16) conversations with community partners and leaders**.** Individuals and groups interviewed represented the perspectives of the following organizations:

- Christ Community Health Services
- Church Health
- MIFA
- Shelby County Community Services
- Shelby County Health Department
- St. Jude Hematology Providers
- St. Jude HPV and Cancer Outreach
- St. Jude Huntsville Clinic
- St. Jude Patient Assistance Coordinator
- St. Jude STEM and Education Outreach
- St. Jude Survivorship
- Tennessee Hospital Association
- The Works
- U of M Epidemiology
- U of T: Health Science Center (UTHSC)
- Urban Child Institute

2025-2027 Implementation Strategy Plan Action Item Owners

- Emily Browne, DNP, APN, RN, Director-Transition Program
- Jennifer Morgan, RN, Director-Domestic Affiliate Nursing Program
- Kate Ayers, PhD, Director-STEMM Education & Outreach
- Robyn Pennella, Program Manager-External Quality Data
- Audrey Cole, Data & Education Coordinator, Hematology

- Samantha Ransone, PhD, Director-Medical Content & Patient Outreach
- Andrea Stubbs, PhD, Administrative Director-HPV Cancer Prevention
- Julia Brown, Manager- HPV Cancer Prevention
- Karrie Reed, Program Manager, Infectious Diseases Dept.- Outreach team
- Valerie Crabtree, PhD, Member, Vice President- Psychosocial Services
- Lauren McCann, LMSW, Administrative Director-Psychosocial Services
- Carla London, DNP, APN, RN, Psychosocial Services Program Manager-APP
- Abby Cooley, Program Coordinator, Family Guest and Volunteer Services
- Kaylee Fisher, Program Manager- Psychology Services
- Andrew Elliott, MD, Assistant Member, Director, Psychiatry Division
- Niki Jurbergs, PhD, Psychology Service Chief / Member