



**2016**

# Thomas Jefferson University Hospitals Community Health Needs Assessment Report

## **Acknowledgements**

Authors and originators:

Rickie Brawer, PhD, MPH, MCHES, Co- Director, Center for Urban Health, Thomas Jefferson University Hospital and Assistant Professor, Department of Family and Community Medicine, Jefferson University, Sidney Kimmel Medical College

James Plumb MD, MPH, Director Center for Urban Health, Vice Chair Community Medicine, Professor, Department of Family and Community Medicine, Jefferson University, Sidney Kimmel Medical College

F. Abby Cabrera, MPH, Administrative/Community Benefit Coordinator, Center for Urban Health

Ann D. Clark, MS, OTR/L, Vice President for Clinical and Support Services

Monica Doyle, MBA, Senior Vice President for Strategy and Business Development

Heather Prasad, MHA, Director of Strategy and Business Development

Jane Elgis Berkowitz, MRP, MA, Consultant

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## **Executive Summary**

### **Executive Summary**

Thomas Jefferson University Hospital (TJUH) is a Pennsylvania nonprofit organization located in Philadelphia County, Pennsylvania that considers its community benefit service area to include proximate neighborhood/zip codes where almost 420,000 people live. This Community Health Needs Assessment (CHNA) utilizes information collected from the Public Health Management Corporation's household health survey, multiple secondary data and literature sources, ninety internal experts and external representatives of health care and community based organizations who have knowledge of the health and social conditions of these communities, and focus groups with TJUH employees living in community benefit target zip codes, who have knowledge of the health and social conditions of these communities.

TJUH's community benefit area is an area with relatively high underlying economic and structural barriers that affect overall health, such as income, culture/language, education, insurance, and housing. Most health status indicators are static, and many are worse than the Healthy People 2020 goals. Racial/ethnic and income disparities exist, and for most indicators, people of color and/or Hispanic origin fare far worse than their Caucasian neighbors.

This CHNA also includes focused sections on the following special populations: adults age 60+, immigrants/refugees, the homeless, the LGBT community, returning citizens from prison, and veterans.

Using the data presented in this CHNA and a prioritization process, TJUH will mainly focus its resources and assets on the following domains:

- 1) Language Access
- 2) Regular Source of Care
- 3) Obesity
- 4) Chronic Disease Prevention and Management – diabetes, cardiovascular disease, hypertension and stroke
- 5) Hospital and Emergency Department Utilization
- 6) Health Insurance
- 7) Women's Cancer
- 8) Colon Cancer
- 9) Social and Health Care Needs of Older Adults
- 10) Workforce Development and Diversity



## Introduction

*Over the past century the major causes of morbidity and mortality in the United States have shifted from those related to communicable diseases to those due to chronic diseases. Just as the major causes of morbidity and mortality have changed, so too has understanding of health and what makes people healthy or ill. Research has documented the importance of the social determinants of health (for example, socioeconomic status and education), which affect health directly as well as through their impact on other health determinants such as risk factors. Targeting interventions toward the conditions associated with today's challenges to living a healthy life requires an increased emphasis on the factors that affect the current causes of morbidity and mortality, factors such as the social determinants of health. Many community-based prevention interventions target such conditions. Community-based prevention interventions offer three distinct strengths. First, because the intervention is implemented population-wide it is inclusive and not dependent on access to the health care system. Second, by directing strategies at an entire population an intervention can reach individuals at all levels of risk. And finally, some lifestyle and behavioral risk factors are shaped by conditions not under an individual's control. For example, encouraging an individual to eat healthy food when none is accessible undermines the potential for successful behavioral change. Community-based prevention interventions can be designed to affect environmental and social conditions that are out of the reach of clinical services.<sup>1</sup>*

*"The best care/access in the world won't trump the social issues"* (CBO representative)

### **"Jefferson"**

Thomas Jefferson University and Jefferson Health (also known collectively as "Jefferson") is an academic medical center dedicated to educating the health professionals of tomorrow in a variety of disciplines; discovering new treatments and therapies that will define the future of clinical care; and providing exceptional primary through complex quaternary care to patients in the communities served throughout the Delaware Valley. Jefferson's mission is: *Health is All We Do*. Its Vision is: *to reimagine health, education and discovery to create unparalleled value and to be the most trusted healthcare partner*.

Founded in 1824 as Jefferson Medical College (JMC), and now known as Sidney Kimmel Medical College at Thomas Jefferson University (TJU), the University also includes the Jefferson Colleges of Biomedical Sciences, Health Professions, Nursing, Pharmacy, and Population Health. TJU enrolls more than 3,800 future physicians, scientists and healthcare professionals.

Jefferson Health is the clinical arm of the organization. It includes Thomas Jefferson University Hospital (Magnet®-designated), Jefferson Hospital for Neuroscience, Methodist Hospital (collectively referred to as TJUHs), Abington Hospital (Magnet®-designated), Abington-Lansdale Hospital (Pathway to Excellence® designation), Abington-Jefferson Health outpatient campuses and urgent care centers, and physicians.

Thomas Jefferson University Hospital (TJUH) is Magnet®-designated and is one of only 14 hospitals in the country that is a Level 1 Trauma Center and a federally designated Regional Spinal Cord Injury Center. Jefferson's Regional Spinal Cord Injury Center of the Delaware Valley, in affiliation with Magee Rehabilitation Hospital, is designated as one of the nation's Model Spinal Cord Injury Centers by the National Institute on Disability and Rehabilitation Research. TJUHs has 951 licensed acute care beds and provides the full range of clinical care, both in inpatient and ambulatory settings and in all specialties and subspecialties.

TJUH continues its record of excellence in health care with recognition from *U.S. News & World Report's* annual listing of top hospitals and specialties. In 2013-14, the magazine ranked TJUH among the nation's top 20 hospitals. In 2015-16 *U.S. News & World Report* ranked TJUH among the nation's best hospitals for:

- Cancer
- Ear, Nose and Throat
- Gastroenterology and GI Surgery
- Neurology and Neurosurgery
- Ophthalmology (staffed by Wills Eye Hospital)
- Orthopedics (staffed by Rothman Institute and The Philadelphia Hand Center)
- Urology

Both TJUH and Abington Hospital have been recognized as *Top Performers on Key Quality Measures®* by The Joint Commission for attaining and sustaining excellence in accountability measure performance for heart attack, heart failure, pneumonia and surgical care. *Aetna Institute of Excellence®* designated TJUH as a transplant facility for adult bone marrow, liver, and kidney transplants and *Aetna Institutes of Quality®* named TJUH as a facility for spine surgery. TJUH is also one of the first hospitals in the nation to receive a *Blue Distinction Center* designation from Independence Blue Cross for cardiac care & Maternity Care, as part of the Blue Distinction Centers for Specialty Care® program. Additionally, TJUH received *Joint Commission Certification* in Joint Replacement — hip, knee and spine surgery – and *Advanced Certification* in:

- Stroke (Comprehensive Stroke Center)
- Ventricular Assist Device (VAD)
- Palliative Care

Jefferson Health also includes 16 outpatient and urgent care centers as well as numerous physician practices located in Bucks, Montgomery, and Philadelphia counties in Pennsylvania, and Camden County in New Jersey. Outpatient and community-based services are delivered through an extensive network of owned and affiliated physician practices, satellite medical and surgical centers, outpatient laboratories, imaging centers, and retail pharmacies.

## **Models**

With the growing burden of chronic disease, the medical and public health communities are reexamining their roles and opportunities for more effective prevention and clinical

interventions. The potential to significantly improve chronic disease prevention and impact morbidity and mortality from chronic conditions is enhanced by adopting strategies that incorporate a social ecology perspective, realigning the patient-physician relationship, integrating population health perspectives into the chronic care model, and effectively engaging communities.

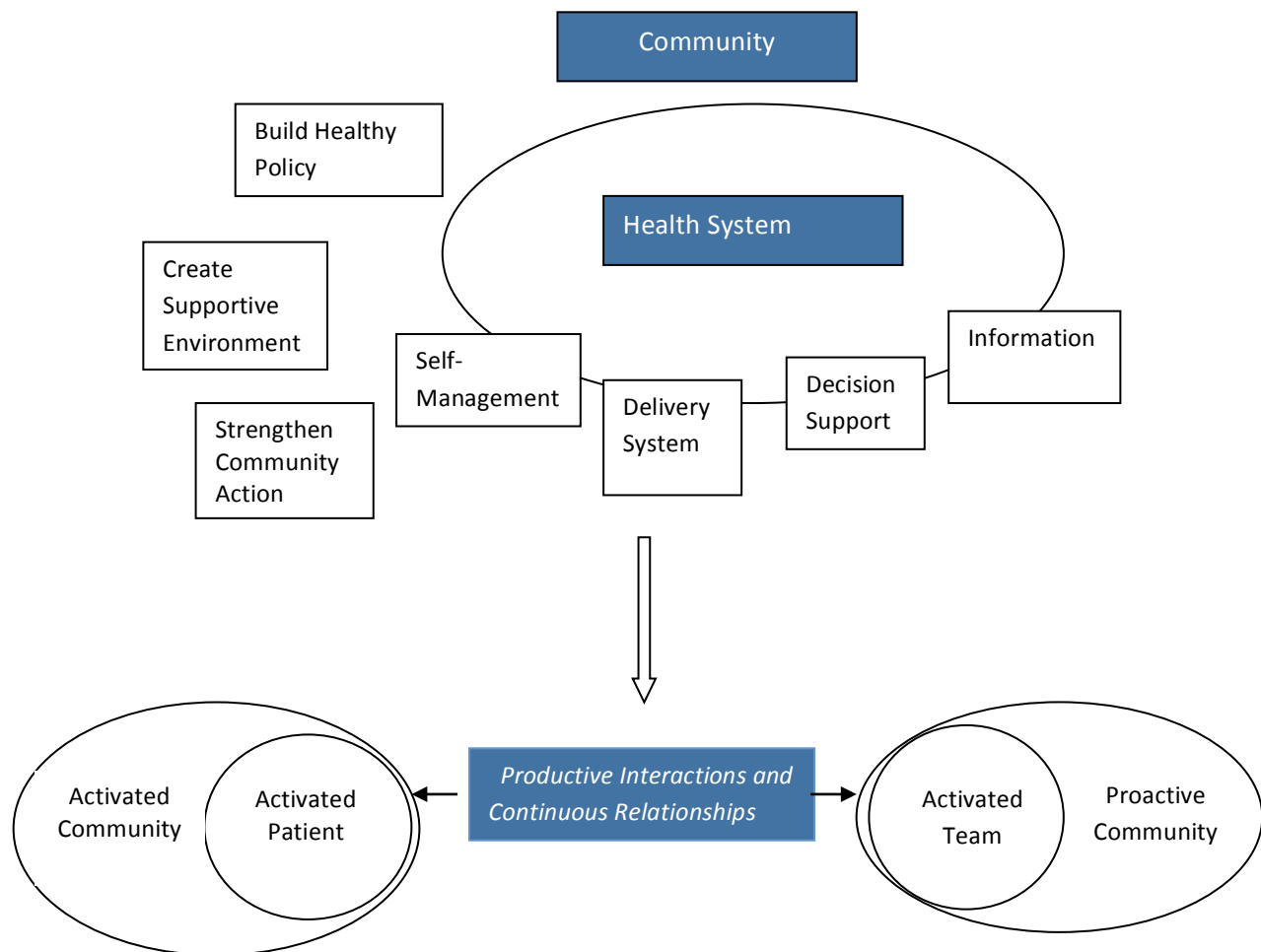
Jefferson highly values the principles of community engagement articulated by the Centers for Disease Control and has built its community benefit efforts on a community engagement model.

### **Principles of Community Engagement<sup>2</sup>**

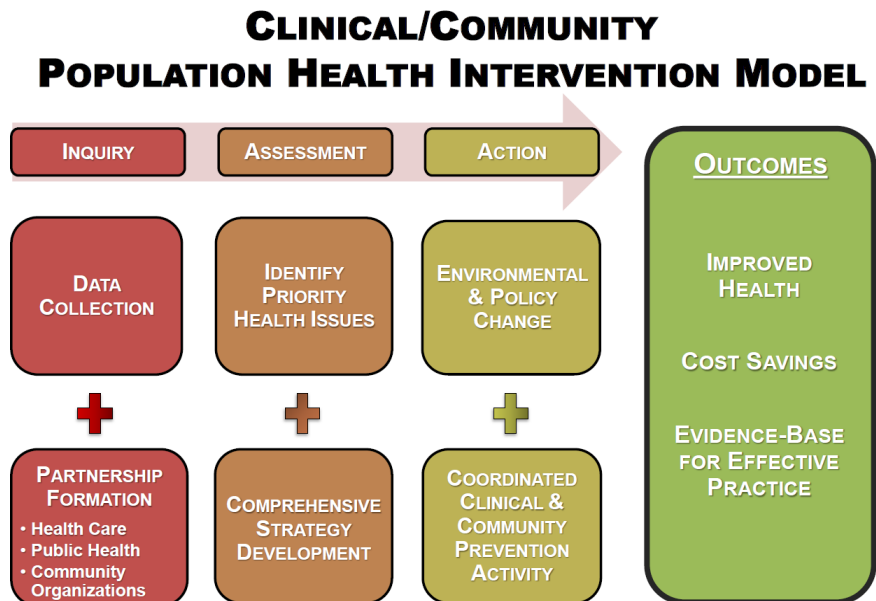
<b>Principle</b>	<b>Key elements</b>
Set Goals	<ul style="list-style-type: none"> <li>• Clarify the purposes/goals of the engagement effort</li> <li>• Specify populations and/or communities</li> </ul>
Study Community	<ul style="list-style-type: none"> <li>• Economic conditions</li> <li>• Political structures</li> <li>• Norms and values</li> <li>• Demographic trends</li> <li>• History</li> <li>• Experience with engagement efforts</li> <li>• Perceptions of those initiating the engagement activities</li> </ul>
Build Trust	<ul style="list-style-type: none"> <li>• Establish relationships</li> <li>• Work with the formal and informal leadership</li> <li>• Seek commitment from community organizations and leaders</li> <li>• Create processes for mobilizing the community</li> </ul>
Encourage self-determination	<ul style="list-style-type: none"> <li>• Community self-determination is the responsibility and right of all people</li> <li>• No external entity should assume that it can bestow on a community the power to act in its own self-interest</li> </ul>
Establish partnerships	<ul style="list-style-type: none"> <li>• Equitable partnerships are necessary for success</li> </ul>
Respect diversity	<ul style="list-style-type: none"> <li>• Utilize multiple engagement strategies</li> <li>• Explicitly recognize cultural influences</li> </ul>
Identify community assets and develop capacity	<ul style="list-style-type: none"> <li>• View community structures as resources for change and action</li> <li>• Provide experts and resources to assist with analysis, decision-making, and action</li> <li>• Provide support to develop leadership training, meeting facilitation, skill building</li> </ul>
Release control to the community	<ul style="list-style-type: none"> <li>• Include as many elements of a community as possible</li> <li>• Adapt to meet changing needs and growth</li> </ul>
Make a long-term commitment	<ul style="list-style-type: none"> <li>• Recognize different stages of development and Provide ongoing technical assistance</li> </ul>

Jefferson also recognizes the value of an Expanded Chronic Care Model<sup>3</sup> as a framework for addressing chronic disease in a comprehensive way that respects clinical care, the health system, community and patients as equal partners in meeting the Triple Aim of improving population health, the patient experience, and reducing per capita costs.

**Figure 1 – Expanded Chronic Care Model**



The Community Benefit Steering Committee described below recommends using the following model<sup>4</sup> to guide planning and programmatic efforts, and to explain to internal and external stakeholders the rationale for the Community Health implementation plan.



## **Purpose of the Community Health Needs Assessment (CHNA)**

Ongoing, unprecedented increases in the demand for healthcare are challenging for communities and healthcare providers in this era of limited fiscal resources. Regulatory changes also have resulted in new obligations. One of the mandates of the Patient Protection and Affordable Care Act (PPACA) is a Community Health Needs Assessment. Starting in 2013, every three years tax-exempt hospitals must conduct an assessment and implement strategies to address priority needs. The Health Reform Act spells out requirements for the Community Health Needs Assessment. This assessment is central to an organization's community benefit/social accountability plan. By determining and examining the service needs and gaps in a community, an organization can develop responses to address them.

A Community Health Needs Assessment is a disciplined approach to collecting, analyzing, and using data (including community input) to identify barriers to the health and well-being of its residents and communities, leading to the development of goals and targeted action plans to achieve those goals. The assessment findings can be linked to clinical decision making within health care systems as well as connected to community health improvement efforts. The assessment engages health care providers and the broader community by providing a basis for making informed decisions, with a strong emphasis on preventing illness and reducing health disparities.

***Specifically, the PPACA mandates a section in the IRS Code –Section 501(r) for hospitals to obtain/maintain 501(c)(3) status:***

- Each hospital facility must conduct a community health needs assessment at least once every three taxable years and adopt an implementation strategy to meet the community health needs identified through the assessment
- The community health needs assessment must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or public health expertise
- The CHNA be made widely available to the public

For the 2016 CHNA, the Department of Treasury and the IRS is encouraging cross institution collaboration. To that end the Healthcare Improvement Foundation, in partnership with the Hospital and Health System of Pennsylvania and the U.S. Department of Health and Human Services (Region 3) convened the region's hospitals in the Collaborative Opportunities to Advance Community Health (COACH) Project. The goals of COACH are to:

- Gather input from public health authorities and key community stakeholders
- Explore growing number of health and epidemiologic data sources
- Collaborate with public health and other stakeholders to prioritize needs, coordinate interventions, and establish measures for evaluating results

Four principles are guiding the development of a strategy for leveraging community benefit programs to increase their influence: defining mutually agreed-on regional geographic boundaries to align both community benefit and accountable health community initiatives,

ensuring that community benefit activities use evidence to prioritize interventions, increasing the scale and effectiveness of community benefit investments by pooling some resources, and establishing shared measurement and accountability for regional population health improvement.<sup>5</sup>

The Community Health Needs Assessment was conducted by Jefferson Hospitals' Center for Urban Health. Staff responsible for conducting the assessment are: Dr. James Plumb MPH (Director of the Center for Urban Health and faculty in the Department of Family and Community Medicine and the College of Population Health MPH Program), Rickie Brawer, PhD, MPH (Associate Director of the Center for Urban Health and faculty in the Department of Family and Community Medicine and the College of Population Health MPH Program), and Abby Cabrera MPH.

To undertake the IRS mandate in 2016, TJUHs formed an Internal Community Benefit Steering Committee (CBSC). The role of the CBSC is to provide guidance about conducting the health needs assessment, to suggest community experts/organizations that should be included in the process, to provide suggestions for additional resources to be included, to review the needs assessment findings and recommendations, and to provide guidance and insight into priorities and strategies for the implementation plan. Members of the internal CBSC are listed below:

<b>Community Benefit Steering Committee Members</b>	
President Jefferson Hospitals	
Associate Chief Medical Officer	
Chief Medical Officer – Jefferson Health System	
Senior Vice President Hospital Operations	
Senior Vice President and Associate Chief Medical Officer	
Chief Administrative Officer	
Chief Patient Experience Officer	
Senior Vice President and Chief Medical Information Officer	
Executive Vice President/Chief Operating Officer	
Senior Vice President and Chief Marketing Officer	
Senior Vice President Patient Services, Quality & Safety, and Chief Nursing Officer	
Chief Administrative Officer, Vice President - Business Affairs	
Senior Vice President for Strategy and Business Development	
Senior Vice President for Finance and Chief Financial Officer	
Senior Vice President and Executive Director for Farber Institute of Neuroscience	
Chief Patient Safety/Quality Officer	
Senior Vice President for Clinical and Support Services	
Senior Vice President, Facilities and Campus Planning	
Vice President, Clinical & Support Services	
Director – Center for Urban Health	
Co-Director – Center for Urban Health	
Director of Strategy and Business Development	
Administrative/Community Benefit Coordinator – Center for Urban Health	

Specifically, the CBSC was charged to:

- Develop a strategic plan based on a comprehensive needs assessment
- Align the plan with TJUH's Strategic Plan



- Develop an annual action plan and budget
- Monitor plan implementation and institute corrective measures if needed
- Conduct ongoing evaluation of community benefit structure and processes
- Evaluate the effectiveness of individual projects and the impact of community benefit initiatives as a whole
- Communicate with external and internal audiences

The CBSC also identified underlying principles for the implementation plan to address priority health issues and social determinants of health identified in the assessment. These include:

- Targeting reduction of health disparities
- Building on Jefferson strengths and resources
- Involving two or more of mission elements: patient care, education and research
- Embracing community engagement and partnerships
- Sustainability, economically and programmatically, over time

In addition to these principles, the CBSC chose additional factors in determining a neighborhood focus of its community benefit approach to maximize effectiveness and address disparities. These urban neighborhoods:

- Are geographically proximate to both TJUH and Methodist. As an academic medical center, Jefferson serves a region that spans three states. For purposes of community benefit, the steering committee agreed that the focus for community benefit should be narrowed to include those neighborhoods in Philadelphia that are most proximate to TJUHs campuses. These communities include Lower North Philadelphia, Transitional Neighborhood, Center City, and South Philadelphia
- Have a density of high-risk patients who demonstrate poor health indicators (health disparities)
- Have a poverty rate >20%
- Have assets and resources that are not linked and coordinated to TJUHs outreach
- Have individuals and organizations with developed historical relationships with Jefferson staff or have the potential for partnering to address specific health and social issues

Neighborhood resources, ethnic diversity, and fragmentation of services within Philadelphia pose formidable organizational challenges in community benefit programming. Even though TJUHs geographical reach expands across the Greater Delaware Valley, the key urban factors (noted above) offer Jefferson opportunities for effective urban population health improvement strategies.

Jefferson's Community Benefit Program (CBP) adopts a comprehensive notion of health determinants that are spread across domains of behavioral risk, social and economic circumstances, environmental exposures, and medical care. The balance and effects of many of these determinants, e.g. availability of healthy foods, parks and other safe places to play and exercise, exposure to environmental irritants, and safe housing, are specific to Jefferson's specific locale and are built into the Community Benefit Plan.

## Community Health Needs Assessment Methods

### *Literature Review and Secondary Data Sources*

In preparation for the community health needs assessment more than 30 secondary data sources were reviewed including:

- 100,000 Homes campaign – Data on homelessness in Philadelphia
- 2014 Pennsylvania Health Equity Conference Resources
- 2015 The Nielsen Company, © 2015 Truven Health Analytics Inc.
- American Diabetes Association<sup>6</sup>
- Behavior Risk Factor Surveillance System (BRFSS)
- Centers for Disease Control and Prevention
- Child Opportunity Index
- City of Philadelphia data: (Economic data, School data, Transportation, Vacant properties, City zoning/food work initiatives, Homelessness)
- Community Commons
- Community Needs Index
- County Health Rankings and Roadmaps 2015
- Drexel University School of Public Health - Center for Hunger Free Communities
- Enroll America
- Feeding America – Map the Meal Gap
- FRAC – Food Hardship in America 2012
- Healthy People 2020
- Kaiser Family – State Health Facts
- Maternity Care Coalition Early Head Start Community Assessment
- Overlooked and Undercounted – The Self-Sufficiency Standard
- Pennsylvania Department of Health
- Pew Charitable Trusts: Philadelphia 2015 - State of the City
- Philadelphia Corporation on Aging
- Philadelphia Health Department
- Public Health Management Corporation - Household Health Survey
- Reports from a variety of community coalitions focused on specific neighborhoods or health issues such as Promise Neighborhoods, Philly Rising Initiatives, Sharswood Blumberg, City District Planning Reports to reduce crime/violence, and coalitions to improve access to Behavioral Health Services
- Restaurant Opportunities Centers United
- SEAMAAC Asian Health Survey
- The Annie E Casey Foundation - Kids Count
- TJUH and Methodist 2015 utilization data
- U.S. Census Bureau
- Various articles from academic journals
- Various articles from the popular press
- Walkable Access to Healthy Food in Philadelphia, 2010-2012
- Youth Risk Behavior Surveillance System (YRBSS)

### ***Primary Data Sources:***

#### **TJUHs Strategic Plan**

The strategic plans for TJUHs were reviewed and potential areas of alignment with community benefit strategies were identified.

#### **Interviews and Meetings**

More than 90 interviews were conducted with individuals representing health care and community based organizations working with the medically underserved, low-income and minority populations that have knowledge of the health and underlying social conditions that affect health of the people in their neighborhood and broader community. These interviews were conducted by a qualitative public health researcher from TJUHs Center for Urban Health to gain insight about health needs and priorities, barriers to improving community health, and the community assets and efforts already in place or being planned to address these issues and concerns. The interviews conducted with faculty and health providers from Methodist Hospital, Jefferson Neurosciences and Jefferson University Hospital were designed to gain their perspective about the health issues of their patients and community and to identify Jefferson's and other efforts to address these issues. Interviewees were asked to prioritize the needs/ recommendations discussed during their interview. Throughout 2014 and 2015, meetings were also held with a variety of community based organizations to understand how TJUH might partner to address health needs of the communities they serve. The table below lists the organizations and clinical departments of those interviewed, the sector they represent (community or Jefferson), and the focus of the interview/meeting based on area(s) of expertise.

<b>Organization</b>	<b>Community/ Jefferson</b>	<b>Focus</b>
ACCESS Matters	Community	Family Planning; Maternal Health
The Augustinian Defenders of the Rights of the Poor (ADROP)	Community	Immigrant Health; Social Determinants of Health
American Diabetes Association	Community	Diabetes
American Heart Association	Community	Heart Disease/Stroke
Asian Chamber of Commerce of Greater Philadelphia	Community	Immigrants
Bhutanese American Organization-Philadelphia (BAO-P)	Community	Refugee Health and Social Services
Broad Street Ministries	Community	Homeless
Cambodian Association	Community	Immigrants
Chinatown Community Development Corporation	Community	Immigrant Health; Social Determinants of Health
City Councilman 1st District	Community	City Government
Coalition Against Hunger	Community	Food Access/ Food Security
Congreso de Latinos Unidos	Community	Latino Health and Social Needs

Organization	Community/ Jefferson	Focus
Council for Relationships	Community	Behavioral Health
Delaware Valley Regional Planning Council	Community	Built Environment; Social Determinants of Health
Department of Behavioral Health and Intellectual Disabilities	Community	Behavioral Health
Diversified Community Services	Community	Neighborhood Community Center
Food Trust	Community	Food Security; Access to Food; Nutrition; Obesity
Greater Philadelphia Business Coalition on Health	Community	Work Place Wellness
Greater Philadelphia Health Action; Chinatown Medical Services	Community	Pediatrician, Federally Qualified Health Center; Asian Health
Hispanic Association of Contractors and Enterprises (HACE)	Community	Immigrant Health; Social Determinants of Health
Healthy Rowhouse Initiative	Community	Housing; Social Determinants of Health
Health Federation	Community	Federally Qualified Health Center
Health Promotion Council	Community	Community Health Promotion
Healthcare Improvement Foundation	Community	Health Literacy
Hepatitis B Foundation	Community	Hepatitis B
Legal Clinic for the Disabled	Community	Medical Legal Partnership
Lutheran and Children's Services	Community	Immigrant/Refugee; Behavioral Health
Metropolitan Area Neighborhood Nutrition Alliance (MANNA)	Community	Food Access and Nutrition
Mayor's Office of Immigrant and Multicultural Affairs	Community	Immigrant Health; Social Determinants of Health
Maternity Care Coalition	Community	Maternal Child Health; Early Childhood Development; Social Determinants of Health
Mayor's Office on Planning	Community	City Planning; Built environment
Mazzoni Center	Community	LGBT
Methadone Clinic	Community	Addictions
Nationalities Services Center	Community	Immigrant/Refugee
Nemours Pediatrics	Community	Children
New Kensington Community Development Corporation	Community	Social Determinants of Health; Community Development Corporation

Organization	Community/ Jefferson	Focus
Norris Square Community Alliance Head Start	Community	Early Childhood Development
Philadelphia Association of Community Development Corporations	Community	Community Development; Social Determinants of Health
Philadelphia Corporation on Aging	Community	Older Adult Health and Social Services
Philadelphia Department of Public Health	Community	Public Health
Philadelphia Housing Authority	Community	Low Income Housing; Social Determinants of Health
Philadelphia Police Department	Community	Community Violence; Social Determinants of Health
Philadelphia Refugee Mental Health Collaborative	Community	Behavioral Health; Immigrant Health; Social Determinants of Health
Philadelphia Reentry Coalition	Community	Prison Re-entry
Philadelphia School District	Community	Education and Health Services
Project Home and Steven Klein Wellness Center	Community	Homeless; Primary Care
Refugee Health Partners	Community	Immigrant/Refugee
Schools: Independence Charter School; Southwark School	Community	Children grades K-8
Southeast Asian Mutual Assistance Associations Coalition (SEAMAAC)	Community	Immigrants/Refugees
Self-Help and Resource Exchange (SHARE)	Community	Food Access/ Food Security
South Philadelphia Aging Coalition	Community	Older adults
United Communities Southeastern Philadelphia	Community	Neighborhood Community Center; Immigrant/Refugee; Behavioral Health; Youth, Addictions
Veterans Multi-Services Center	Community	Veterans
Jefferson Obstetrics and Gynecology Associates (JOGA) clinic	Jefferson	Maternal Health
Comprehensive Stroke Center/Neurosciences	Jefferson	Stroke
Cancer Patient Services	Jefferson	Cancer; Social Determinants of Health
Cancer Research	Jefferson	Cancer
Cardiovascular Health	Jefferson	Heart Disease/Stroke
Case Management Social Work	Jefferson	Social Determinants of Health
Jefferson Elder Care - Occupational Therapy	Jefferson	Fall Prevention – Older Adults
Diabetes Center	Jefferson	Diabetes

Organization	Community/ Jefferson	Focus
Emergency Department	Jefferson	Emergency Medicine, Injury Prevention, Chinatown Clinic
Family Medicine	Jefferson	Primary Care
Family Medicine – Geriatric Clinic	Jefferson	Family Medicine; Geriatrics
Family Medicine - Refugee Health Clinic	Jefferson	Refugee; Family Medicine
Family Medicine - Social Work	Jefferson	Social Determinants of Health
Hospitalists	Jefferson	Inpatient Healthcare
Maternal Addiction Treatment Education & Research (MATER)	Jefferson	Pregnancy and Addictions
Methodist	Jefferson	General
Myrna Brind Center for Integrative Medicine	Jefferson	Stress management
Occupational Therapy	Jefferson	Disabilities, Older Adults, Refugees
Pastoral Care Department	Jefferson	Pastoral Care, Violence Prevention
Pathways to Housing	Jefferson	Homeless
Pharmacy	Jefferson	Pharmacy/Medication Issues
Physical Therapy	Jefferson	Injury Prevention/Gerontology
Rehabilitation Psychologist	Jefferson	Patient Mental Health
Recreational Therapy Rehab	Jefferson	Disabilities, Older Adults
Cardiovascular Clinical Services	Jefferson	Cardiovascular disease
Student Life, Diversity and Inclusion, Health Professions	Jefferson	Diversity and Inclusion, Workforce Development, Pipeline Programs
TJUH Nurse Magnet	Jefferson	Patient Care; Community Service
TJU Nursing	Jefferson	Homeless, Immigrants/Refugees, Social Determinants of Health,
TJUH Nursing	Jefferson	Breastfeeding; Women’s Health, Injury prevention

### ***Focus Groups***

Focus groups were conducted with TJUHs employees who live in the neighborhoods that are part of TJUH’s CB area. This was done purposefully in order to involve them in the needs assessment process, and to engage these employees in future efforts to improve community health. A list of employees who live in zip codes that make up the community benefit area was obtained from Human Resources. Employees were randomly selected from each zip code and contacted about their interest in participating in the focus groups. Four focus groups were held, two with employees from South Philadelphia, one with employees from Lower North Philadelphia, and one with employees from Transitional Neighborhoods. Forty-three employees

participated. Focus groups were conducted by qualitative public health researchers from TJUHs Center for Urban Health.

Focus group questions were designed to elicit the major health and social concerns of the neighborhood and larger community, barriers to accessing health and social services and improving lifestyles, perceptions about existing and/or potential interventions to address community health improvement, and specific recommendations that TJUHs could do to improve the health of the community. Each focus group was asked to prioritize the needs/recommendations identified during the focus group discussion.

### ***Gaps in Data***

Data on health status of immigrant populations (hypertension, diabetes, heart disease rates, obesity prevalence, etc.), is lacking due to language issues. While surveys are conducted in Spanish, this is not the case for other racial/ethnic groups for whom English is not their primary language. For this reason additional key informant interviews were conducted with community organizations serving the immigrant refugee communities, particularly the Asian communities, to better understand their health and related social needs.



## Philadelphia and TJUH Community Benefit Area Demographics

According to the official 2010 census, Philadelphia is the fifth largest city in the country with 1.56 million people. After declining for more than half a century, Philadelphia's population is growing, adding almost 72,000 residents in 8 years.

The city's residents are a diverse population: 37% non-Hispanic white, 42% non-Hispanic African American<sup>a</sup>, 13% Hispanic or Latino<sup>b</sup>, and almost 7% non-Hispanic Asian.<sup>7</sup>

Jefferson has geographically defined its community benefit area (CB) in the following way:

Area	ZIP Codes	Sub Area	ZIP Codes
Lower North Philadelphia (LN)	19121, 19122, 19132, 19133	Lower North east of Broad Lower North west of Broad	19122, 19133 19121, 19132
Transitional Areas (TN)	19123, 19125, 19130		
Center City (CC)	19102, 19103, 19106, 19107		
South Philadelphia (SP)	19145, 19146, 19147, 19148	South Phila east of Broad South Phila west of Broad	19147, 19148 19145, 19146
TJUH Community Benefit areas (TJUH CB)	19121, 19122, 19132, 19133, 19123, 19125, 19130, 19102, 19103, 19106, 19107, 19145, 19146, 19147, 19148		

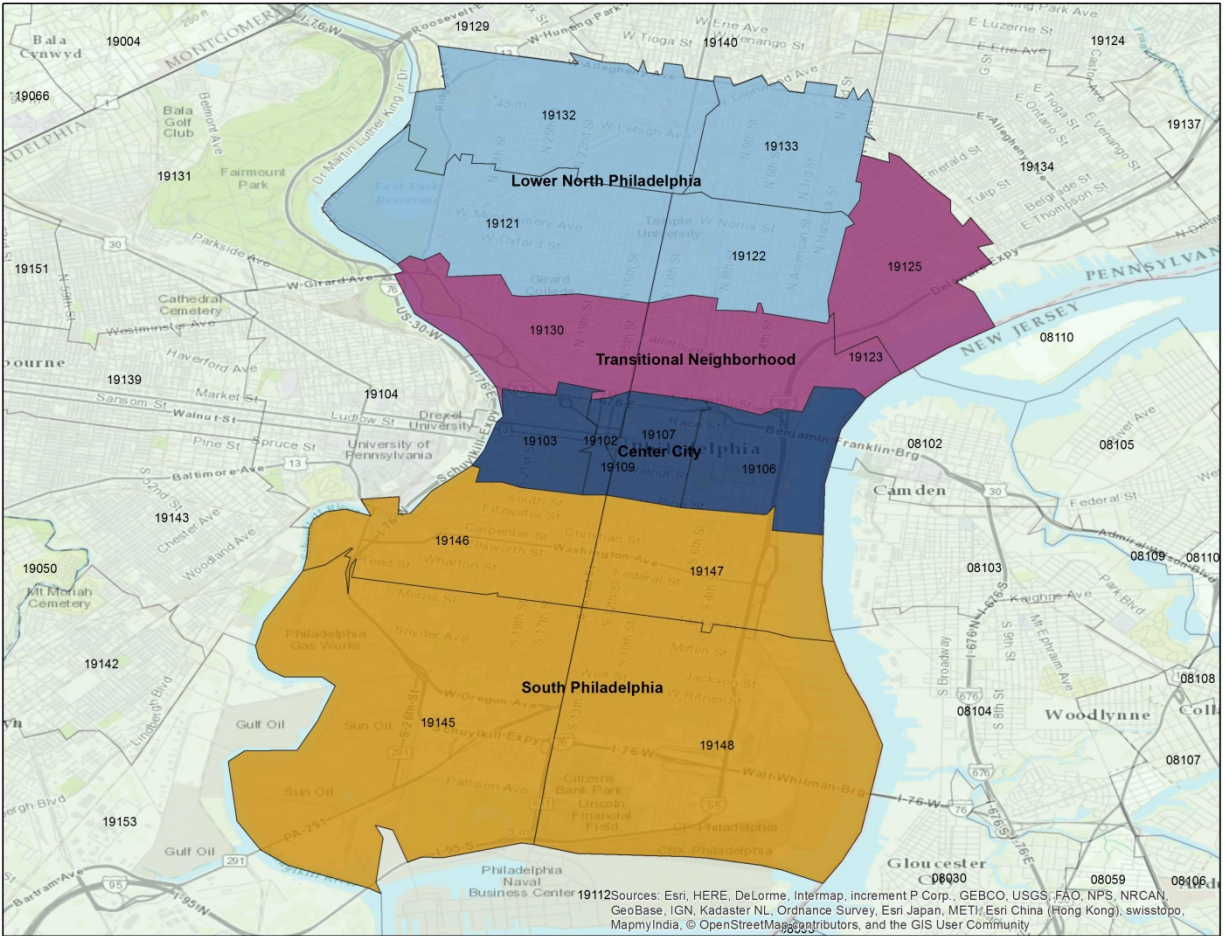
The map that follows displays these areas. Each area has been assigned a color which will be used throughout this report in graphs to depict that specific area. Data throughout the CHNA is based on zip code and/or Philadelphia planning districts. The majority of TJUHs CB area is encompassed within three planning districts, Lower North, Central and South. A map depicting the overlap between zip codes and planning districts is provided in the appendices.

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<sup>a</sup> The terms black or African American are both used in this document depending on the source of the data.

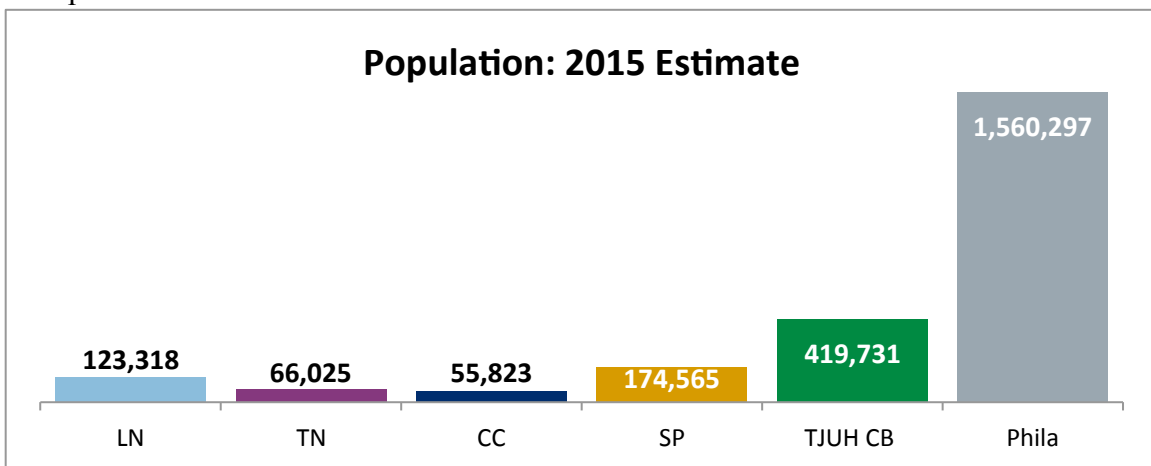
According to the Census Bureau website, these terms are used interchangeably and refer to people having origins in any of the black racial groups of Africa. (<https://www.census.gov/prod/cen2010/briefs/c2010br-06.pdf>)

<sup>b</sup> The terms Latino and Hispanic are both used in this document depending on the source of the data. According to the U.S. Census Bureau "Hispanics or Latinos are those people who classified themselves in one of the specific Spanish, Hispanic, or Latino categories ... -"Mexican," "Puerto Rican", or "Cuban"-as well as those who indicate that they are "another Hispanic, Latino, or Spanish origin." .... The terms "Hispanic," "Latino," and "Spanish" are used interchangeably."



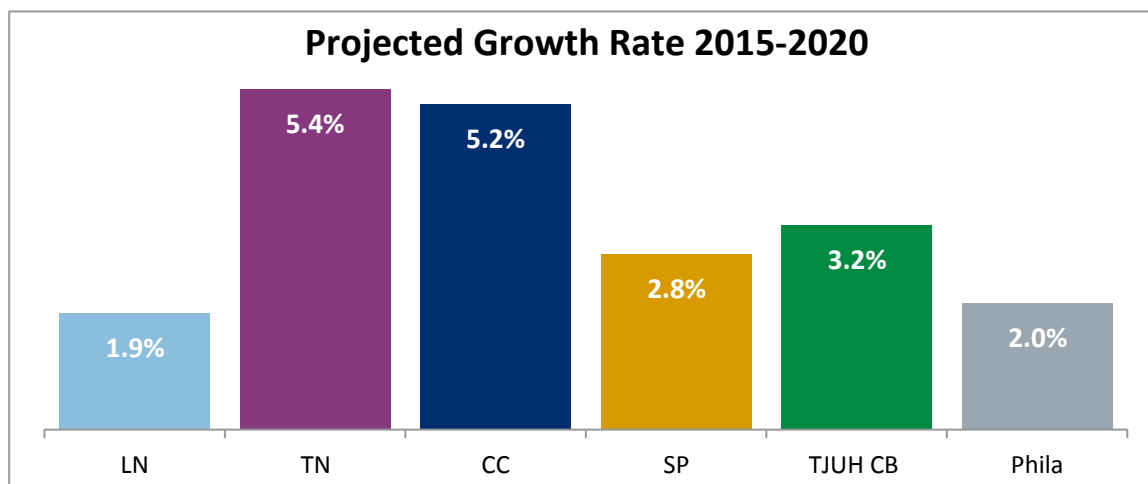
### Philadelphia and TJUH's CB Area Demographics

Almost 420,000 people live in TJUH's CB area. This represents 27% of all residents of Philadelphia.



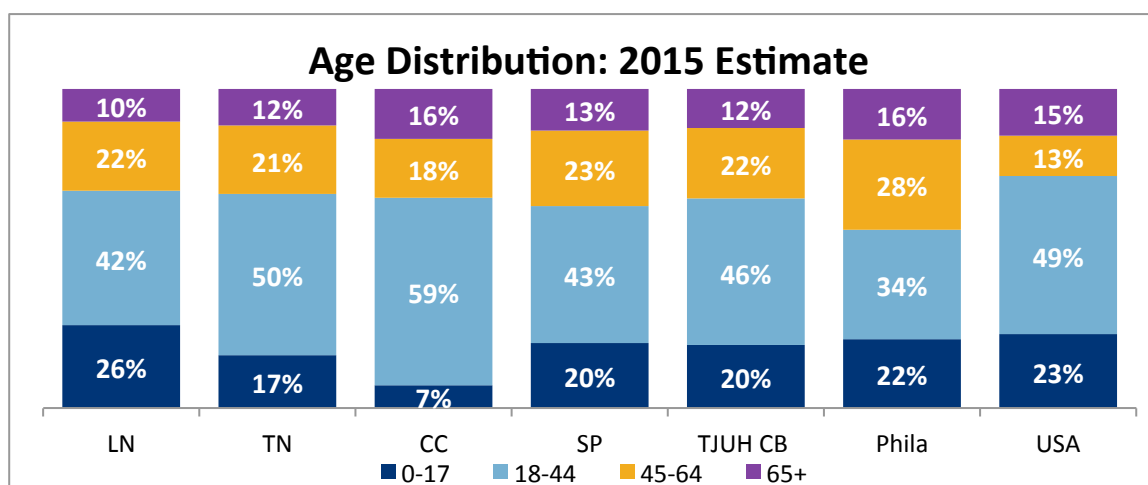
*The Nielson Company, © 2015 Truven Health Analytics*

While Philadelphia only anticipates a 2.0 % increase in population between 2015 and 2020, TJUH CB areas are gaining population faster: Transitional Neighborhoods is expected to grow by 5.4%, Center City by 5.2% and South Philadelphia by 2.8%.<sup>8</sup>



*The Nielson Company, © 2015 Truven Health Analytics*

Similar to Philadelphia, TJUH's CB area is 52% female and 48% male and varies little across CB areas. Lower North Philadelphia has more youth ages 0-17 than the rest of Philadelphia and TJUH's CB area. Center City has a higher percentage of adults aged 18-44 than Philadelphia and is more likely than other TJUH CB areas to have adults over age 65+.



*The Nielson Company, © 2015 Truven Health Analytics*

Compared to Philadelphia, TJUH's CB area is slightly more likely to be non-Hispanic White or non-Hispanic Asian, and less likely to be non-Hispanic African American. Non-Hispanic Whites are more likely to live in Center City, South Philadelphia, and Transitional Neighborhoods; non-

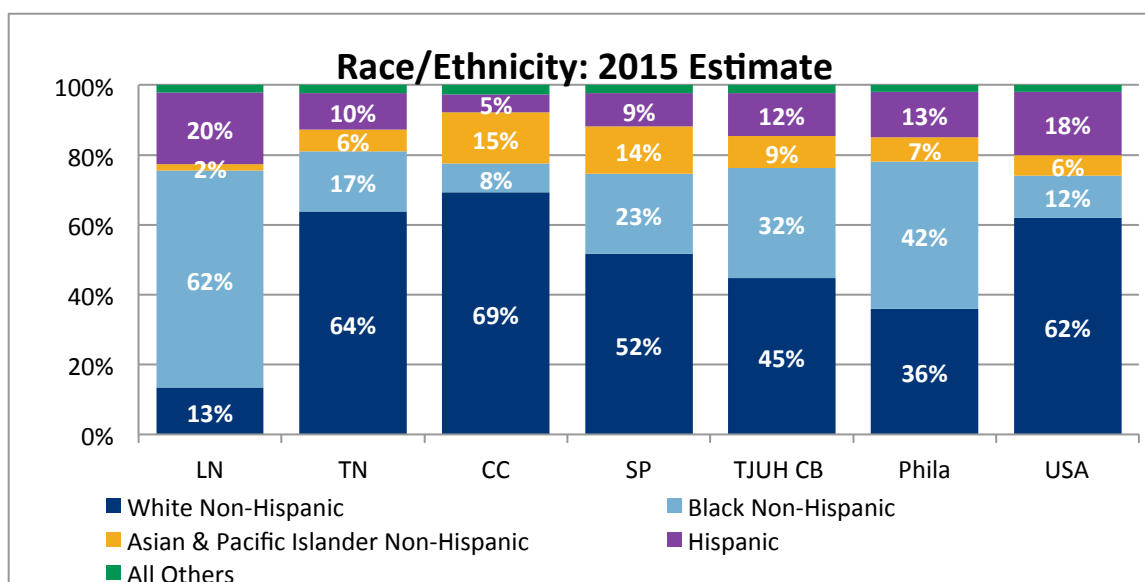
Hispanic Blacks are more likely to live in Lower North Philadelphia west of Broad Street and in South Philadelphia west of Broad Street.

More than 198,000 residents in Philadelphia identify themselves as Hispanic. The majority of Hispanics in the Philadelphia area are from Puerto Rico (72%) and live predominantly in Eastern North Philadelphia; 17% are Mexican with the remaining Hispanic population from Latin America, the Caribbean, Central America, and South America. In TJUH's CB area 50,367 (12%) of the population is Hispanic. This represents about 25% of all Hispanics in Philadelphia. The majority of these residents live in North Philadelphia (24,664) and South Philadelphia (15,711) east of Broad Street. Southeast Philadelphia is home to a growing immigrant population from Mexico. Although they share a common language, each Hispanic community is culturally unique, and internally diverse by gender, generation, class, and race.

The non-Hispanic Asian community in Philadelphia represents 7.0% of the total population. Slightly more than one-third of these residents (37,776) live in TJUH's CB area. The majority of Asian residents in TJUH's CB area live in South Philadelphia (24,440) and Center City (8,373). The Asian community in Center City is predominantly of Chinese descent, while South Philadelphia residents include immigrants from Vietnam and refugees from Cambodia (the largest population of Asian residents as well as newly resettled refugees from Burma, Nepal, and Bhutan).

See the Special Population section on Immigrants and Refugees for additional information.

Philadelphia also has the second largest Irish, Italian, and Jamaican American populations in the entire United States.



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## Social Determinants of Health

*We cannot succeed as a city if hundreds of thousands of our fellow citizens are so disconnected from the resources needed to live in a decent home, have enough food to eat, support themselves and contribute through a job, or make a better life for themselves or their children (Shared Prosperity).<sup>9</sup>*

The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices.<sup>10</sup>

A “place-based” organizing framework, reflecting five (5) key areas of social determinants of health (SDOH), was developed by Healthy People 2020.<sup>11</sup>

These five key areas (determinants) include: Economic Stability (Poverty, Employment, Food Security, Housing Stability); Education (High School Graduation, Enrollment in Higher Education, Language and Literacy, Early Childhood Education and Development); Social and Community Context (Social Cohesion, Civic Participation, Perceptions of Discrimination and Equity, Incarceration/Institutionalization); Health and Health Care (Access to Health Care, Access to Primary Care, Health Literacy); and the Neighborhood and Built Environment (Access to Healthy Foods, Quality of Housing, Crime and Violence, Environmental Conditions). Each of these five determinant areas reflects a number of critical components/key issues that make up the underlying factors in the arena of social determinants of health.

HP2020 provides a variety of resources, organized by domain, exploring the ways communities across the country are addressing social determinants of health.<sup>12</sup>

Health services that do not consciously address social determinants exacerbate health inequities. If a revitalized primary health care is to be the key approach to organize society to minimize health inequities, action on social determinants has to be a major constituent strategy. Success in reducing health inequities will require ensuring that the broad focus of primary health care and the social determinants is kept foremost in policy.<sup>13</sup>

The Robert Wood Johnson Foundation Commission to Build a Healthier America issued 10 cross-cutting recommendations for improving the nation’s health. According to the Commission, how long and how well Americans live depends more on where they live, learn, work and play than on medical care, which accounts for only an estimated 10 to 15 percent of preventable early deaths.<sup>14</sup> The Commission found the strongest evidence for interventions that can have a lasting effect on the quality of health and life in programs that promote early childhood development and that support children and families. Therefore, many of the recommendations aim to ensure that the nation's children have the best start in life and health.

Extensive research documents the impact of social factors such as income, educational attainment, access to food and housing, and employment status on the health and longevity of Americans, particularly lower-income populations. These findings attribute as much as 40

percent of health outcomes to social and economic factors. Asthma is linked to living conditions, diabetes-related hospital admissions to food insecurity, and greater use of the emergency room to homelessness.<sup>15</sup>

Six years after analysts introduced the concept of the “Triple Aim,” its goals of improved health, improved care, and lower per capita cost of care have become the organizing framework for the health care system. As a result, growing numbers of providers are concluding that investing in interventions addressing their patients’ social as well as clinical needs makes good business sense.

Gottlieb et al. suggest that primary care providers can address social determinants of health on three different levels: individual, institutional, and community.<sup>16</sup> For example, a growing number of primary care clinics now employ social workers to whom primary care physicians (PCPs) can refer individual patients in need of assistance with obtaining food or finding housing. Integrating social determinants into individual-level patient care is a natural fit with the daily routine, skill set, and comfort zone of providers. Providers can also enhance their impact by taking action at institutional and community levels. At an institutional level, a clinical practice might encourage employees to walk by marking off a trail on their grounds. At a community level (local, state, or national), PCPs could advocate for building new public facilities for physical activity or keeping gym classes in low-resource schools, particularly in communities that have been identified as having a high prevalence of disease or disease risk factors.

Primary care providers have a number of assets to address social determinants of health. Their patient data can be used to identify patterns of health outcomes that indicate the need to explore social determinants (eg, a pattern of uncontrolled pediatric asthma in one area of town may indicate substandard housing). The stories of individual patients are also powerful tools for raising the visibility of an issue. PCPs can leverage the respect afforded their profession and their expertise about health and illness to raise the awareness among policymakers and the general public about the impact of social conditions on health. They are also aided in this effort by their resources as members of the professional class who know decision-makers, gatekeepers of access to health resources, and the ability to reach their professional colleagues and their patients.<sup>17</sup>

A range of tools, both broad and targeted, are available to providers to address patients’ unmet social needs. Broad interventions—usually provided at primary care clinics—link clinic patients to local resources that can address their unmet social needs. For example, Health Leads, which operates in hospital clinics and community health centers in six cities, enables health care providers to write prescriptions for their patients’ basic needs, such as food and heat. Trained volunteers who staff desks at the hospitals and clinics connect patients to local resources to address those needs. Across all sites, Health Leads volunteers addressed at least one need of 90 percent of patients referred to them. Medical-Legal Partnerships (MLPs) place lawyers and paralegals at health care institutions to help patients address legal issues linked to health status. This program has had marked success: an MLP in New York City targeting patients with moderate to severe asthma found a 91% decline in emergency department visits and hospital admissions among those receiving housing services.<sup>18</sup>

The patient centered medical home (PCMH) also offers an important opportunity to promote population health through systematically addressing the social determinants of health. The PCMH offers new opportunities for monitoring the basic unmet needs of vulnerable adults, particularly the elderly, and linking them to community services.<sup>19</sup>

There are also emerging efforts to integrate social and environmental needs into the health care system. In particular, a number of delivery and payment reform initiatives within Medicaid address the diverse needs of the population served through an increased focus on social determinants of health.<sup>20</sup> Through the State Innovation Models (SIM) Initiative a number of states are engaged in multi-payer delivery and payment reforms that include a focus on population health and recognize the role of social determinants. The National Association for Community Health Centers, in partnership with the Association of Asian Pacific Community Health Organizations, the Oregon Primary Care Association, and the Institute for Alternative Futures, recently launched a new program to implement, test, and promote a national standardized patient risk assessment protocol in primary care settings to assess and address patients' social determinants of health.<sup>21</sup>

The Institute of Medicine report - *Capturing social and behavioral domains and measures in electronic health records: phase 2* –recommends that standardized social and behavioral data be incorporated into patient electronic health records (EHRs).<sup>22</sup> This data can provide crucial information about factors that influence health and the effectiveness of treatment. Such information is useful for diagnosis, treatment choices, policy, health care system design, and innovations to improve health outcomes and reduce health care costs.

In Philadelphia, measures of social determinants include: reading proficiency, on-time high school graduation, post-secondary education, unemployment, poverty, child poverty, children in single-parent households, and social capital.<sup>23</sup>

### **Two indices measure social determinants of health in Philadelphia - the County Health Rankings and the Community Need Index.**

1) The **2015 County Health Rankings** for Pennsylvania ranked Philadelphia last of all 67 counties in the state for social and economic factors - high school graduation, some college, unemployment, children in poverty, income inequality, children in single-parent households, social associations, violent crime, and injury deaths.

<http://www.portal.state.pa.us/portal/server.pt?open=514&objID=596007&mode=2>

2) **Community Need Index** - In 2005 Dignity Health, in partnership with Truven Health, pioneered the nation's first standardized Community Need Index (CNI). The CNI identifies the severity of health disparity for every zip code in the United States and demonstrates the link between community need, access to care, and preventable hospitalizations. The CNI accounts for the underlying economic and structural barriers that affect overall health. These barriers include those related to income, culture/language, education, insurance, and housing. The CNI gathers data about a community's socio-economy (percentage of elderly living in poverty; percentage of the uninsured or unemployed, etc). A score is then assigned to each barrier condition (with 1 representing less community need and 5 representing more community need). The scores are then aggregated across the barriers and averaged for a final CNI score



(each barrier receives equal weight in the average). A score of 1.0 indicates a zip code with the lowest socio-economic barriers, while a score of 5.0 represents a zip code with the most socio-economic barriers<sup>21</sup>

The CNI score is highly correlated to hospital utilization – high need is associated with high utilization. The CNI considers multiple factors that limit health care access, and therefore may be more accurate than existing needs assessment methods. In addition, the most highly needy communities experience admission rates almost twice as often as the lowest need communities for conditions where appropriate outpatient care could prevent or reduce the need for hospital admission such as pneumonia, asthma, congestive heart failure, and cellulitis. Of cities in the United States with populations of more than 500,000, Philadelphia (CNI score 4.0) is among the top 10 cities with the highest need. The chart below provides the CNI for zip codes in Jefferson’s CB area (<http://cni.chw-interactive.org/printout.asp>).

CNI Scores by ZIP Code							
19102	2.4	19121	4.8	19123	3.6	19145	4.2
19103	2.4	19122	4.8	19125	4.4	19146	3.8
19106	3.0	19132	4.6	19130	3.4	19147	3.2
19107	3.6	19133	4.8			19148	4.2

Zip Code Mean score for Philadelphia = 3.8      Mean Score per person in Philadelphia= 4.0

The sections that follow provide an overview of social determinants affecting Philadelphia and perceptions from community members, those serving the community and its most vulnerable people, and health care providers. The information about social determinants provided in the sections that follow relate to the **general** community benefit population. Social determinant issues that pertain to **special** populations will be provided in the CHNA section for *Special Populations*.

Focus group participants and interviewees recognized the impact of social determinants on the health of the community and the need to address “upstream” factors in order to improve health.

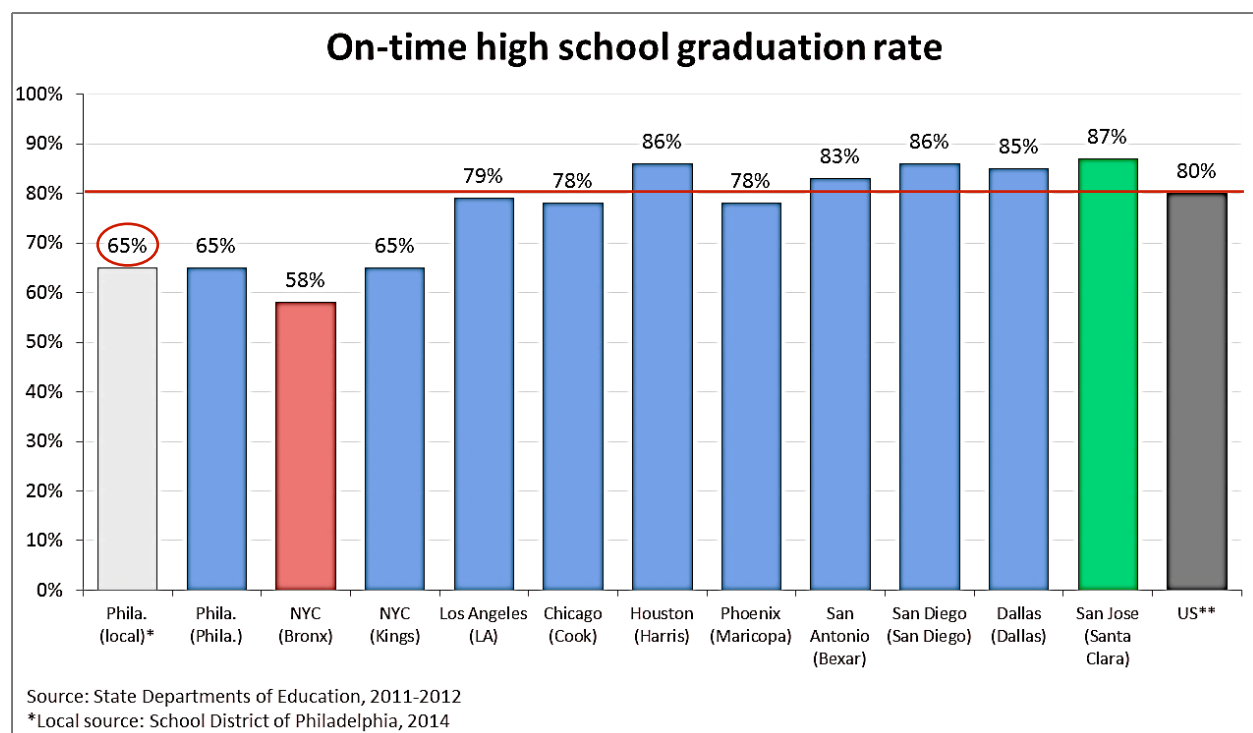
*“We need to practice medicine in an “upstream” fashion. By the time we see patient they are ready to “fall off the cliff.”*

*“What the needs are? They aren’t medical. I would like to know about their living situation. I see a lot of 50-65 year olds – kids and grandkids living with them - it’s stressful being home.”*

*“What impacts health - employment, incarceration, education. Then on top of all that social dynamics, that would put stress on anyone... and now we want you to navigate the health system. It’s like climbing a mountain – and on top low literacy.”*

## Education

Compared to those with a college education, people with less education die earlier, live with more chronic illness, have less healthy lifestyle behaviors, experience more chronic stress and have higher health care costs. More education translates to better health in part because of its association with future earnings and relationship to poverty. People with lower education face more challenges in paying for health insurance, co-pays for health care services and prescription drugs, and access to primary care.<sup>24,25,26</sup> While education impacts the quality of one's health, health can impact future success such as employment and earning potential. Philadelphia ranks 22<sup>nd</sup> in educational attainment among the nation's 25 largest cities. Lower levels of educational attainment are strongly correlated to poverty.<sup>27</sup> The Healthy People 2020 goal for on-time high school graduation is 82.4%.

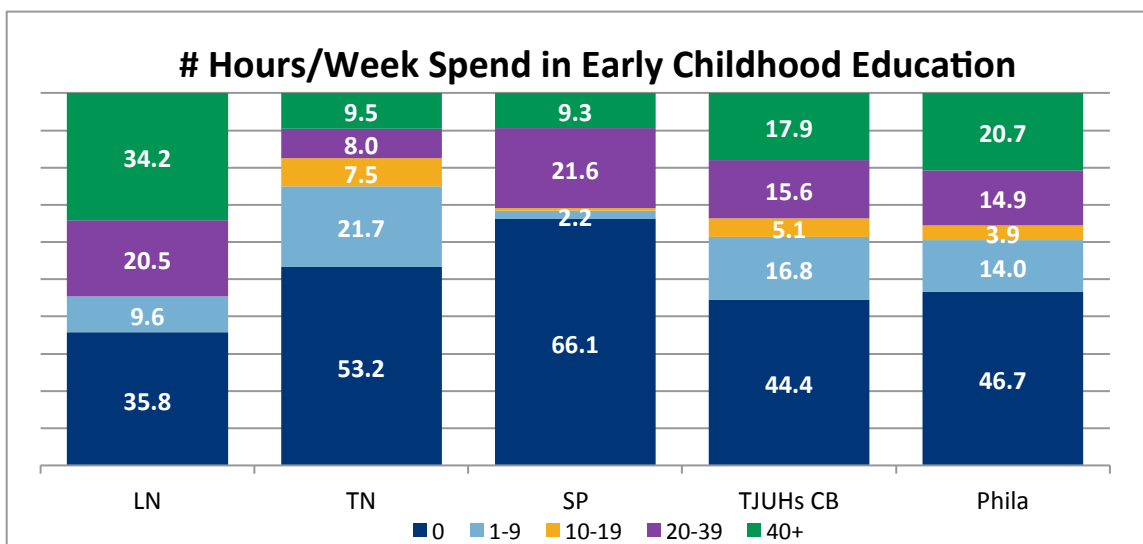


**Early learning:** *The five years from infancy to kindergarten are the most important in life. Poverty and the trauma that often accompanies it can slow the development of infants, toddlers, and preschool children. It can affect how physically and emotionally healthy they grow up, how well they get along with others, and how well they learn. High quality early learning is one of the most effective means to help children overcome the effects of inter-generational poverty and develop the tools they need to succeed in school, get good jobs, and raise healthy families themselves.*<sup>28</sup>

Almost 43,000 children in Philadelphia receive subsidized child care and 1,147 children are waiting to receive subsidized child care. Only 16.4% of children enrolled in childcare are in Keystone STARS 3 or 4 programs.<sup>29</sup> Since 2013, the capacity to enroll in STAR 3 or 4 programs

(higher quality programs) has increased by 4,500 slots allowing 19,131 children access to high quality learning experiences.<sup>30</sup>

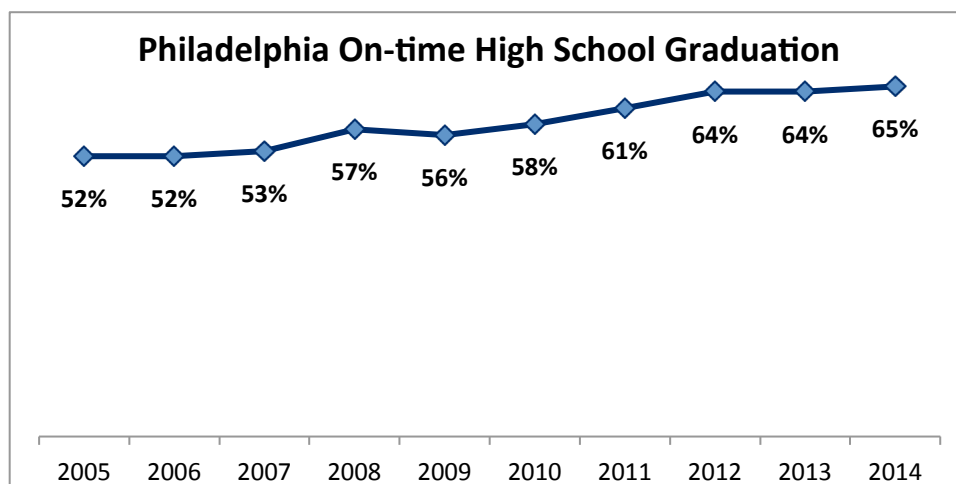
Among the neighborhoods in Jefferson's community benefit area, children in Lower North Philadelphia spend the most time in early education. Children in South Philadelphia and Transitional neighborhoods spend the least amount of time in early childhood education and compare unfavorably to the city rate. The sample size for Center City residents was too small for meaningful analysis.



PHMC Household Health Survey 2015

Mayors Nutter and Kenney's vision to improve the health and well-being of Philadelphia's youngest citizens includes improving access to health care and other services and assuring that all children in Philadelphia benefit from high-quality early learning experiences. *A Running Start Philadelphia: For Every Child, Birth to Five* addresses how the city can guarantee the best learning opportunities for its youngest citizens as a way to offset the long-term, systemic poverty in some neighborhoods. *A Running Start* offers goals and strategies for expanding early-learning opportunities in the city and assuring that current services are of the highest quality. The goal of the program is to ensure that children enter school prepared to learn and to expand opportunities for year round learning. According to Mayor Nutter, "High-quality early learning is a proven way to help people overcome poverty, which is why we need to make it part of every child's birthright as Philadelphians, as Pennsylvanians, and as Americans."<sup>31</sup> Early learning is an essential component of Philadelphia's anti-poverty strategy.

**School-aged children:** Philadelphia school enrollment patterns have shifted over the past decade with fewer children attending public and parochial schools, while enrollment in tax-payer funded charter schools has nearly doubled. Math and reading scores steadily improved between 2005 and 2011, but have consistently decreased since 2011. Improving on-time high school graduation rates has been a major focus of the city. While on-time graduation has steadily improved since 2005 (52% compared to 68% in 2015), Philadelphia students remain well below the state on-time high school graduation rate of 85%.<sup>29,32</sup>



*School District of Philadelphia*

Furthermore, on-time high school graduation rates among Philadelphia students vary by race/ethnicity. In 2011, 72% of non-Hispanic Asians graduated on time, while 44% of Hispanics graduated on time. The on-time graduation for non-Hispanic Blacks and non-Hispanic whites was similar: 56% and 55% respectively.

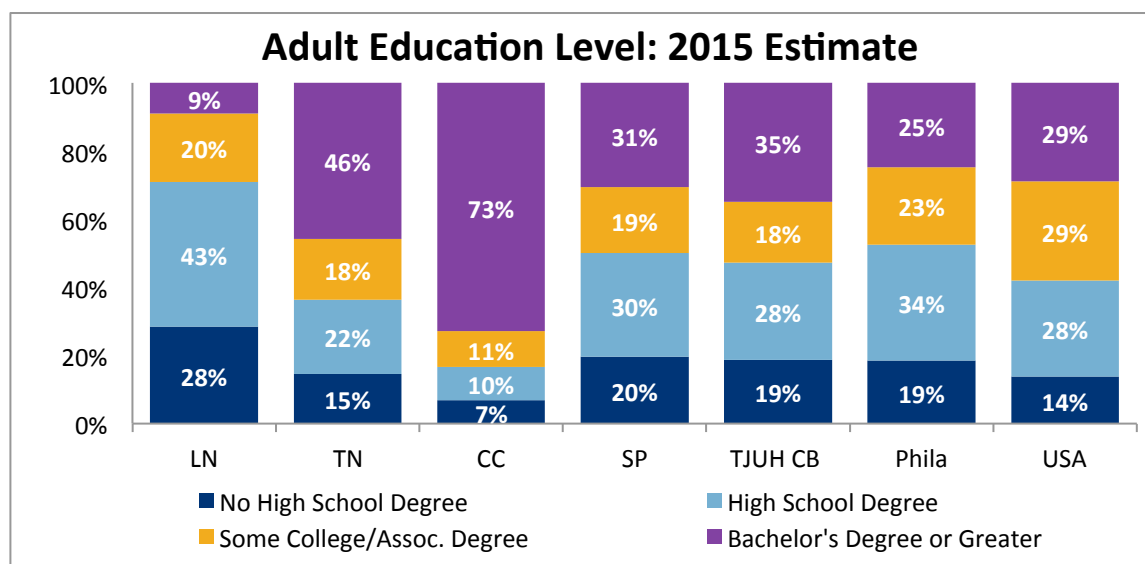
Philadelphia students had the highest dropout rate (5.3%) in the state for the 2013-2014 school year; this rate is more than three times higher than the Pennsylvania drop-out rate for students in publically funded schools grades 7-12 during the same year. Statewide African Americans and Hispanic/Latino students are most likely to drop-out from school (3.7%). The majority of high school students in Pennsylvania who drop out of school do so during grades 10-12 because of academic problems, behavior issues, child care responsibilities, dislike of school, and/or desire/need to get a job.<sup>33</sup>

Compared to all students in Pennsylvania, students in Philadelphia are more likely to be classified as an English language learner (7.7% to 9.8%) reflecting the rich diversity of the immigrant and refugee population in the city.<sup>32</sup> The English learner rates at schools in Jefferson's community benefit area can be as low as 2-3% and as high as almost 50% (47.7% Furness High School).<sup>34</sup>

**Educational attainment:** Educational attainment (percentage of college graduates aged 25 and older) has steadily increased in Philadelphia, but still lags behind comparable cities. While Philadelphia's overall level of educational attainment remained low (25.2%) compared to other cities and the nation as a whole (29.6%), the rate of city residents' ages 25 to 34 with bachelor's degrees (39.8%) exceeds national levels (32.9%). This suggests a positive educational attainment trend for the city.<sup>32</sup>

The level of education among residents in TJUH's CB area varies greatly. Residents living in Transitional Neighborhoods and Center City are more likely to have college degrees or higher (46% and 73% respectively) compared to Philadelphia (25%), while residents in Lower North Philadelphia neighborhoods are more likely not to have graduated from high school (28%) compared to Philadelphia (19%). Overall, 19% of adults over age 25 living in TJUH's CB area

report they did not graduate from high school compared to 14% nationwide. High school graduation rates vary across zip codes within TJUHs CB areas. In lower North Philadelphia high school graduation among adults aged 25 and older ranged from 76% in 19121 to only 58% in 19133. Among the Transitional Neighborhoods 19130 had the highest rate (almost 92%) and 19125 had the lowest high school graduation rate (77%). In South Philadelphia 86% of people living in 19146 and 19147 graduated from high school compared to 79% in 19145 and 71% in 19148. Only zip code 19107 in Center City had a high school graduation rate less than 90% (86%).



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The Philadelphia School District's Office of Strategic Partnerships (OSP) assists the District in developing a system of excellent schools by identifying, coordinating, and matching partner and volunteer resources and aligning them with the goals and priorities of Action Plan 3.0 to maximize student outcomes. OSP works to cultivate sustainable partnerships at the system and school levels to create a permanent service delivery system that connects corporate and community resources with schools to meet student needs with fidelity and equity.

The School District of Philadelphia (SSDP) currently has 134,530 students enrolled in 149 elementary, 16 middle, and 53 high schools. The racial/ethnic make-up is African American (51.1%), Asian Pacific Islander (8.4%), Caucasian (13.8%), Hispanic (19.5%), and Multiracial (7.3%). The SDP also directs 83 Charter Schools, enrolling 63,441 students. The SDP provides 57,500 free breakfasts and 92,500 free lunches daily.

Mayor Kenney and Councilman Clarke are calling for the creation of 25 community schools. The community school model puts schools at the core of community life. Through partnerships with various community organizations, the school becomes a resource for community members to address their educational, physical, social, and emotional needs. Community schools acknowledge that students cannot perform well if their lives outside of the classroom are chaotic: community schools that focus on the whole child better prepare graduates for higher education and the workforce. Community schools are seen as a way to close the income achievement gap.

particularly in communities with large populations of disadvantaged students such as Philadelphia. This model provides opportunities for fruitful partnerships between hospitals, healthcare providers, universities and schools. The Community Preventive Services Taskforce recommends the implementation and maintenance of school-based health centers (SBHCs) in low-income communities, based on sufficient evidence of effectiveness in improving educational and health outcomes.<sup>35</sup> Improved educational outcomes include school performance, grade promotion, and high school completion. Improved health outcomes include the delivery of vaccinations and other recommended preventive services, asthma morbidity, emergency department and hospital admissions, contraceptive use among females, prenatal care and birth weight, and other health risk behaviors.

Healthcare providers who care for children and adolescents also play a role in encouraging high school graduation and high quality early education opportunities. The Mayor's Office on Education is encouraging health care providers to counsel parents that *"the best way to ensure your child's health and future success is to encourage them to graduate from high school."* In addition, the American Academy of Pediatrics supports the role of pediatricians in promoting the educational and socio-emotional needs of young children with advocacy groups and encourages pediatricians to educate policy makers about the relationship between quality child care and future educational success. Pediatricians are encouraged to ask families about childcare arrangements and to be familiar with and promote quality programs that foster early brain and child development.<sup>36</sup>

**Issues, challenges, unmet needs and priorities identified by key informants and focus group participants related to education include:**

- *"Health, food and education can't be separated. Low health literacy in children increases the chance of low health literacy as adults. We need to educate kids!"* (focus group)
- *"To create a workforce pipeline for adults you need to work with two generations at a time. You need quality early education for children and quality workforce development for parents."* (key informant)
- *"Some parents are disabled and can't work for 2-3 months. The family can't afford not to have the income, so the child stops their education (college) to go to work. Otherwise, people are serious about education."* (key informant)
- *Missing school and truancy are problems. When kids are suspended their parents can't go to work and the whole family suffers financially. Some parents don't send their children to school if they have health problems because the nurses aren't full time. If a parent becomes ill and can't walk their child to school, then the child misses school and risks becoming truant.* (key informant)
- *"Physicians should talk to parents about how their children are doing in school and suggest that one of the most important things they can do to help their child be a healthy adult some day is to make sure the child finishes high school."* (key informant)

**Based on internal and external key informants, focus groups, existing relationships and programs, and secondary data, actions addressing education may include:**

- 1. Working with pediatricians and family medicine physicians to “prescribe” high school graduation as a preventive health measure. Encourage parents to help their children to stay in school.**
- 2. Providing tutoring/mentoring and educational experiences for youth and adolescents**
- 3. Pursuing opportunities to engage in city initiatives such as the Community Schools concept and the Mayor’s Office of Education’s Graduation Coach Program that seek to increase educational attainment by engaging adults in students' lives. The Graduation Coach Campaign (GCC) seeks to increase high school graduation rates and post-secondary educational attainment in Philadelphia. As a larger vision, the GCC seeks to encourage a culture shift in which every adult feels socially responsible for the educational attainment of students, and in which information about how to succeed in education becomes common knowledge in communities.**
- 4. Continuing to support Thomas Jefferson University's partnership with the Independence Charter and Southwark Elementary schools. Expand the model to other schools in the TJUHs community benefit area.**



## Income and Poverty

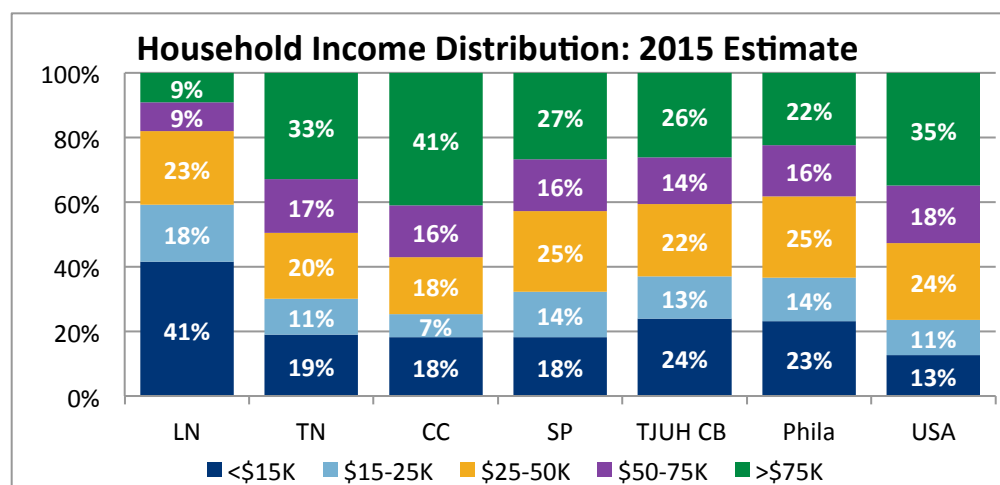
Median household income in Philadelphia in 2013 was \$36,836 compared to \$52,250 in the United States.<sup>32</sup> Of the 26 largest cities in the U.S., Philadelphia had the third lowest median household income as reported in 2013.<sup>37</sup>

TJUH's community benefit area includes some of the highest and lowest median incomes among Philadelphia's 46 zip codes. Five zip codes within Jefferson's community benefit area have median incomes among the 10 highest in the city and 4 zip codes have median incomes among the 10 lowest in the city. These numbers reflect Philadelphia's persistently high unemployment rates plus the relatively low number of high paying jobs.<sup>32</sup>

Median Household Income by ZIP Code							
Center City		Lower North		Transitional Neighborhoods		South Philadelphia	
Zip Code	Median Income	ZIP Codes	Median Income	ZIP Codes	Median Income	ZIP Codes	Median Income
19102	\$76,962	19121	\$16,105	19123	\$48,798	19145	\$35,761
19103	\$63,709	19122	\$23,509	19125	\$41,186	19146	\$42,068
19106	\$93,720	19132	\$24,233	19130	\$62,721	19147	\$60,400
19107	\$44,402	19133	\$14,185			19148	\$39,413

*Pew Philadelphia State of the City 2015*

All zip codes in Lower North Philadelphia have median incomes below the median income for Philadelphia.



*Census 2010 with Truven Projections for 2015*

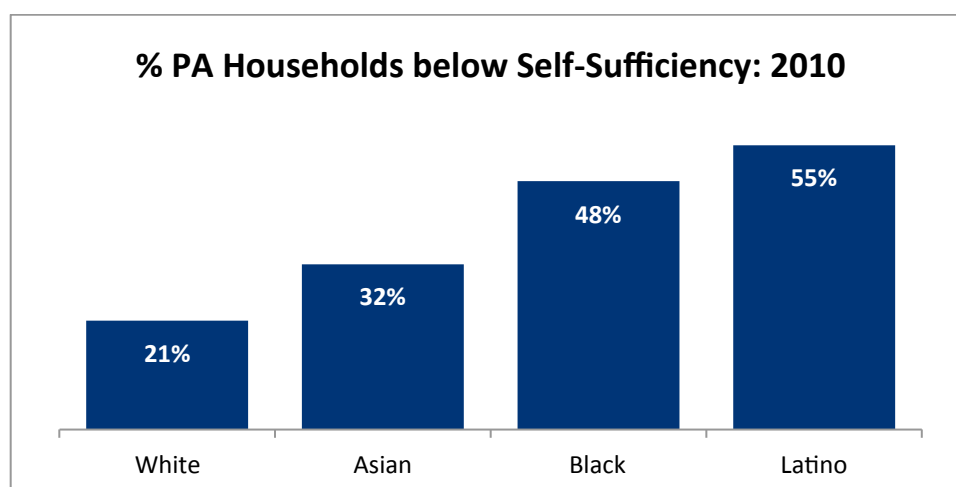
Poverty can result in elevated mortality risk, increased prevalence of medical conditions and disease incidence, depression, intimate partner violence, and poor health behaviors. In 2013, Philadelphia had one of the highest percentages of people in poverty and deep poverty – people with incomes below half of the poverty line –of any of the nation’s 26 most populous cities. The annual salary for a single person at half the poverty line is about \$5,700; and for a family of four, about \$11,700. Philadelphia’s deep-poverty rate was 12.9%, or approximately 200,000 people.<sup>37,38</sup> The table below compares the health status of people above and below 200%FPL. People living below 200% FPL are much more likely have fair or poor health, a mental health condition, and diabetes, and have higher rates of smoking and obesity.

**Health Status by Poverty Level for TJUHs CB Area**

	Fair/Poor Health	Mental Condition	Diabetes	High BP	Smoke	Obese
<b>&lt;200% FPL</b>	36.1%	34.7%	19.8%	40.8%	28.8%	35.9%
<b>&gt;200% FPL</b>	8.5%	17.6%	9.4%	25%	16.6%	21.5%

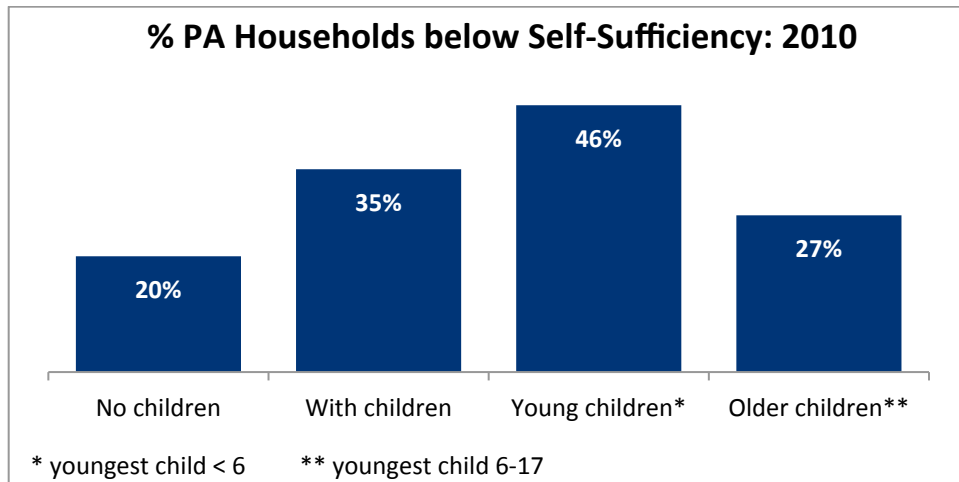
*PHMC Household Health Survey 2015*

Another way to measure economic welfare is to employ the Self-Sufficiency Standard. The Self-Sufficiency Standard is defined as the income a household must earn to meet its basic needs (housing, childcare, food, health care, transportation, and taxes) without public or private assistance and is based on the size of the family and where they live.<sup>39</sup> A family with one adult, one infant and one preschooler living in Philadelphia in 2012 needed \$57,746 annual income to meet the self-sufficiency standard and a household of four needed \$61,199 a year. In 2012, 42.2% of households (161,361 households) in Philadelphia were below the Self Sufficiency Standard compared to 25.6% of households in Pennsylvania. In Pennsylvania, Black and Latino residents are more likely to live in households that are below the self- sufficiency level.<sup>40</sup>



*Self-Sufficiency Standard for Pennsylvania, 2010*

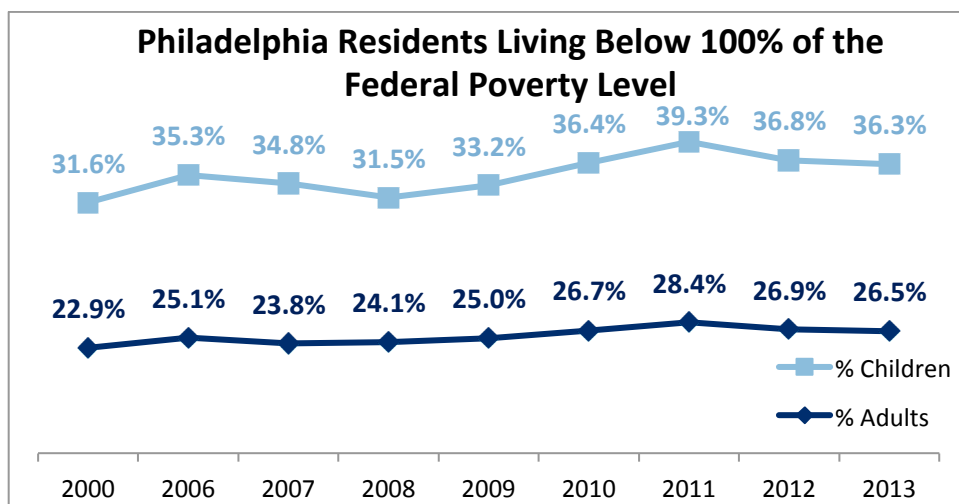
Thirty five percent of all children live in households below the self-sufficiency threshold and households with younger children are the most likely to be financially insecure.



*Self-Sufficiency Standard for Pennsylvania, 2010*

The 2014 Federal Poverty guidelines are defined as a range based on household size - \$11,770 for a household of one to \$28,410 for a household of five. According to PEW's Philadelphia–State of the City report 2015, 26.3% of residents (more than 400,000 residents) live below the poverty line, and slightly more than three out of ten are eligible for food stamps (about 490,000 individuals in 2014).<sup>32</sup> The poverty rate improved steadily since 2011; however, it has not yet recovered to pre-2008 levels. In 25 of the city's 46 residential zip codes, 20% of residents had incomes that were below the poverty line.

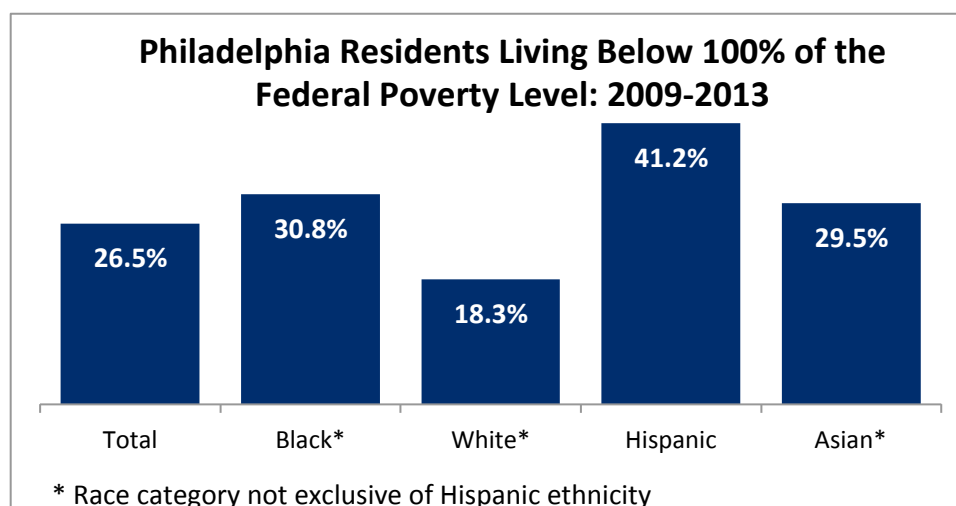
While negative health effects resulting from poverty are present at all ages, children in poverty experience greater morbidity and mortality than adults due to increased risk of accidental injury and lack of health care access. Children's risk of poor health and premature mortality may also be increased due to the poor educational achievement associated with poverty. According to the 2015 County Health Profile, 36% of Philadelphia's children under age 18 live in poverty, a rate that far exceeds Pennsylvania (19%), the United States (23%), and most of the largest cities in the United States.<sup>38,41</sup>



*U.S. Census Bureau/American Community Survey*

In addition, 59% of children in Philadelphia live in single parent households compared to 33% in Pennsylvania; the national benchmark is 20% of children living in single parent homes. Adults and children in single-parent households are at risk for adverse health outcomes such as mental health problems (including substance abuse, depression, and suicide) and unhealthy behaviors such as smoking and excessive alcohol use.

Hispanic and Black American residents are more likely to be living in poverty than Whites.<sup>38</sup>



*U.S. Census Bureau/American Community Survey*

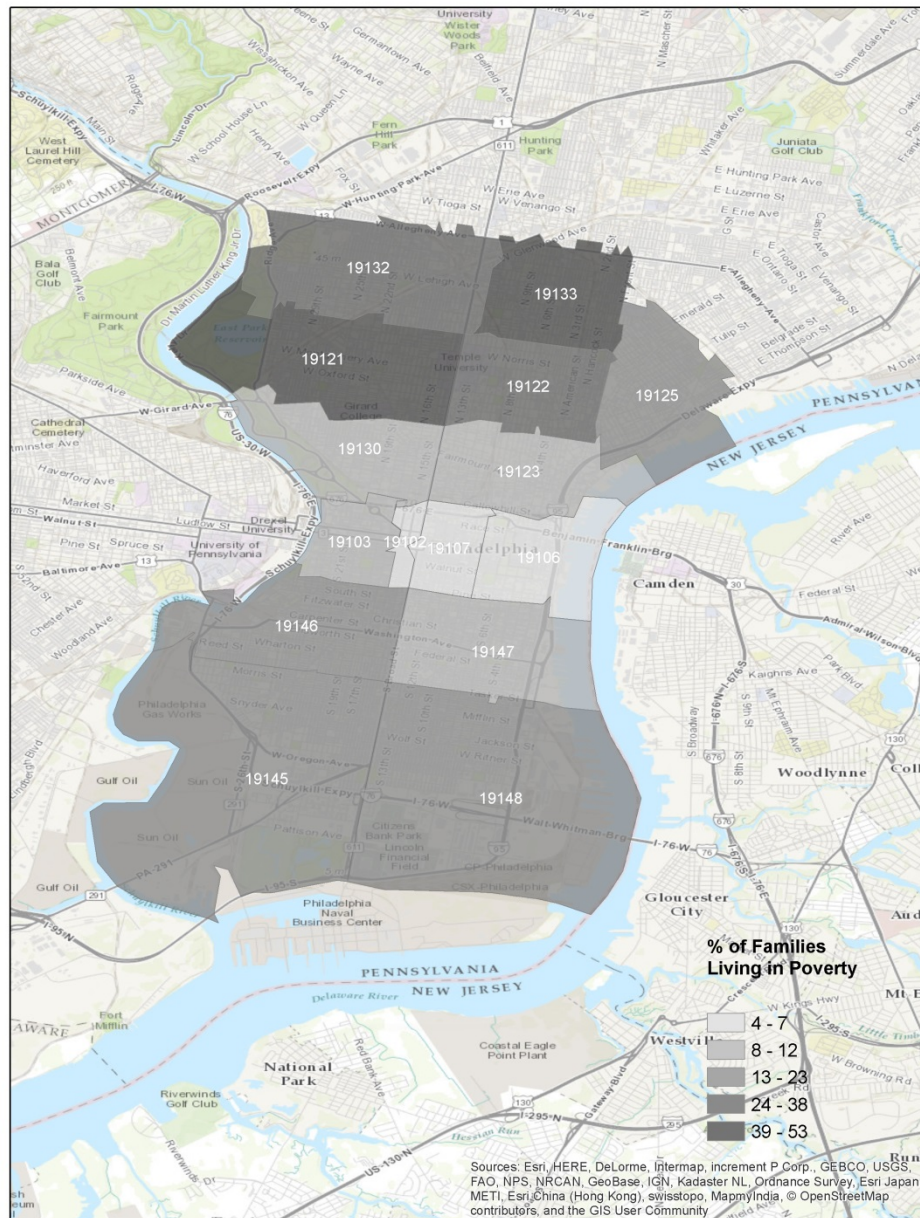
Among TJUHs CB neighborhoods, Lower North Philadelphia residents are almost twice as likely to live below 100% poverty as others in Philadelphia (41.4% vs. 23.6%) and four times more likely than those living in Center City. In addition, people living in TJUHs CB area are more likely than other Philadelphians to live below 50% of the federal poverty level (9.3% vs. 7.6%) and Lower North residents are twice as likely to live below 50% of the federal poverty level compared to all Philadelphians. However, data from the Public Health Management Corporation's 2015 Household Health Survey appears to indicate that deep poverty in Philadelphia may be decreasing (12.3% in 2012 to 7.6% in 2015). This also appears to hold for the percentage of residents living at or below 100% of the federal poverty level in Philadelphia (26.3% in 2012 to 23.6% in 2015).

#### **TJUHs Community Benefit Area Percent Living in Poverty**

Poverty Level	LN	TN	CC	SP	TJUHs CB	Phila
Less than 50% Poverty	14.1	2.6	9.1	8.3	9.3	7.6
Less Than 100% Poverty	41.4	14.5	10.4	18.7	23.9	23.6
Less Than 150% Poverty	58.6	26.2	17.6	31.2	37.0	36.5
Less Than 200% Poverty	69.7	34.0	20.9	37.7	44.7	46.4

*PHMC Household Health Survey 2015*

Within TJUHs CB area poverty (less than 100% FPL) varies across zip codes. In Lower North Philadelphia poverty ranges from 33% in 19133 to 38% in 19122, 44% in 19121 and 53% in 19133. In the Transitional neighborhoods zip code 19125 has the highest rate of poverty (23%). In South Philadelphia the percentage of people living in poverty ranges from 9% in 19147 to 19% in 19145 and 19148, and 23% in 19146. The poverty rates in the remaining zip codes are below 13% of the population.



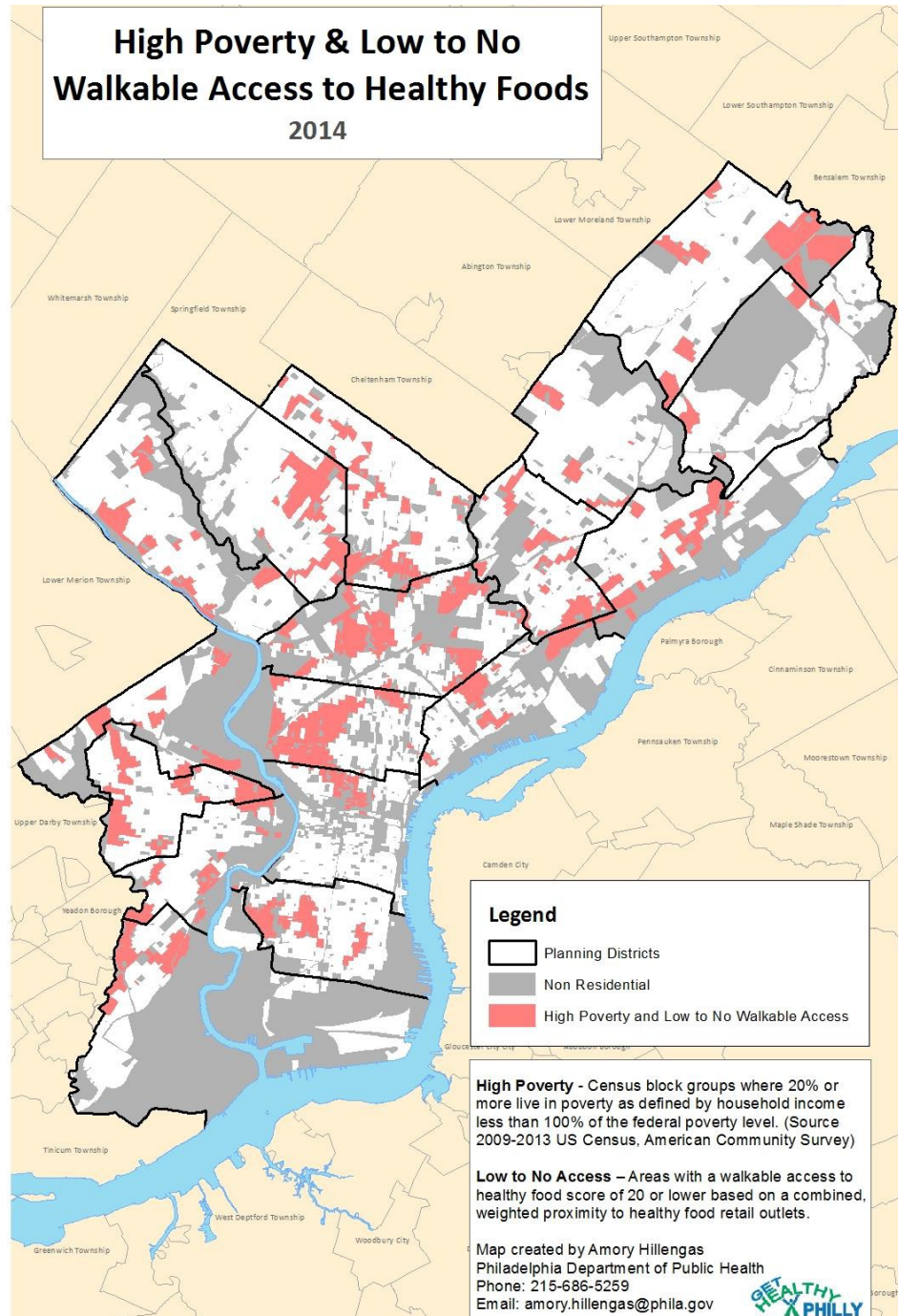
*Census 2010 with Truven Projections for 2015*



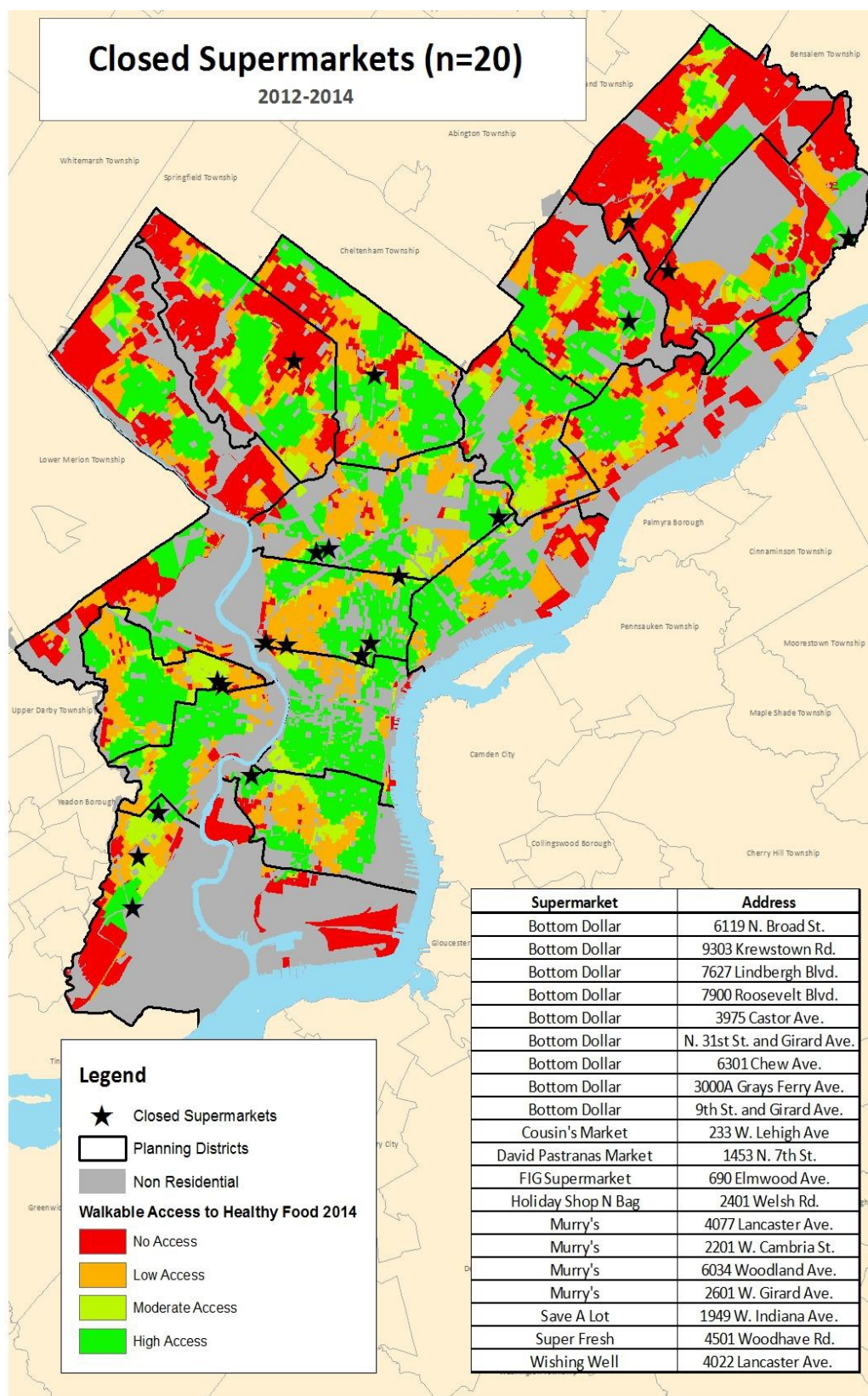
## ***Access to Healthy and Affordable Food: Food as Preventive Medicine***

Nationally 1 in 6 people - about 49 million people - in the United States may have experienced food insecurity at some point in 2013. Among children the rate may be even higher with 1 in 5 children -16 million children- being food insecure. According to *Feeding America – Map the Meal Gap*, in 2013 21.2% of Philadelphians were considered food insecure representing about 326,390 people. Overall, 23.5% of children (80,990 children) in Philadelphia are estimated to be food insecure. Seventy-two percent of food insecure children are likely to be eligible for publically funded food assistance programs.<sup>42</sup> Through *Get Healthy Philly* the Philadelphia

Department of Public Health (PDPH) and its partners, such as the Food Trust and the American Heart Association, have implemented or expanded multiple strategies to increase access to healthy affordable food in low income neighborhoods. These strategies include increasing access to farmers markets, the Healthy Corner Store initiative, Philly Food Bucks, and the Healthy Hospital initiative. The most recent food access analysis conducted by the PDPH shows that as of 2014, 1 in 4 Philadelphians lives in a high poverty neighborhood with limited or no access to healthy food. Barriers to healthy food access are poverty, no walkable access, and supermarket closings.



Since 2012 twenty supermarkets have closed in Philadelphia.<sup>43</sup>



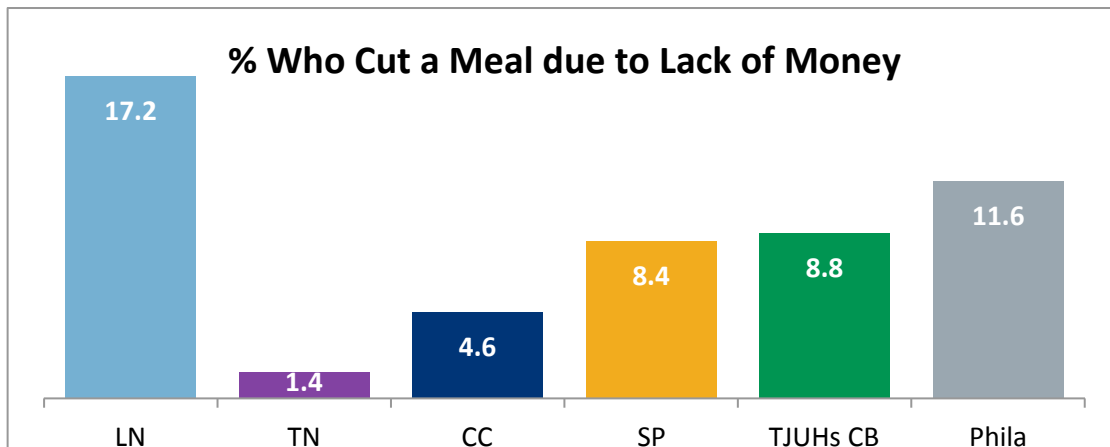
Food insecure adults (defined as those with limited access to sufficient nutritious food) are more likely to be at risk for diabetes, hypertension, and high cholesterol. Women who are food insecure are more likely to experience major depression and/or anxiety, gain excessive weight during pregnancy, have low weight babies, and experience birth complications compared to women who are food secure. Seniors are also adversely affected by hunger. In a pilot study conducted by the Coalition Against Hunger and a Jefferson Family Medicine geriatric practice, 22% of older adults screened positive for food insecurity compared to 9% nationally.<sup>44</sup> Food insecure seniors are more likely to have lower levels of iron and protein, 40% more likely to report an experience with congestive heart failure, 53% more likely to report a heart attack, twice as likely to develop asthma and 60% more likely to experience depression compared to older adults who are food secure.<sup>45</sup> In addition, persistently food insecure individuals were more than 8 times more likely to have medication adherence problems compared to those who were food secure. Lack of medication adherence has been associated with the cost of medications and paying for rent, food, utilities, and other expenses.<sup>46</sup>

Food insecurity impacts a child's development both in terms of brain development and growth and has been shown to be related to increases in childhood obesity. Children and adolescents who experience food insecurity and hunger are more likely to require hospitalization, be at risk of chronic health care conditions such as anemia, asthma, obesity, and oral health problems. They may also be more likely to experience psychosocial issues that affect their ability to fully engage in daily activities such as school and peer relationships. Food insecurity has also been linked to cognitive development. Children who are food insecure tend to perform more poorly in school and lag behind academically. Behavior challenges are also evident among children who experience food insecurity. These children are at greater risk for truancy, and behavioral problems such as aggression at school, hyperactivity, anxiety, mood swings and bullying.<sup>42</sup> These health and behavioral risks may contribute to the cycle of poverty and future success as an adult.

The Special Supplemental Nutrition Program (SNAP) for Women, Infants, and Children (WIC) and food stamps, are the "best medicine" to treat food insecurity according to Children's Watch. In Philadelphia uptake of SNAP by eligible households in 2013 was 73.1%.<sup>9</sup> According to the PHMC 2015 Household Health Survey, 330,278 Philadelphia residents receive SNAP and 62,298 receive WIC. In addition, 82% of children in Philadelphia qualify for the free lunch program. Within Jefferson's Community Benefit area, 75% of children in South Philadelphia, 64% in Center City, 86% in the Transitional Neighborhoods, and 90% in Lower North neighborhoods are eligible for free lunch.<sup>47</sup>

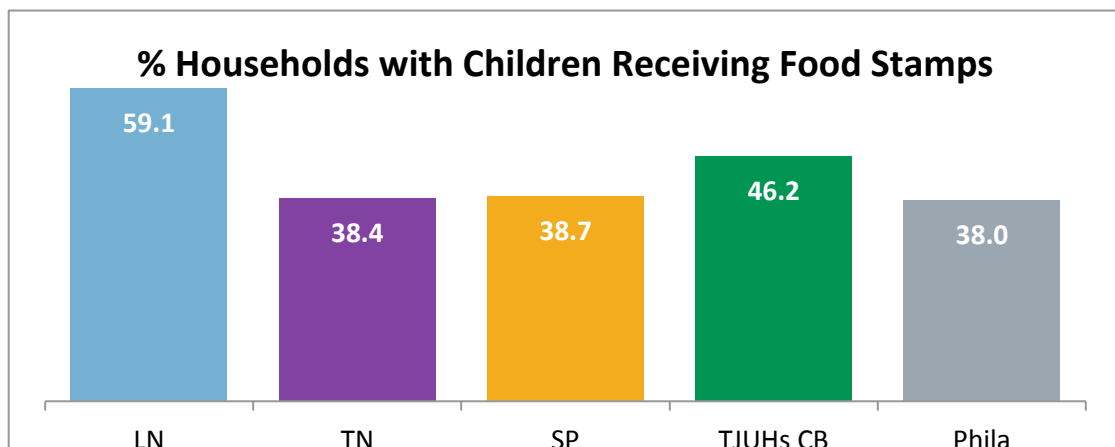
The percent of adults who reported cutting a meal due to cost is an indicator of possible food insecurity. The majority of neighborhoods in Jefferson's community benefit area compare favorably to the Philadelphia rate for cutting a meal due to cost. However, the rate in Lower North Philadelphia exceeds the rate in Philadelphia (17.2% and 11.6% respectively).



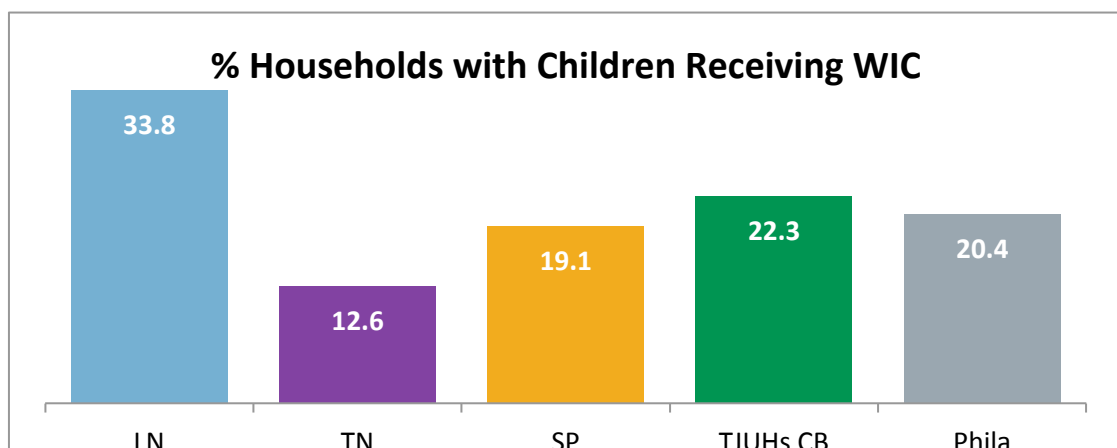


*PHMC Household Health Survey 2015*

In addition, 46% of children in TJUHs CB area live in households receiving food stamps and 22% are receiving WIC.



*PHMC Household Health Survey 2015*



*PHMC Household Health Survey 2015*

The Mayor's Office of Community Service provides the home within City government for the Philadelphia Food Policy Advisory Council (FPAC). FPAC facilitates the development of responsible policies that improve access for Philadelphia residents to culturally appropriate, nutritionally sound, and affordable food that is grown locally through environmentally sustainable practices.

FPAC members establish programmatic subcommittees in order to research, study, evaluate, and make recommendations on priority issues. The subcommittees drive the Council's work forward through regular meetings and collaboration. The current programmatic subcommittees are Anti-hunger, Good Food procurement, Urban Agriculture and Zero Waste.

According to the SHARE Food Program Philadelphia, a member of FPAC and an organization addressing food security through Philadelphia, food cupboards and backpack programs, between 2002 and 2012 the number of households participating in its program increased from 53,370 to 223,553 and the total number served increased five-fold from 130,631 to 624,720 individuals served.<sup>48</sup> Food insecurity is not abating; the number receiving food relief from SHARE in the past four years grew 31%. In 2015 SHARE's helped an average of 607,513 low income individuals each month and according to the Executive Director of SHARE Philadelphia, clients will use food assistance on average 8-9 times per year. Almost 40% of those served were children and 11% were elderly. In the last year SHARE distributed more than 26.6 million pounds of food.

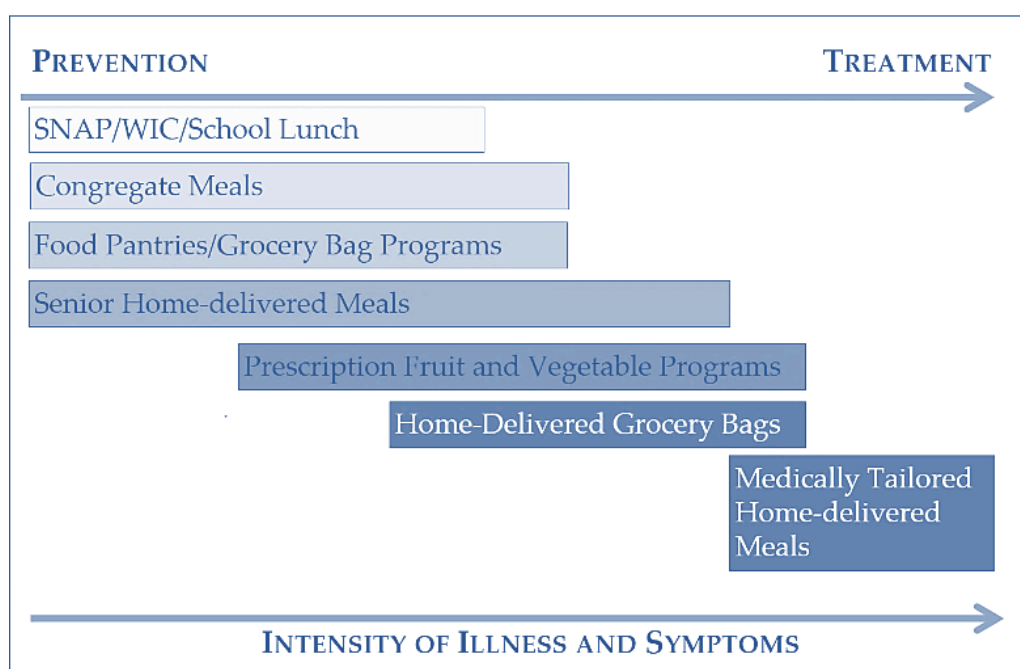
Despite increases in utilization of food assistance services in Philadelphia, such as SHARE, Philabundance and the Coalition Against Hunger, some households may still not be taking advantage of Government food assistance programs. Additionally, results from a 2015 survey conducted by the Coalition Against Hunger show that 89.7% of emergency food programs in Philadelphia either ran out of or had to provide less food to clients at some point in the past year, 58.2% of feeding programs reported seeing more people compared to the same time period in the previous year, and 90% are interested in providing healthier food options to clients such as fresh fruit and vegetables, lower sodium and sugar canned goods, and whole grain products.

A growing body of evidence suggests that food insecurity not only increases the risk of adverse health outcomes and complicates the ability to manage illness, but also increases health care costs. A recent study by Tarasuk and Gunderson, published in the *Canadian Medical Association Journal*, looked at the impact of food security on adverse health outcomes. Canada has a one-payer system and universal coverage which enabled the researchers to analyze data of more than 67,000 adults who completed the Canadian Community Health Care Survey. The researchers found that health care costs were significantly higher for food insecure people even after adjusting for other socioeconomic factors. Health care costs were 49% higher for the food insecure and 121% higher for those with very low food security. Higher costs were seen across inpatient hospitalizations, emergency room visits, primary care, home health and prescription drug use. Health care costs increased as food insecurity increased.<sup>49</sup>

While most programs in the city provide food assistance as a means to prevent illness, MANNA provides home-delivered medically appropriate meals and nutrition counseling free of charge to clients experiencing life-threatening illnesses such as cancer, HIV/AIDS, heart disease, diabetes, and renal disease. Research shows that nutrition-specific Diagnosis Related Groups (DRGs) are

among the top 10 reasons that Medicare beneficiaries are readmitted to the hospital.<sup>50</sup> In June 2013, results from a three year study assessing the impact of MANNA's services were published in the *Journal of Primary Care and Community Health*. Study results showed that MANNA clients' average monthly health care costs decreased by 62% or almost \$30,000 over three months; hospital visits were cut in half and length of stay was 37% shorter; and MANNA clients were 23% more likely to be discharged from the hospital to their homes rather than a health care facility. In 2015 MANNA prepared more than 732,000 meals for 2,191 clients and helped treat clients with 67 diseases. The majority of MANNA clients are poor – two thirds are below the poverty line, two thirds are African American (67%), and most are between 18 and 64 years old.

The model below, developed by the Food is Medicine Coalition, displays the scope of food assistance programs needed to prevent food insecurity and options for treatment of those who are ill and in need of healthy, affordable food in order to improve health outcomes and potentially reduce emergency department and hospital utilization.



*Food & Nutrition Services: Food Is Medicine Coalition (FIMC)*

Healthcare has a role to play in raising awareness about food assistance programs. Healthcare providers can screen patients for food insecurity and *prescribe a referral* to local food assistance programs for those who screen positive (Wholesome Wave Food RX Program). In October 2015 the American Academy of Pediatrics (AAP) urged pediatricians to screen all patients for food insecurity and to refer parents to appropriate agencies so children do not go hungry. The AAP suggested that pediatricians use the following two question screening tool that identifies food insecure families 97% of the time:

*“Please let us know if either of these statements is true for your family:”*

- “Within the last 12 months we worried whether our food would run out before we got money to buy more”
- “Within the past 12 months the food we bought just did not last and we did not have money to get more”

The new AAP policy also encourages pediatricians to advocate for programs that provide healthy, affordable food for children.

Physicians can also refer patients to nutrition services such as MANNA to improve patient outcomes, patient satisfaction, and reduce health care costs.

**Issues, challenges, unmet needs and priorities identified by key informants and focus group participants related to access to healthy and affordable food include:**

- The refugee community would like increased access to vacant lots for urban farming (key informant)
- The cost of food of obtaining healthy food is a barrier. *"A lot of people who come to SHARE can't even afford an apple, can they?"* (key informant)
- *"Health and food are not separate issues. If you don't have the right food your health condition gets worse, you need to connect the two. Food deserts are a mental health problem."* (key informant)
- **Food insecurity is high and has been increasing over the past several years**
  - Food insecurity, food deserts, and safety issues are underlying causes of obesity and diabetes
  - *"I know one thing is that sometimes people don't know what resources are available to them. I know of a neighbor, she's actually in a hospital bed most of the time... she didn't have anything in her house to cook food. She didn't even have a microwave or anything. Her doctors were recommending food to her, but the only food she had to cook was the little bit that was in her house, and she didn't say anything to them. And finally someone realized.... And got her Meals on Wheels."* (focus group)
  - *"Families needing assistance are often headed by a grandparent. People's benefits don't last the whole month. Hunger in these families, particularly with children not yet in school, may not be apparent to outsiders –invisible hunger".* (Key informant)
  - Use of food cupboards has increased over the previous year. Food cupboards continue to run out of food before the end of the month. Availability of healthy food options in food cupboards is limited. *"The local food cupboard handed out bags of tortilla chips and frozen pizzas. This was all that was delivered at the end the month."* (key informant)
  - Food insecurity is an issue among older adults
  - The need for affordable healthy grocers/markets was identified as a priority by focus groups and key informants

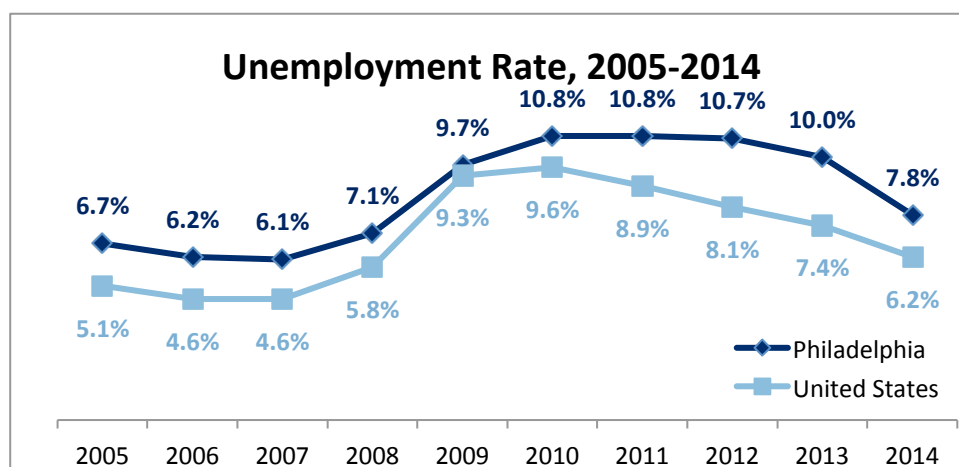
- *Food access report- getting worse - 15+ supermarkets closed (PRIORITY)*
  - *Need innovative ways to get healthy food to people*
  - *"Need to figure out how to get supermarkets into the city"*
- **Screening for food insecurity** is not systematically being done
  - *"Primary care offers an opportunity to screen as does screening inpatients. This could be done at the same time you sign people up for MA - you can screen for SNAP (food stamp eligibility). Consider integrating this into programs you do to enroll people into insurance. Also, consider giving a \$25 food voucher to patients being discharged who may be food insecure ...it's cheaper than a readmission".*  
(key informant)

**Based on internal and external key informants, focus groups, existing relationships and programs, and secondary data, actions addressing food access may include:**

1. **Raise awareness about food as medicine:**
  - **Screen for SNAP eligibility when determining MA eligibility**
  - **Screen for food insecurity in Jefferson physician practices (particularly pediatrics and geriatrics) and refer to the Coalition Against Hunger as needed. Screen patients for food insecurity prior to discharge from the hospital/Emergency Department and refer to MANNA, Meals on Wheels, or other food assistance programs as appropriate.**
  - **Provide food cupboard resources to patients seen in primary care practices**
2. **Conduct "healthy food" drives for area food cupboards in partnership with SHARE**
3. **Co-locate BenePhilly Centers (Benefit Bank) in healthcare sites such as Methodist Hospital.** The Benefit Bank online service was selected as the benefit access tool for the six community-based centers, known as BenePhilly Centers, which opened in Philadelphia in 2014. These centers are a key component of Shared Prosperity Philadelphia, Philadelphia's anti-poverty initiative that emphasizes expanding access to public benefits and essential services.

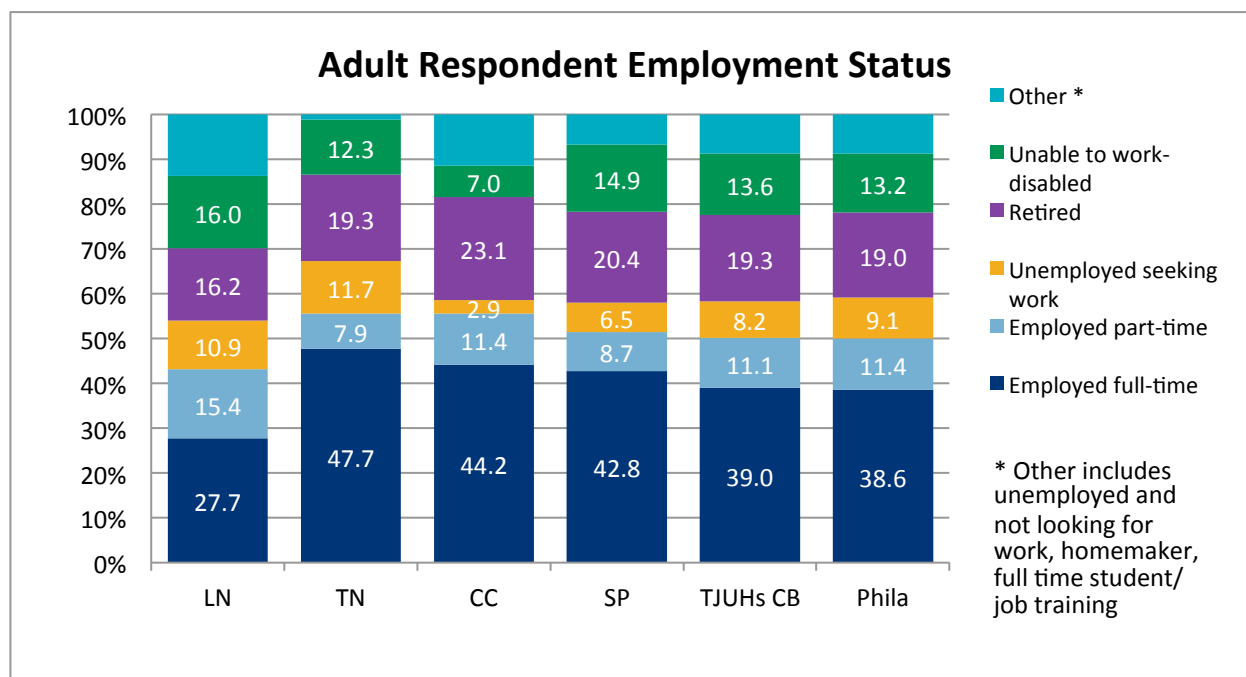
### ***Employment and Job training***

In Philadelphia, unemployment fell in 2014 to an annualized rate of 7.8%, the lowest since before the Great Recession, and was trending even lower by the end of the year.<sup>32</sup> It remained substantially higher than the national rate of 6.2%. The numbers of jobs grew by 8,800, the biggest 12-month gain in 15 years. Even so, the rate of increase lagged behind national job growth. The education and medical sectors remained the bulwark of the city's economy, accounting for more than 30% of all jobs. Of the city's 15 largest employers, 12 are in "eds and meds." Philadelphia's unemployment rate remains the highest in comparison to all other local workforce investment areas in Pennsylvania.



PEW Philadelphia 2015 – State of the City

Less than half of working-age adults in the city are currently employed, and 40% of those who do have jobs earn poverty wages. Philadelphia ranks in the bottom 10% of U.S. cities in terms of both post-secondary educational attainment and labor force participation. These high levels of unemployment and poverty lead to lack of health insurance, overuse of the emergency department for primary care, and delayed care as well as poorer health outcomes.



PHMC Household Health Survey 2015

Compared to the employed, the unemployed in the TJUHs CB areas are more likely to report their health as fair or poor, a diagnosed mental health condition, be obese and smoke.

	Fair/Poor Health	Mental Condition	Diabetes	High BP	Smoke	Obese
<b>Employed full-time</b>	5.5%	12.3%	9%	13.4%	19.8%	21.5%
<b>Employed part-time</b>	16.9%	23.2%	11.1%	25.9%	8.6%	21.1%
<b>Unemployed</b>	19.4%	44.4%	7.8%	19.4%	31.7%	38.3%

*PHMC Household Health Survey 2015*

*"Health is major reason why people lose their job within the first year or return to prison"* (key informant). The implications of poor health on labor market outcomes are enormous for patients, families, employers and policy makers. Poorly managed health conditions have been associated with increased absenteeism, poor productivity, decreased job retention, and fragmented work histories. In a survey sponsored by Nationwide Better Health, 85% of respondents reported that unplanned absences are normally due to a health condition, either their own or that of a family member.<sup>51</sup> Half of these absences were due to a recurring health condition. Mental and physical health illnesses, personal problems, the need to be with their families or job-related stress also increase lost productivity at work. According to the Partnership for Prevention, reducing just one health risk can increase productivity by 9% and reduce absenteeism by 2%. Absence management leads to a healthier workforce and keeps people on the job at full strength to maximize a company's productivity and profit.<sup>52</sup>

The relationship between health and productive employment is illustrated by the results of a 2014 comprehensive needs assessment conducted to inform the Sharswood-Blumberg Neighborhood Transformation Plan. The Sharswood-Blumberg neighborhood, one of the most distressed neighborhoods in Philadelphia, is located in the Lower North section of Jefferson's community benefit area. Residents of this community are more likely to be poor compared to the City (52.5% vs. 26.3%) and unemployed (80% vs. 8.4%). The assessment showed that health was the major barrier to residents finding (35%) and retaining employment (39%) followed by transportation and need for education/training.<sup>53,54</sup>

For Philadelphia's vulnerable adults, finding a job with family-sustaining wages is only the first hurdle on the path to economic stability. Because of physical and mental health challenges, a lack of peer support and limited work experience, low skilled adults often find it difficult to not only obtain jobs but retain their jobs. Once employed, many residents in these communities need to receive on-going counseling and supporting services to improve their work habits, manage work-related stress, balance family and work obligations, and effectively manage chronic health conditions.

1. *Workforce Diversity*: According to Healthy People 2020, public health infrastructure is fundamental to the provision and execution of public health services at all levels.<sup>55</sup> A strong infrastructure provides the capacity to prepare for and respond to both acute (emergency) and chronic (ongoing) threats to the nation's health. Infrastructure is the foundation for planning, delivering, and evaluating public health. As minority populations in Philadelphia and the United States increase, a more diverse public health workforce will be needed. In Philadelphia, Hispanics and African Americans are

underrepresented in the public health workforce. In addition, while there are Asian providers, language barriers across Philadelphia's diverse Asian communities exist. According to Cohen, Gabriel, and Terrell, increasing the racial and ethnic diversity of the health care workforce is essential for the adequate provision of culturally competent care to our nation's burgeoning minority communities. A diverse health care workforce will help to expand health care access for the underserved, foster research in neglected areas of societal need, and enrich the pool of managers and policymakers to meet the needs of a diverse populace. The long-term solution to achieving adequate diversity in the health professions depends upon fundamental reforms of our country's precollege education system.<sup>56</sup>

There exists a growing literature related to the use of community health workers/navigators/coaches (CHWs) to increase the diversity of the workforce and in care management, facilitation of transitions of care, chronic disease management and bridging cultural divides. Interviews with organizations serving immigrants shared the need to train members of limited English speaking communities in health professions including health care providers and community health workers. There are multiple programs in Philadelphia, including Thomas Jefferson University's Institution for Emerging Health Professions, which train CHWs. This has the potential to provide job opportunities for minority populations and meaningful employment. Utilization of CHWs has also been shown to improve the quality and outcomes of care. Statewide efforts are now underway to create standards for CHW training and to explore certification for the profession.

Under the leadership of Jefferson's Senior Vice President and Chief Diversity Officer, a Diversity Steering Committee is focusing on *reimagining diversity and inclusion to promote and cultivate an inclusive environment that celebrates the diversity of our patients, families, students, workforce and the communities we serve*. A major goal is to develop a diverse workforce that reflects the communities served by Jefferson.

TJUH also participates in the *WorkReady* Philadelphia program which provides employment opportunities for high school students to build their employment skills. Interviews also highlighted the need to develop a pipeline to improve the capacity of Philadelphia youth to enter health professions. Key informant interviews in the Asian community, citing the need to increase bilingual providers, also supports the goals of increasing workforce diversity and the opportunity for meaningful employment.

Education in science, technology, engineering, and mathematics has received growing attention over the past decade, with calls both for greater emphasis on these fields and for improvements in curricula and instruction within and across them. In the policy arena and increasingly among educators, these subjects together are referred to as STEM. Multiple reports issued by influential education, policy, and business groups have argued the case for expanding and improving STEM education from K-12. Among other things, the case rests on the idea that a STEM education can lead to productive employment and is critical to the nation's innovation capacity. Many employers and public officials believe that all people, particularly young people, needs to have some degree of scientific and technological literacy in order to lead productive lives as citizens,



whether or not they ever work in a STEM-related field. In today's science- and technology-rich society, such literacy is important.<sup>57</sup>

**Issues, challenges, unmet needs and priorities identified by key informants and focus group participants related to workforce development include:**

- *"We need training programs, especially for young people. They need to start them out young. A lot of older people already have the resources and young people don't have the resources, they just got out there, and there's no one to encourage them, there's no programs to train them, not that you have to go to college, I'm talking about hands-on like carpentry and assess their natural skills and what they can do... Don't leave them there at that level, moving nowhere, wondering if anything's going to get better... Need more support in the system" (focus group).*

**Based on internal and external key informants, focus groups, existing relationships and programs, and secondary data, actions addressing workforce development may include:**

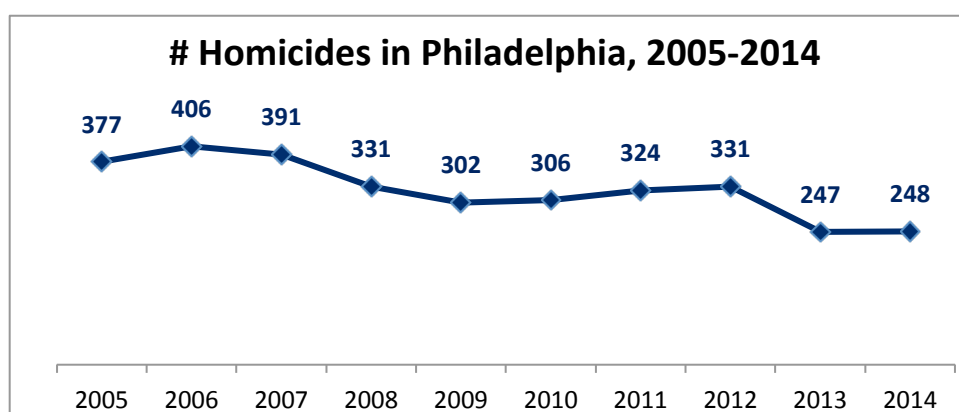
1. **Partner with Nationalities Services Center, the Welcoming Center, and others for employment training programs that prepare refugees and immigrants for health related careers**
2. **Provide community health worker (CHW) training and training for medical interpretation for young refugee and immigrant adults who are bilingual**
3. **Continue to support Jefferson's CHW program through scholarships, curriculum review, and employment**
4. **Develop a youth health careers pipeline program in partnership with Thomas Jefferson University**
5. **Provide tutoring/mentoring as part of pipeline into health professions**
6. **Continue the Cristo Rey program and the *WorkReady* program with Philadelphia Youth Network at TJUHs.**
7. **Continue to integrate health into workforce development programs such as Federation on Neighborhood centers, Project HOME, and Pennsylvania Horticulture Society**

***Community Safety and Violence***

*Community Crime and Violence:* The health impacts of community safety include the impact of violence on the victim, symptoms of post-traumatic stress disorder (PTSD), psychological distress due to chronic exposure to unsafe living conditions and various other health factors and outcomes including birth weight, diet and exercise, and family and social support. Exposure to crime and violence has been shown to increase stress, which may exacerbate hypertension and other stress-related disorders and behaviors such as smoking in an effort to reduce or cope with stress. Exposure to violent neighborhoods has been associated with increased substance abuse and sexual risk-taking behaviors as well as risky driving practices.<sup>58</sup>

Violent crime is represented as an annual rate per 100,000 population. Violent crimes are defined as offenses that involve face-to-face confrontation between the victim and the perpetrator, including homicide, forcible rape, robbery, and aggravated assault. Based on data for 2010-2012, there were 1,190 violent crimes per 100,000 in Philadelphia compared to 357 for the state and the Healthy People 2020 national benchmark of 66. Although the rates are high, in 2014 the number of violent and major crimes in Philadelphia was the lowest in three decades. The total number of violent crimes decreased from 21,609 in 2005 to 15,771 in 2014. Similarly, the total number of major crimes decreased from 82,030 in 2005 to 68,815 in 2014.<sup>58</sup>

After increasing between 2009 and 2012, the number of homicides in Philadelphia decreased from 331 in 2012 to 248 in 2014 resulting in a homicide rate of 16 per 100,000 residents.<sup>32</sup> Violent crime in Philadelphia is not evenly distributed; in 2014, seven of the city's 22 police districts accounted for almost 60 %of the violence. The typical homicide victim in Philadelphia is male (91%), African American (77%), between the ages of 18-34 (58%), has a previous arrest record (92%), and is killed by a gunshot (81%). Among the 10 comparable cities Philadelphia ranked 6<sup>th</sup> behind Detroit (43.6), Baltimore (33.9), Cleveland (26.4), Pittsburgh (23.2) and Washington DC (16.2).<sup>32</sup>



PEW Philadelphia 2015 – State of the City

Neighborhoods with high violence encourage isolation and therefore inhibit the social support needed to cope with stressful events. Additionally, exposure to the chronic stress of community violence contributes to the increased prevalence of certain illnesses, such as upper respiratory illness and asthma.

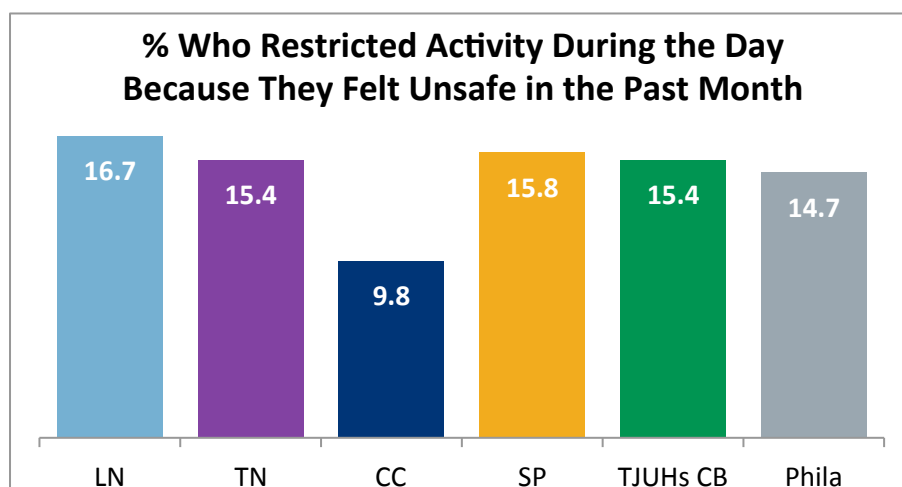
The table below depicts the violent crimes in TJUHs CB area by police district. Violent crime rankings range from the second highest rate of crime in the city (North Philadelphia – west) to one of the lowest ranking in the City (South Philadelphia is ranked 19th out of 22 police districts).

Police District	Principal Neighborhood	Rank 2013	Total Number	Rank 2015	Total Number
22	North Phila./West	2	1,535	2	1507
3	South Phila./East	12	822	13	677
26	North Phila./East	13	658	12	691
6	Center City/East	15	517	16	425

Police District	Principal Neighborhood	Rank 2013	Total Number	Rank 2015	Total Number
17	Point Breeze	16	514	15	522
9	Center City/West	17	433	18	353
1	South Phila/West	19	344	19	279

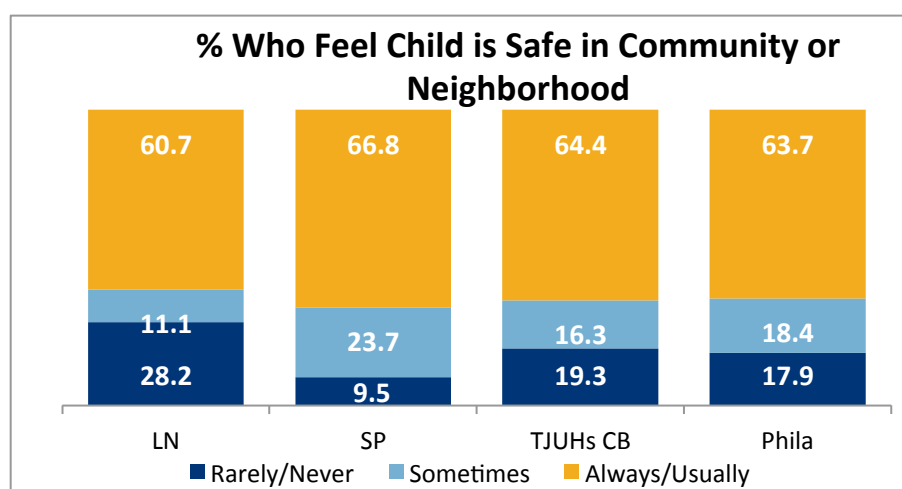
*PEW Philadelphia 2013 and 2015 – State of the City*

In 2012 (the last year this information was collected) in TJUHs CB area, 15.4% of people reported restricting their activity during the day because they felt unsafe. In recent focus groups, community residents reported restricting physical activity, such as walking in the community or going to the park/playground, because of safety concerns for themselves and their children.



*PHMC Household Health Survey 2012*

Almost 20% of parents in TJUHs CB area felt their child was unsafe in the neighborhood in 2012.



*PHMC Household Health Survey 2012*

Understanding shared risk and protective factors of violence can inform how to prevent multiple forms of violence. Violence prevention and intervention efforts should promote joint action that connects the health and social service systems, including the criminal justice system.

One organization focusing on community violence/safety is PhillyRising,<sup>59</sup> which targets neighborhoods throughout Philadelphia that are plagued by chronic crime and quality of life concerns, and establishes partnerships with community members to address these issues. The PhillyRising team coordinates the actions of City agencies to help neighbors realize their vision for their community through sustainable, responsive, and cost-effective solutions. The basic goal of PhillyRising is to lower crime, in both a real and perceived sense, and to increase residents' self-sufficiency and involvement in their communities. The PhillyRising collaborative does this by significantly altering the way the City delivers services to residents in areas with chronic crime and disorder problems that require a coordinated multi-agency response.

Another organization dedicated to safety is the South Philadelphia Prevention Coalition (SPPC), developed by the Southeast Philadelphia Collaborative (SEPC) and the South Philadelphia School Safety Task Force, and currently coordinated by SEPC staff. The overall goal of SEPC is to connect organizations that have a stake in collectively addressing the needs of young people ages 13-18 in the 19147 and 19148 zip codes. Membership consists of a diverse group of people who work in fields that are inherently invested in youth substance abuse prevention. These include healthcare, law enforcement, youth programs, and representatives from school, youth, and parent communities. In 2014 the SPPC coalition was awarded a Drug Free Communities grant. This program provides funding to community-based coalitions to support organizing efforts that prevent youth substance abuse. The Drug Free Communities program supports the philosophy that local drug problems require local solutions and requires that coalitions include representatives from a variety of sectors. In addition to representing healthcare on the coalition, Jefferson's Center for Urban Health is the evaluator for the Drug Free Communities grant. The goals of SPPC include:

- Planning monthly street clean-ups hosted by youth and adults
- Increasing the number of coalition partners
- Creating a cohesive social media strategy
- Regularly surveying youth and adults about substance abuse and access in South Philadelphia
- Completing and publishing community factsheets about neighborhood substance use and access
- Supporting a clear disciplinary protocol for substance use offenses in schools
- Collaborating with school police to train officers on prevention and treatment options in South Philadelphia
- Encouraging more extensive health education opportunities in local schools

Drug addiction, guns and violence were identified as priorities by key informants and focus group participants.

*Bicycle and Pedestrian Safety:* Bicycle use nationally and in Philadelphia has steadily increased due to concerted national efforts of the U.S. Department of Transportation's Safer Streets Safer People initiative, the Mayors' Challenge for Safer People and Safer Streets (which Philadelphia signed on to in 2014), and local efforts by groups such as the Bicycle Coalition of Philadelphia. In 2012 in response to recommendations in the *Philadelphia 2035* plan, the *Philadelphia Pedestrian and Bicycle Plan* was adopted by the Philadelphia City Planning Commission. In 2015 the Surgeon General released a call to action for increasing walkability throughout the nation as a public health strategy. According to the 2014 American Community Survey, Philadelphia is the top bicycle commuting city among the nation's 10 most populous cities. Center City has the highest rate of pedestrian transport, and the South Philadelphia planning district has the highest bicycle use as a means of transportation in the City.<sup>60</sup>

**% Pedestrian and Bicycle Mode of Transportation by Planning District for Jefferson's Community Benefit Area**

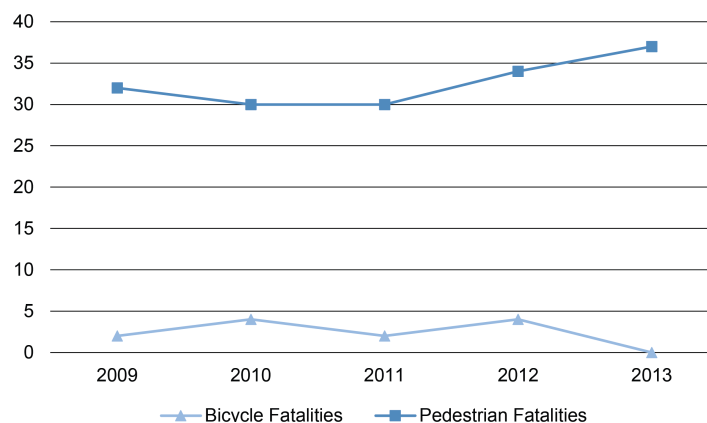
Planning District	Pedestrian	Bicycle	Other
Central	30.0	4.9	65.1
Lower North	8.6	2.8	88.6
South	8.8	6.5	84.7
Lower South	2.2	2.2	95.6
Philadelphia	8.5	2.0	89.5

*Philadelphia Pedestrian and Bicycle Plan Progress Report, 2015*

Barriers to walkable and bikeable communities involve safety concerns such as driver, biker, and pedestrian behaviors including distractions such as texting and headphones, perceived crime, street and sidewalk conditions, and traffic safety dangers. Vision Zero is a Philadelphia initiative to reduce bike accidents to zero.

Traffic crashes are one of the leading causes of injuries and death in the United States and Philadelphia. Seat belts, air bags, and speed restrictions have made huge gains in preventing injuries due to motor vehicle crashes; however, pedestrians and bikers have not reaped the same benefits. While fatalities and injuries from motor vehicle accidents decreased 6% between 2009 and 2014, pedestrian fatalities during the same timeframe increased approximately 16%.

**Philadelphia Pedestrian and Bicycle Fatalities 2009-2013**



*Pedestrian & Bicycle Crash Report 2009-13, Mayor's Office of Transportation and Utilities, April 2015*

In Philadelphia in 2014, 359 pedestrians and 82 bicyclists were hospitalized as a result of a motor vehicle collision. In addition, 14 pedestrians and 130 bicyclists were hospitalized for accidents not involving automobiles.

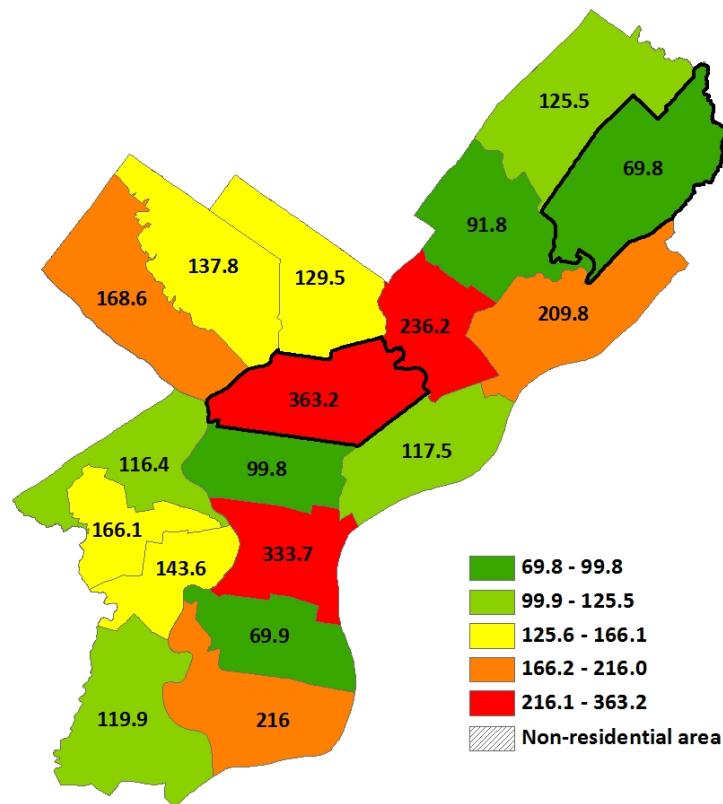
#### Philadelphia County 2014 Hospitalized Injury Profile

Mechanism	# Hospitalized	Median Charges	Total Charges
MVT Bicyclist	82	\$69,984	\$9,919,509
MVT Pedestrian	359	\$80,429	\$60,503,177
Bicyclist, other	130	\$52,237	\$11,847,915
Pedestrian, other	14	\$61,330	\$946,955

*PHC4 Hospital Discharge Data 2014*

Lower South and Center City planning analysis sections experienced higher bicycle and pedestrian accidents per 100,000 than other areas of Philadelphia.<sup>61</sup>

#### Bicycle and pedestrian accidents per 100,000



Source: Pennsylvania Department of Transportation, 2013

**Issues, challenges, unmet needs and priorities identified by key informants and focus group participants related to community safety included:**

- **Pedestrian and Bike safety**
  - Vision Zero – City effort to reduce bike injuries to zero. Jefferson is supporting this effort through the ED Center for Fall Prevention.
  - The City’s district plan for South Philadelphia calls for creating Safe Pedestrian Zones for seniors that connect destination walking sites such as senior centers, pharmacies, healthcare, etc.
  - Gentrification in some neighborhoods makes walking on some sidewalks dangerous due to construction
  - *"53% of all trauma visits to Jefferson’s Emergency department in 2013 were due to falls. The emergency department at Jefferson is initiating the Center for Injury Research and Prevention to address this and other injuries. We are also involved in the City’s Vision Zero campaign."* (key informant)
- **Interpersonal violence**
  - Prevalence of interpersonal violence (IPV) is high in communities – need to raise awareness of IPV and available resources (multiple key informants and focus groups)
    - *"I won’t take my phone out in my hands. I’ll hold them in my handbag and I always find myself walking in the street instead of walking in the sidewalk. I’ll park and I’ll walk down Oregon Avenue and I’ll still stay off the sidewalk. Isn’t that terrible? Say it out loud and you realize it."* (focus group)
    - *"People go door to door to remind people to vote. You don’t see that with domestic abuse unless a person calls the police, or is injured and goes to the hospital or something. I think that’s the only time a social worker might approach them and say ok, here’s some information, or might go to some place that’s geared towards helping women where they might have posters or pamphlets reminding them. But your person in the neighborhood, they might not find out about it."* (focus group)
    - *"I don’t think people know there are things out there for people who are going through domestic violence. And I think that’s something that needs to be addressed in the community."* (focus group)
  - The Philadelphia Coalition for Anti-Human Trafficking is providing training for ED staff to enhance their ability to recognize signs and symptoms of human trafficking. The Salvation Army in Philadelphia has a local hot line to report possible trafficking. Jefferson is doing a pilot to test screening tool for humanity trafficking. The Hospital Association of Pennsylvania supports this effort.
  - Transsexual violence- *"the caution with which they must live to stay safe."* Mazzoni has a transsexual women’s group where they discuss things like safety
  - There is not a domestic violence provider physically located in South Philadelphia (key informant)
  - *"There is fear among immigrants about deportation so therefore they may not report IPV. In addition, some cultures do not see IPV as inappropriate behavior. Information about IPV is needed in other languages. In general, the community*

*"takes care of it". Cultural leaders need education about resources etc."*(key informant)

- **Drug use**

- Community residents perceive increased drug use in their neighborhoods particularly related to opiate and heroin use. Drug use is viewed as a driver for crime in the neighborhood.
  - *"Crime and the drugs are rampant in my neighborhood."* (focus group)
  - Prescription drugs are sold on the street
  - *Drug "infested neighborhoods"* (focus group)
  - Police are biking through neighborhoods less frequently (focus group)
  - *"We are in the midst of a heroin resurgence like we have never seen. Heroin is seen as a safer lifestyle than crack cocaine because it isn't gang or violence related. Communities don't want these programs in their "backyard".*(focus group)
  - *"14-15 year olds. I see them on the corner buying stuff off of people. Cars, they just go up the street. Someone will just jump in and then jump out putting stuff in their pocket...For a while I did actually take down their license plates numbers, but the cops they deal with so much, what are they going to do? I can't call them every day to keep them off the streets."* (focus group)
  - *"One of my neighbors has a video camera out front and they just recently caught a bunch of kids, pretty young kids. There was a guy walking down the street and they just knocked him over and started kicking him, robbed him, and just ran out. It's kind of a common thing."* (focus group)
  - *"Drug related. All the time. I know somebody who is 20-something who just got beat up by 15 year old kids. Left him in the street. You know, it's robberies... Last week, my kid, listened to the scanner on the phone and he said, 'Mom, make sure the back door is locked up,' somebody was seen going down my alley way. Most of the alleyways don't have locks and if they did they're ripped off, so you know, it's like a thoroughfare for drug dealing and everything."* (focus group)
  - *Social concerns are drugs, drug usage. It's just horrible. There's like kids out there constantly...it's on the corner. Drug dealings on the corners. I think years ago we used to have cops present, you know on their bikes. That has disappeared* (focus group)

- **Gun violence**

- *Gun violence in the community creates chronic stress. People want to move but often can't. That's where I live. It's awful but that's where I am.* (focus group)
- *There is a perceived lack of personal safety, need to get guns off the street (gun control). Driving requires you to pass a test - shouldn't you have to pass a test in order to own a gun and use it?* (key informant)
- *"Well there are shootings all the time. Usually drug related."* (focus group)

- **Truancy** can result from youth fear of walking through certain neighborhoods

- **Lack of community cohesion and trust leads to increased violence**

- **Lack of access to constructive activities for youth**



- *There is a lack of constructive things for youth to do as a result of community centers closing or cost of programs (South Philadelphia key informant)*

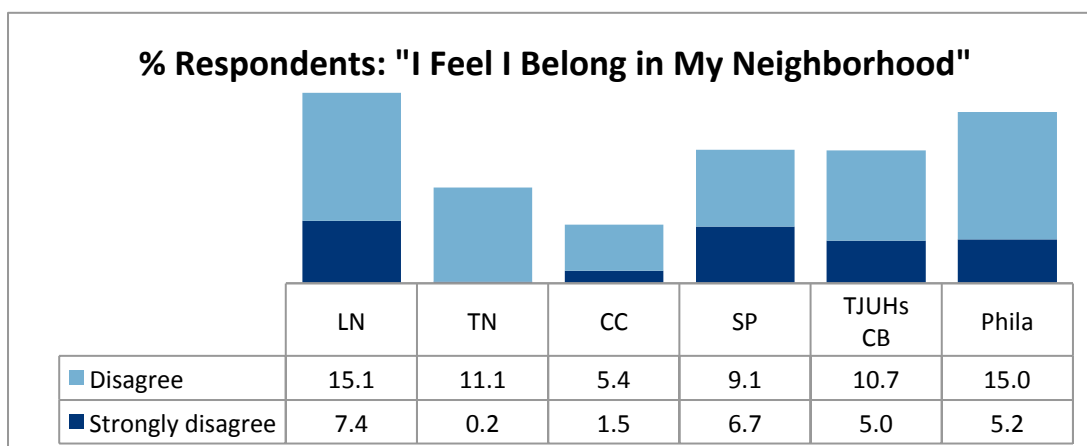
**Based on internal and external key informants, focus groups, existing relationships and programs, and secondary data, actions addressing community safety may include:**

- 1. Work with PhillyRising initiative in South Philadelphia which is addressing violence by reducing substance abuse among youth (focus is on reducing use of entry drugs such as alcohol and marijuana)**
- 2. Raise awareness and provide information about Police Department “Lock Box” drug take back programs among the community and healthcare providers**
- 3. Continue to support bike safety “Vision Zero” and pedestrian safety programs**
- 4. Continue to participate in the South Philadelphia Prevention Coalition which is addressing violence by reducing substance abuse among youth (focus is on reducing use of entry drugs such as alcohol and marijuana)**
- 5. Continue to participate in and support the South Philadelphia Aging Collective’s pedestrian safety and fall prevention initiatives among the elderly**
- 6. Support TJUH/ TJU (Jefferson Center for Injury Research and Prevention and the Institute for Healthy Aging and Supportive Care, Rothman Institute, OT/PT and Rehabilitation programs such as Matter of Balance and Healthy Steps) and community initiatives addressing injury prevention**
- 7. Provide interpersonal violence training for community residents and health care providers**
- 8. Increase access to organized afterschool and summer programming for youth of all ages to promote healthier socialization options**
- 9. Partner with Nationalities Services Center to provide sex trafficking screening training for Emergency Department and other health care providers**
- 10. Partner with the Mazzone Center to train health care providers about transsexual violence**

### ***Family and Social Support***

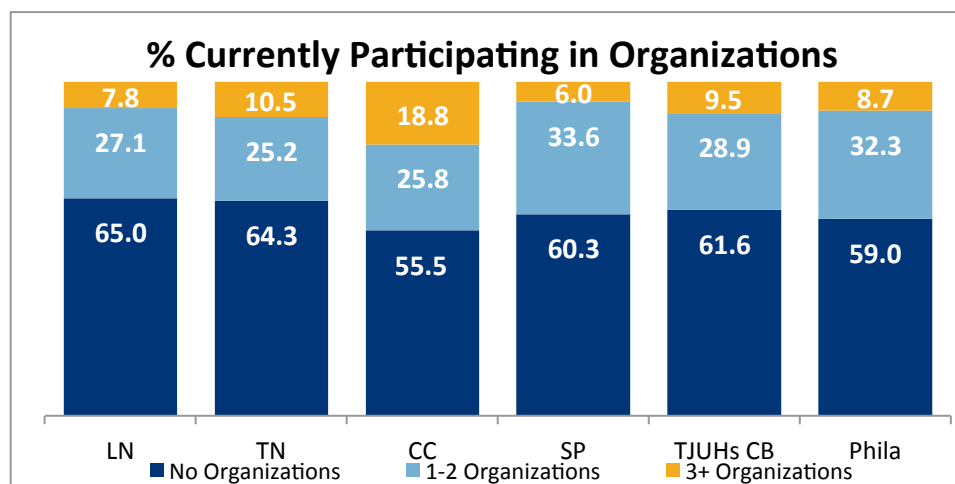
*“A lack of family and social support-- defined as the quality of relationships among family members and with friends, colleagues, and acquaintances, as well as involvement in community life--is associated with increased illness and premature death. Understanding how many individuals in a community are socially isolated also provides a more complete perspective on a community’s health. This is because socially isolated individuals are more likely to be concentrated in communities with poorer community networks. A study that compared Behavioral Risk Factor Surveillance Survey (BRFSS) data on health status to questions from the General Social Survey found that people living in areas with high levels of social trust were less likely to rate their health status as fair or poor. Similar to socially isolated individuals, adults and children in single-parent households are both at risk for adverse health outcomes such as mental health problems (including substance abuse, depression, and suicide) and unhealthy behaviors such as smoking and excessive alcohol use. Not only is self-reported health worse among single parents, but mortality risk also is higher. Likewise, children in these households also experience increased risk of severe illness and death.”<sup>62</sup>*

Social capital refers to the social connectedness of people within a community and has been shown to impact the health status of individuals and populations. Factors such as sense of belonging in a community, participation in community groups, and perception of trust within the community as well as their willingness to help each other are often measured to assess social capital within a community. Compared to Philadelphia, residents in TJUHs CB areas are more likely to agree with the statement “*I feel I belong in my neighborhood.*” However, residents of Lower North Philadelphia, particularly those living west of Broad Street, are more likely to disagree with that statement compared to Philadelphia as a whole (22.5% and 30.3% respectively).



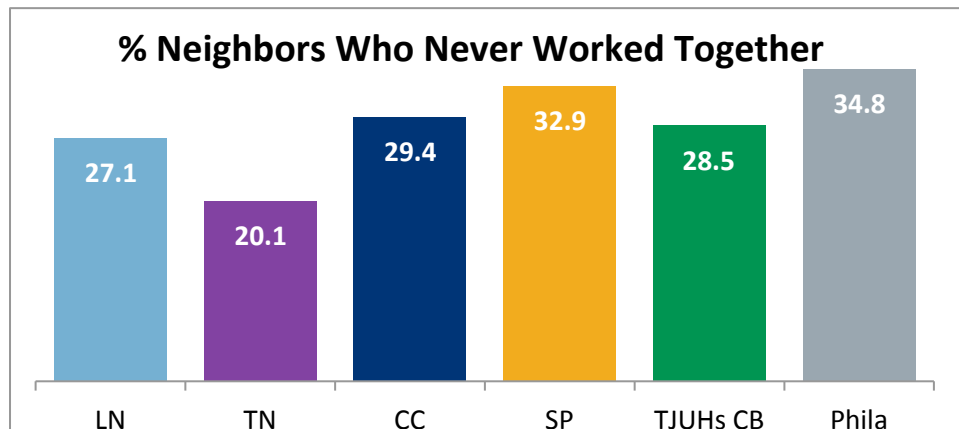
*PHMC Household Health Survey 2015*

Compared to 2012, residents in TJUHs CB area appear to be more positive about neighborhood belonging; however, at the same time, participation in community organizations decreased in all TJUH CB areas and in Philadelphia. More than half of the residents in Philadelphia and TJUHs CB area do not participate in any community organizations.



*PHMC Household Health Survey 2015*

On the other hand, compared to Philadelphia, residents in TJUHs CB area are more likely to have worked on a project together (65.2% vs. 71.5% respectively)



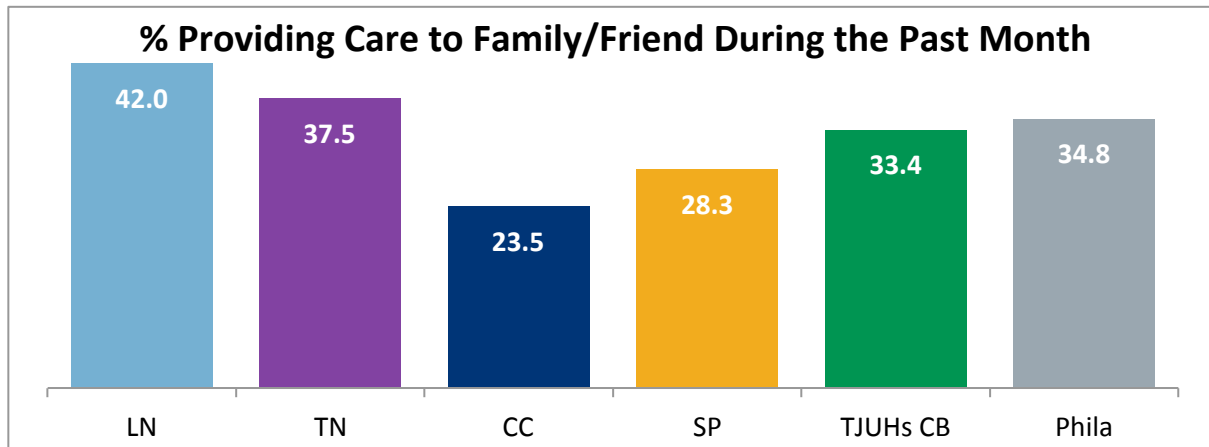
*PHMC Household Health Survey 2015*

Importantly, compared to Philadelphia residents as a whole, people living in TJUHs CB areas, with the exception of Lower North Philadelphia, are more likely to feel that people in their neighborhood can be trusted. Throughout Philadelphia, 75-80% of neighbors are willing to help each other.

Neighborhood	% Agree/ Strongly Agree People in My Neighborhood Can be Trusted	% Rarely or Never Neighbors are willing to help each other
Lower North	43.0	23.3
Transitional Neighborhoods	73.2	20.7
Center City	86.0	20.0
South Philadelphia	62.4	24.3
TJUHs CB area	61.9	22.9
Philadelphia	60.9	22.7

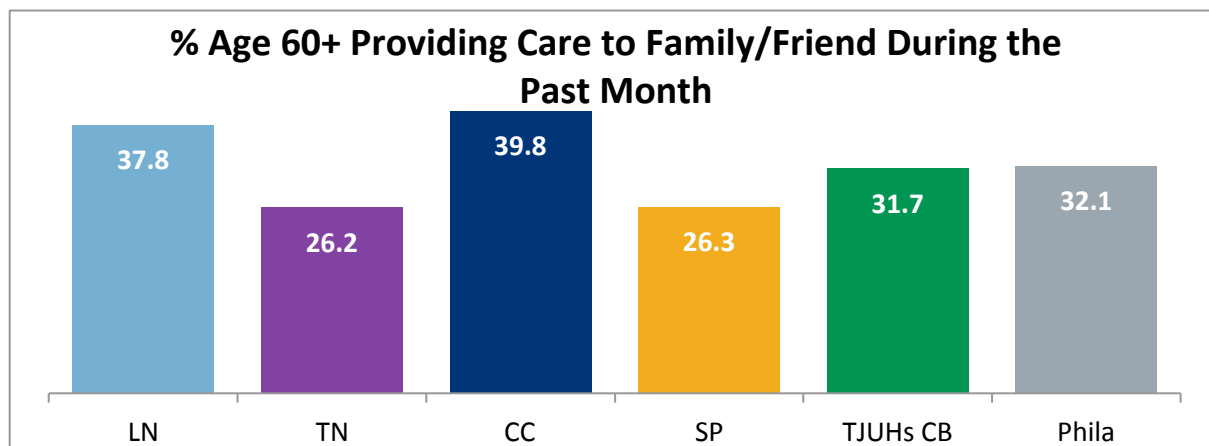
*PHMC Household Health Survey 2015*

One-third of Philadelphians provide care or assistance for family or friends. In Lower North Philadelphia and Transitional Neighborhoods, 42% and 37.5% of residents respectively reported caring for a family member or friend in the past month.



*PHMC Household Health Survey 2015*

Almost one-third of adults over aged 60 in Philadelphia and TJUH's CB say they are providing care for a friend or family member. In Center City, older adults (almost 40%) are more likely to be caring for a friend or family member.



*PHMC Household Health Survey 2015*

**Issues, challenges, unmet needs and priorities identified by key informants and focus group participants related to family and social support include:**

- **Support for Older Adults and Caregivers**
  - Older adults need caregiver support, respite care, and end of life discussions
  - *"These are concerns in the near future because of aging populations, particularly the Bhutanese. Twenty percent have significant issues needing hospitalization and/or tests. Elderly are cared for by someone in the Bhutanese community who doesn't work - caring for the elderly person is seen as their job. Given that this is seen as their job, they may not receive community support. In addition, the family loses the earning potential of the person who is caring for the elderly person."* (key informant)

- *"Need to link to community centers as entry points to services. Develop warm hand-offs between community centers and hospitals and vice-versa. Community centers could provide follow-up with patients/clients. Neighborhood centers could serve as "triage centers" to help with lack of centralization/coordination of information and services. Competition between providers/resources is a barrier. We need to coordinate, not compete and create system changes. We need to change from a culture of self-preservation to one that makes an impact."* (key informant)
- *"Some people who don't have family caregivers may not get social services."* (key informant)
- *"Caregivers need support, education, respite – not enough support for them – can become depressed. We should help loved ones get health care at same time as patients. Create appointments that see patient and caregiver 'dyads.'" (key informant)*
- *"Build social networks to assist older adults: How do we harness and use talents and skills and make them more part of fabric of community?" (key informant)*
- *"Connect young and older people."* (key informant)
- **Support for households with children**
  - *"I see a lot of really young mothers with children and that might not have the same support at home, of family, that can help them with the children and they may need some guidance on just how to be a mother. And you know, understand nutrition for their kids, childcare, and medical care for their children."*
- **Raise awareness about and connecting to community supports/resources for support such as food, caregiving, and transportation**

**Based on internal and external key informants, focus groups, existing relationships and programs, and secondary data, actions addressing family and social support may include:**

- 1. Explore partnerships with community centers to provide follow-up with patients/clients. Neighborhood centers could serve as "triage centers" to help with lack of centralization/coordination of information and services. They address community needs in a holistic way including workforce development, food access, literacy training, and access to health and social benefits. Build their capacity to promote health in the community.**
- 2. Continue to participate in the South Philadelphia Aging Collective initiatives and form new partnerships that support aging in place in other neighborhoods.**
- 3. Explore the feasibility of creating partnerships with community centers, community development corporations (CDCs), and others to provide follow-up with patients/clients needing social services such as housing, food, and legal assistance.**
- 4. Develop a coordinated approach to raise awareness about resources and services available to assist agencies, organizations, and individuals with accessing resources to address individual and family unmet needs.**
- 5. Educate and train to support caregivers of children and older adults**

## ***Built and Natural Environment***

The public health community has become increasingly aware that the design of the built environment can have a major impact on the health of the public. For example, people living in communities with convenient, safe walking paths, bike lanes, bike racks, parks/playgrounds that are in good condition and access to healthy, affordable food sources may be more physically active and have healthier diets. Conversely, poorer health indicators may be expected among residents of communities with high crime rates, few parks or walking paths, numerous alcohol and tobacco outlets, and little access to fresh food. The powerful influence of the built environment on health suggests that public health practitioners should be involved in planning and policy decisions related to land use, zoning and community design. Health practitioners can serve an essential role in collaborating with other professionals and working alongside neighborhood residents to create and promote healthy communities. Health practitioners need to engage in actions that support: (1) assessing the health impact of land use and community design options before decisions are made as well as after improvements are implemented; and (2) policymaking on issues related to the built environment to ensure protection from toxins, access to healthy food outlets, places to walk and recreate, and other health promoting environments.<sup>63</sup>

European research suggests that people who live proximate to areas of greenery are 3 times more likely to engage in physical activity and 40% less likely to be overweight.<sup>64</sup> A 2012 study in Philadelphia conducted by researchers from the University of Pennsylvania found that greening vacant lots may affect health and safety.<sup>65</sup> The study focused on 4000 lots that were cleaned and greened from 1999-2008 by the Pennsylvania Horticulture Society as part of its Vacant Land Stabilization Program. Researchers found significantly lower levels of gun assaults, vandalism, and stress among residents, as well as significantly higher levels of physical activity among residents. Green space may also, according to the research, build social ties that are important for health.

Philadelphia is committed to productive land use and is making great strides towards this goal through new zoning code regulations that support urban agriculture as a land use category and systems to make procurement of vacant lots easier. The new code allows residents to have a say in how the city will be expanded as well as protected. The previous code did not adequately protect parks, gardens and playgrounds from being re-developed, creating loss of valued community resources. In addition, Philadelphia has multiple greening plans and projects that support greening and vibrant sustainable places. These efforts include the Pennsylvania Horticulture Society, the *Next Great City, Green Plan Philadelphia*, and *Philadelphia 2035* (comprehensive plan).<sup>66</sup> In response to Philadelphia 2035, 18 district plans are being created to address land use, planning focus areas and capital program recommendations. District Plans that have been completed within TJUHs CB area include South, Central and Lower North Philadelphia. These efforts and plans include:

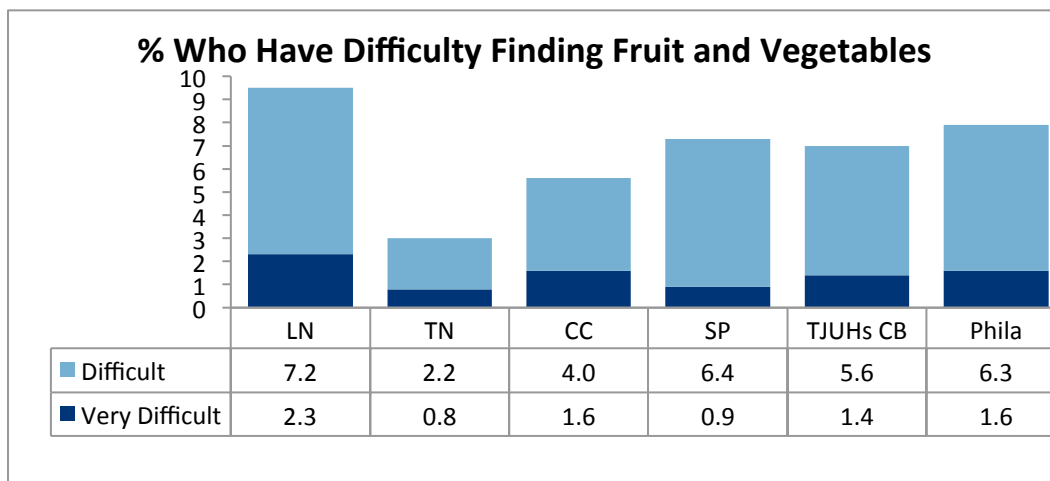
- Planting more trees (goal: 30% tree canopy in all neighborhoods)
- Providing new open space
- Providing new community open space
- Improving maintenance of park, recreation and other facilities
- Changing planning policies on new development

- Improving neighborhood communication and coordination
- Improving maintenance of vacant properties
- Improving lighting
- Improving appearance of transit stops and corridors
- Improving access to parks by transit
- Increasing access to fresh, local produce through urban agriculture and community gardens
- Increasing access to parks, recreation centers, and trails

Implementation of the Vacant Land Bank will make it easier for residents to:

- Repurpose vacant properties into yards, redeveloped buildings, or community gardens
- Create affordable homes
- Develop vacant land parcels
- Support open-space initiatives in neighborhoods with too much pavement and not enough green space
- Return properties to the tax rolls

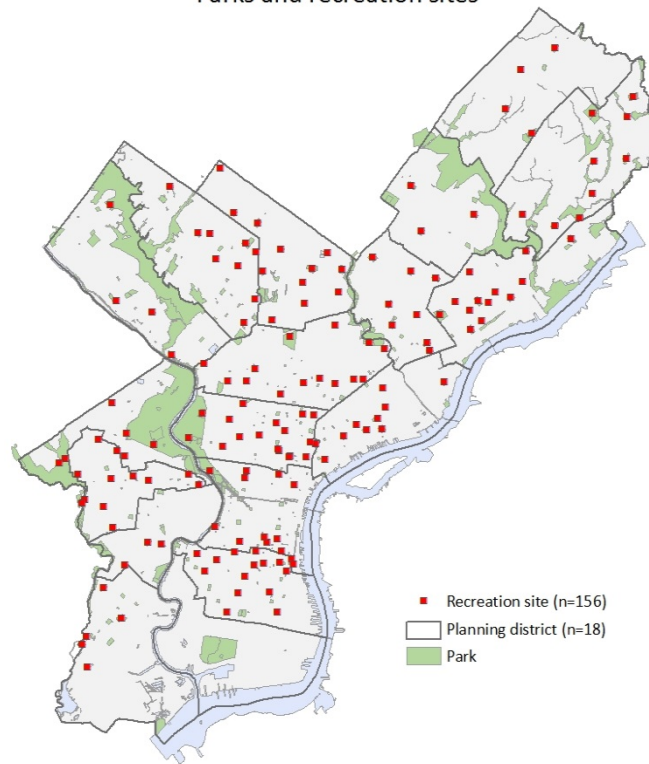
The availability of places to recreate and exercise and the availability of fresh produce can enhance healthy living in Philadelphia. Parks, recreation centers, schoolyards, and community gardens that are in good repair all help foster a sense of community, which leads to strong, safe neighborhoods.<sup>67</sup> The 2015 County Health Rankings includes a Food Environment Index that uses a rating of 0-10 based on factors that contribute to a healthy food environment. The range for this index for the 67 counties in Pennsylvania is 6.3 to 8.7 with a mean of 7.7 for all of Pennsylvania. Philadelphia received a rating of only 6.3 despite extraordinary efforts over the past decade. Even with the low index score, only 7% of respondents in TJUHs CB areas indicated it was difficult to find fruit and vegetables.



*PHMC Household Health Survey 2015*

Philadelphia scored 100%, above the U.S. top performers (92%) and Pennsylvania (85%) for access to exercise opportunities.<sup>68</sup>

### Parks and recreation sites

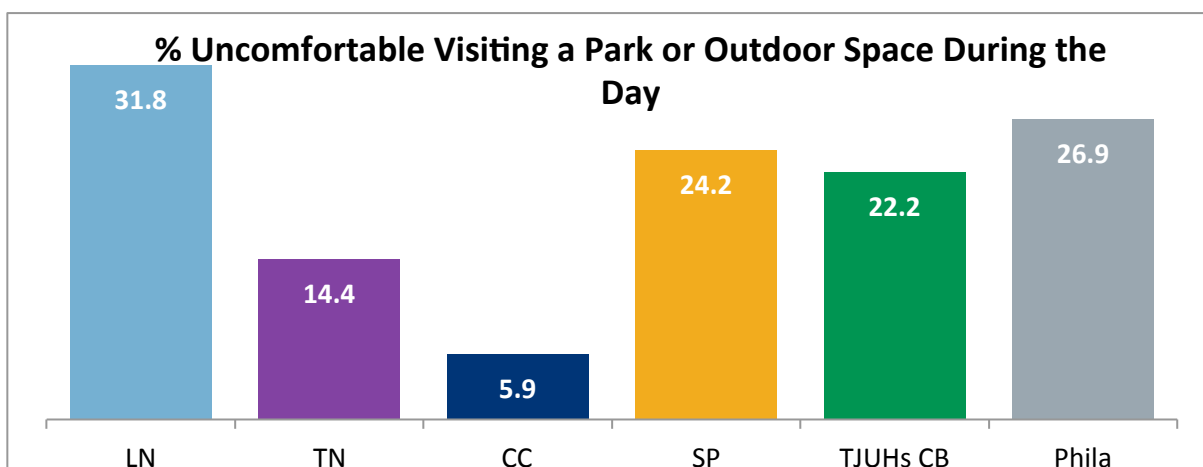


Source: Philadelphia Department of Parks & Recreation, 2015

While Philadelphia boasts 225 miles of bike lanes/trails, 63 neighborhood parks, and 52 recreation facilities, almost 60% of residents say they never or rarely (less than once monthly) use the public recreational facilities.

The parks are used by, cleaned and beautified by the City and community residents. Over the past few years existing Friends Groups and newly formed groups have provided the leadership to improve public parks throughout TJUHs CB area. These groups coordinate park clean-ups and activities that encourage park usage and build community. One park in South Philadelphia, Mifflin Square Park, has engaged its diverse immigrant and refugee community in maintaining the park and has been successful in reducing alcohol use in the park by working with police to increase foot patrols. Children who previously avoided the park because of safety concerns now regularly walk through the park on their way home from school. In South Philadelphia multiple gardens (such as the Teen Orchard Project, Growing Home Refugee Garden and Aida's Garden) have been established through the efforts of many community partners including but not limited to the Public Interest Public Law Center of Philadelphia, Federation of Neighborhood Centers, Pennsylvania Horticultural Society, United Communities, Urban Tree Connection, Southeast Philadelphia Coalition, Mural Arts program, and Nationalities Services Center. Despite all of these efforts, one in four residents in TJUHs CB area and Philadelphia say they are uncomfortable visiting a park or outdoor recreation space during the day.





PHMC Household Health Survey 2015

**Issues, challenges, unmet needs and priorities identified by key informants and focus group participants related to the built environment include:**

- **Perceptions of Community Parks**
  - *“I have a 4 and 5 year old so I’m always looking for things that are safe and affordable for my kids. So the park in my area, I believe there is a rec center attached to it, I don’t know if there’s much going on there. But the park is not safe or attractive.”* (focus group)
  - *“All the parks need to be redone and need security personnel; they are over-run by people doing drugs.”* (focus group)
  - *“They could do a lot with FDR Park, lots of space but it’s a mess, after it’s closed kids go there to do drugs, but there is free parking.”* (focus group)
  - *“Parks are filled with broken glass, drug bags, needles, need to be repaved, it’s dangerous.”* (focus group)
- **Vacant lot greening**
- **Commercial Corridors- improve cleanliness and perception of safety**

**Based on internal and external key informants, focus groups, existing relationships and programs, and secondary data, actions addressing the built environment may include:**

1. **Continue to support efforts to revitalize Mifflin Square Park and others**
2. **Support zoning changes that encourage vacant lot repurposing and long term “ownership”**
3. **Support vacant lot greening, urban gardening, and agriculture efforts**
4. **Continue to work with PACDC and its affiliates on efforts that address the built environment**

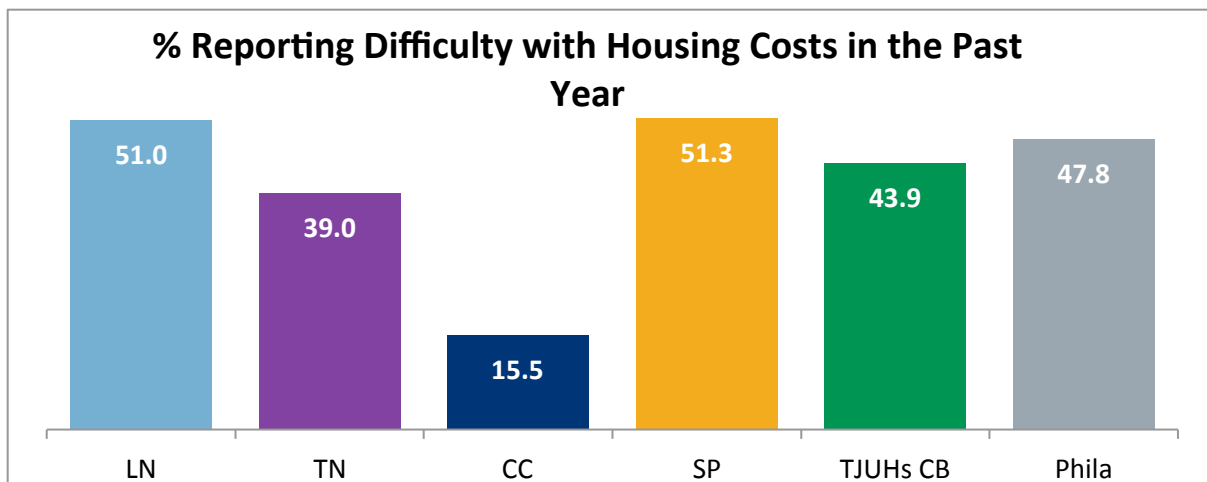
## ***Housing Quality and Instability***

*“Unsafe housing is a danger to the health of millions of people across the United States. Minorities and lower income families have significantly higher odds of living in inadequate housing. And they pay a steep price in their own health.”<sup>69</sup>*

Stable, affordable housing is essential to the health of individuals, families, and communities. Poor quality housing that exposes occupants to mold, pests, and/or chemical toxins is harmful to human health, exacerbating conditions such as asthma and lead poisoning. Lack of affordable housing and housing insecurity have also been found to be detrimental to the mental health of people living in low to moderate income households, for particularly children and adolescents.<sup>70</sup>

Housing affordability allows families and individuals to spend money on other life necessities, such as health care and nutritious food, and supports emotional and mental health by reducing stress related to housing concerns.<sup>71</sup> Housing insecurity can result in overcrowded conditions due to shared housing, having to move to lower quality housing that may have rodents, mold, and/or structural problems, disrupted social networks, and ultimately homelessness. The health effects of becoming homeless are well known and include chronic disease, infectious disease, hunger, injuries, stress, violence, disruption of medical and mental health care, and malnutrition.<sup>72,73,74</sup> Disruption of social networks has also been shown to negatively impact physical and mental health well-being.<sup>75</sup>

Housing contributes to health disparities. Families with fewer financial resources are more likely to experience unhealthy and unsafe housing conditions and be unlikely to be able to resolve them. Housing is considered “affordable” if a family spends less than 30 percent of its income to rent or buy a residence. An estimated 17 million households in the United States pay more than 50 percent of their incomes for housing.<sup>76</sup> The 2015 PHMC Household Health Survey revealed almost half of Philadelphia residents reported difficulty with housing costs in the past year.



*PHMC Household Health Survey 2015*

According to The City of Philadelphia Office of Community Housing Development - Year 4 Consolidation Plan (2015), 53% of renters and 33% of homeowners spend more than 30% of

their income on housing. Nearly a third of renters (31%) and 15% of homeowners have monthly housing payments that exceed 50% of their monthly income. In Philadelphia, 56% of families are considered housing insecure. These families experience homelessness (1%), frequent moves (5%), are behind in rent (26%), and live in crowded situations (25%).<sup>77</sup> Philadelphia has a higher severe housing problem rate (25%) compared to Pennsylvania 15% and top performers in the U.S. (9%).<sup>68</sup>

The Philadelphia Housing Authority (PHA) provides residences for 33,959 families through public housing. Between 2010 and 2014 the waiting list for public housing grew by more than 29,000 households, a 61% increase. For each unit managed by PHA, there are 2.3 households waiting for housing.<sup>32</sup> According to PHA, 80,000 low income individuals are housed by the Authority in 59 developments. There are 87,000 individuals currently on the waiting list. It can take up to 8 years to obtain housing. The average household income for PHA residents is \$12,700. The unemployment rate in the 59 housing developments is 69%.

Families and individuals that lack affordable housing will face difficult decisions about paying for rent, utilities, food, healthcare and medications. The fields of housing, health, planning and preservation can create and partner on initiatives that preserve and lead to more affordable housing and improved health, safety and quality of life for residents. At the same time, these efforts can reduce the use of unnecessary health services resulting in health care cost savings. For example, a 2013-2014 pilot study conducted at St. Christopher Children's Hospital found that removing asthma triggers in a home (\$3,500 average cost) improved the family's health within 6 months and resulted in a 400% decrease in repeat hospitalization/emergency room visits, and a 53% reduction in missed school days.<sup>78</sup>

The Healthy Rowhouse Project in Philadelphia, funded by the Oak Foundation, is a coalition representing the fields of health, housing, planning, and preservation professionals dedicated to improving substandard conditions in rowhouses owned and/or occupied by lower income residents with particular emphasis on housing for seniors and children. Built prior to World War II, Philadelphia rowhouses make up 70% of all housing units in Philadelphia and provide a unique opportunity for low and moderate income individuals to afford housing. Seventy-eight percent of adults over age 60 in Philadelphia own their homes. However, much of this housing is deteriorating and repairs by owners can be difficult to afford. Preserving and repairing rowhouses is less expensive than building new affordable housing. Ten to twenty homes can be repaired compared to the cost of building one new affordable housing unit (assumes \$15,000-\$30,000 repairs vs. \$300,000 to build a new row home). Repairing occupied houses can improve health, reduce injuries, preserve neighborhoods and prevent homeowners from being displaced or losing their homes. Other potential partnerships between healthcare and low income public housing include co-located health services that support patient health care coordination and navigation including on-site community health workers, case managers and health education programs. Finally medical legal partnerships can help low income renters and homeowners address landlord issues that affect health such as eviction, fixing leaky roofs, mold and lead remediation, and extermination of bed bugs. According to interviews conducted with geriatric case managers, bed bugs can limit seniors' access to senior transportation services impacting their ability to get to health care services.

**Issues, challenges, unmet needs and priorities identified by key informants and focus group participants related to housing quality and instability include:**

- **Housing for the disabled**
  - Adaptive modification housing program has funding but is oversubscribed
  - Lack of housing for the disabled: “There isn’t enough housing stock and the PHA stock available that is accessible is not 'held' for people with disability.” (key informant)
- **Health status among low income housing residents**
  - High percentages of residents have chronic diseases such as diabetes, asthma, cardiovascular disease, etc.
  - High asthma rates among children – “*There is a need for remediation of housing to reduce asthma triggers and lead exposure.*” (key informant)
  - Need chronic disease management services and education
  - People cannot afford transportation to and from doctor
  - “*Most residents won’t go to hospital until they have an acute need - asthma attack.*” (key informant)
- **Need convenient health services**
  - “*Health Services must be place-based.*”(key informants)
  - No pharmacies within walking distance (Sharswood-Blumberg area)
  - Interested in Urgicare located in neighborhood
  - Co-locate health services into elderly and family low income housing complexes
  - “*PHA doesn’t have the resources to provide health for 80,000 residents; therefore, where can health services be leveraged?*” (key informant)
- **Impact of gentrification** – “*Point Breeze is booming with development but gentrification creates issues for residents. Residents are getting "priced out" of the neighborhood. The cost of living is going up due to high housing prices. Renters are getting priced out. Poor people can't live there because rents are too high. The concerns for low income people are rent increases, tax increases, and it becomes too expensive to maintain their houses given fixed incomes and rising cost of living in the neighborhood.*” (key informant)
- **Affordable Housing:**
  - “*Affordable housing up to code is sparse- multiple L+I violations. There is a shortage of housing for low income and disabled. Housing costs are more than 30% of their income. Utility costs are higher because of housing disrepair. You can use utilities or have food - “heat or eat” phenomena.*” (key informant)
  - “*Housing is overcrowded and needs to be repaired. Multiple families may be living in one residence. A family may be staying in one bedroom – mom, dad, and the kids. Mold, leaky roof, etc., but it’s still better than being on the streets. People stay (in poor housing) since they can’t afford other housing and for stay for social support.*” (key informant)
  - “*Older housing is in disrepair. Older adults and those on fixed income can’t maintain them. This results in increased risk of falls particularly among the elderly.*” (key informant)
  - “*Affordable housing isn’t easy to access- issue for young families and the working poor - it's easier to get for elderly. You can get access to the shelter*”

*system but some don't want to do that. We need more affordable housing.” (key informant)*

- *“PHA waiting list too long for 65+ - more housing is needed... You need to work your way through shelter systems first to get housing.” (key informant)*

**Based on internal and external key informants, focus groups, existing relationships and programs, and secondary data, actions addressing housing quality and instability may include:**

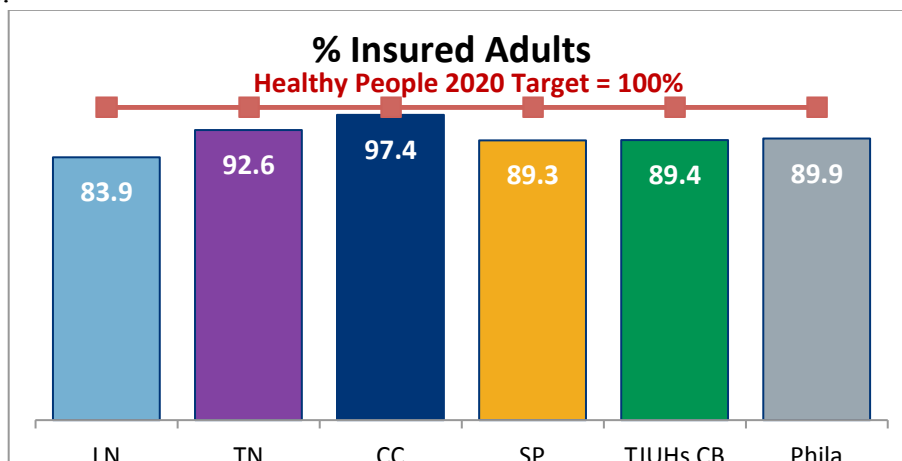
- 1. Continue to work with Philadelphia Association of Community Development Corporations (PACDC) and its affiliates on efforts that address the built environment**
- 2. Co-locate health and social services in or near low-income housing**
- 3. Assess housing stability as part of the social determinants section of the electronic health record**
- 4. Continue to participate in the Healthy Rowhouse Initiative**
- 5. Consider training community health workers, case workers students, and community organizations to conduct safe housing assessments**
- 6. Explore examples of housing interventions by health systems**

## Health Care Access

Health care access is determined by multiple factors including health insurance, transportation, language and literacy, and cultural competency.

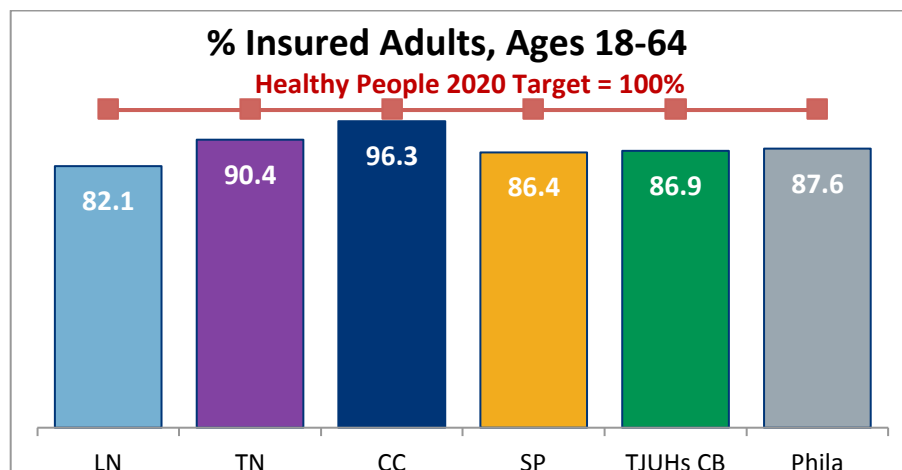
### *Health Insurance*

Under the Affordable Care Act millions of Americans became eligible for new coverage opportunities in 2014. As of September 2015, 17.6 million Americans gained coverage in large part to the Affordable Care Act and 10.5 million more are uninsured but eligible for Marketplace coverage. The Healthy People 2020 goal is for everyone in the United States to have health insurance. In Philadelphia the percentage of uninsured adults decreased to 10% in 2014 from 15% in 2012.



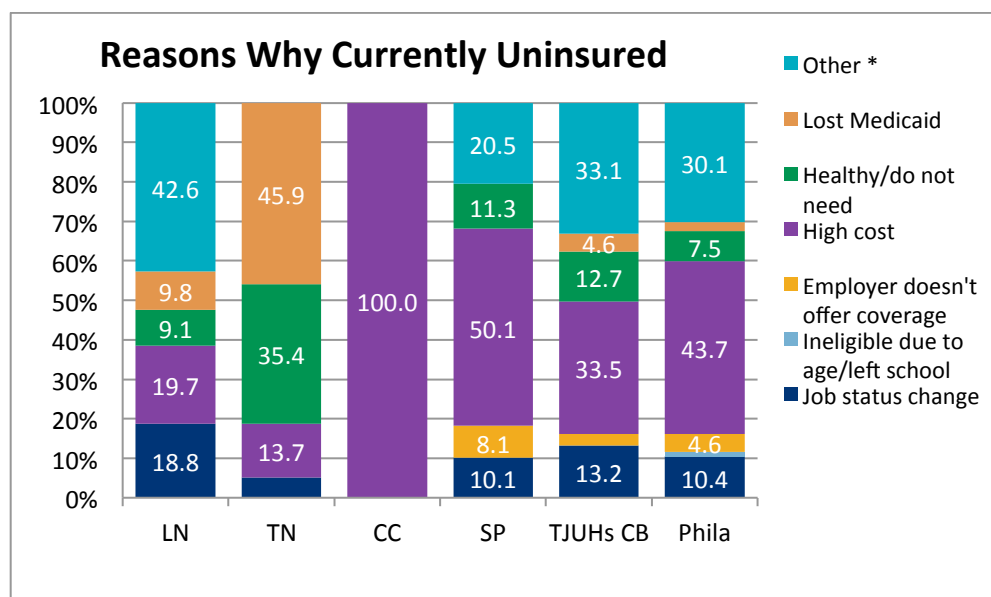
*PHMC Household Health Survey 2015*

Among adults aged 18-64 in Philadelphia, 13.1% lack health insurance, an improvement of 7% compared to rates in 2012. The percent of adults aged 18-64 without insurance ranges from 3.7% in Center City (up 1 percentage point from 2012) to 17.9% in Lower North Philadelphia (up percentage points from 2012). However, the uninsured rates exceed 23% in zip codes 19122 (Lower North Philadelphia) and 19146 (South Philadelphia).



*PHMC Household Health Survey 2015*

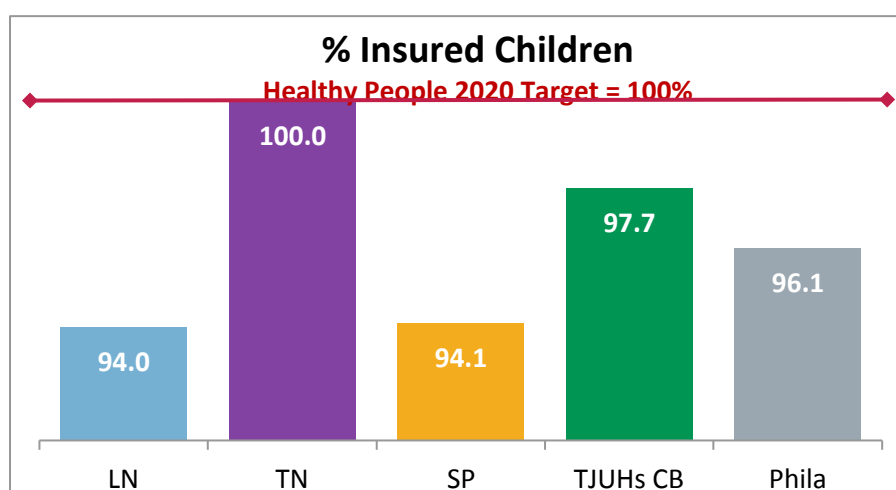
Cost and employers not offering coverage were the most frequent reasons given for not having insurance; however, being healthy was also seen as a major reason for not having health insurance.



\* Other includes insurance company refused coverage; objections to ACA; difficulties using healthcare.gov; death or divorce

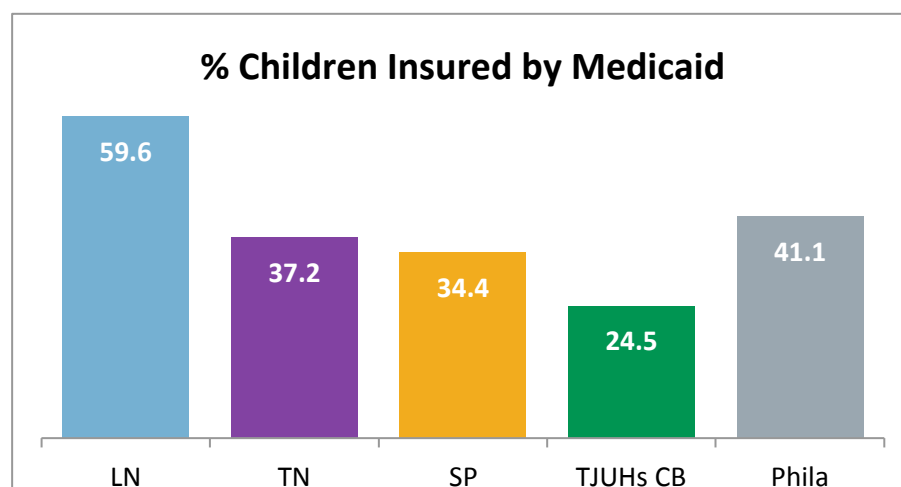
PHMC Household Health Survey 2015

The rate of uninsured children in Philadelphia (3.9 %) has decreased slightly since 2012 (4.6%). In TJUHs CB area 2.3% of children lack health insurance. Survey respondents reported that all children in Transitional Neighborhoods have health insurance compared to 94% in Lower North and South Philadelphia Neighborhoods.



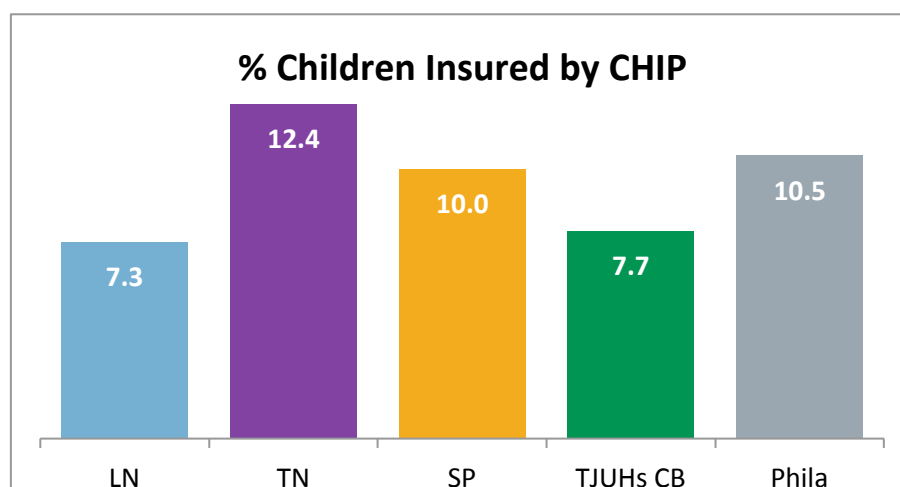
PHMC Household Health Survey 2015

Almost 60% of children in Lower North Philadelphia are insured through Medicaid.



*PHMC Household Health Survey 2015*

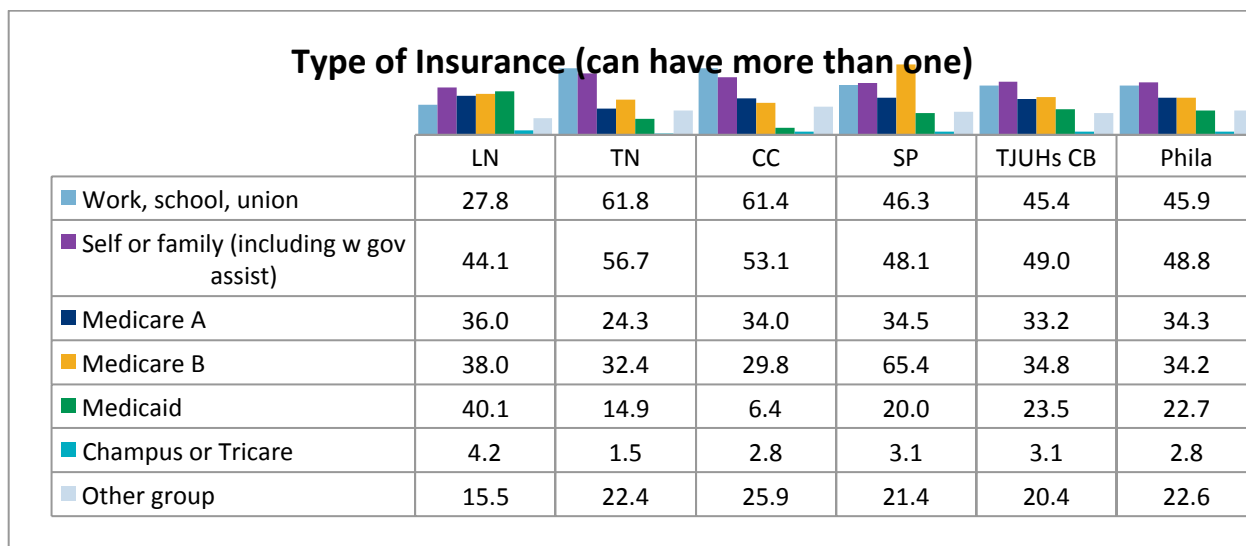
CHIP insures 7 to 12% of children in TJUHs CB areas.



*PHMC Household Health Survey 2015*

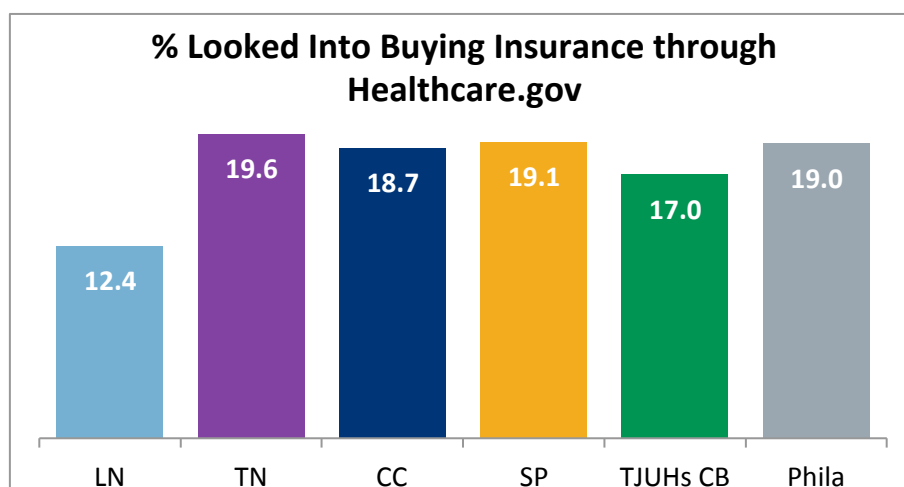
Philadelphians are heavily dependent on employer, self or family insurance, and government programs for health care insurance. According to PHMC Household Health Survey for 2015, 46% of adults in Philadelphia are insured through employment or unions, 34% have Medicare, and 23% have Medicaid. Adults in TJUHs CB area are slightly more likely to be insured by Medicaid, particularly those living in Lower North Philadelphia (40%). Adults in Center City (53%) and the Transitional Neighborhoods (57%) are more likely to be self-insured or have insurance through a family member.





*PHMC Household Health Survey 2015*

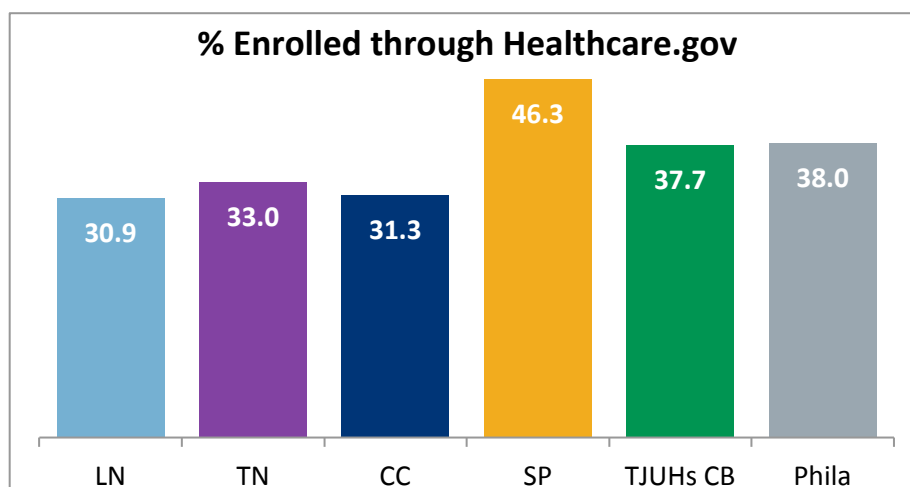
Almost one in five people in Philadelphia enrolled for health insurance through Healthcare.gov. Fewer people in Lower North Philadelphia looked into buying health insurance through the government exchange although they are the least likely in TJUHs CB area to be insured.



*PHMC Household Health Survey 2015*

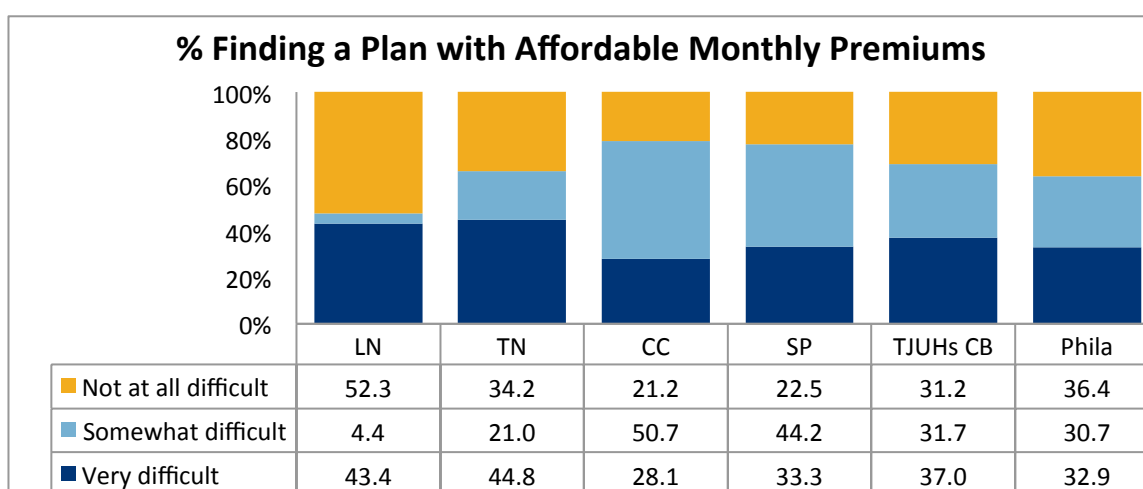
Recent research found that nearly half of the uninsured lack confidence in choosing a health insurance plan.<sup>79</sup> For those who are not familiar with health insurance, have limited English literacy, or are living with disabilities, navigators play an important role in ensuring that people understand the health coverage options available to them. This is particularly evident in South Philadelphia where English is a second language for a large population. As part of the Get Covered America initiative, TJUH in partnership with Enroll America, sponsored open enrollment activities at Methodist Hospital in South Philadelphia in 2014 and 2015 to support people applying for coverage. In addition, a coalition facilitated by SEAMAAC led efforts to assist individuals in South Philadelphia for whom English is not their primary language. The successes of these efforts are reflected in the high Healthcare.gov enrollment rates in South

Philadelphia (46.4%) compared to Philadelphia and the rest of TJUHs CB area. Even with increased enrollment, there is much work to be done: focus group and key informant interviews underscored the need for community education about how to use health insurance appropriately and have documented that newly insured individuals are getting into financial problems resulting from missteps in using their health insurance.



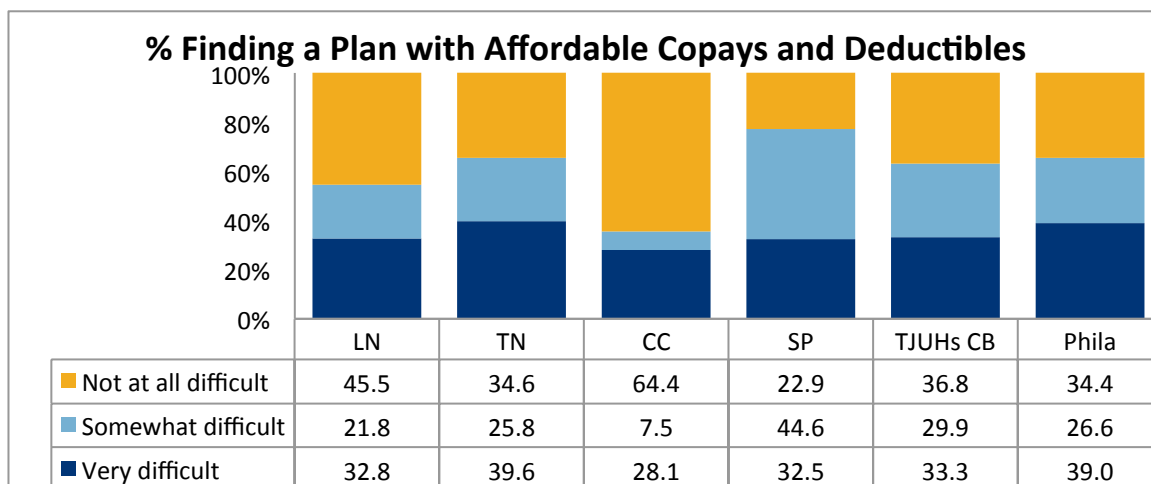
*PHMC Household Health Survey 2015*

Affordability of health insurance premiums, co-pays, and deductibles is a concern for the majority of residents in TJUHs CB areas with more than 60% of residents in TJUHs CB neighborhoods reporting somewhat or great difficulty affording co-pays, deductibles, and monthly premiums. Almost 80% of Center City and South Philadelphia residents report that it was somewhat or very difficult to find a plan with affordable monthly premiums.



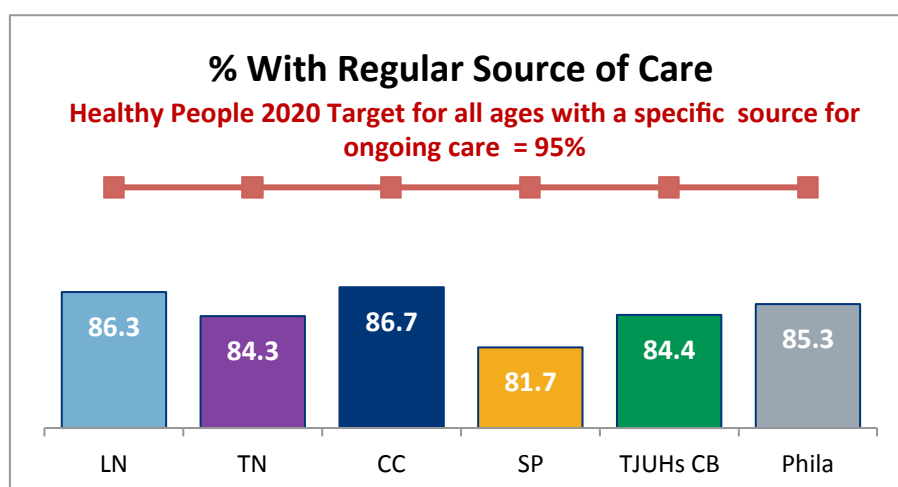
*PHMC Household Health Survey 2015*

However, only 35% of Center City residents indicated that it was somewhat difficult or very difficult to afford co-pays and deductibles compared to almost 80% of residents in South Philadelphia.



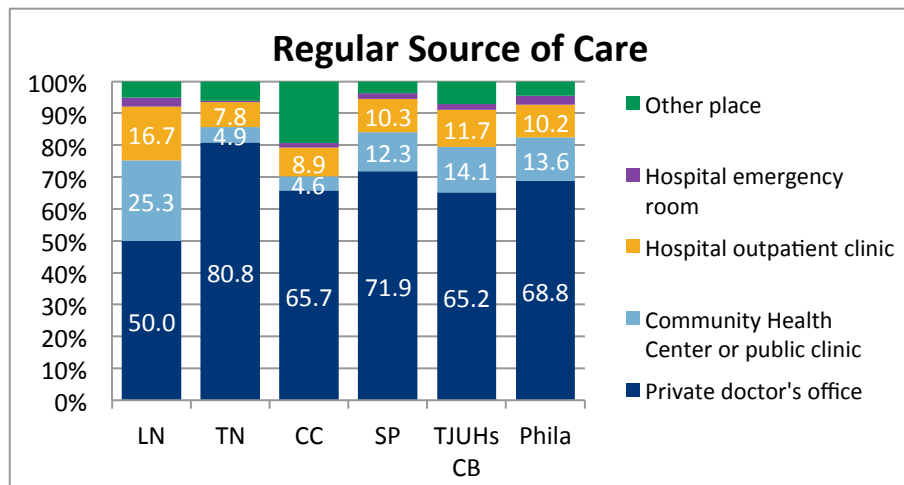
PHMC Household Health Survey 2015

Most residents in TJUHs CB area and Philadelphia have a regular source of care (more than 80%); however, this is well below the Healthy People 2020 goal of 95%.



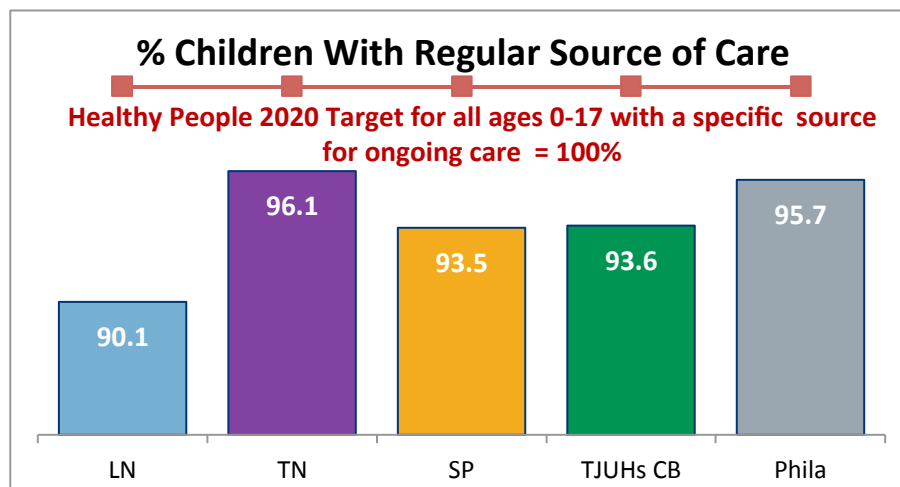
PHMC Household Health Survey 2015

Residents living in the Transitional Neighborhoods are most likely to see a private physician for care. Lower North residents are almost twice as likely to use community health centers or public clinics and hospital outpatient clinics for their primary care compared to other Philadelphians.



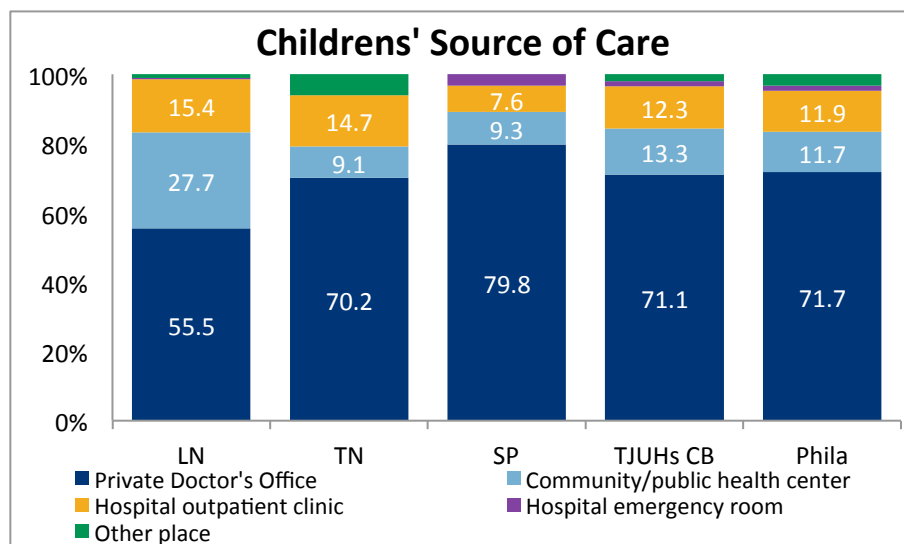
PHMC Household Health Survey 2015

Although almost all children in Philadelphia have a regular source of care, the Healthy People 2020 goal of 100% has not been reached. Children in TJUHs CB areas are less likely than children in Philadelphia to have a regular source of care (93.6% vs. 95.7%). Children living in Lower North Philadelphia are the less likely than other children in TJUHs CB area to have a regular source of care (90.1%).



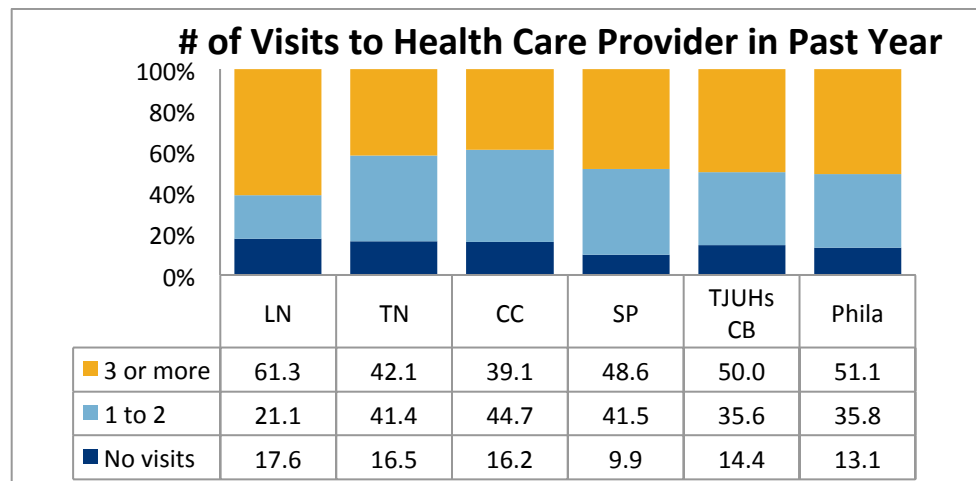
PHMC Household Health Survey 2015

With the exception of Lower North Philadelphia, children in TJUHs CB area are most likely more likely to receive care at a private doctor's office. Children living in Lower North are more likely to receive care at community health centers (27.7%) and hospital outpatient clinics (15.4%) than are children in Philadelphia.



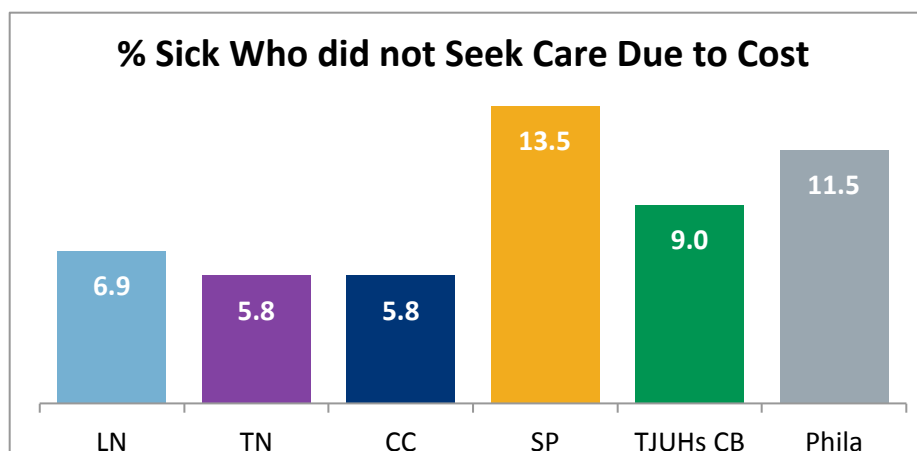
PHMC Household Health Survey 2015

Despite high regular source of care rates, 14.4% of residents in TJUHs CB area did not see a healthcare provider in the past year. On the other hand, half of the individuals living in TJUHs CB and in Philadelphia saw a health care provider 3 or more times in the past year. South Philadelphia residents in zip codes 19146 and 19148 were more likely to see a health care provider in the past year (82% and 93% respectively) than they were in 2012 (71% and 74% respectively). This may reflect successful efforts to increase health insurance coverage in South Philadelphia.



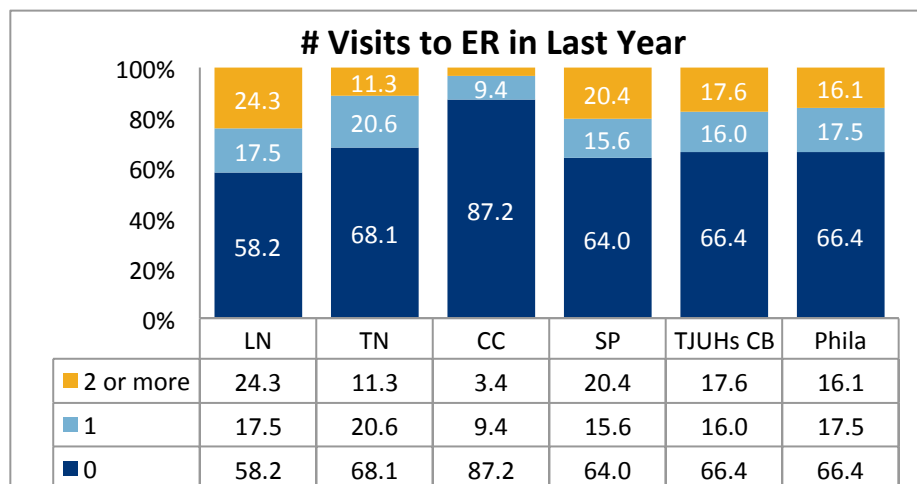
PHMC Household Health Survey 2015

Residents from South Philadelphia were more likely than others in Philadelphia and TJUHs CB area to forego getting care when they were sick due to cost.



*PHMC Household Health Survey 2015*

Almost 42% of adults in the Lower North neighborhood had one or more visits to the emergency department in the past year, compared to only 13% of Center City residents and 34% of Philadelphians overall. People living in South Philadelphia also reported higher emergency department visits with 20% having 2 or more visits in the past year.



*PHMC Household Health Survey 2015*

According to 2013 and 2014 data from Jefferson and Methodist Hospital emergency departments (ED), there were 160,588 total visits to the ED. Sixty percent of these visits 96,736 were from residents living in TJUH's CB area. The majority of ED visits from TJUH's CB area were from South Philadelphia (72.13%). Overall, 42.5% of the ED visits made by residents within TJUH's CB area were rated a 4 or 5 on the acuity scale that is used in the emergency department. Acuity scores of 4 or 5 are sometimes considered non-emergent or ambulatory care sensitive conditions and preventable through primary care. People using TJUHs ED from outside of TJUHs CB area are statistically more likely to have an acuity score of 1 or 2 ( $p < .0001$ ). Those using ED services from within TJUHs CB area are statistically more likely to have an acuity score of 4 or 5 ( $p < .0001$ ).

On average, individuals using TJUHs emergency departments had 1.7 visits over the two year period. High ED utilization for the 2013 and 2014 timeframe is defined as an individual patient who had 6 or more visits. Overall, there were 2,684 patients (1.9% of all patients) who are considered high utilizers. High utilizers are more likely to be between 25 and 54 years old (61.8%), insured by Medicaid (57.3%), and living in South Philadelphia (76%). In the TJUHs CB area, 1,846 individual patients (2.9% of TJUHs CB area residents) are considered high utilizers for the two year timeframe. The chart below displays the number of high utilizers by zip code:

<b>Zip Code/ TJUHs CB Area</b>	<b># High Utilizers within Zip Code</b>
19102	3
19103	28
19106	11
19107	127
<b>Center City</b>	<b>169</b>
19123	26
19125	13
19130	13
<b>Transitional Neighborhood</b>	<b>52</b>
19121	91
19122	33
19132	75
19133	30
<b>Lower North Philadelphia</b>	<b>229</b>
19145	531
19146	272
19147	100
19148	493
<b>South Philadelphia</b>	<b>1,396</b>

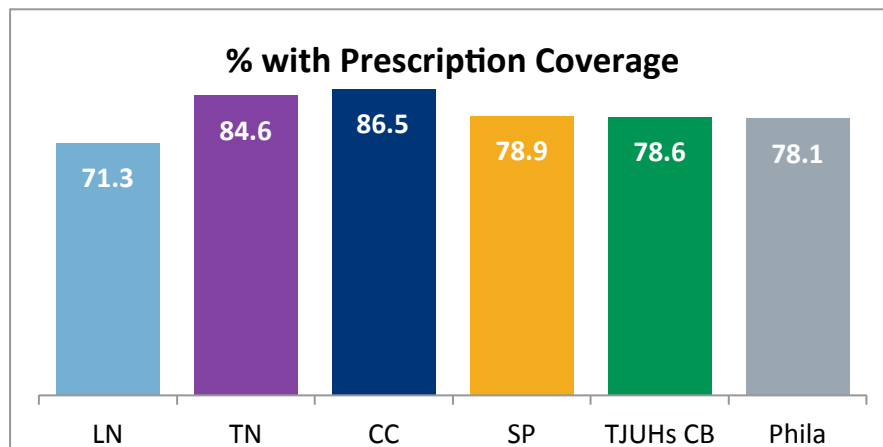
The following chart lists the most frequent reasons residents from TJUHs CB area came to TJUH or Methodist's emergency department. These diagnoses represent 50% of all ED visits by people living in the TJUHs CB area. Many of these visits, such as viral infections, ear infections, headaches, and asthma could have been seen in a primary care setting.

<b>Most Frequent Emergency Department Visit Diagnoses in TJUHs Community Benefit Area: TJUH and Methodist Combined: 2013 and 2014</b>			
<b>Diagnosis</b>	<b>Frequency</b>	<b>Diagnosis</b>	<b>Frequency</b>
Sprain	6,806	Fractured leg	977
Abdominal pain	4,588	Pregnancy complication	902
Superficial injury	4,549	Chronic obstructive pulmonary disease	858
Chest pain	4,139	Viral infection	822
Back problem	3,576	Other GI diagnosis	817
Skin infection	3,552	Epilepsy/copy number variants	776

**Most Frequent Emergency Department Visit Diagnoses in TJUHs Community Benefit Area: TJUH and Methodist Combined: 2013 and 2014**

<b>Diagnosis</b>	<b>Frequency</b>	<b>Diagnosis</b>	<b>Frequency</b>
Upper respiratory infection	2,960	Unclassified	771
Joint disease	2,874	Hypertension	767
Open wound extremity	2,818	Gastroenterology	737
Urinary tract infection	2,626	Other upper respiratory	733
Other injury	2,622	Urinary stone	728
Headache/migraine	2,421	Pelvic inflammatory disease	717
Other connective tissue	2,101	Other GU diagnosis	705
Other lower respiratory	1,977	Nausea/vomiting	699
Social administration	1,930	Bronchitis	679
Open wound head	1,852	Hemorrhage pregnancy	625
Asthma	1,709	Other ear diagnosis	615
Fractured arm	1,656	Dysrhythmia	612
Teeth diagnosis	1,596	Fever of unknown origin	608
Allergy	1,450	Syncope	582
Other aftercare	1,376	Otitis media	552
Other nervous diagnosis	1,061	Pneumonia	551
Alcohol-related disorders	1,030	Eye infection	547
Other skin diagnosis	1,021	Anxiety disorder	506
Dizziness	1,019	Substance related disorders	503

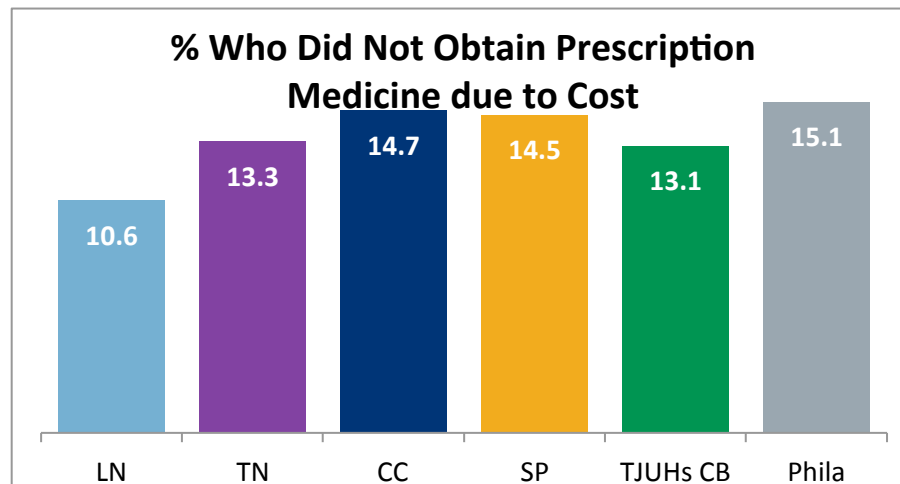
The majority of people in Philadelphia have prescription coverage (78.1%). On average, one in five residents in TJUHs CB area lack prescription insurance; almost one third of North Philadelphia residents lack prescription coverage.



*PHMC Household Health Survey 2015*

People living in Center City and South Philadelphia were slightly more likely not to have filled a prescription due to cost (14.7% and 14.5% respectively) than residents of other TJUHs CB areas; however, this rate is similar to Philadelphia as a whole.





PHMC Household Health Survey 2015

**Issues, challenges, unmet needs and priorities identified by key informants and focus group participants related to health insurance and access to care include:**

- **Focus group and key informant interviews have underscored the need for community education about how to use health insurance appropriately and have documented that newly insured individuals are getting into financial problems resulting from missteps in using their health insurance.**
  - *“Health Insurance navigation - need help with understanding their insurance. What is covered?; What is not by their insurance?; What do terms mean; Who can help guide this?; Can someone in doctor's office do this?; What hospitals and specific providers are in plan; What medications?”* (key informant)
  - Using ED for primary care – *“They don’t realize they have to pay.”* (key informant)
  - Refugees and immigrants have difficulty navigating healthcare, understanding insurance, and obtaining healthcare because of lack of understanding of the U.S. healthcare system and language issues
  - *“Need financial person to work with patients to help them understand how (in what order) to pay bills – get financial help.”* (key informant)
  - *“Some plans I find hard to find in network. I had Blue Cross and they just tell us to find in network providers but their online page wasn’t very helpful. I don’t know where they get their numbers from; you dial a 1-800 number and get a lot of inconsistency. A lot of HMOs now require you to be in-network but a lot of people don’t know what that means. Can’t I just have a list and pick where to go? But it’s not that easy even then, even if you know the right number to call and the right person to ask.”* (focus group)
  - Health insurance plans vary in their coverage for mental health which is confusing for patients and providers

- Health insurance plans vary in services that are covered and have regulations that require multiple or separate visits for care that could be provided in a single visit. This creates barriers for low income patients who cannot take time off from work.
- Medicare doesn't cover contraception- *"Therefore, younger women who are disabled (behavioral/mental or physical) and on Medicare and want contraception can't get it."* (key informant)
- *"Community needs better knowledge base about insurance, deductibles, co-pays, paying bills, etc."* (key informant)
- **Emergency Department** utilization for primary care/ ambulatory care services
  - Employment: *"Patients work and can't take time off or they will lose their job"* (key informant)
  - Child care issues – *"Need to wait for someone to get home in the evening to watch children. Therefore they use the ED since primary care is not always available in the evening or on weekends."* (key informant)
  - Timely test results – *"A patient could use outpatient healthcare, but the ED is faster in terms of getting results and treatments –crosses all socioeconomic lines. To address this we need to address healthcare systems. We need a system that gets patients testing results in a more timely way - not waiting two weeks. People are "scared" and want test results so they know whether or not they need to be scared. We aren't set up to do this. Urgicare works for some. May not know where it is; however, doesn't offer comprehensive testing that is available in the ED."* (key informant)
  - *"Evening/weekend hours not available in primary care."* (key informant)
  - Access to social services, benefits and community resources – *"The emergency department has a social worker who is available 10-12 hours daily who can help address social service and health needs and link to resources. However, in "off hours" ED is not sure what to do or how to handle these needs."* (key informant)
  - *"Some say they can't afford to pay the co-pays, and they'll end up in the emergency room because they can't afford anything else."* (focus group)
  - Childcare in the Emergency Department: *"It happens all the time in the ER, where a woman comes in, she's sick, and has a child with her. She needs to have a test done, and can't because there is nobody to watch the child. I've volunteered to stay with the child, but we're not allowed to because it's a liability issue to leave their child with us. Because if something would happen, it would be our responsibility. So, how are we going to get this woman to get an MRI when she's got a 2 year old with her? Who's going to watch a 2 year old while she's getting an MRI?"* (focus group)
- **Continuity of care**
  - *"A fair number of people who are uninsured have poor access to preventive care. By the time they come in they have life threatening conditions. After hospital discharge there is no PCP they can report to except city health center."* (key informant)
  - Partner with the Health Department. *"We need to create a better partnership with city health centers and FQHCs. We can't schedule appointments for them- there isn't a doctor we can sign off to. So just discharged patients show up and stand in line. These are high-risk patients. They keep coming back. We need to*

*have a different approach. Maybe we could prioritize them to clinic doctor to be seen.” (key informant)*

- *“Follow-up care is needed for patients who don’t warrant admission but are just on the edge of being too sick to go home. We need a way to follow-up with them so they aren’t readmitted. Need community based services to assist with follow-up such as free clinics, FQHCs, and physician assistant visits.” (key informant)*

**Based on internal and external key informants, focus groups, existing relationships and programs, and secondary data, actions addressing health insurance and access to care may include:**

- 1. Provide health insurance education and counseling**
- 2. Need a 24 hour call line where patients can call and talk with someone (nurse or nurse practitioner) and have their questions addressed (even after they leave the ED)**
- 3. Create a more effective care coordination system between ED’s, hospitals, primary care, FQHCs and City Health Centers**
- 4. Continue to support Enroll America’s activities at community sites**
- 5. Advocate for a more coordinated system of mental health coverage**
- 6. Continue to review collaborative relationship with the Unity Clinic**
- 7. Expand primary evening and weekend hours**
- 8. Educate community around PDPH project to limit co-pays for hypertensive medications**
- 9. Continue to work with the PDPH Community Health Improvement Plan – access to care committee**

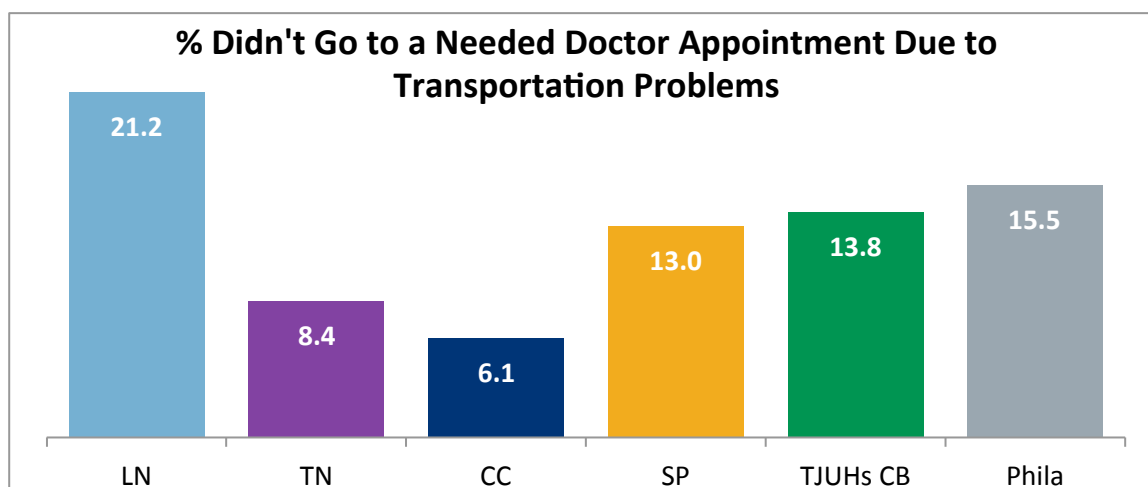
### ***Transportation***

The Transportation and Health Tool (THT) was developed by the U.S. Department of Transportation and the Centers for Disease Control and Prevention to provide easy access to data that practitioners can use to examine the health impacts of transportation systems. The tool provides data on a set of transportation and public health indicators for each U.S. state and metropolitan area that describe how the transportation environment affects safety, active transportation, air quality, and connectivity to destinations. The tool provides information and resources to help agencies better understand the links between transportation and health and to identify strategies to improve public health through transportation planning and policy. It also presents state or metropolitan area comparisons of key transportation and health issues.<sup>80</sup>

Philadelphia compares well to other metropolitan areas, with several metrics achieving top or high performance scores:

Transit commuting – 100<sup>th</sup> percentile  
Automobile commuting – 97<sup>th</sup> percentile  
Walking commuting – 79<sup>th</sup> percentile  
Bike commuting – 60<sup>th</sup> percentile

For most people in Philadelphia public transportation is the predominant method of travel to work and throughout Philadelphia. Thirty-five percent of Philadelphians do not own a car and among adults aged 60 and over, 55% do not own a car. Transportation challenges resulted in 13.8% of people in TJUHs CB area cancelling a doctor appointment due to a transportation problem compared to 15.5% in Philadelphia. More than one in five people in Lower North Philadelphia reported that transportation problems resulted in cancelling a doctor appointment. Transportation costs and convenience were identified by key informant interviews and focus groups as barriers to seeking health care.



PHMC Household Health Survey 2015

In Philadelphia County, the Medical Assistance Transportation Program (MATP) is run by LogistiCare Solutions. LogistiCare manages non-emergency medical transportation benefits for the medically fragile, disabled, and under-served and elderly enrolled in Medicaid and Medicare portions of managed care organizations. For persons receiving Medical Assistance all medical rides must be arranged through the Department of Public Welfare's Medical Assistance Transportation Program. Rides can be reserved 30 days in advance but must be made at least three days in advance. Through this program, clients receive tokens for SEPTA in order to go to medical appointments, or if unable to take public transportation, van service is available.

**Issues, challenges, unmet needs and priorities identified by key informants and focus group participants related to health care access and transportation include:**

- **Cost of transportation** for parking or public transportation
  - *“People don't come even if the diabetes class is free because of transportation costs.” (key informant)*
  - *“Co-pays can be as much as \$50 per visit depending on insurance type and have been rising. Between transportation, copays, and other costs a single visit could be as much as \$100 out of pocket” (key informant)*
  - *“I think most patients have a hard time getting to use health services because they don't have the transportation, or a car to help them get back and forth and I*

*know some insurance they'll help you with taxi vouchers, but that's only for patients with taxi vouchers and not for patients without."* (key informant)

- **Transportation challenges**

- Customized Community Transport (CCT) is SEPTA's elderly paratransit
  - *"The majority of time it works really well but need to know how to access (fill out form etc.)."*
  - Complaints that CCT transportation has long waiting times for van - (4-6 hours not uncommon)
  - CCT tough to work with- paperwork often an issue. Difficult for families to complete application and work with CCT.
  - Drivers not trained to recognize cognition or memory issues. *"They will drop rider off and leave them not checking to see if they are safe (to stay on schedule). Frail elderly may be left out in cold if needed paperwork was not completed."* (Focus group)
  - People who use CTC are always late to appointments and picked up late. *"I leave at 6:30 and my patient is still in the waiting room waiting for CTC."*
  - Sometimes patients may be on the bus for 2 hours or more
- Bus and train transportation
  - City looking at areas to install bus shelters and benches
  - *"Bus routes to Center City are not convenient, particularly after hours, and can require multiple transfers and long walks to bus stops which can be problematic for the elderly and ill."* (key informant)
  - Fear of falling prevents seniors from taking public transportation
    - Support citywide "give up your seat for elderly campaign"
    - Increase awareness about safer ride times to ride SEPTA (e.g. 10 am to 2 pm is safe ride time)
    - SEPTA –is there training for staff of awareness for elderly issues?
    - Train SEPTA and CCT drivers on needs of elderly (ramps, canes, cognitive impairment, mental health issues) *"Public transportation does not work for the elderly for those using walker/cane; can't walk that far, can't stand at the bus stop to wait, and can't get up the steps"* (focus group)
    - Need better transportation system for disabled. We should offer transportation assistance for patients like they do for cancer
- *"Jefferson used to have a van to transport elderly to hospital but now there is a 'regulation' that prohibits bringing people to the hospital ('can't pull people into services') although van services back to homes is permitted. People don't see their doctor because of transportation issues."* (key informant)
- Travel Trainers help people learn how to use public transportation. Increase awareness of this federally funded program by the National Center for Mobility (target refugee, immigrant and disabled communities)
- Uber discussed as option at different locations
  - Penn's Village has contract with Uber: \$5 flat fee for those who qualify to doctor appointments (key informant)

- **Reliance on caregivers, friends, and neighbors for transportation**
  - Elder isolation: difficulty accessing healthcare due to lack of finances and transportation. *"The elderly rely on family (if there is any, friends and neighbors for help)." (focus group)*
  - *"Many children and parents are working full-time and can't come in themselves or take family members to visits or tests." (focus group)*
  - *"Elder care and other resources for elderly: many elderly live alone and need help in home and with meeting basic needs, e.g., grocery shopping, getting and taking medication, getting to physicians. Family members are busy with their own lives. Caregivers need help and support to deal with stress. Transportation and pharmacy issues are also important." (focus group)*
  - Have dyad appointments for patients and caregivers to reduce stress on family
- **Medication issues** related to transportation
  - Partner with local pharmacies to deliver medications. Many areas lack pharmacies within walking distance

**Based on internal and external key informants, focus groups, existing relationships and programs, and secondary data, actions addressing health care access and transportation may include:**

1. Explore possible TJUH van transportation system
2. Explore prescription and food delivery
3. Use community health workers to facilitate arranging transportation
4. Raise awareness about LogistiCare transportation services among providers and the community
5. Raise awareness that SEPTA is free for people aged 65+
6. Explore use of Uber services
7. Champion a "give-up-your-seat" campaign
8. Physician practices could try to schedule more appointments for elderly during safer times to travel on public transportation (10 am-2pm)
9. Explore Sarasota Memorial Hospital comprehensive approach to transportation challenges as a best practice

## ***Cultural Competence***

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.<sup>81</sup>

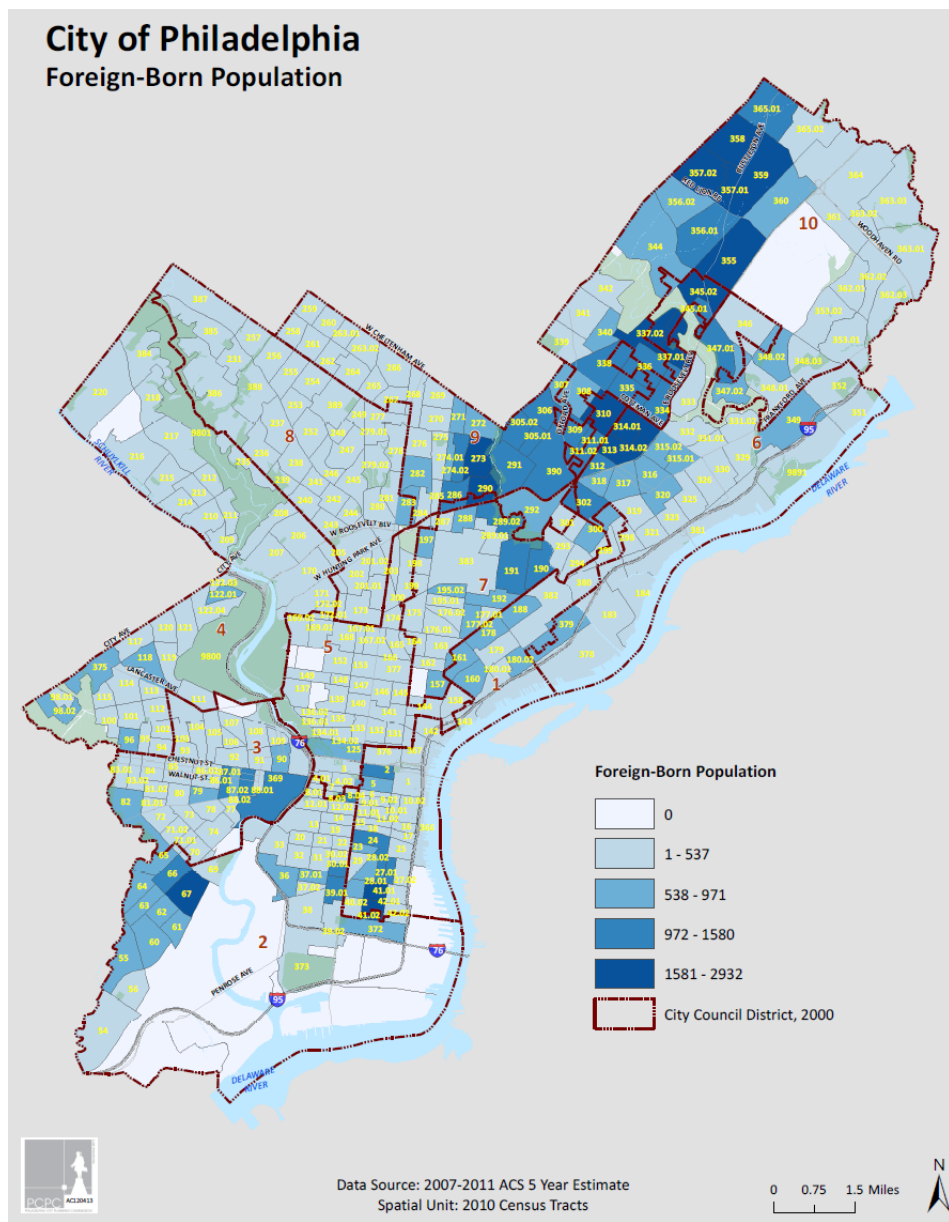
Culture and language may influence: health, healing, and wellness belief systems; how illness, disease, and their causes are perceived by the patient/consumer; behaviors of patients/consumers who are seeking health care; attitudes toward health care providers; the delivery of services by a provider who looks at the world through his or her own set of values.

Assuring cultural competency is a key factor in closing the disparities gap in health care. Cultural competency enhances the way patients and doctors can come together to talk about health concerns without cultural differences hindering the conversation. Health care services that are respectful of and responsive to the health beliefs, practices, and cultural and linguistic needs of diverse patients can help bring about positive health outcomes.

The increasing population growth of racial and ethnic communities and linguistic groups, each with its own cultural traits and health profiles, presents a challenge to health care delivery. The provider and the patient each bring their individual learned patterns of language and culture to the health care experience which must be transcended to achieve equal access and quality health care.

As described above, Jefferson's community benefit area serves diverse communities, one of the most diverse areas of the City, including large immigrant and refugee populations, a significant homeless/sheltered population with complex mental and physical health issues, a growing elderly population, and the LGBT community. Focus groups and key informants both suggested that TJUHs staff and providers would benefit from learning more about the communities they serve.

In Philadelphia, 12.7% of the population is foreign born; concentrations of foreign-born residents are dispersed throughout the city, and people from each country tend to cluster in communities.



Within TJUHs CB area the percentage of foreign born ranges from 22.3% in Center City (zip code 19107) to only 1.2% in North Philadelphia west of Broad Street (zip code 19132)<sup>32</sup>

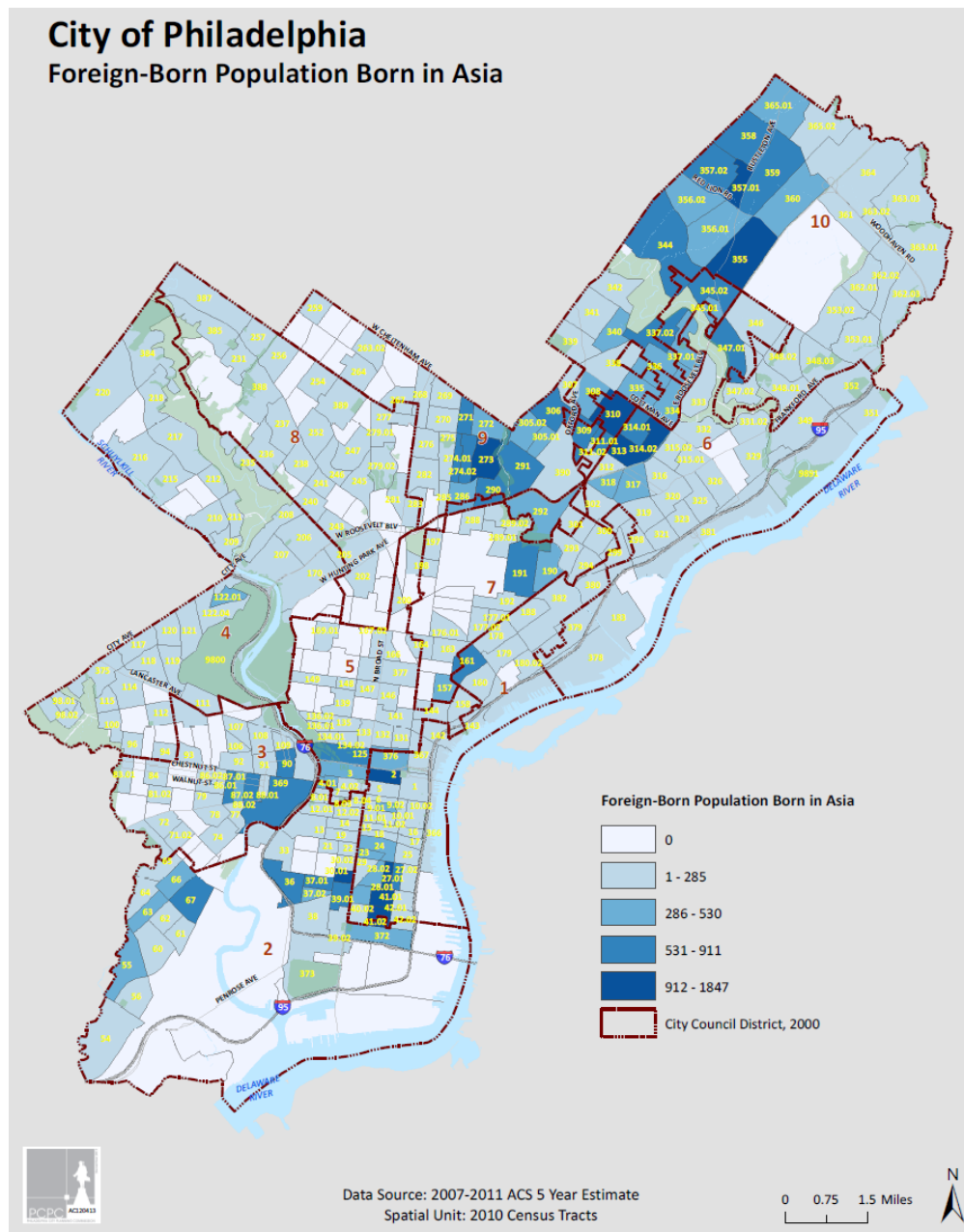
ZIP Code	Neighborhood	% Foreign Born Residents
19107	Center City	22.3
19102	Center City	20.5
19148	South Philadelphia East	20.5
19147	South Philadelphia –Bella Vista	17.4
19103	Center City West	16.0
19145	South Philadelphia West	13.0
19106	Center City-Society Hill	10.0
19125	Kensington/Fishtown	8.8
19146	South Philadelphia - Schuylkill	7.8
19122	North Philadelphia - Yorktown	7.7



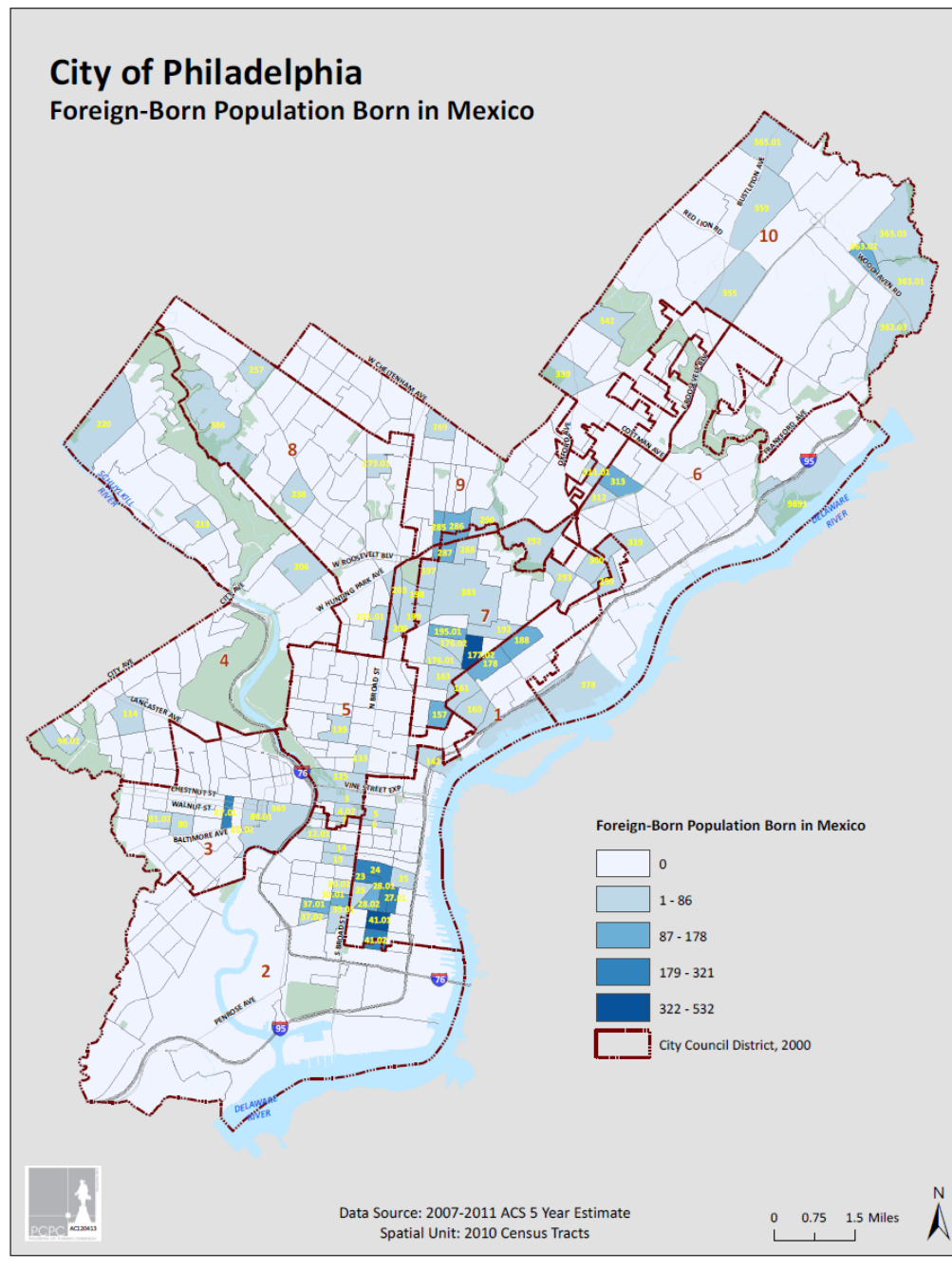
ZIP Code	Neighborhood	% Foreign Born Residents
19130	Fairmount South	7.7
19123	Northern Liberties	7.5
19133	North Philadelphia - East	4.1
19121	Fairmount North	3.1
19132	North Philadelphia - West	1.2

*Pew State of the City –Philadelphia 2015*

The foreign born population in Philadelphia originates from across the globe, with concentrations from Asia and Mexico. Their settlement patterns differ, with people from Asia dispersed in many more neighborhoods than people from Mexico.



South Philadelphia is home to people from a variety of countries.



**Issues, challenges, unmet needs and priorities identified by key informants and focus group participants related to culture include:**

- We need to train healthcare providers and staff to be respectful of and responsive to the health beliefs, practices, and cultural needs of diverse patients including those dealing

with interpersonal violence, mental health conditions, sexually related health issues such as LGBT, cognitive impairment, homelessness, and drug addictions.

- *“I don’t know what it’s like for a woman on methadone to go to PCP who says “oh this program is for addicted moms.” No- they are in treatment! We need training for providers to deal with people/ women on drugs who are high or are in treatment. How do we shine a “light” on these issues for providers?”* (key informant)
- *“People who experience trauma are asked to explain what happened multiple times and as a result continue to relive their traumatizing incident.”* (key informant)
- *“Need to decrease the stigma and stereotyping of homeless mentally ill among health care staff.”* (key informant)
- *“Physicians don’t understand the needs of LGBT patients. Cultural competence in treating LGBT in hospital is needed. There is perceived or actual “disrespect” based on LGBT experiences. LGBT may have to explain their sexuality issues to others over and over again.”* (key informant)
- **Refugees and immigrant care** - Varied cultural beliefs about risk factors, signs and symptoms and use of health services
  - *“Each refugee and immigrant brings his/her own values, beliefs and attitudes to the healthcare setting. Effective care requires an understanding of how to effectively treat patients based on their culture.” For example, “Culturally, the Bhutanese don’t plan ahead. They stop-in the clinic, go home, and then come back for care. They don’t like that they have to plan to schedule appointments, plan for their translation needs, and consider transportation. Even signing into building is difficult, and they often get turned away at reception desks since there is no translation there.”* (key informant)
  - *“Refugees and immigrants may have cultural issues around medication/therapy for mental health issues. They don’t link mental and physical health. For many people, including refugees and immigrants, behavioral health issues are not a priority and may be less valued.”* (key informant)
  - *“The Bhutanese like and trust physicians, but may not ask questions.”* (key informant)
  - *“People wait until they are very ill, go to emergency department and die a few days later.”* (key informant)
- Build cultural competence around dealing with grief- both community and patient-loss (key informant)
- Use community health workers as cultural brokers and health system navigators (key informant)

**Based on internal and external key informants, focus groups, existing relationships and programs, and secondary data, actions addressing cultural awareness may include:**

- 1. Consider partnering with community based organizations for medical interpreter services and community health worker services. Provide training and oversight.**
- 2. Provide cultural competence training for staff and providers about refugees and immigrants, homeless, LGBT, geriatric care, mental illness, addictions/substance abuse, and cognitive impairment.**

## *Literacy and Language*

Health literacy is a stronger predictor of individual health status than age, income, employment status, education level, or racial/ethnic group.<sup>82</sup> Inadequate health literacy, as measured by reading fluency, independently predicts all-cause mortality and cardiovascular death among community dwelling elderly persons.<sup>83</sup> Health literacy also contributes to disparities associated with race/ethnicity and educational attainment in self-rated health and some preventive measures.<sup>84</sup> Race/ethnicity (African American and Latino/Hispanic), age (older than 65), not completing high school, poverty, and not speaking English prior to entering school have also been associated with lower literacy levels.<sup>85</sup> Older adults are disproportionately more likely to have below basic health literacy than any other age group. Almost two-fifths (39%) of people age 75 and over have a health literacy level below basic compared with 23% of people age 65–74 and 13% of people age 50–64.<sup>85</sup>

Low patient literacy is associated with limited disease-related knowledge and self-management, poor adherence to treatment, and a 30-50% increased odds of hospitalization. Preventable hospitalizations are also associated with poor health literacy.<sup>86</sup> The Joint Commission's National Patient Safety Goals specifically address communication issues related to provider-patient interaction.<sup>87</sup>

The health literacy of patients is often underestimated by health care providers and may not even be considered as a factor in patient care.<sup>88,89,90</sup> The safety of patients cannot be assured without mitigating the negative effects of low health literacy and ineffective communications on patient care. However, there is more to health literacy than understanding health information.<sup>86</sup> Health literacy also encompasses the educational, social, and cultural factors that influence the expectations and preferences of individual, and the extent to which those providing healthcare services can meet those expectations and preferences.<sup>86</sup>

In addition, the growing prevalence of chronic conditions and an aging population requires even more attention to effective strategies to address health literacy. One in four Americans has multiple chronic conditions, with hypertension being the most common. Individuals with chronic conditions are much more likely to be hospitalized and account for 84% of all health care spending. More than 50% of people with serious chronic conditions use 3 or more different physicians. Those with chronic conditions report not receiving adequate information – e.g., 14% report receiving different diagnoses from different providers, only 16% report receiving information about drug interactions, 17% received conflicting information from providers, and 19% report having duplicate tests or procedures. The role health literacy plays in these disconnects between information provided, medication use, and duplicate testing is significant.<sup>86</sup> While the above data reflects all adults, older adults, given the higher prevalence of chronic disease, are more at risk for disconnects in communication.

The Program for the International Assessment of Adult Competencies (PIAAC) 2012 study of adult skills, was an international survey of 13 industrialized nations; 5,010 adults aged 16-65 were surveyed in United States. PIAAC assesses literacy, numeracy, and problem solving in information rich environments (defined as the capacity to access, interpret, and analyze information found, transformed, and communicated in digital environments); and provides a rich

array of information regarding respondents' use of skills at work and in everyday life, their education, their linguistic and social backgrounds, their participation in the labor market, and other aspects of their well-being.<sup>91</sup>

PIAAC found that:

- A larger proportion of adults in the United States than in other countries have poor literacy and numeracy skills, and the proportion of adults with poor skills in problem solving in technology-rich environments is slightly higher than average, despite the relatively high educational attainment among adults
- Socio-economic background has a stronger impact on adult literacy skills in the United States than in other countries. Black and Hispanic adults are substantially over-represented in the low-skilled population
- Literacy skills are linked not only to employment outcomes, but also to personal and social well-being. In the United States, the odds of being in poor health are four times greater for low-skilled adults than for those with the highest proficiency – double the average across participating countries

According to the Institute of Medicine, a health literate organization:

- Uses health literacy strategies in interpersonal communications and confirms understanding at all points of contact
- Provides easy access to health information and services and navigation assistance
- Designs and distributes print, audiovisual, and social media content that is easy to understand and act on
- Addresses health literacy in high-risk situations, including care transitions and communications about medicines
- Communicates clearly what health plans cover and what individuals will have to pay
- Has leadership that makes health literacy integral to its mission, structure, and operations
- Integrates health literacy into planning, evaluation measures, patient safety, and quality improvement
- Prepares the workforce to be health literate and monitors progress
- Includes populations served in the design, implementation, and evaluation of health information and services
- Meets the needs of populations with a range of health literacy skills while avoiding stigmatization

Healthy People 2020 added an objective related to health communication and health information technology, with the goals of:

- Supporting shared decision-making between patients and providers
- Providing personalized self-management tools and resources
- Building social support networks
- Delivering accurate, accessible, and actionable health information that is targeted or tailored

- Facilitating the meaningful use of health IT and exchange of health information among health care and public health professionals
- Enabling quick and informed action to health risks and public health emergencies
- Increasing health literacy skills
- Providing new opportunities to connect with culturally diverse and hard-to-reach populations
- Providing sound principles in the design of programs and interventions that result in healthier behaviors
- Increasing Internet and mobile access

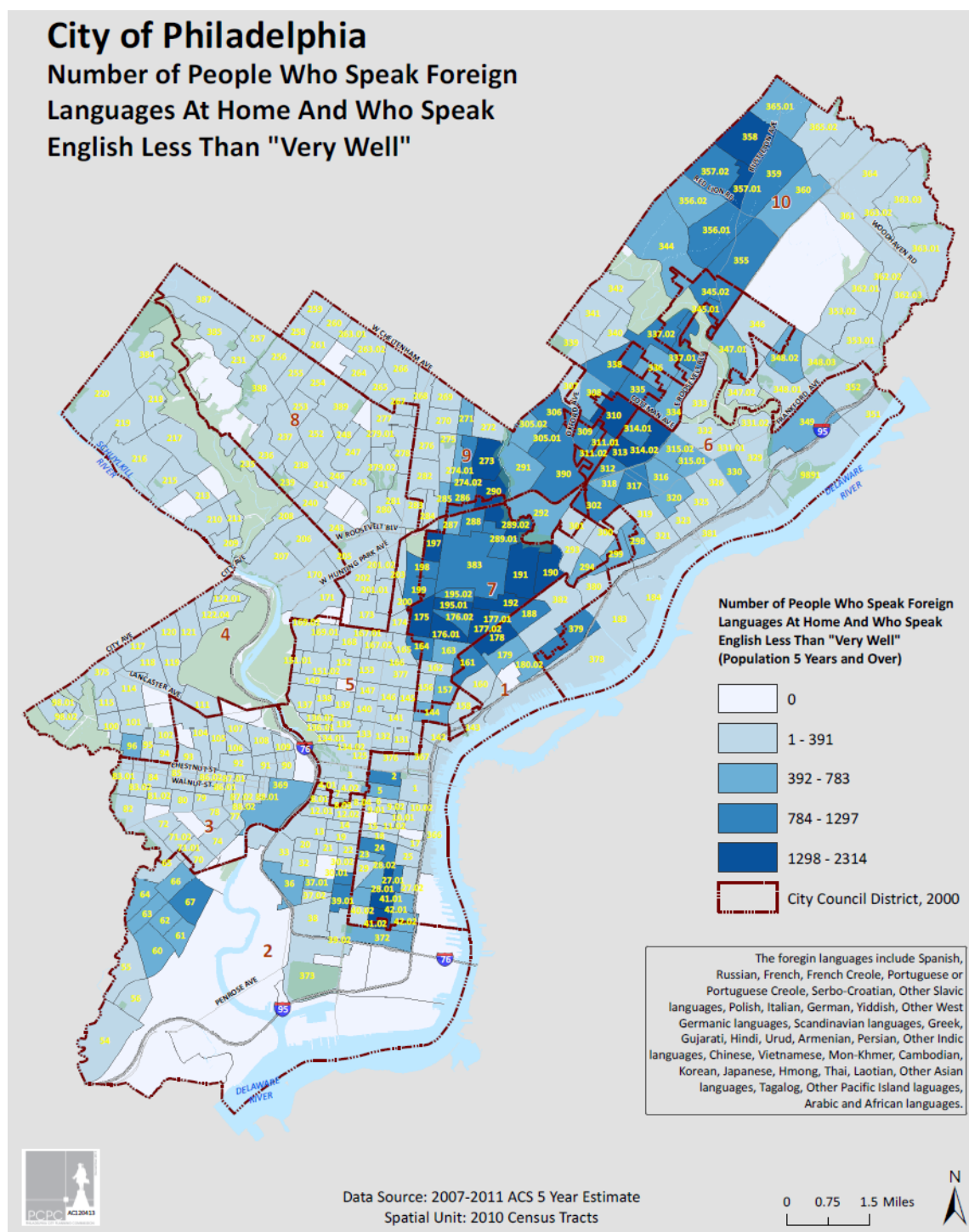
There has been little progress nationally and regionally in addressing the impact of limited literacy.<sup>86</sup> The reasons for this are complex and include the following:

- Demands for reading, writing and numeric skills are intensified due to health care systems' complexities, advancements in scientific discoveries, and new technologies
- Health professionals and staff have limited education, training, continuing education, and practice opportunities to develop skills for improving health literacy;
- Studies indicate a desire on the part of adult learners and adult education programs to form partnerships with health communities, but there have been limited opportunities to engage.<sup>86</sup>

In Philadelphia, 22% of residents read at the below basic level<sup>85</sup> and more than half of all Philadelphians will have difficulties with some aspects of health literacy. A person with below basic literacy can circle the date of a medical appointment and can identify how often a person should have a specified medical test based on information in a clearly written pamphlet, but may have difficulty with tasks such as determining when they should take a prescription medication and when to take the medication based on eating.<sup>92</sup>

In Pennsylvania, ineffective communication among providers, between providers and patients, and between providers across healthcare settings were among the common themes related to Pennsylvania hospital readmissions reported between January and August 2009.<sup>93</sup> Use of custom individualized discharge instructions that incorporate health literacy principles (plain language strategies, such as using words with fewer than three syllables, short sentences and paragraphs, large font, limited medical jargon, abundant white space, teach-back techniques to confirm patient understanding, and visual methods including pictures, multimedia, use of pill-boxes, and graphic medication schedules)<sup>93,94,95</sup> as well as strategies designed to improve care transitions are suggested for use in inpatient settings to enhance patient learning and improve handover communication into community settings.<sup>93</sup> The Center for Urban Health and the Healthcare Improvement Foundation have been providing health literacy training for 13 hospitals in Southeastern Pennsylvania, including Jefferson staff, using a “train the trainer” model. Jefferson has been systematically training nursing staff and others in communication techniques such as *plain language* and *Teachback* and to date has trained close to 3,000 employees.

In Philadelphia, those who speak foreign languages at home and who speak English less than very well are likely to have low health literacy. There are several concentrated areas of foreign born individuals within TJUH's CB neighborhoods.



Residents of Philadelphia speak many languages. When 1,000 individuals or 5% of the population, whichever is less, speak a language other than English, then forms and materials used by health care providers should be translated into these languages. There are approximately 30 languages in Philadelphia that meet this criterion.<sup>96</sup> The data listed below does not include the Bhutanese, Nepali and the Burmese refugees who have settled in South Philadelphia since 2010. According to key leaders serving the refugee community, there are more than 1,000 individuals from these countries now living in South Philadelphia.

## Philadelphia County, Pennsylvania

Source: American Community Survey  
Aggregate Data, 5-Year Summary File, 2006–2010

Show **more languages** spoken in Philadelphia  
County

[Sort alphabetically](#)

	Ages 5 +	%
English	1,112,441	79.12%
All languages other than English combined	293,544	20.88%
Spanish	136,688	9.72%
Chinese	23,075	1.64%
Vietnamese	12,499	0.89%
Russian	10,885	0.77%
French	9,240	0.66%
Other Asian languages	8,639	0.61%
African languages	8,217	0.58%
Mon-Khmer, Cambodian	7,933	0.56%
Italian	7,773	0.55%
Arabic	6,558	0.47%
French Creole	6,325	0.45%
Polish	5,825	0.41%
Other Indo-European languages	5,343	0.38%
Korean	4,608	0.33%
Portuguese	4,512	0.32%
Other Slavic languages	3,939	0.28%
Gujarathi	3,681	0.26%
German	3,597	0.26%
Hindi	3,447	0.25%
Other Indic languages	3,064	0.22%
Tagalog	3,064	0.22%
Other Pacific Island languages	2,070	0.15%
Urdu	1,850	0.13%
Greek	1,581	0.11%
Hebrew	1,559	0.11%
Japanese	1,077	0.08%
Laotian	1,069	0.08%
Other West Germanic languages	1,056	0.08%
Yiddish	891	0.06%
<b>Total:</b>	<b>1,405,985</b>	

Data are estimates based on a sample and are subject to sampling variability. Data are not displayed where there were insufficient samples with which to compute an estimate.

Note that 2010 ACS Aggregate Data for Chinese include numbers reported for Cantonese, Chinese, Formosan, Mandarin, and other variants.



**Issues, challenges, unmet needs and priorities identified by key informants and focus group participants related to health literacy and language include:**

- **Language Issues**
  - Translation
    - Need more resources in other languages, especially Indonesian, Vietnamese, Laotian, and Bhutanese (key informant)
    - Rule for hospitals: *"Translation should be considered necessary if 1,000 patients or 5% population in service area speak a given language, then the institution should translate."* (key informant)
  - Interpretation
    - *"African Languages- so many spoken- interpretation services are difficult to get."* (key informant)
    - *"No continuity across departments in terms of language access, which makes it confusing for patients to navigate on their own"* (key informant)
    - *"Refugees go to ethnic community based organizations for language assistance in healthcare navigation. "Volunteers" or individuals who have no or limited medical interpretation training provide interpretation. Volunteers and community organizations receive no or limited compensation for services provided."* (key informant)
    - (Due to language) *"Refugees need escorts every time they need healthcare- You can't show them several times and expect them to do it, particularly elders."* (key informant)
    - *"There has to be a better way to help immigrants who don't speak English."* (focus group)
  - Language Line
    - *"Difficult for older people to use phone due to hearing loss."* (key informant)
    - Telephonic interpreters don't provide context particularly for behavioral health issues (key informant)
    - *"Need context so patient feels comfortable. Hard for patients to ask follow-up questions."* (key informant)
    - *"Don't trust interpreter. Interpreters are too direct."* (key informant)
    - There is a lack of training on how to use language access
    - *"It's difficult to schedule appointments in other languages. Need language interpretation available at all points of care including the front desk."* (key informant)
    - *"Language line not consistently used across all healthcare providers particularly specialty care. Interpretation not consistently offered or patients are asked to bring a family member or child to translate."* (key informant)
  - Behavioral Health
    - *"Phone interpretation not effective for mental health patients."* (key informant)
    - Community Behavioral Health provides in-person interpreters but they don't have specialized training. If client doesn't have Medicaid, then CBH doesn't provide an in-person interpreter, only a phone interpreter (key informant)

- Signage
  - *"Need to look at how we interact with non-English speakers and immigrants - Super confusing. Need signage."* (key informant)
- Health literacy
  - *"More need for teach-back so patients understand."* (key informant)
  - *"Why would I go to the doctor if I don't understand what is being said?"* (key informant)

**Based on internal and external key informants, focus groups, existing relationships and programs, and secondary data, actions addressing health literacy and language may include:**

- 1. Continue to provide health literacy training to TJUH and JUP physicians and staff**
- 2. Continue to support health literacy system changes such as patient education materials, informed consent, and patient-provider education**
- 3. Adopt health literacy universal precautions throughout Jefferson**
- 4. Review signage needs across TJUHs campuses**
- 5. Provide training on language line use and use of interpreters for health care providers and staff at all points of contact**
- 6. Support medical interpreter training of community health workers and community based organizations providing navigation services to clients**
- 7. Explore potential for technology such as Skype so non-verbal cues are evident during communication**

## Health Status

### *Mortality*

Philadelphia ranks 65 of the 67 counties in Pennsylvania for mortality and 67 of 67 for overall health outcomes.<sup>37</sup> Between 2000 and 2012, life expectancy increased for all groups with the largest increases among non-Hispanic Black men, and non-Hispanic Asian and Hispanic women. However, between 2010 and 2012, life expectancy for males was 72.3 years, a decrease of 0.2, and life expectancy for females was 79.3 years, a decrease of 0.9 years. Disparities in life expectancy are striking: on average, non-Hispanic Black men live 69 years, while non-Hispanic Asian women live 91.8 years.<sup>97</sup> The Centers for Disease Control and Prevention's (CDC) Community Health Status Indicators (CHSI) methodology ranks male life expectancy in Philadelphia in the least favorable quartile compared to peer counties.<sup>98</sup>

Between 2000 and 2012, age-adjusted mortality rates per 100,000 population decreased for all causes except unintentional injury. Most of the increase in unintentional injury deaths was due to an increase in deaths from accidental drug poisonings (overdoses).

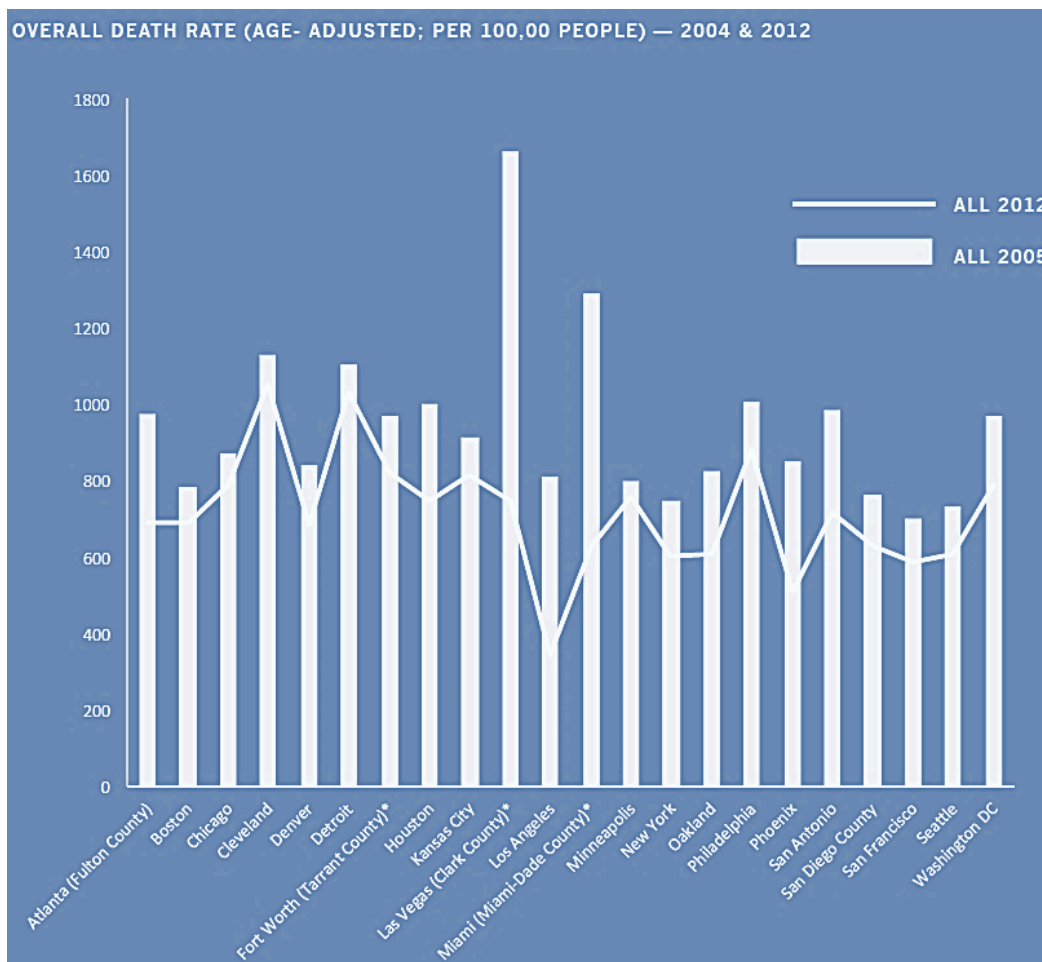
**Mortality Trends: Age Adjusted Mortality per 100,000 Population**

Cause of Death	Rank 2012	Rate 2000	Rate 2012	% Change
<b>All causes</b>	--	1087.1	879.2	-19.1
Malignant neoplasms	1	249.7	206.8	-17.2
Heart disease	2	296.1	202.8	-31.5
Unintentional injuries (accidents)	3	48.4	53.7	+11.0
Cerebrovascular disease	4	68.5	42.4	-38.1
Chronic lower respiratory disease	5	40.9	40.4	-1.2
Diabetes	6	27.7	22.1	-20.2
Nephritis	7	27.3	20.5	-24.9
Homicide	8	20.6	19.7	-4.4
Septicemia	9	36.8	19.6	-46.7
Influenza and pneumonia	10	22.4	13.1	-41.5
Lung cancer	--	70.4	57.9	-17.8
Colorectal cancer	--	28.1	17.5	-37.7
Breast cancer	--	19.4	14.8	-23.7
HIV	--	18.6	5.9	-68.3
Prostate cancer	--	15.1	12.6	-16.6
Suicide	--	10.6	10.6	0

*2012 Vital Statistics Report, City of Philadelphia Department of Public Health*

In a 2012 report by the Big Cities Health Coalition, Philadelphia was ranked among 20+ large cities in the United States to compare key health indicators. Philadelphia ranked fourth of eleven cities that had higher age-adjusted cancer mortality rates (206.8 per 100,000 population) than in the U.S. total (166.5) and is in the least favorable quartile compared to peer counties according to the CDC CHSI methodology for cancer deaths. In the case of heart disease mortality,

Philadelphia once again ranked higher than the U.S. total (105.4) at 7<sup>th</sup> (202.8). All of the big cities reported lower diabetes mortality rates than the U.S. total (69.1) and Philadelphia ranked 11<sup>th</sup> (22.1). HIV mortality rates dropped in almost every city since 2004; however, HIV mortality in Philadelphia (5.9) ranked 9th, higher than the U.S. (2.2).<sup>37</sup> Philadelphia also ranked in the least favorable quartile compared to peer counties using the CDC's CHSI methodology for chronic kidney disease deaths and unintentional injury deaths (includes motor vehicle accidents).



*Big Cities Health Inventory, 2015 \*2005 data for Fort Worth (Tarrant County), Las Vegas (Clark County), Miami (Miami-Dade County), and San Diego County are city only; 2012 data are county level*

The prominent racial variations in life expectancy are driven by substantial differences in key mortality rates in Philadelphia. For example, non-Hispanic Blacks have the highest mortality rates for heart disease, cerebrovascular disease, homicide, septicemia, nephritis, diabetes, HIV, and all cancers. Non-Hispanic Blacks have stroke mortality rates that are almost twice that of non-Hispanic Whites. The homicide rate for non-Hispanic Blacks is more than twice that of Hispanics and more than ten times that of non-Hispanic Whites.

Cause of Death	White non-Hispanic	Black non-Hispanic	Asian	Hispanic	All Races/ Ethnicities
Malignant neoplasms	185.5	235.7	101.4	160.6	206.8
Heart disease	187.1	228.8	64.7	145.2	202.8
Unintentional injuries (accidents)	65.7	46.3		48.0	53.7
Cerebrovascular disease	33.1	50.7	39.9	31.6	42.4
Chronic lower respiratory disease	48.2	34.8		24.6	22.1
Diabetes	16.6	29.7		24.6	22.1
Nephritis	15.9	27.6			20.5
Homicide	3.2	37.8		18.4	19.7
Septicemia	19.4	20.3			19.6
Influenza and pneumonia	14.6	11.7			13.1
<b>All causes</b>	816.4	982.4	358.5	685.0	879.2
<b>Other Causes of Special Interest</b>					
HIV		8.6			5.9
Lung cancer	56.2	63.2		27.0	56.9
Colorectal cancer	14.2	21.4			17.5
Breast cancer	12.2	18.5			14.8
Prostate cancer	7.9	20.7			12.6
Suicide	16.5	6.4			10.7
Infant mortality per 1,000 live births	4.9	15.6	6.1	6.7	10.1

*2012 Vital Statistics Report, City of Philadelphia Department of Public Health*

*Rates shown are age-adjusted rates per 100,000 Population. Values are not displayed when there are fewer than 20 deaths per 100,000*

Disparities by gender are also evident across racial groups. Compared to non-Hispanic White males, death rates for non-Hispanic Black males were:<sup>97</sup>

- nearly 15 times higher from homicide
- 3 times higher for prostate cancer and 2 times higher for colorectal cancer
- 1.7 times higher for diabetes
- 1.3 times higher for heart disease, septicemia, and all-cause mortality

Non-Hispanic black males had the highest rates of death for each major cause except unintentional injuries (accidents), chronic lower respiratory disease, influenza and pneumonia, and suicide.

Compared to non-Hispanic White females, death rates for non-Hispanic Black females were:<sup>97</sup>

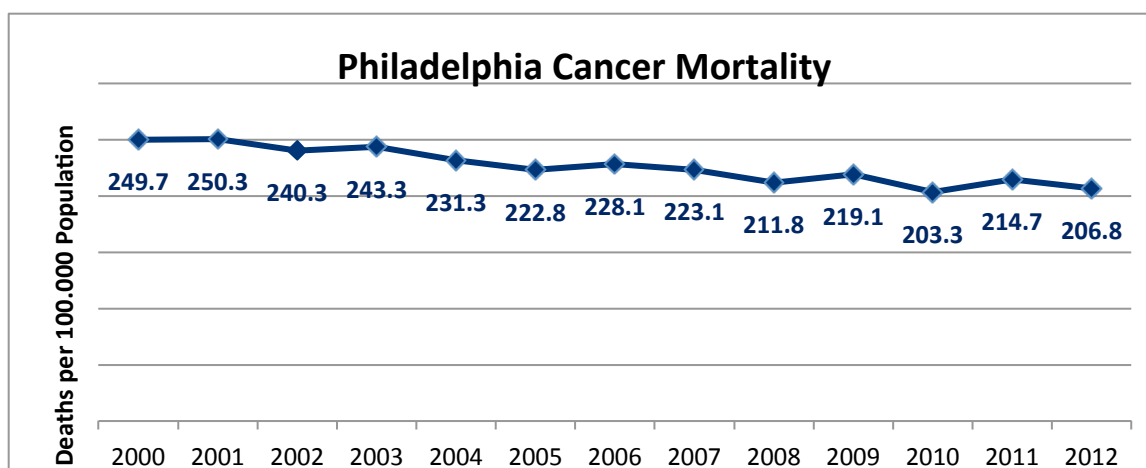
- 1.9 times higher for diabetes and kidney disease
- 1.6 times higher for cerebrovascular disease
- 1.2-1.4 times higher for heart disease and all cancers

Not surprisingly, cause of death varies by age group.

<b>Top 10 Causes of Death by Age Group: Philadelphia</b>	
<b>Age Group</b>	<b>Major Causes of Death</b>
15-24	Assault (homicide) Unintentional injuries (accidents) Intentional self-harm (suicide) Malignant neoplasms Heart disease Anemias Chronic lower respiratory diseases Congenital malformations, deformations and chromosomal abnormalities Essential hypertension and hypertensive renal disease In situ neoplasms, benign neoplasms and neoplasms of uncertain or unknown behavior
25-44	Unintentional injuries (accidents) Assault (homicide) Heart disease Malignant neoplasms Intentional self-harm (suicide) HIV Chronic lower respiratory diseases Diabetes mellitus Septicemia Chronic liver disease and cirrhosis
45-64	Malignant neoplasms Heart disease Unintentional injuries (accidents) Chronic lower respiratory diseases Diabetes mellitus Cerebrovascular disease Septicemia Chronic liver disease and cirrhosis Intentional self-harm (suicide) Nephritis, nephrotic syndrome and nephrosis
65+	Heart disease Malignant neoplasms Cerebrovascular disease Chronic lower respiratory diseases Nephritis, nephrotic syndrome and nephrosis Diabetes mellitus Alzheimer's disease Septicemia Unintentional injuries (accidents) Influenza and pneumonia

2012 Vital Statistics Report City, of Philadelphia Department of Public Health

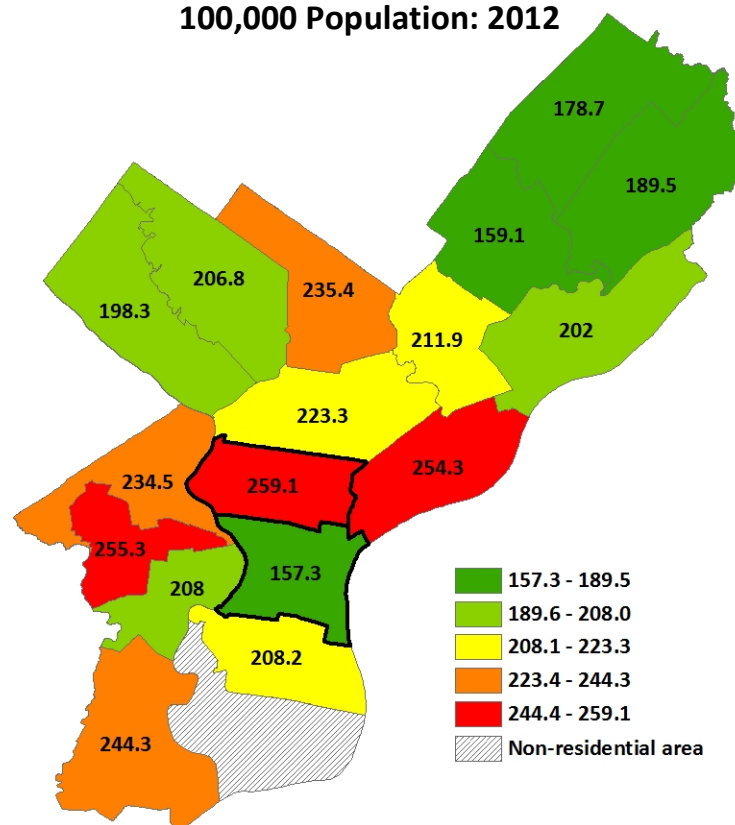
Cancer mortality rates in Philadelphia have decreased significantly since 2000.



*2012 Vital Statistics Report, City of Philadelphia Department of Public Health*

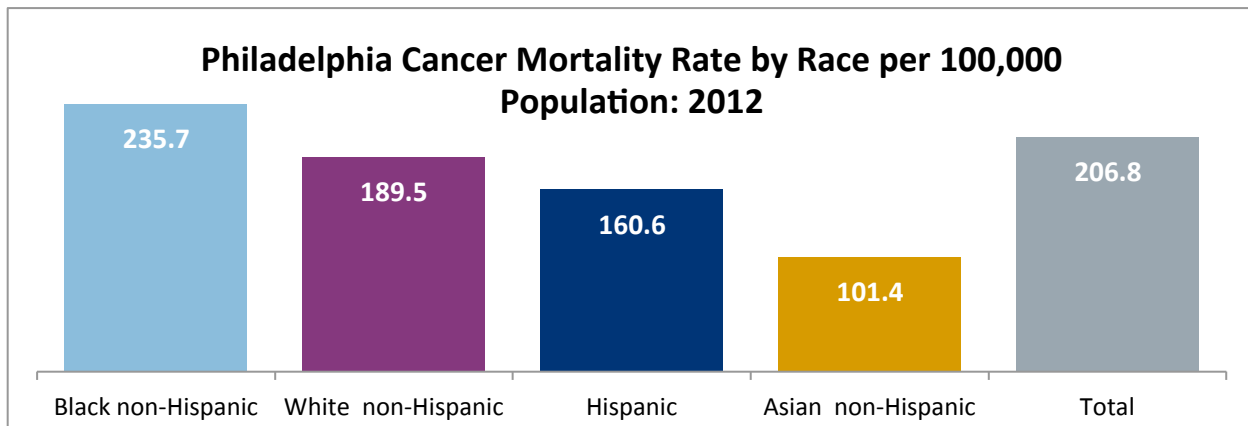
Planning districts with higher levels of poverty and a greater percentage of people of color had higher mortality rates. The Lower North planning district, which includes the zip codes in TJUHs Lower North CB area, had one of Philadelphia's highest cancer mortality rates.

### Philadelphia Age-Adjusted Cancer Mortality Rate per 100,000 Population: 2012



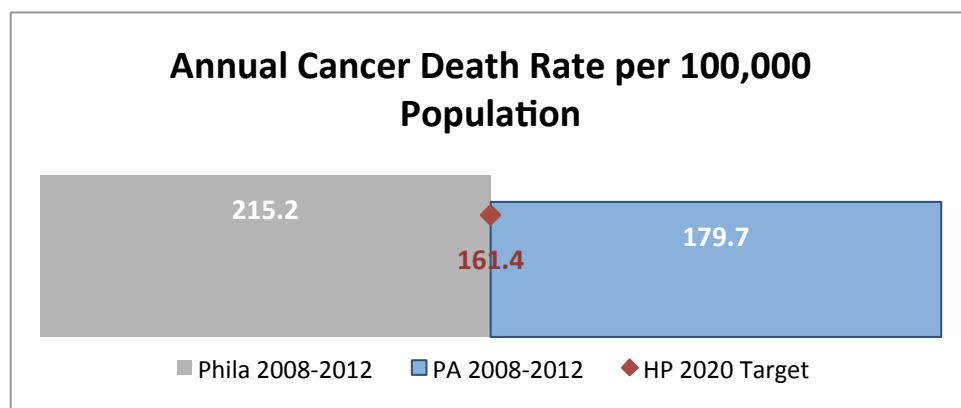
Source: Vital Statistics, Pennsylvania Department of Health, 2012

In large part Philadelphia's high cancer mortality rate is driven by a predominately non-Hispanic black population, the racial group with Philadelphia's highest cancer mortality rate.



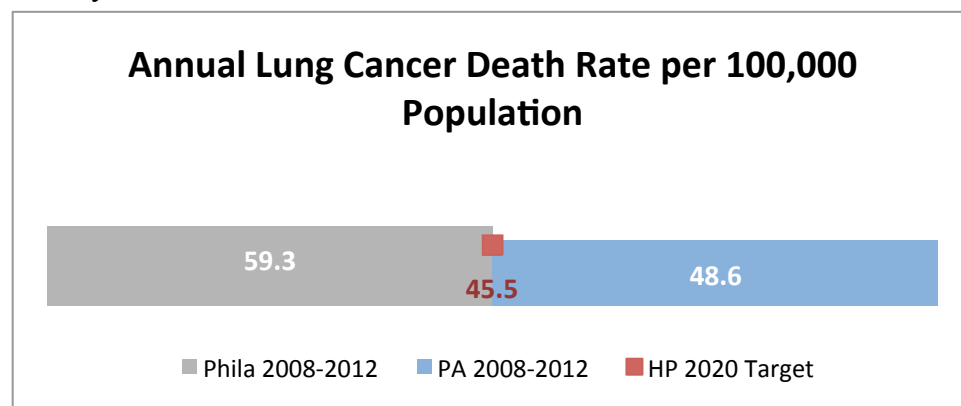
*2012 Vital Statistics Report, City of Philadelphia Department of Public Health*

All cancer mortality in Philadelphia exceeds the Healthy People 2020 target, and is higher than the rate for Pennsylvania.



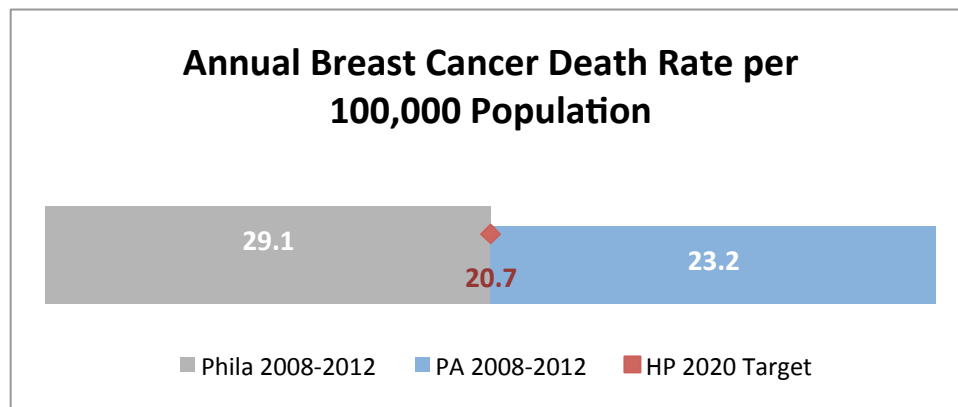
*National Cancer Institute, Centers for Disease Control and Prevention, State Cancer Profiles*

Lung cancer mortality in Philadelphia exceeds the Healthy People 2020 target, and is higher than the rate for Pennsylvania.



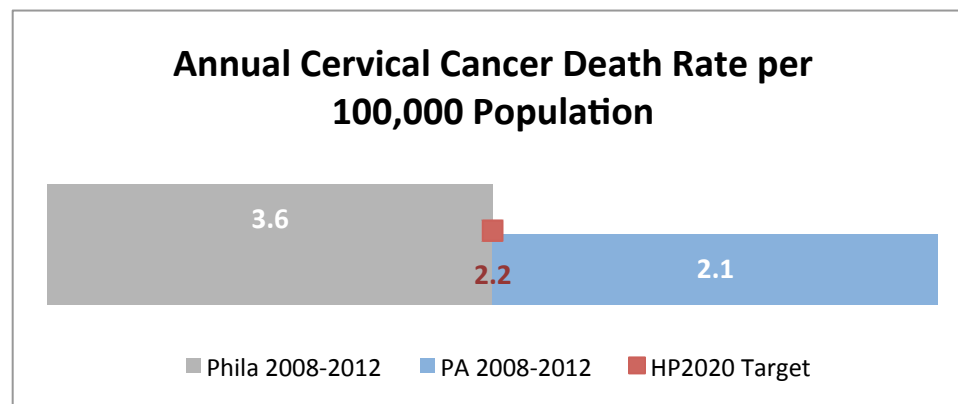


*National Cancer Institute, Centers for Disease Control and Prevention, State Cancer Profiles*  
Breast cancer mortality in Philadelphia exceeds the Healthy People 2020 target, and is higher than the rate for Pennsylvania.



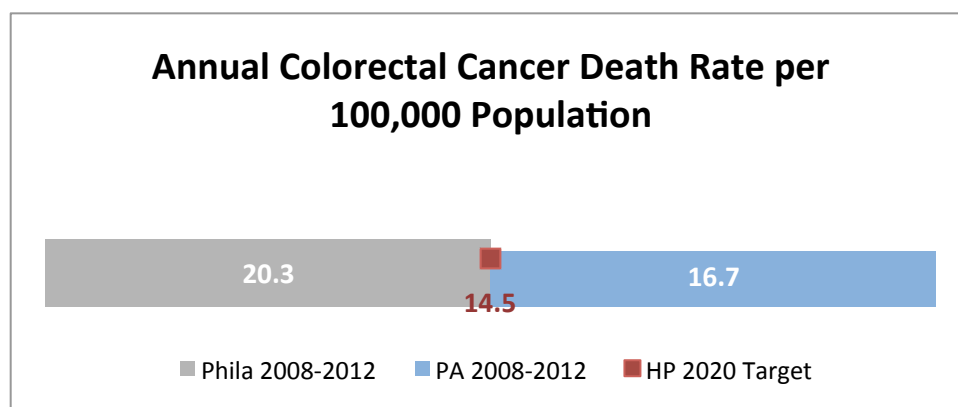
*National Cancer Institute, Centers for Disease Control and Prevention, State Cancer Profiles*

Cervical cancer mortality in Philadelphia exceeds the Healthy People 2020 target, and is higher than the rate for Pennsylvania.

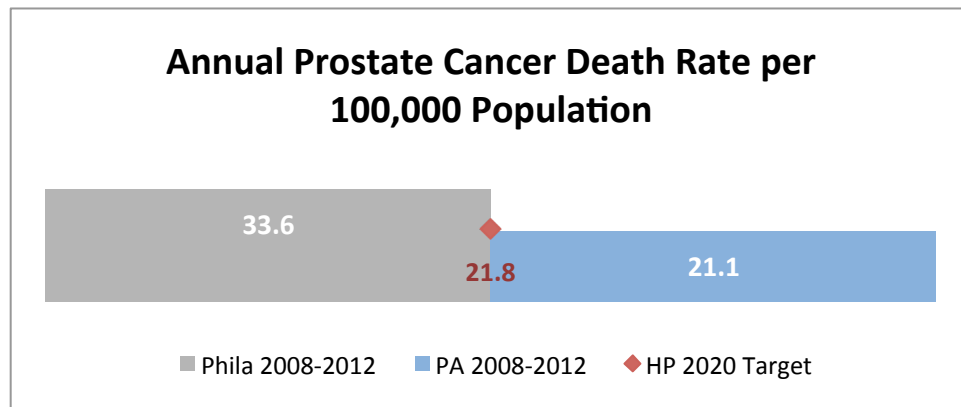


*National Cancer Institute, Centers for Disease Control and Prevention, State Cancer Profiles*

Colorectal cancer mortality in Philadelphia exceeds the Healthy People 2020 target, and is higher than the rate for Pennsylvania.

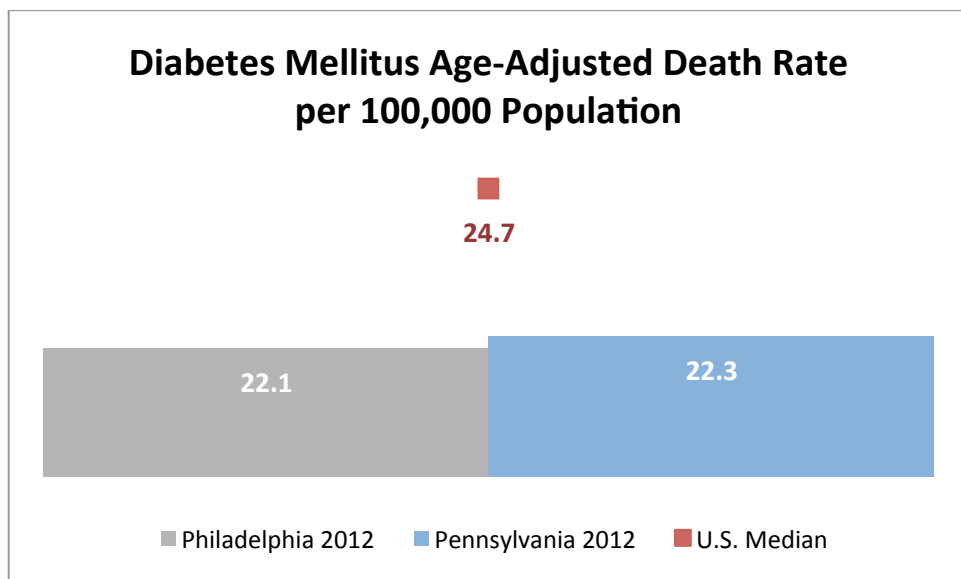


*National Cancer Institute, Centers for Disease Control and Prevention, State Cancer Profiles*  
Prostate cancer mortality in Philadelphia exceeds the Healthy People 2020 target, and is higher than the rate for Pennsylvania.



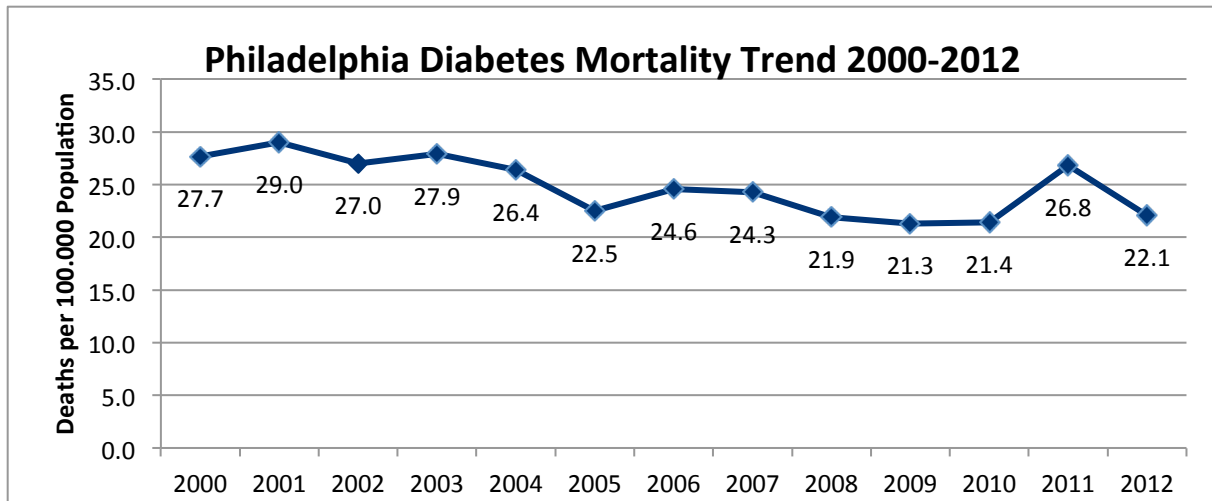
*National Cancer Institute, Centers for Disease Control and Prevention, State Cancer Profiles*

Deaths related to diabetes mellitus in Philadelphia and Pennsylvania are in the middle two quartiles when compared to peer counties according to the CDC CHSI methodology and compare favorably to the U.S. median mortality rate. This comparator is used instead of the Healthy People 2020 rate because Healthy People 2020 diabetes-related mortality data are derived from the multiple-cause-of-death files which include all mentions of diabetes on the death certificate and are approximately three times higher than if only diabetes as the underlying cause is counted.



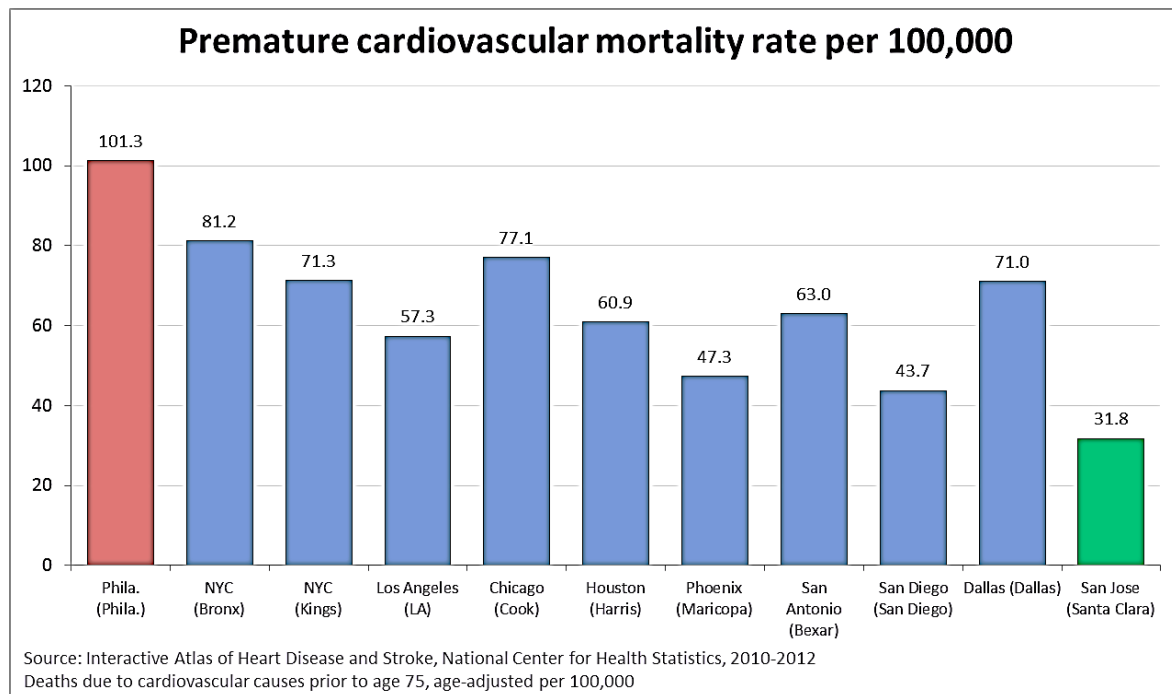
*2012 Vital Statistics Report, City of Philadelphia Department of Public Health  
National Vital Statistics System, 2012*

Diabetes mortality rates in Philadelphia are decreasing.

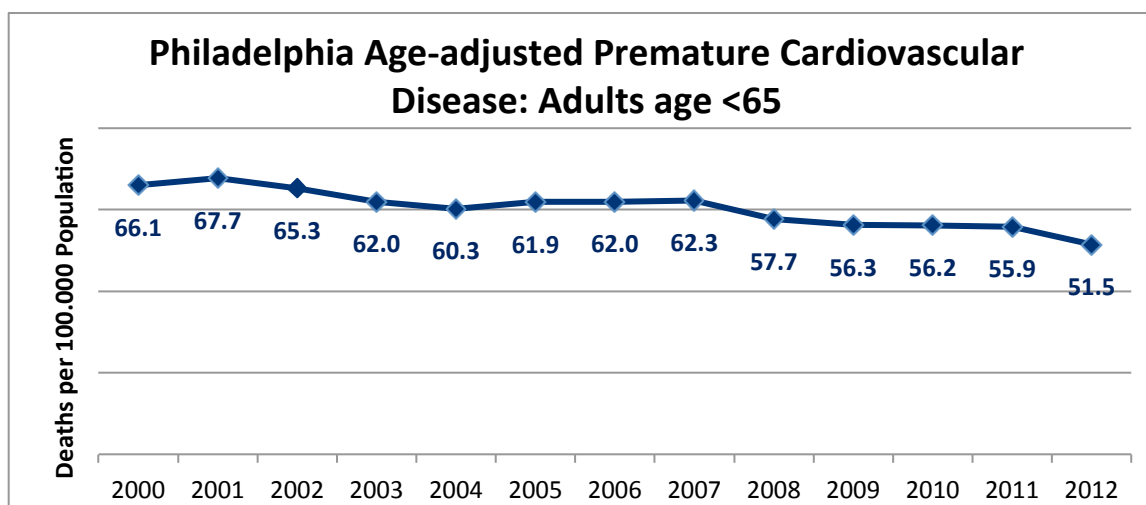


2012 Vital Statistics Report, City of Philadelphia Department of Public Health. Age-adjusted mortality rates

Among major metropolitan areas in the United States, Philadelphia ranks the highest in premature cardiovascular mortality.

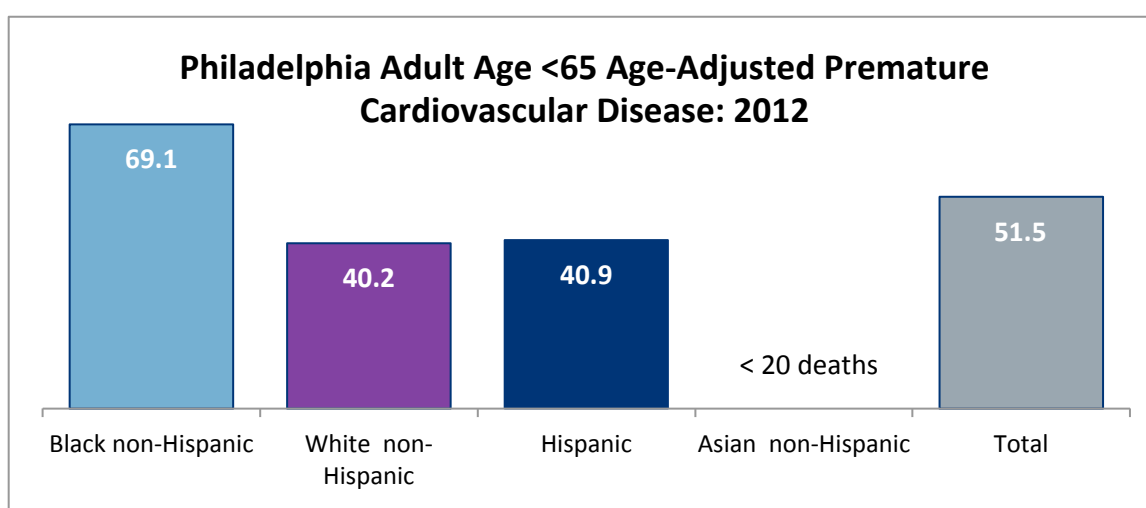


In Philadelphia, premature cardiovascular mortality rates have steadily declined over the past 12 years. Note that U.S. premature cardiovascular deaths are measured for adults up to age 75, and Philadelphia cardiovascular deaths are measured for adults up to age 65.



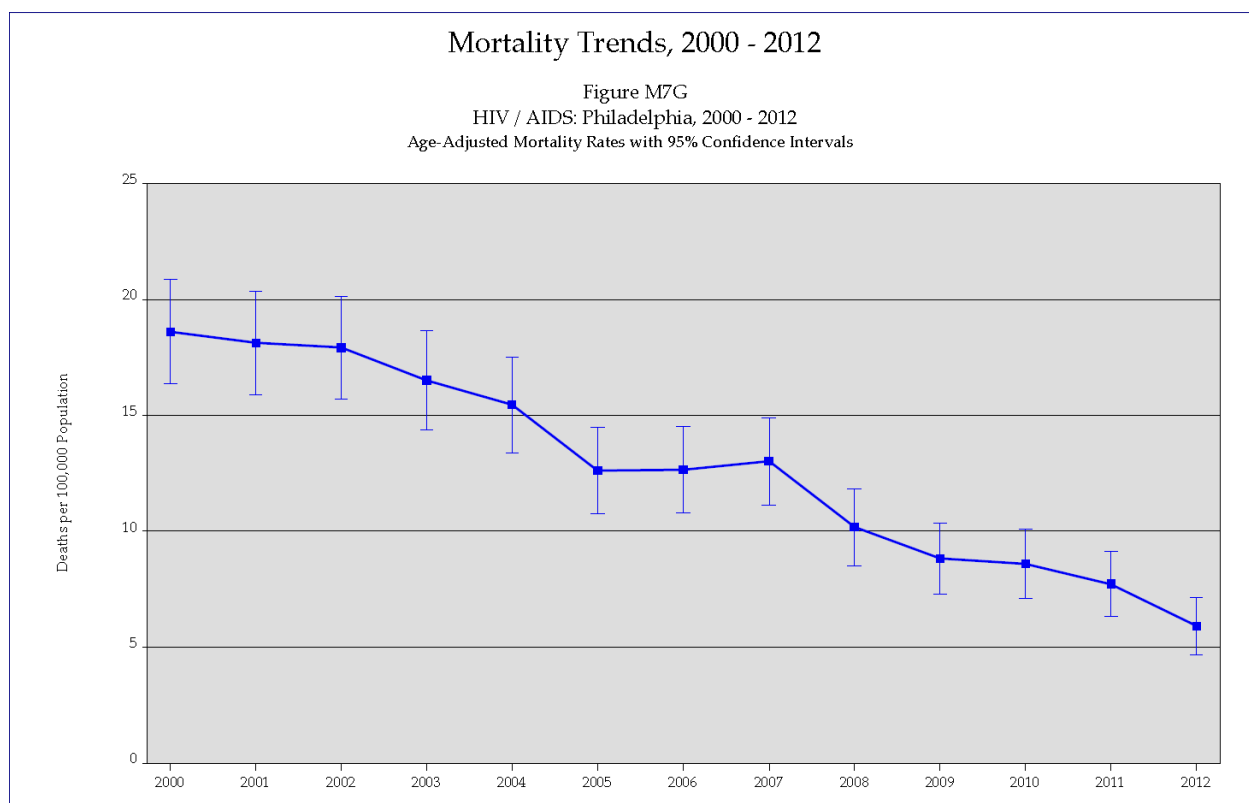
*2012 Vital Statistics Report, City of Philadelphia Department of Public Health*

Premature cardiovascular disease mortality varies markedly across racial/ethnic groups in Philadelphia.



*2012 Vital Statistics Report, City of Philadelphia Department of Public Health*

In Philadelphia, there was a steady decline in HIV mortality from 2000-2012.

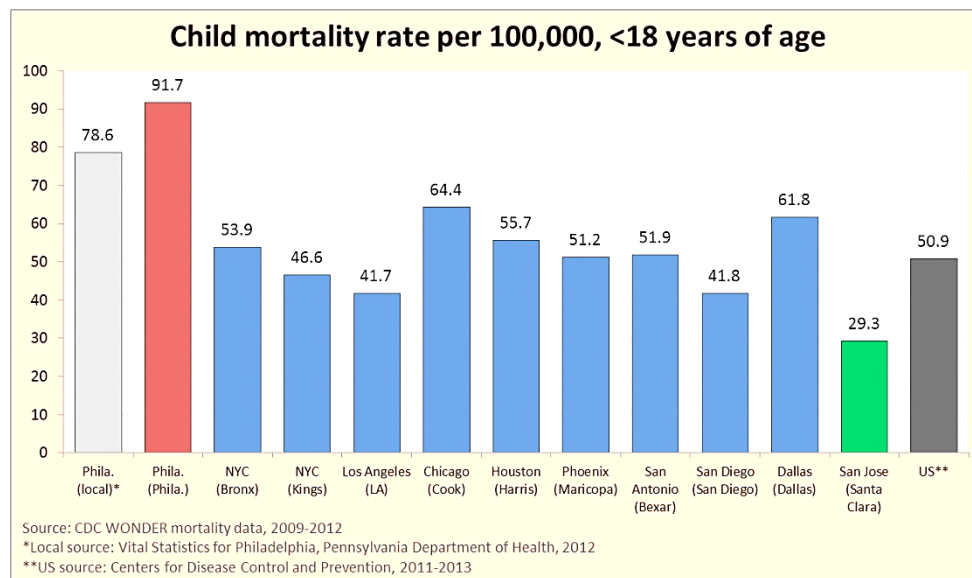


*2012 Vital Statistics Report, City of Philadelphia Department of Public Health. Age-adjusted mortality rates with 95% confidence intervals*

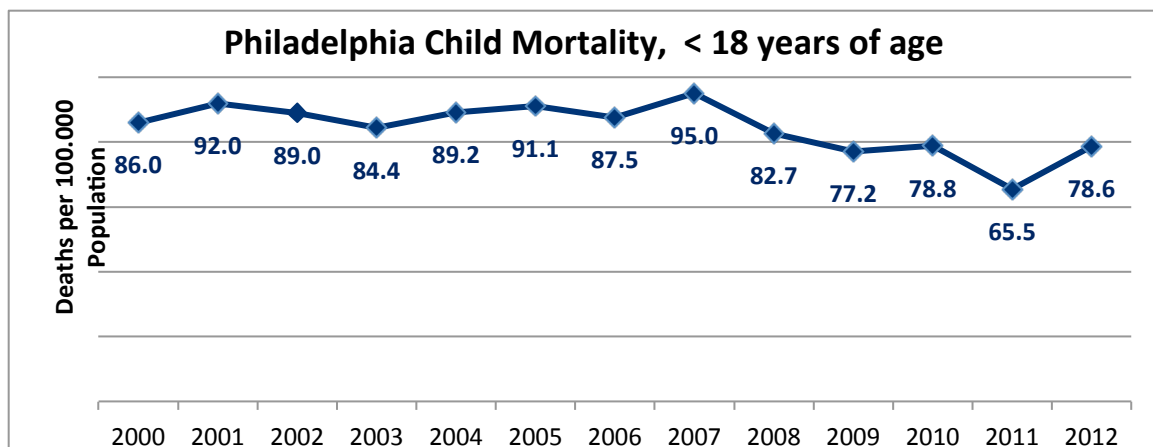
## Maternal, Infant and Child Health

Improving the health and well-being of mothers, infants, and children is an important public health goal for the United States.<sup>99</sup> The well-being of our youngest citizens is essential to the future health of the country and has important implications for the challenges the health care system will face in the future. Pregnancy provides an opportune time to discuss health with mothers to be and to initiate healthier behaviors and practices that can impact the health and quality of life of families.

**Childhood Mortality:** Philadelphia, compared to peer cities, had the highest mortality rate for children under 18 years of age at 78.6 per 100,000.



With the exception of 2011, the child mortality rate in Philadelphia has remained relatively stable since 2000.



2012 Vital Statistics Report, City of Philadelphia Department of Public Health

### Philadelphia Child Mortality, < 18 years of age: 2012

Race/Ethnicity	Rate
Black non-Hispanic	117.3
White non-Hispanic	33.5
Hispanic	56.9
Asian non-Hispanic	43.6
Total	78.6

2012 Vital Statistics Report, City of Philadelphia Department of Public Health

**Child mortality rate per 100,000,  
<18 years of age**

Legend:

- 27.3 - 42.5
- 42.6 - 75.6
- 75.7 - 85.2
- 85.3 - 92.6
- 92.7 - 128.8
- Non-residential area

Map Data (Census Tract Mortality Rates):

Census Tract	Mortality Rate
31	27.3
49	42.5
27.3	42.5
67.4	42.5
98.8	92.7 - 128.8
90.3	85.3 - 92.6
42.5	42.5
128.8	92.7 - 128.8
85.2	75.7 - 85.2
101.4	92.7 - 128.8
92.6	85.3 - 92.6
87.1	85.3 - 92.6
81.2	75.7 - 85.2
52.2	42.6 - 75.6
75.6	75.7 - 85.2
34.8	42.6 - 75.6
77.6	75.7 - 85.2

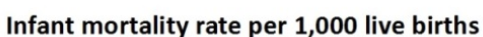
Source: Vital statistics, Pennsylvania Department of Health, 2012

infant deaths) followed by birth defects (26 deaths).<sup>97</sup>



2012 Vital Statistics Report, City of Philadelphia Department of Public Health

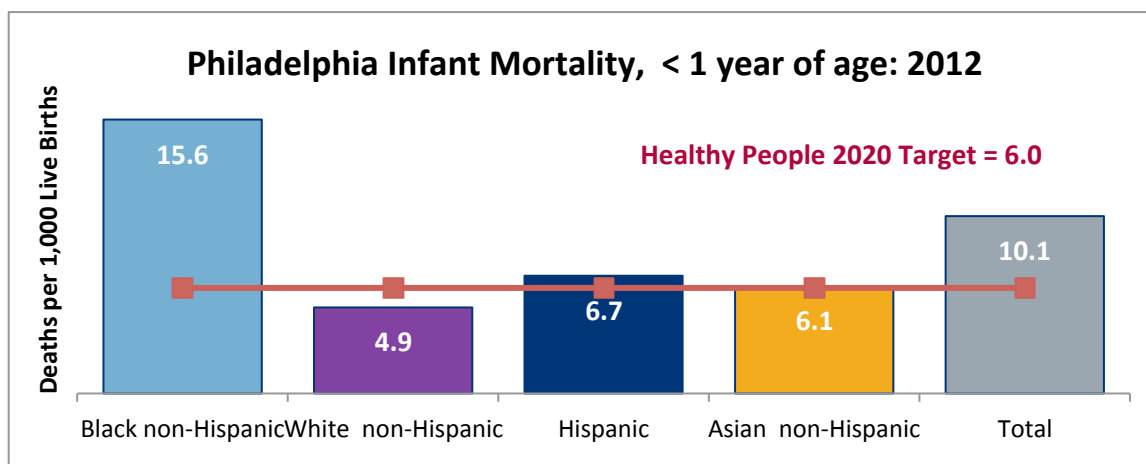
live births).



Source: Vital Statistics, Pennsylvania Department of Health, 2012

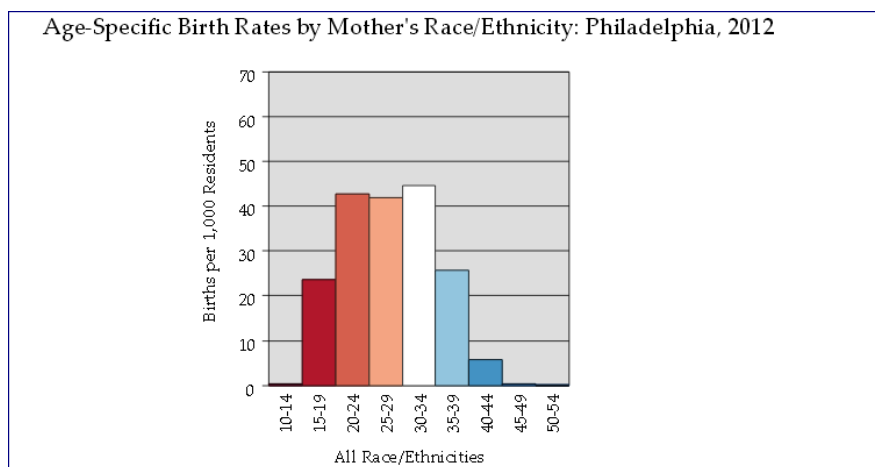


Infant mortality rates vary by race and ethnicity with Black non-Hispanics having the highest rate per 1,000, more than 3 times higher than the White non-Hispanic infant mortality rate.



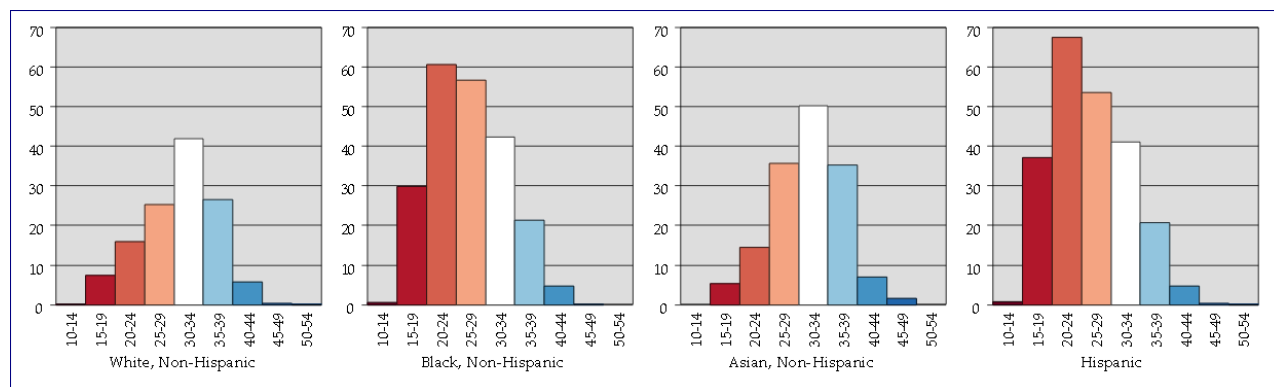
*2012 Vital Statistics Report, City of Philadelphia Department of Public Health*

**Birth Rate:** Overall, between 2003 and 2012, the birthrate in Philadelphia ranged from 14.3 to 15.8 births per 1,000 female residents and increased across all race/ethnic groups. In 2012, the overall birthrate in Philadelphia was 15.0, and was highest among women age 30-34.



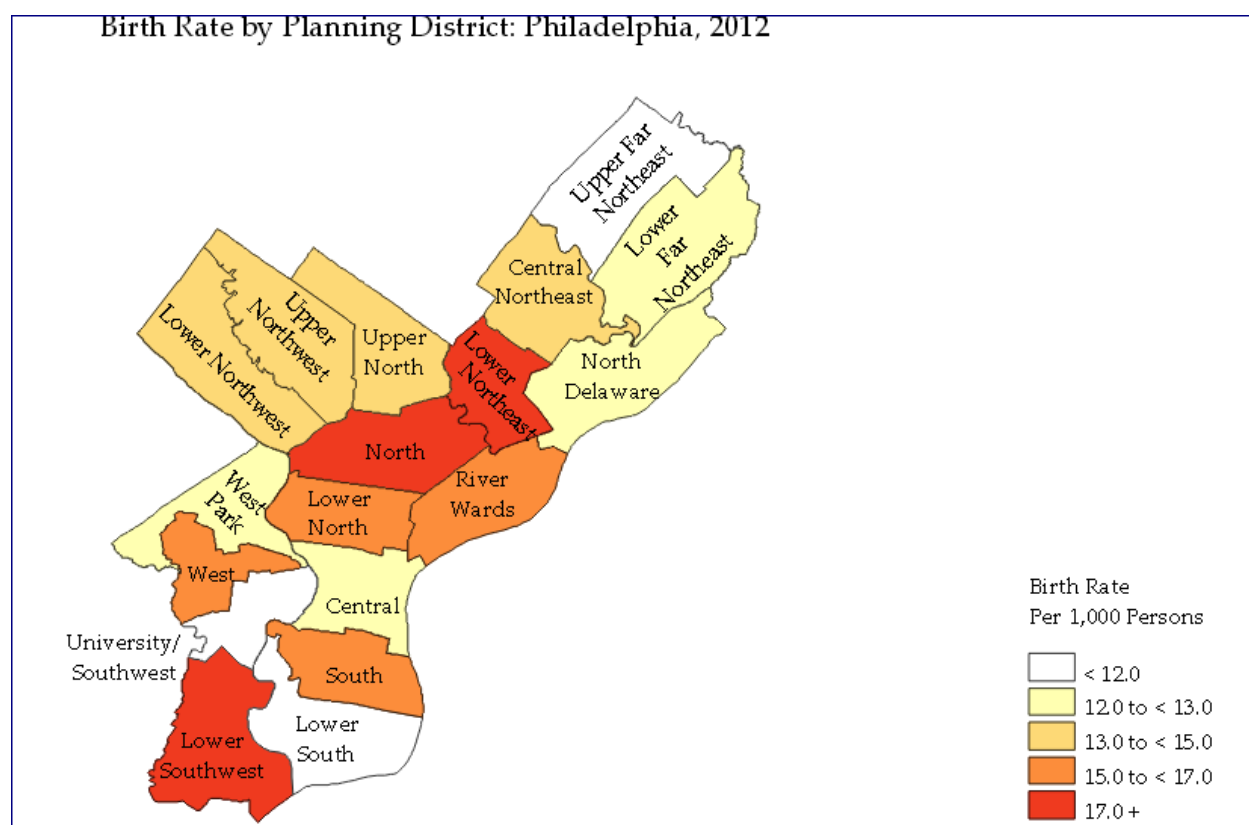
*2012 Vital Statistics Report, City of Philadelphia Department of Public Health*

Birth rates are highest among Hispanics (20.0) and Black non-Hispanics (15.9), followed by 14.3 among Asian non-Hispanics and 10.4 among White non-Hispanics. There are variations by age: Hispanic and Black non-Hispanic women in their 20s had highest birth rates while more White and Asian non-Hispanics had babies when in their 30s.



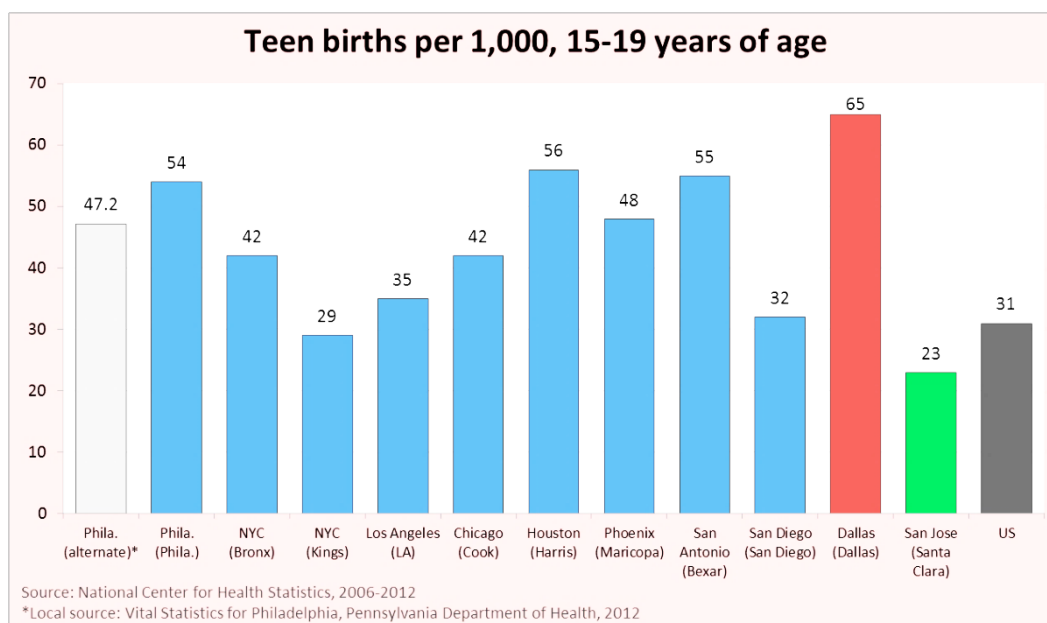
2012 Vital Statistics Report, City of Philadelphia Department of Public Health

The birthrate in TJUHs CB areas ranged from 7.6 in Lower South to 15.9 and 16.4 in South and Lower North respectively.

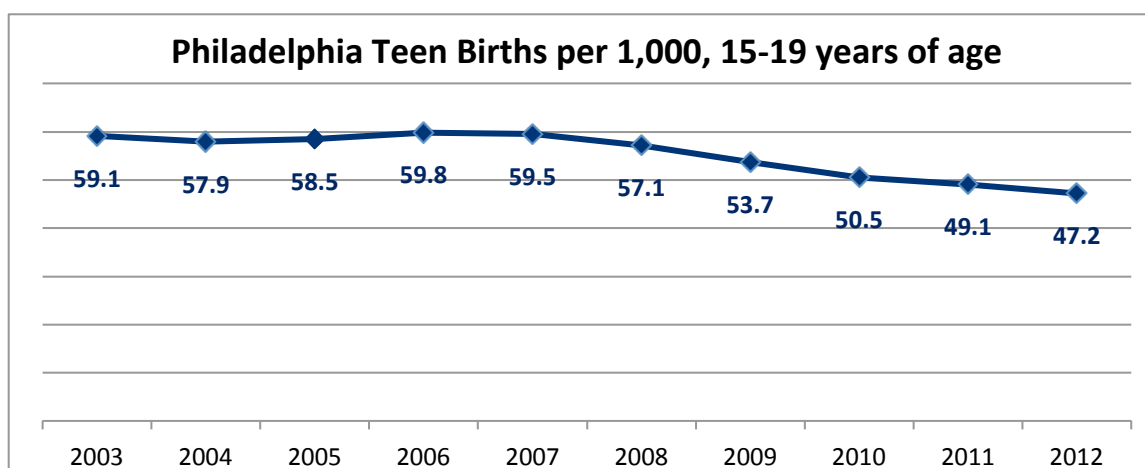


2012 Vital Statistics Report, City of Philadelphia Department of Public Health

**Teen Pregnancy:** Philadelphia exceeds the teen pregnancy rate for the state (24 per 1,000) and the nation (31 per 1,000) and has among the highest teen pregnancy rates of its peer cities.

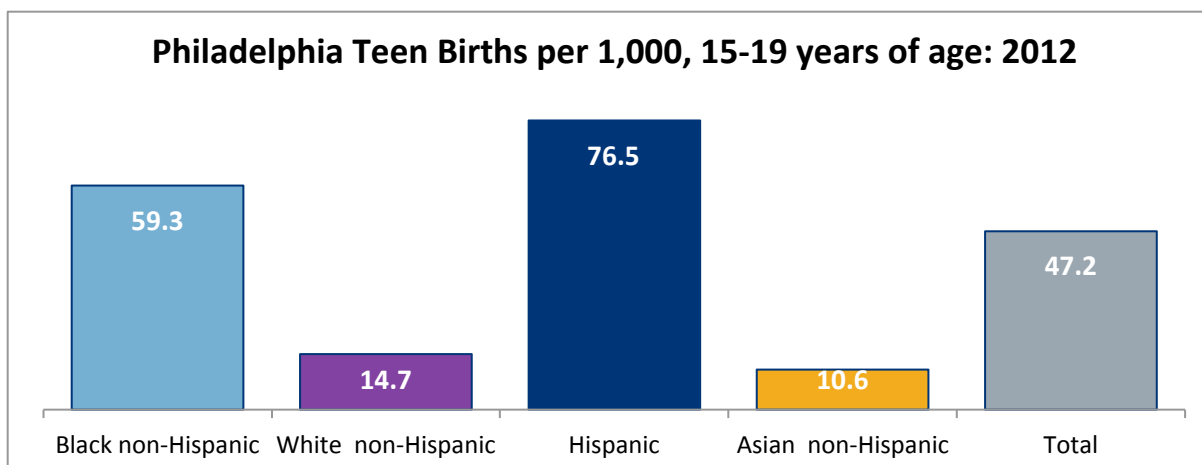


The rate of births to teens 15-19 years of age has steadily decreased between 2006 and 2012 from 59.8 to 47.2 births per 1,000. The Healthy People 2020 goal is to reduce pregnancies among 15-17 year old females to less than 36.2 per 1,000 and to less than 105.9 for females aged 18-19 years old.



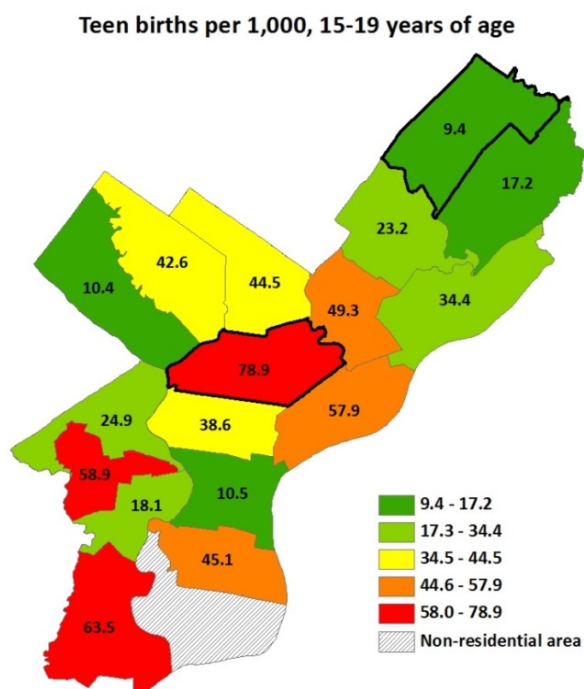
2012 Vital Statistics Report, City of Philadelphia Department of Public Health

In 2012, the highest rate of births to teens aged 15-19 was among Hispanics and non-Hispanic Blacks. From 2003 to 2012, the rate of births to teens decreased among non-Hispanic Black women from 74.3 births to 59.3 births per 1,000 and among Hispanics from 107 to 76.5 per 1,000 births.



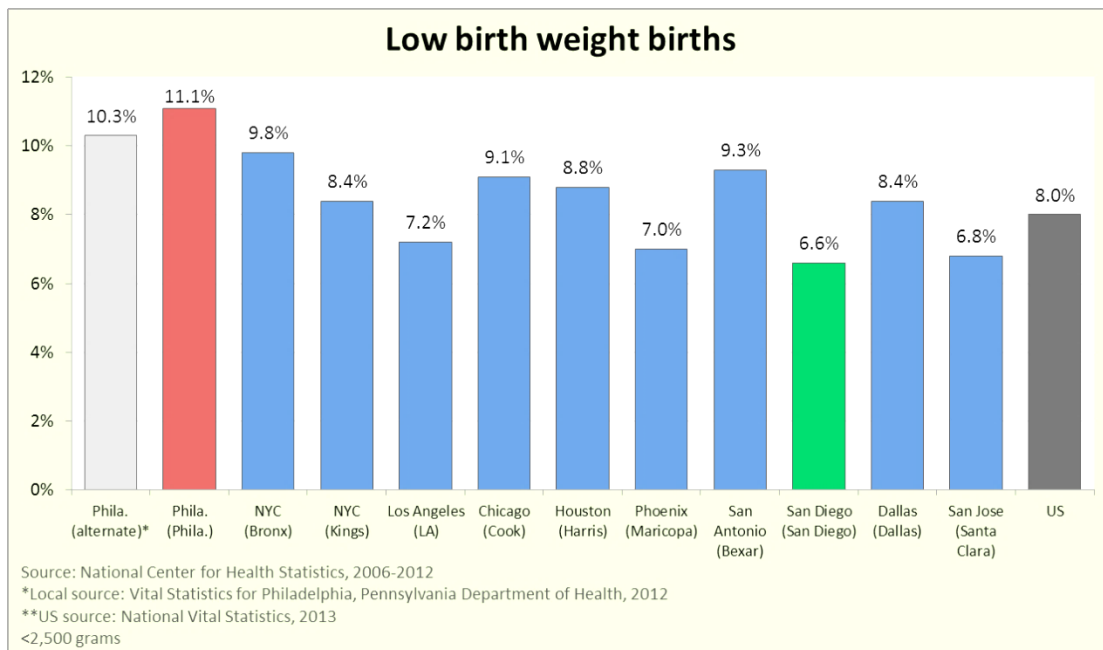
*2012 Vital Statistics Report, City of Philadelphia Department of Public Health*

Lower North and South Philadelphia have the highest teen pregnancy rates of TJUHs CB areas (38.6 and 45.1 respectively). Some public high schools in Philadelphia provide access to condoms and information about adolescent sexuality issues through the ELECT program.

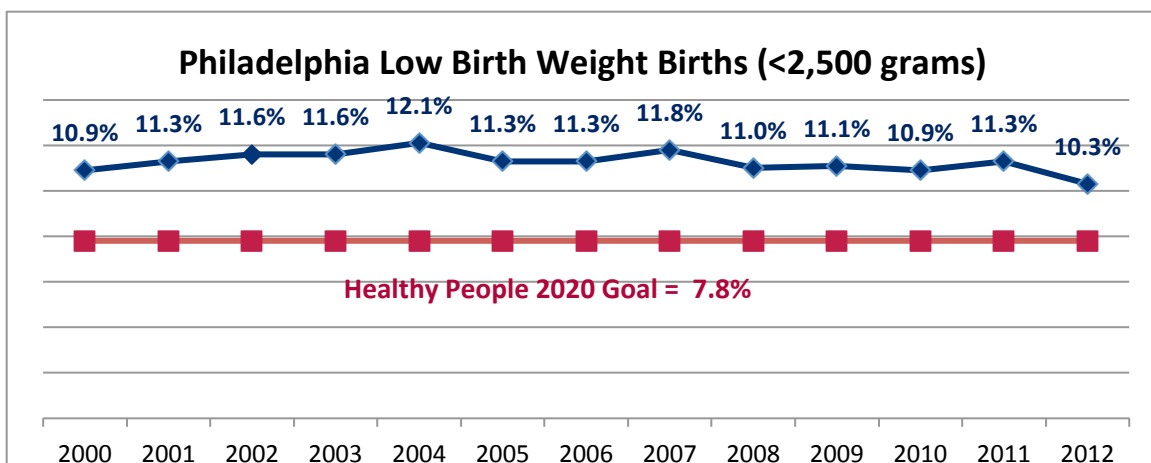


Source: Vital Statistics, Pennsylvania Department of Health, 2012

**Low Birth Weight:** Babies weighing less than 2,500 grams at the time of birth are considered to be of low birth weight. Philadelphia has the highest rate of low birth weight babies among its peer cities and exceeds the rate for the nation.

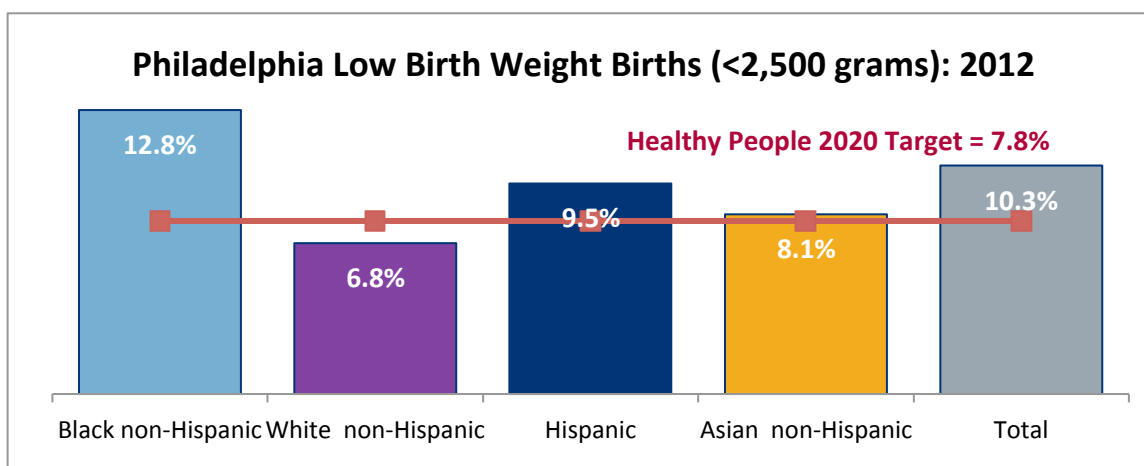


In 2012, 10.4% of all live births in Philadelphia were of low birth weight. Babies weighing less than 1,500 grams at the time of birth are considered to be of very low birth weight. In 2012, 2.3% of all live births were of very low birth weight. Overall, the percent of low and very low birth weight births has remained relatively stable between 2000 and 2012. The Healthy People benchmark for 2020 is no more than 7.8% of babies will be low birth weight.



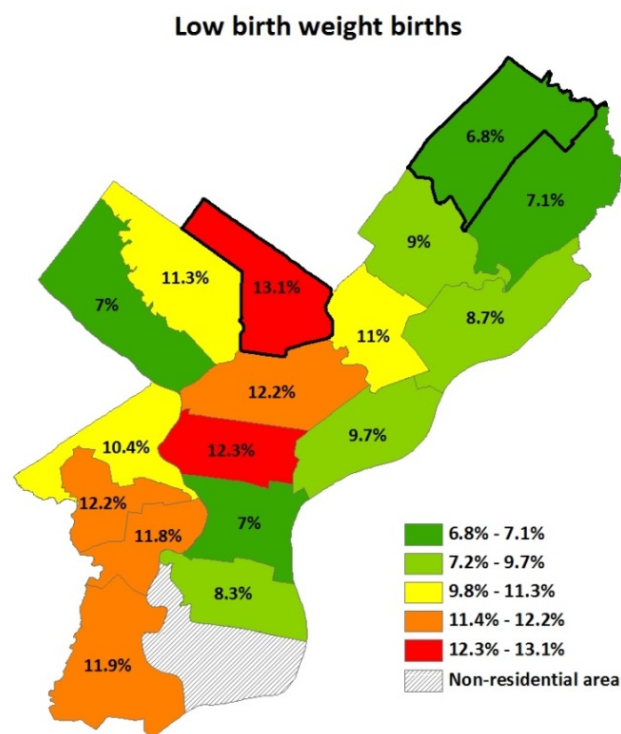
2012 Vital Statistics Report, City of Philadelphia Department of Public Health

The racial/ethnic group with the highest rate of low birth weight babies in 2012 was non-Hispanic black women. As with low birth weight, the racial/ethnic group with the highest rate of very low birth weight in 2012 was non-Hispanic black women; 3.2% of their babies weighed less than 1,500 grams when born.



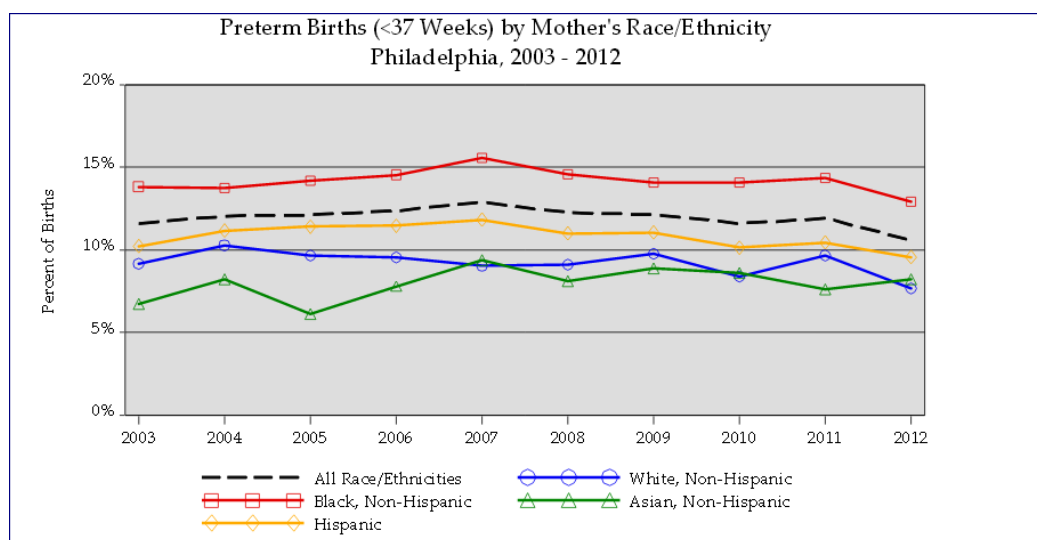
*2012 Vital Statistics Report, City of Philadelphia Department of Public Health*

The low birth weight rate in Lower North Philadelphia (12.3%) is among the highest in Philadelphia. Low birth rates in Central Philadelphia (7%) and South Philadelphia (8.3%) compare favorably among Philadelphia's Planning Districts and births to mothers from Central Philadelphia achieve the Healthy People 2020 goal.



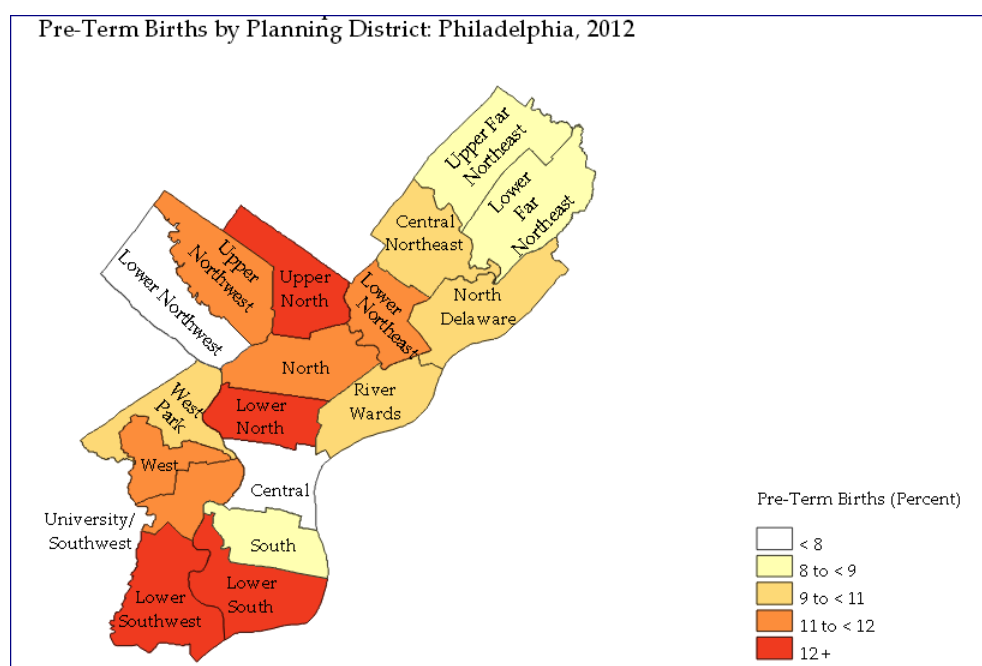
Source: Vital Statistics, Pennsylvania Department of Health, 2012  
<2,500 grams

**Preterm Births:** Preterm births are defined as births with less than 37 completed weeks of gestation. In 2012, 10.7% of births in Philadelphia were preterm. The highest rate of pre-term births was among non-Hispanic Black women, with 12.9% of their babies being born preterm (a decrease from 14.1% in 2010). Overall, the percent of preterm births remained stable from 2003 to 2011 (between 11.5% and 12.5%) but in 2012 the rate dropped to 10.6%.



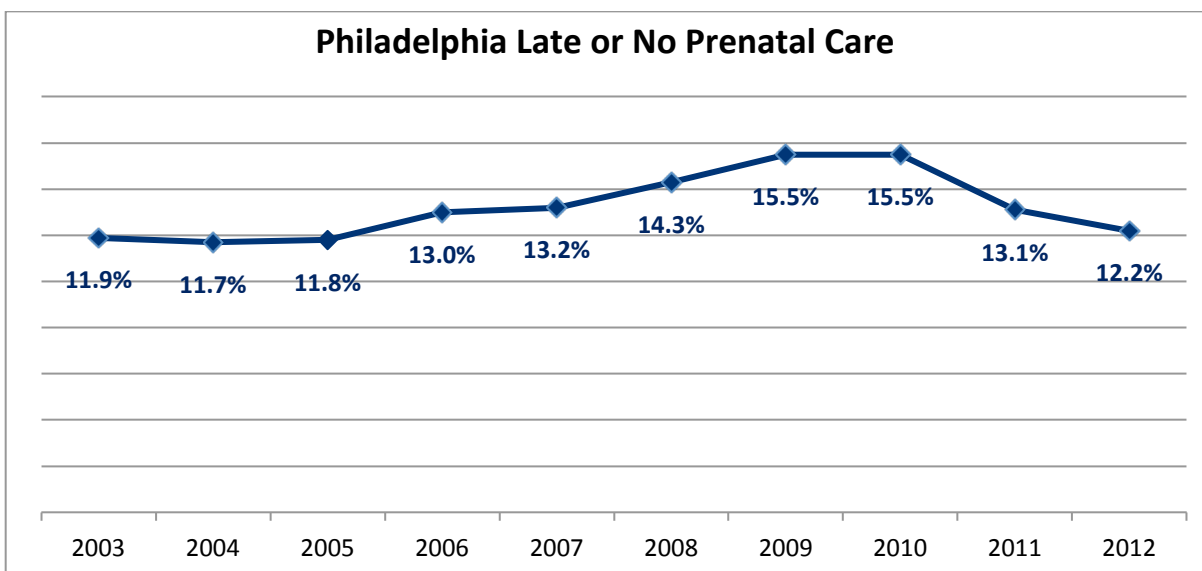
2012 Vital Statistics Report, City of Philadelphia Department of Public Health

Preterm birth rates in TJUHs CB area in 2012 were 13.7% in Lower North, 12.8% in South Philadelphia (note- rate based on very small number of births (39) - interpret with caution), 8.8% in South Philadelphia, and 6.8% in Central Philadelphia. The Healthy People 2020 target for preterm birth is less than 11.4% of births occur with less than 37 completed weeks of gestation.



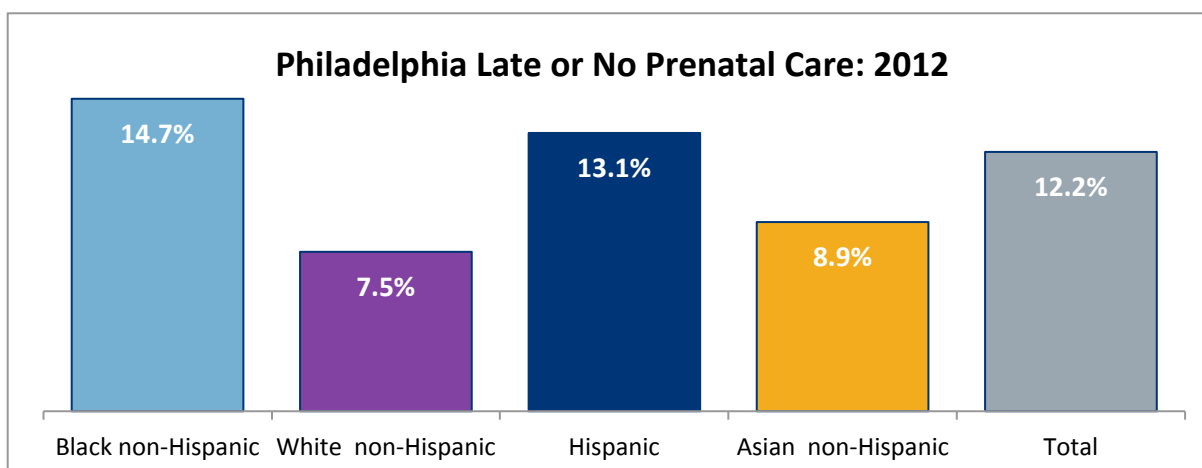
2012 Vital Statistics Report, City of Philadelphia Department of Public Health

**Prenatal Care:** The Healthy People 2020 target for initiation of prenatal care in the first trimester is 77.9%. Late or no prenatal care is defined as not initiating prenatal care until the third trimester or not getting prenatal care at all. Prenatal care is often not noted on Pennsylvania birth certificates; however, since 2003 this omission has been reduced from 41% to 16% in 2012. Of birth certificates with prenatal care information, 12.2% of women in Philadelphia had no prenatal care or did not start prenatal care until their third trimester. This is a decrease from 15.5% in 2010.



*2012 Vital Statistics Report, City of Philadelphia Department of Public Health*

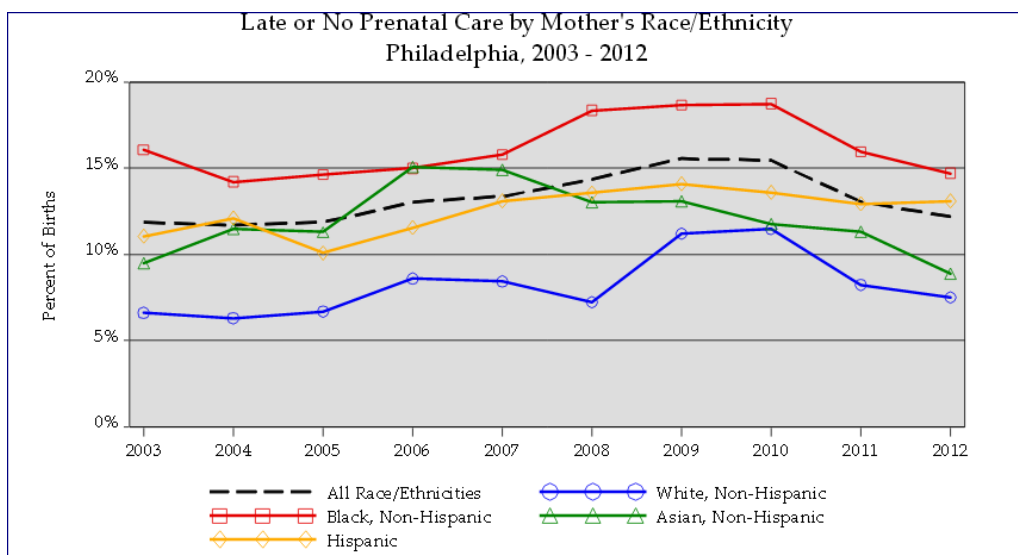
Non-Hispanic black women continue to have the highest percentage of late or no prenatal care; however, the rate has decreased since 2010 (18.7%).



*2012 Vital Statistics Report, City of Philadelphia Department of Public Health*



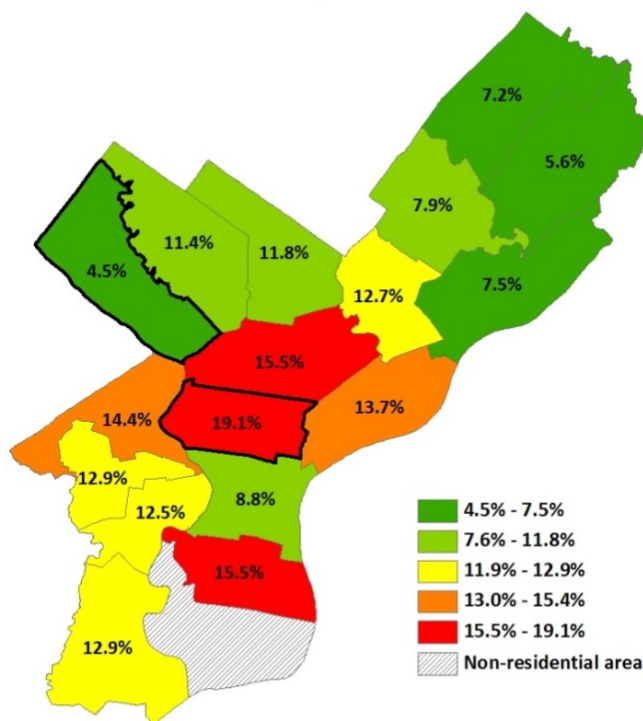
From 2010 to 2012, fewer women of all race/ethnic groups are delaying or not receiving prenatal care, although the improvement among Hispanic women is minimal.



*2012 Vital Statistics Report, City of Philadelphia Department of Public Health*

In TJUHs CB area the percentage of women getting late or no prenatal care ranges from 8.8% in Central Philadelphia to 19.1% in Lower North Philadelphia. South Philadelphia (15.5%) and Lower North Philadelphia have the highest rates for late or no prenatal care in the City.

#### Late or no prenatal care



Source: Vital Statistics, Pennsylvania Department of Health, 2012  
Prenatal care beginning in third trimester or no prenatal care at all

***Substance use during pregnancy:*** Substance use during pregnancy is a substantial public health problem and a risk factor for poor neonatal outcomes. Substance abuse in pregnancy has increased over the past three decades in the United States, resulting in approximately 225,000 infants yearly with prenatal exposure to illicit substances. Opioid abuse in pregnancy includes the use of heroin and the misuse of prescription opioid analgesic medications. According to the 2010 National Survey on Drug Use and Health, an estimated 4.4% of pregnant women reported illicit drug use in the past 30 days. Poor obstetric outcomes can be up to six times higher in patients abusing opiates.<sup>100</sup>

Pregnant women with substance use disorders can be challenging to engage in prenatal care and substance abuse treatment. Several barriers impede access to treatment: fear of losing custody of the child, stigma attached to mothers misusing substances, lack of access to specific treatment programs for addiction in pregnancy, and lack of support from partners or families.<sup>101,102</sup>

Opioid-assisted therapy during pregnancy can prevent complications of illicit opioid use and narcotic withdrawal and encourage prenatal care and drug treatment. The Maternal Addiction, Treatment, Education and Research (MATER) program at Thomas Jefferson University is the largest substance abuse treatment program for pregnant and parenting women in the United States and is a nationally and internationally recognized mode for substance abuse in this vulnerable population. The opioid epidemic affecting the U.S. continues to grow. The number of opioid-exposed neonates seeking care at MATER increased from 74 in 2013, to 82 in 2014, and in 2015 an estimated 90 to 100 births were anticipated. MATER provides comprehensive substance abuse treatment services in outpatient settings (The Family Center) and short and long term medically monitored residential treatment at My Sister's Place. In 2014, approximately 340 women received services from MATER, 145 women were admitted into the treatment program, and 80 women gave birth. Eighty-three percent of MATER clients who gave birth were stabilized on Methadone at TJUH prior to being admitted into the MATER program. Birth outcomes show that 75% of births occurred at or later than 38 weeks and 75% had normal birth weights.

***Breastfeeding Initiation:*** The cognitive and physical development of infants and children is influenced by the health, nutrition, and behaviors of their mothers during pregnancy and early childhood. Breastfeeding is one of the most effective preventive health measures for infants and mothers. Breast milk is widely acknowledged to be the most complete form of nutrition for most infants, with a range of benefits for the infant including lowering health risks, and improving growth, immunity, and development.<sup>103,104</sup> Short- and long-term benefits to mothers who breastfeed include decreased risks of breast and ovarian cancers, diabetes, rheumatoid arthritis, cardiovascular disease, and more rapid maternal weight loss after birth. Furthermore, research suggests that breastfed babies have lower risks of asthma, childhood leukemia, childhood obesity, ear infections, eczema, diarrhea, vomiting, lower respiratory infections, sudden infant death syndrome (SIDS) and Type 2 diabetes.<sup>105</sup>

Hospitals and birthing facilities can play a significant role in breastfeeding initiation. Birth facility policies and practices significantly influence whether a woman chooses to start breastfeeding and how long she continues to breastfeed. The Baby-Friendly Hospital Initiative is a global program sponsored by the World Health Organization (WHO) and the United Nations

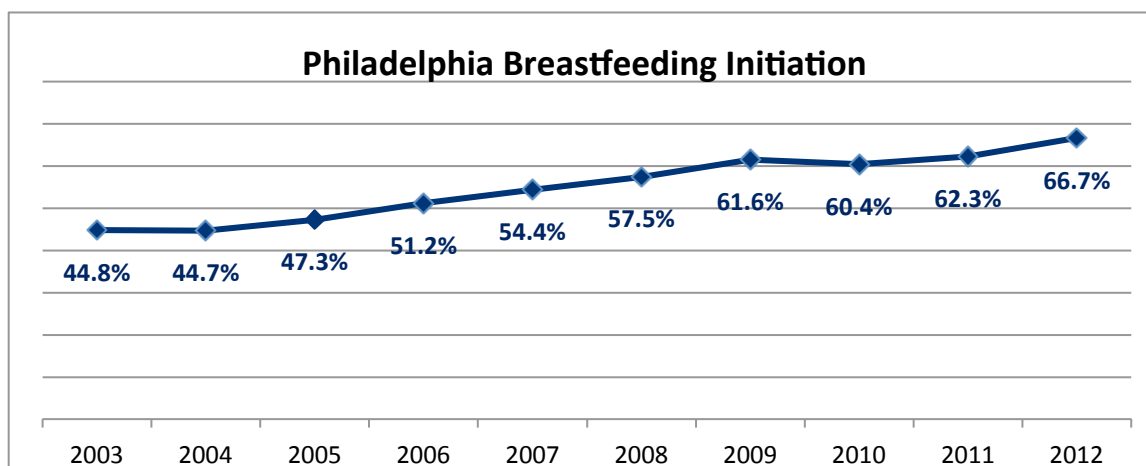
Children’s Fund (UNICEF) to encourage and recognize hospitals and birth centers that offer an optimal level of care for lactation based on the WHO/UNICEF Ten Steps to Successful Breastfeeding for Hospitals. Additionally, achieving *Baby Friendly* certification is a key component of the Philadelphia Department of Health’s Community Health Improvement Plan for chronic diseases related to the root causes of obesity (healthy affordable food and safe places for physical activity). Its goal is to partner with community organizations to “*Increase the number of birthing hospitals with Baby Friendly breastfeeding certification*”. Achievements include the following:

- The Philadelphia Department of Public Health’s Maternal, Child & Family Health (MCFH) funds credentialed lactation workers to give individual breastfeeding counseling at 6 health centers; is actively engaged with the Baby Friendly Hospital initiative; supports the MCFH lactation consultant as co-chair of the Multi-Hospital Task Force; and provides breastfeeding training for healthcare professionals and Child Care program staff
- The Maternity Care Coalition implemented the North Philadelphia Breastfeeding Program, a community-based doula program enhancing birth and breastfeeding experiences of families in North Philadelphia in zip codes 19122, 19123, 19124, 19125, 19132, 19133, 19134, 19140
- The Maternity Care Coalition facilitates the Hospital Baby Friendly Coalition which includes all 6 birthing hospitals in Philadelphia. Two of the six hospitals achieved *Baby Friendly* designation in 2015. Three delivery hospitals continue to work towards the *Baby Friendly* designation and one delivery hospital is aiming to also earn the Pennsylvania Department of Health Keystone Ten Initiative designation, which is similar to *Baby Friendly*. TJUH anticipates achieving Baby friendly status fall of 2016.

The following are Healthy People 2020 goals related to breastfeeding:

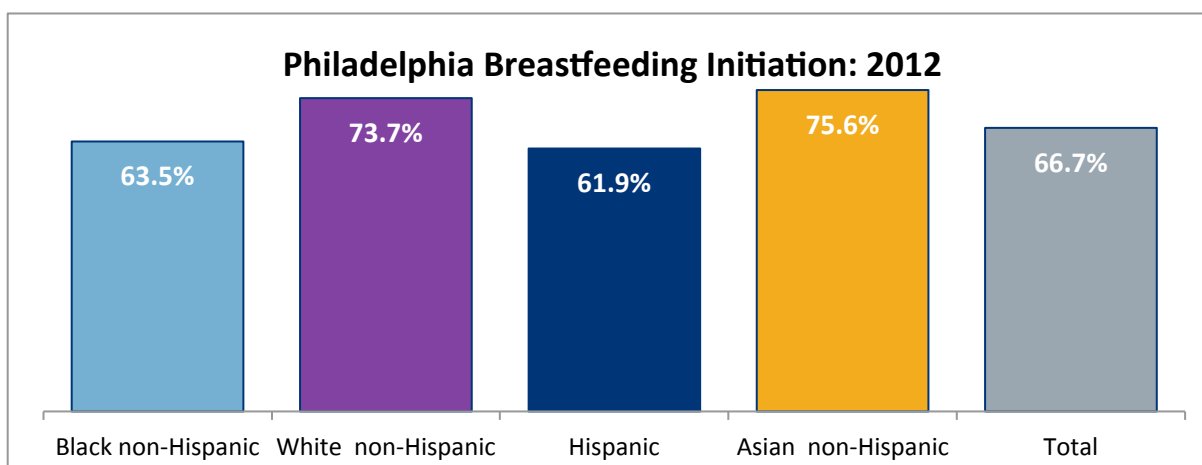
- Increase the proportion of infants who are ever breastfed to 81.9%
- Increase the proportion of infants who are breastfed at 6 months to 60.6%
- Increase the proportion of infants who are breastfed at 6 months to 34.1%
- Increase the proportion of infants who were breastfed exclusively through 3 months to 46.2%
- Increase the proportion of infants who were breastfed exclusively through 6 months to 25.5%
- Increase the proportion of employers that have worksite lactation support program to 38%
- Reduce the proportion of breastfed newborns who receive formula supplementation within the first 2 days of life to 14.2%
- Increase the proportion of live births that occur in facilities that provide recommended care for lactating mothers and their babies to 8.1%

In Philadelphia the breastfeeding initiation rates have steadily improved since 2003 (44.8% to 66.7% breast feeding initiation).



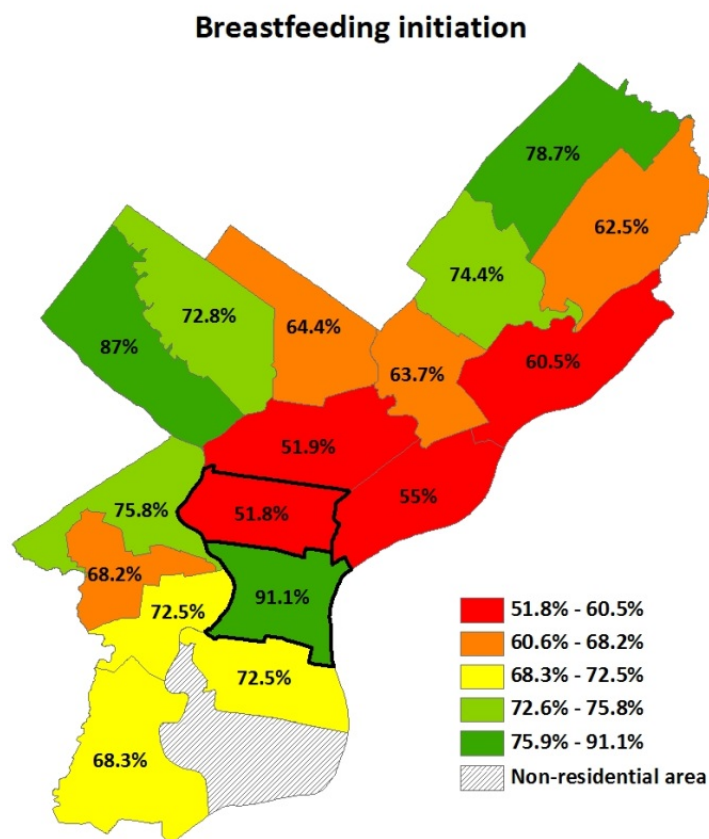
*2012 Vital Statistics Report, City of Philadelphia Department of Public Health*

Breastfeeding initiation rates are highest among non-Hispanic White and Asian women and lowest among the Hispanic community.



*2012 Vital Statistics Report, City of Philadelphia Department of Public Health*

Breastfeeding initiation rates vary in Philadelphia from 51.8% in Lower North Philadelphia to a high of 91.1% in Central Philadelphia reflecting a significant variation in within TJUHs CB area.



In the United States, about half of infants are routinely cared for by someone other than a parent. Infants attend child care centers or are cared for in a variety of home-based settings including licensed family child care homes or the home of a family member, friend, or neighbor. Consequently, child care facilities can play an important role in supporting breastfeeding among mothers whose infants are cared for in these facilities.<sup>106</sup>

**Issues, challenges, unmet needs and priorities identified by key informants and focus group participants related to maternal child health included:**

*"We should look at Philadelphia as a global health issue not just individual medical issues."* (key informant)

*"To break cycle of poverty we need to keep boys out of jail and prevent girls from becoming pregnant."* (key informant)

- **Access to gynecologic services**
  - Insurance:
  - OB/GYNs get referrals that can't be handled by the City Health Centers. Many clients don't have insurance.

- *"If an uninsured woman has fibroids she can't get emergency MA insurance since she only has fibroids, not cancer or another emergency. A dilation and curettage (D&C) needs to be done in the emergency room to stop the bleeding. Once this procedure is done then cancer can be diagnosed, and the patient can get emergency MA. However, the D&C services provided up to point of diagnosis are not covered."* (key informant)
  - Medicare doesn't cover contraception. Therefore, *"younger disabled women (behavioral/mental or physical) who are on Medicare and want contraception can't get it unless they can afford to pay for it."* (key informant)
  - Health literacy training is needed for health professionals. Need better communication skills
  - Need cultural competence training for OB providers and staff in additions
- **Access to OB services**
  - Need for information/training on condom use, safe sex practices, relationship violence, pre-conception counseling (smoking, vitamins, emotional readiness, financial readiness, diabetes etc.), pregnancy prevention, and pregnancy termination
  - Shortage of OBs in South Philadelphia
  - *"Need improved access to prenatal care. Improve infant birth outcomes (early prenatal care, birth weight, preterm birth, teen pregnancy, drug use during pregnancy.)"* (key informant)
  - Convenience:
    - *"Women can't afford to set 5 hours aside for prenatal care – not convenient to get prenatal care due to work schedule. Prenatal care office hours between 8am – 4pm are not convenient for working women –appointments during office hours blows the whole day in terms of working."* (key informant)
    - *"Skype with women who can't make appointments or use skype as a home visit. This is being done to encourage breastfeeding. We need to use technology better."* (key informant)
  - Coordinated care:
    - *"Fragmentation of behavioral health, health care and obstetrical care is hurting everyone, putting people at risk and even death."* (key informant)
    - Women can go to a hospital emergency department to deliver where they did not receive care. The emergency department doesn't have access to patient charts across EDs, so all prenatal tests are repeated. The OB chairpersons group supports a city-wide OB chart and a "maternity passport" accepted by city emergency departments. Need global consent and global HIPPA form that can be used citywide so that women who go to an ED that was not the assigned birthing hospital do not have tests repeated that have been done at another health provider (FQHC, City Health Center, or private care). (key informant)
    - *"Lack of ED access to patient electronic health record. Need to identify funding to support coordination efforts for a databank."* (key informant)
    - Develop protocol standards for all obstetrical care in the city. There are some concerns that this may not be practical/feasible
    - Consider providing community school based OB/GYN health services (South Philadelphia High School as site)

- Cultural Competence and language:
  - *"I don't know what it's like for a woman on methadone to go to PCP who says 'oh this program (MATER) is for addicted moms' No- they are in treatment-Need training for providers to deal with people/ women on drugs who are high or are in treatment-How do we shine a 'light' on these issues for providers?"* (key informant)
  - *"Growing Asian community - About 85% of MCC clients (313 families) in South Philadelphia are Asian (Indonesian)." (key informant)*
  - *"Need bilingual, culturally competent providers. While phone translators are better than nothing, they are not the solution."* (key informant)
  - Pregnant women face language, transportation, cultural competence, social isolation, and access issues.
  - *"The challenge of serving multiple languages is really significant; can't staff for all of the languages. Need in person translators but there isn't enough time available."* (in the office visit) (key informant)
- **Prenatal care**
  - Perceptions about prenatal care
    - *"There is a lack of health promotion or education about the importance of prenatal care. This results in misconceptions that women don't need prenatal care."* (key informant)
    - *"She had a baby at 29, or 32 weeks, and she was just fine."* (key informant)
    - *"Women are getting things on internet to induce labor."* (key informant)
  - Insurance issues:
    - Unintended pregnancy – *"MA won't cover abortion; a woman with an unintended is pregnancy less likely to get prenatal care."* (key informant)
    - Care for undocumented pregnant women is *"heart breaking". Many get late or no prenatal care. In Philadelphia the Health Centers will provide care for undocumented, but women fear deportation and they do not have insurance to cover hospital charges for birth of the baby (enter through ED)."* (key informant)
  - Interpersonal violence (IPV) during pregnancy
    - Pregnant women who go to ED and are pregnant may have concerns about disclosing IPV and if asked about IPV, may not want to disclose it and therefore don't get prenatal care (key informant)
  - Care coordination:
    - Need care coordination and co-located services (key informant)
    - Utilize a group prenatal care visit - centering concept – utilize technology to reach women such as a mobile app (key informant)
  - Assistance with social determinants of health:
    - Barriers to prenatal care: insurance, language and cultural barriers, behavioral health, lack of childcare at clinics (key informant)
    - *"Single pregnant moms with no transportation face barriers that impact getting prenatal care and postpartum visits. On-site health care visits would cut down on missed post-partum appointments. Co-locate pediatric visits, primary care. This would be particularly helpful for pregnant women on*

*methadone who need to go to MATER clinic daily and can't afford all the transportation costs, childcare costs etc."* (key informant)

- Need additional social work support for low income women needing referrals to public benefits and services (key informant)
- Co-located legal services - *"It would be good to have a lawyer at the hospital as part of the clinic to address legal needs related to housing, utility shut-offs, insurance, and benefit denial issues..."* (key informant)
- Food access- healthy pregnancy (nutrition) impacted by food deserts (key informant)
- *"The best care in the world won't trump the social issues. Women are released from the hospital with no place to go, no cribs. etc."* (key informant)
- *"Patient navigation model is needed to coordinate care and services. Patient navigator services needed prior to birth, at birth, and frequently after birth. Rather than having 15 inadequate services, why not one comprehensive service."* (key informant)
- **Obesity prevention**
  - Need nutrition counseling pre-pregnancy through post pregnancy to prevent obesity (key informant)
  - Need nutrition/ healthy cooking education for cooks and staff in My Mother's place (key informant)
  - Access to healthy food may be problematic (focus group)
- **Teen pregnancy**
  - Teenagers – *"no sex ed in schools in ways that make sense – teens see only the good side – by the time they learn it isn't all good, it's too late"* (focus group)
  - Sexual health issues- *"We need reproductive health for youth, but politically this may be difficult. Sexual health needs to be talked about in school, at home - not learned from friends."* (key informant)
  - Health resource centers
    - Not every high school or charter school has a resource center. There are 13 in Philadelphia. (key informant)
    - Provide birth control options - On-site condoms, STD testing, pregnancy testing, contraception referrals, and morning after pills should be available. (key informant)
  - Pediatricians need to talk about contraception (key informant)
  - *"Teen moms feel judged- condescended to."* (focus group)
- **Mental Health Issues**
  - *"A significant number of women are experiencing mental health issues and substance use –they less likely to attend (prenatal care)with these issues."* (key informant)
  - *"Mental health is a prevalent and important issue for pregnant women."* (key informant)
  - Need co-located mental health services. (key informant)
  - *"Women's lives become 'appointments and travel'- on site co-located services would be helpful."* (key informant)
  - *"Depression and bi-polar illness among women are problems. They don't take meds due to cost or cost shifting (need money to pay rent, feed children, etc). It's very difficult for people with behavioral health issues to get regular care. People on SSI*



- (mental health disabled) are less likely to be on treatments or medications. There is no money to get to care/appointments and some have had a negative experience with therapists. Behavior providers say that more clinical behavioral care is needed."* (key informant)
- **Postpartum care**
    - Low rate of postpartum visits – *"not clear to women as to why they need to come back"* (Key informant)
    - Spacing pregnancies:
      - Should discuss contraception to reduce having another child. Need to link primary care and family planning reproductive life plans (pregnancy prevention) (key informant)
      - Long acting reversible contraception (LARC) - improve birth spacing through access to LARC. Insurance doesn't reimburse for LARC (insertion of an IUD) at time of delivery. *"To prevent pregnancies that are too close or in women not wanting to get pregnant right away, inserting long term acting contraception (LARC) such as IUD at time of delivery and not just at postpartum visit should be an option. This is also important because many women cannot or don't return for their postpartum visit. However, insurance only pays for LARC at the postpartum visit. Insurers should be encouraged to pay for LARC at the time of delivery. Consider going into the community with van to provide LARC services to those who need it."* (key informant)
      - Positive Messaging - *"Need to find language to talk about positive words to describe why birth spacing is a good thing versus 'you are trying to limit the number of children I can have'."* (focus group)
    - Cultural competence:
      - *"Women dealing with trauma who are coming for post-partum care are sometimes treated poorly. These women should have same provider otherwise they have to tell story over and over again and very traumatizing to have to repeat [reliving the trauma]."* (key informant)
    - Need to increase number of women who get a postpartum visit. Also need to get women in before 12 weeks. (key informant)
    - Depression:
      - Patients can be screened for depression in waiting room by psychiatry residents/Fellows. No data available for effectiveness (key informant)
  - **Breastfeeding**
    - Baby Friendly Hospitals:
      - The Keystone 10 initiative is designed to help all hospitals in Pennsylvania. All birthing hospitals in Philadelphia are completing Baby Friendly policy and system requirements. (key informant)
      - Philadelphia continues to pursue becoming the first Baby Friendly City in the U.S. Pennsylvania Hospital and University of Pennsylvania Hospital achieved Baby Friendly status in November 2015. Jefferson is set to achieve certification Fall 2016. (key informant)
      - On-going training needed to retain baby friendly status. Partnership with PDPH to train new nurses (key informant)

- Health literacy and cultural beliefs pertaining to breastfeeding need to be addressed (key informant)
- Recommendations to support breastfeeding women:
- Train African American nursing assistants to increase breastfeeding rates among African Americans; employ the “peer to peer” model (key informant)
- Work with/support African American women who breastfeed to do peer education about breastfeeding (key informant)
- Increase breastfeeding rates in the hospital among Asian women. Train Asian women in the community as peer educators to address language and culture barriers. (key informant)
- Support a free "warm line" and breastfeeding support group. The warm line and/or support group would be facilitated by a nurse to moderate the groups, not educate women. (key informant)
- Fax discharge summary for WIC patients to WIC who then follow-up with new moms. (key informant)
- Link support to telehealth initiatives. (key informant)
- **Incarceration and pregnancy**
  - Maternity Care coalition (MCC) is providing health and wellness training in prison for pregnant women and goal setting workshops. They are advocating for lactation programs and are in process of bringing breast pumps into jail. MCC has doulas who accompany women when they deliver. (key informant)
  - *"The prison commissary has very little healthy food and women gain on average 40 pounds while incarcerated. Need to advocate for healthier food particularly for pregnant women. Salt from condiments increases swelling in legs of pregnant women"* (key informant)
- **Parenting education**
  - Parenting education is needed to reduce risk of child mortality. *"A single parent who works long hours and has children in high school/middle school was asked 'what are you most proud of concerning your children?' She responded, 'Their being alive'."* (key informant)
    - Teenage parents need parenting education (focus group)
    - Parents need increased awareness about normal child development (key informant)

**Based on internal and external key informants, focus groups, existing relationships and programs, and secondary data, actions addressing maternal and child health may include:**

- 1. Co-locate health and social services, and increase awareness of resources to improve access to social and health services such as BenePhilly sites, mental health services and medical legal partnerships. Raise awareness about and refer to existing community resources (behavioral/mental health services, transportation, housing, food assistance)**
- 2. Improve access to language services**
- 3. Improve teenage access to contraception and sexual health services and information**

- 4. Provide cultural competence and health literacy training for health care providers and staff, particularly those working with pregnant women with addictions and experiencing trauma**
- 5. Through coordination of obstetrical services across the city, address access to care issues including need for OBs and long wait times to obtain prenatal care services**
- 6. Explore expanding availability of evening and weekend office hours to better meet the needs of working women**
- 7. Explore initiating “Maternity Passport”**
- 8. Advocate for changes to insurance regulations to support LARC services that are more convenient for patients**
- 9. Continue to pursue *Baby Friendly Hospital* status.**
- 10. Support lactation spaces in employment for nursing mothers. Train peer educators to support breastfeeding particularly among populations with low rates. Increase access to support for breastfeeding through a “warm line.”**
- 11. Use community health workers for care management. Create a more formal relationship with MCC and others to improve utilization of prenatal care and transitions home after birth.**

## ***Childhood Health***

In early and middle childhood, children are typically healthy; however, during this time children can become at risk for conditions such as:

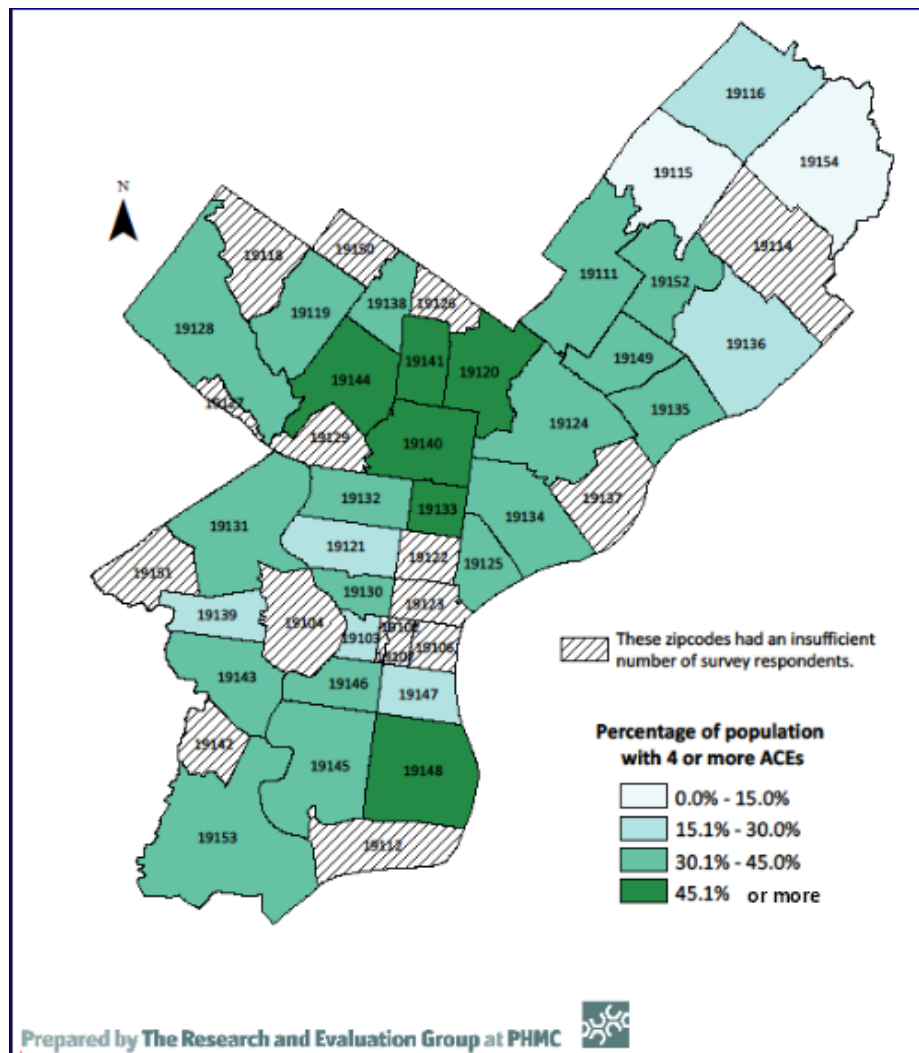
- Developmental and behavioral disorders
- Child maltreatment
- Asthma and other chronic conditions
- Obesity and related chronic diseases
- Dental caries
- Unintentional injuries

The impact of adverse childhood experiences (ACE) on mental and physical health has been well documented through studies conducted by the CDC and Kaiser Permanente.<sup>107</sup> Traumatic events in childhood include physical or sexual abuse, witnessing violence at home or in the community, and exposure to alcohol and other addictions. These experiences have been linked to poorer health in adulthood. As the number of ACEs a person experiences increases, the impact on mental and physical health also increases. Health problems found to be related to ACEs include.<sup>108</sup>

<ul style="list-style-type: none"><li>• Alcoholism and alcohol abuse</li><li>• Chronic obstructive pulmonary disease (COPD)</li><li>• Depression</li><li>• Fetal death</li><li>• Health-related quality of life</li><li>• Illicit drug use</li><li>• Ischemic heart disease (IHD)</li><li>• Liver disease</li></ul>	<ul style="list-style-type: none"><li>• Risk for intimate partner violence</li><li>• Multiple sexual partners</li><li>• Sexually transmitted diseases (STDs)</li><li>• Smoking</li><li>• Suicide attempts</li><li>• Unintended pregnancies</li><li>• Early initiation of smoking</li><li>• Early initiation of sexual activity</li><li>• Adolescent pregnancy</li></ul>
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Physical inactivity and severe obesity have also been shown to increase as ACE scores rise. The Philadelphia Urban ACE Survey conducted by the Public Health Management Corporation was completed in 2013. Results from the survey showed that 33% of Philadelphia adults had experienced emotional abuse, 35% suffered physical abuse as a child, 35% grew up in a household where there was substance abuse, 24% lived in a household where someone was mentally ill, and 12.9% lived in a household with someone who had been incarcerated or was sentenced to spend time in prison. Thirty-seven percent of Philadelphia ACE study respondents had 4 or more ACEs and African American adults and those living at less than 150% of the federal poverty level were significantly more likely to have 4 or more ACEs.<sup>109</sup>

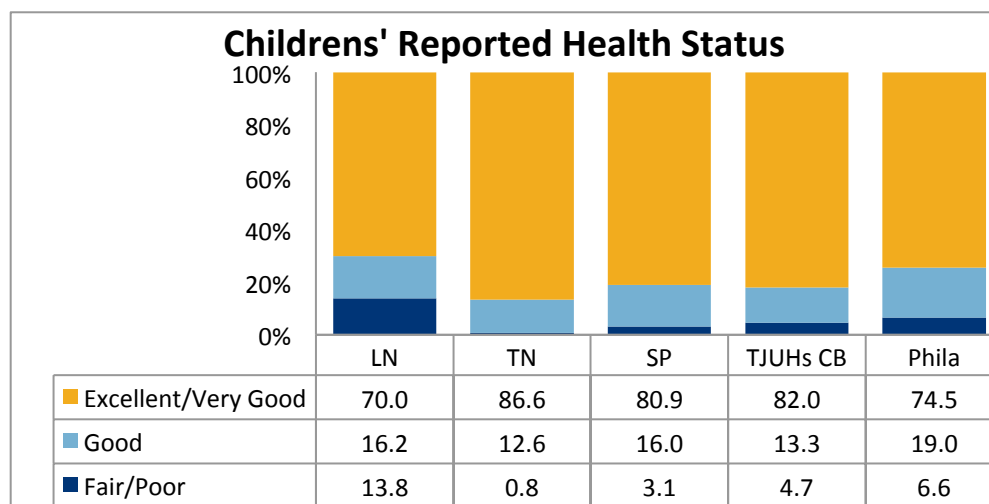
The map below depicts the percentage of the population with four or more ACEs by zip code in Philadelphia. In TJUHs CB area, more than 45% of residents living in zip codes 19148 (South Philadelphia) and 19133 (North Philadelphia) had 4 or more ACEs.



Social and environmental conditions can affect children's future health and well-being as adolescents and adults. Multidisciplinary interventions that address social determinants of health are needed to address early and middle childhood issues. These interventions include ensuring that caregivers, families, and educators have the information, skills, resources, and support they need including access to quality health care, to create nurturing, supportive, and safe environments in home, schools, and communities.

Early and middle childhood experiences can impact school success, healthy eating and physical activity habits, healthy decision making, and healthy relationships with family and friends. Health promotion efforts initiated in early childhood education and childcare programs can change the trajectory of future health and well-being. Providers and parents need training and tools to promote healthy habits and environments. The Philadelphia ACE taskforce, initiated in 2012, continues to meet to address childcare, education, and health interventions and policy issues to reduce exposure to adverse childhood events and promote health and well-being of families.<sup>110,111</sup>

**Overall Children's Health Status:** The majority (93.5%) of parents or guardians in Philadelphia rate their child's health status of respondents rated the health status of children as excellent/very good or good. Within TJUHs CB area, children living in Lower North Philadelphia were twice as likely to be rated with fair/poor health status (13.8%) compared to Philadelphia (6.6 %) and three times more likely compared to TJUHs CB area (4.7%).



PHMC Household Health Survey 2015

**Early Childhood Obesity:** Childhood obesity is a major public health concern. Nationally approximately 17% of children and adolescents aged 2 to 19 are obese, and 9.7% of infants and toddlers (birth to 2 years) have high weight for recumbent length at the 95<sup>th</sup> percentile or higher.<sup>112</sup> Children who are overweight or obese by age 5 are five times as likely to be overweight or obese as adults.

Head Start programs are required to do growth screening annually. Body mass index data from Head Start programs affiliated with the Norris Square Community Association, for 998 children enrolled was analyzed by staff from TJUHs Center for Urban Health. Overall, 31% of children aged 2-5 were found to be overweight or obese (BMI greater than or equal to 85<sup>th</sup> percentile). The overweight/obesity rates varied across sites and ranged from 21% to 39%. Head Start staff was also interviewed about their perceptions of the prevalence of overweight/obesity among the children and what they felt needs to be done to promote healthier lifestyles. Although nearly one third of Head Start children are overweight or obese, only one of the Head Start sites named obesity as a health issue affecting the children.

*"We do not have a big obese problem at this center"*

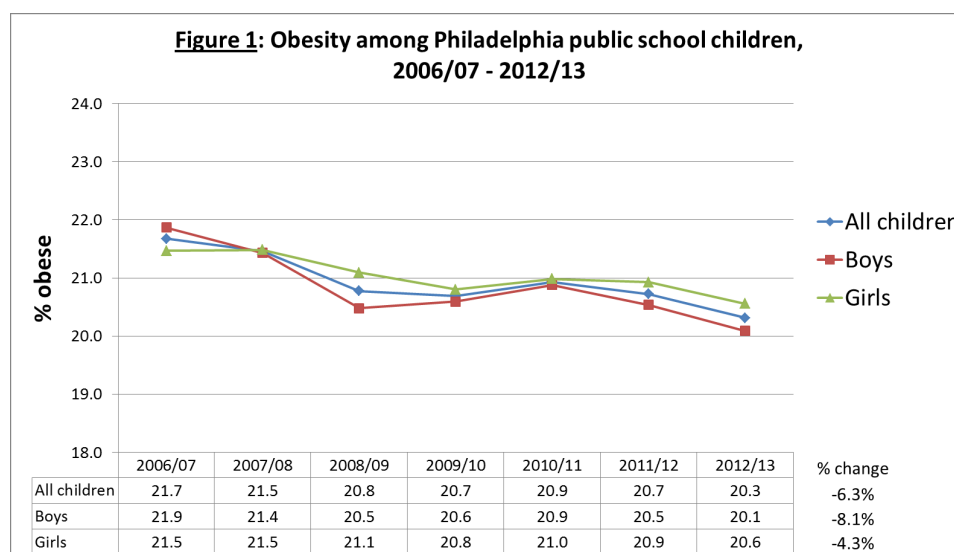
*"I guess it's an issue, but not sure"*

*"More and more the norm is to be overweight, so they say I'm average, but average isn't healthy"*

The Head Start programs have policies that promote healthy snacks and food brought from home but parents do not always adhere to the policies: *“They try to come in here with the potato chips and donuts and the kids drinking Yoo-hoo in the morning. They know the routine though, it all goes straight into the trash. The trash can is right at the door; nothing goes into the classroom.”*

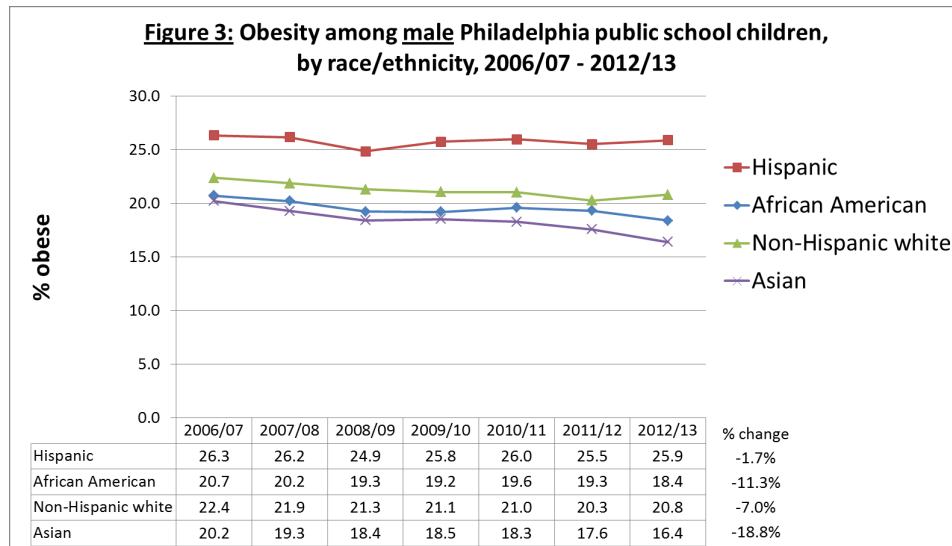
Head Start staff felt that a multi-pronged approach was needed to reduce BMI among the preschoolers. Interventions that promote healthy eating and physical activity such as creating gardens at the day care centers and providing cooking classes for the children and parents were highlighted. Improving access to healthy affordable food was also seen as needed in order for families to increase their consumption of fresh fruit and vegetables. The Head Start programs provide an excellent opportunity to provide interventions that prevent obesity among our youngest children. The Community Health Improvement Plan (chronic disease focus) of PDPH’s *Get Healthy Philly* initiative is committed to promoting healthy eating and physical activity to preschool aged children and their families. TJUH has initiated discussions with multiple Head Start programs to develop programming.

According to annual growth screening data from the Philadelphia School District, obesity rates among children ages 5-18 years decreased between 2006/2007 (21.7%) and 2012/2013 (20.3%) due to the efforts of many organizations across Philadelphia. Despite these decreases, the obesity rate in Philadelphia for children and adolescents remains above the Healthy People 2020 goal of less than 14.5%.



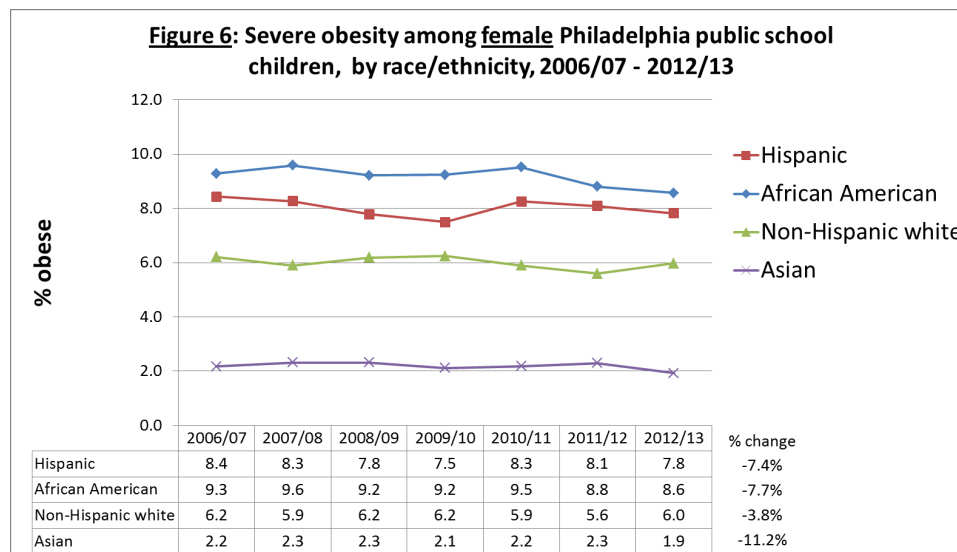
Philadelphia School District

Obesity declines were significantly higher among non-Hispanic Black and Asian boys and boys in grades K-5.



*Philadelphia School District*

Obesity rates trended downward initially for girls but then increased significantly among Hispanic girls and girls in grades K-5. Data for the 2012/2013 school year indicate that Hispanic youth have the highest rates of obesity - 25.9% for boys and 23% for girls.<sup>113</sup>

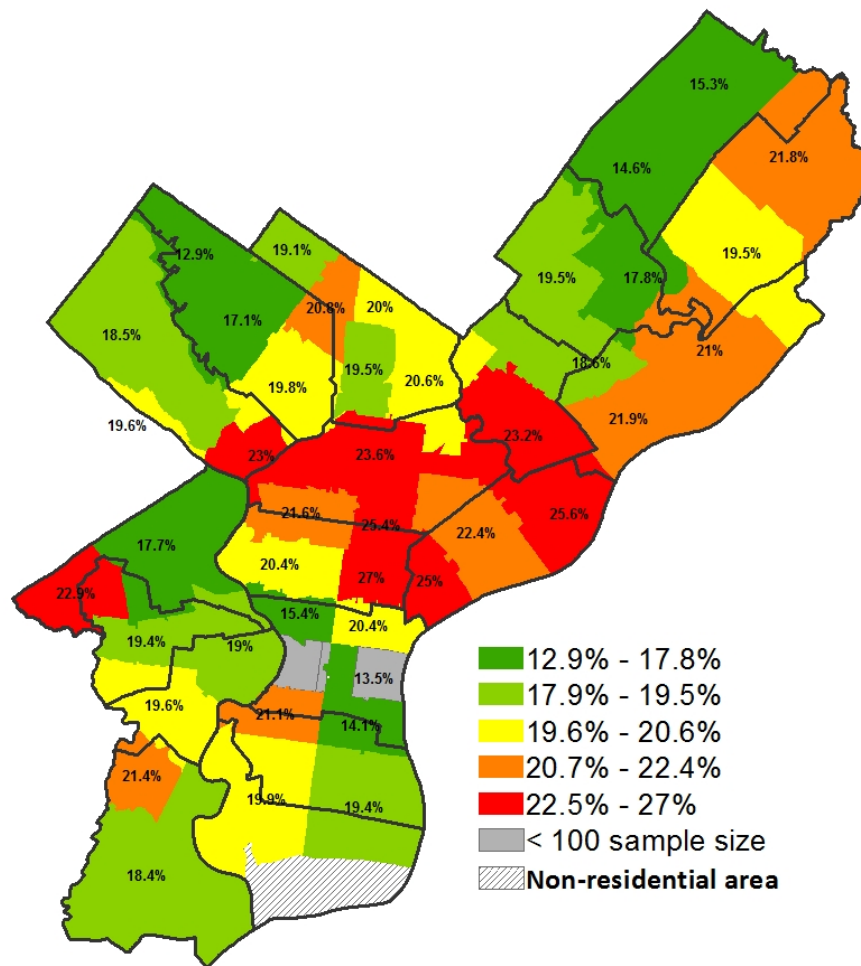


*Philadelphia School District*

Children living in zip code 19146 (South Philadelphia) and zip codes 19132, 19133 and 19122 (Lower North Philadelphia) are more likely to be obese (21.1%, 21.6%, 26.4% and 27% respectively) than others in TJUHs CB area and compared to Philadelphia.



## Child obesity prevalence, 5-18 years of age



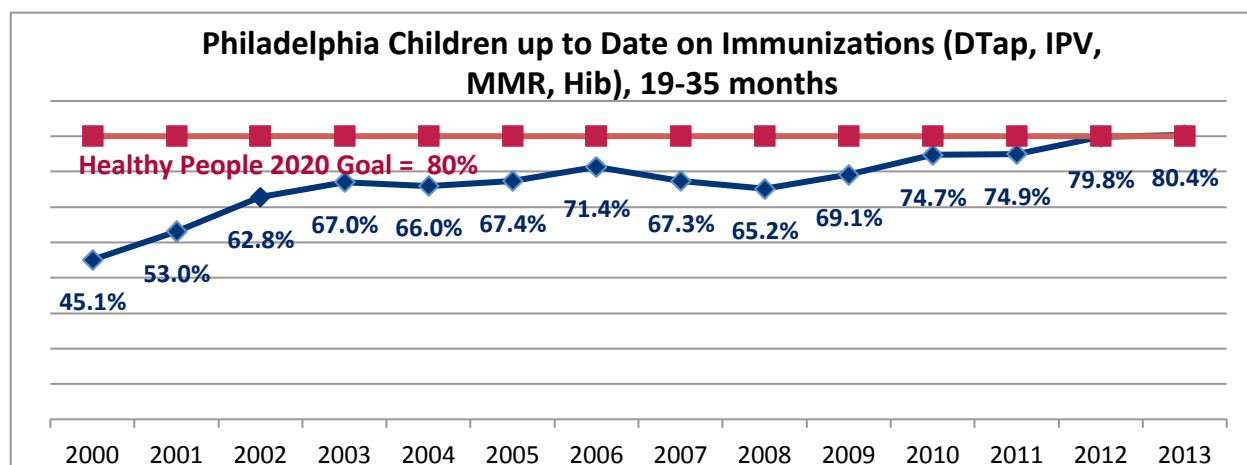
Source: School District of Philadelphia, 2012-2013

Data were not available by planning district and are instead displayed by zip code.

The Philadelphia Department of Public Health's *Get Healthy Philly* collaborative members continue to provide interventions and advocate for policy and system changes designed to reduce overweight and obesity among youth as do many other groups in Philadelphia.

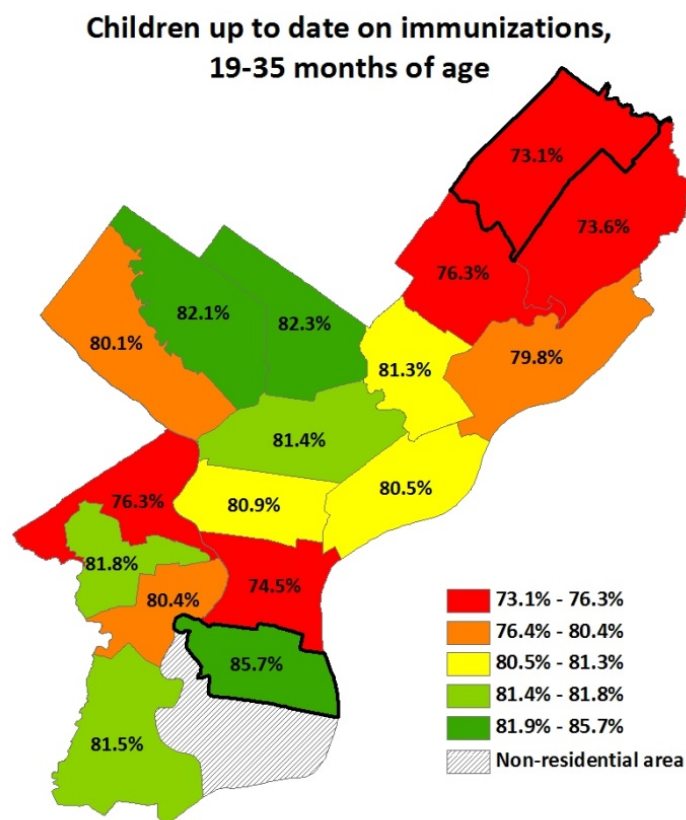
**Childhood Immunizations:** Healthy People 2020 tracks the proportion of children aged 19–35 months who have received the recommended doses of diphtheria, tetanus, and pertussis (DTaP); polio; measles, mumps, and rubella (MMR); Haemophilus influenzae type b (Hib); hepatitis B (Hep B); varicella; and pneumococcal conjugate vaccine (PCV) vaccines. The Healthy People 2020 goal is for 80% of children have received the recommended immunizations by age 35 months. In 2014, 71.6% of children aged 19-35 months had had received the recommended doses of DTaP, polio, MMR, Hib, Hep B, varicella, and PCV vaccines. Philadelphia has achieved the Healthy People 2020 goal for childhood immunizations.

Childhood immunization rates have improved steadily in Philadelphia since 2000, from 45.1% to 80.4% of all children being up to date for immunization at 35 months of age. There is little difference in immunization rates across race and ethnicity; however, it is interesting to note that White, non-Hispanic children have the lowest rates of immunization (78.1) and are below the desired Healthy People 2020 for up to date immunizations for children 19-35 months of age.



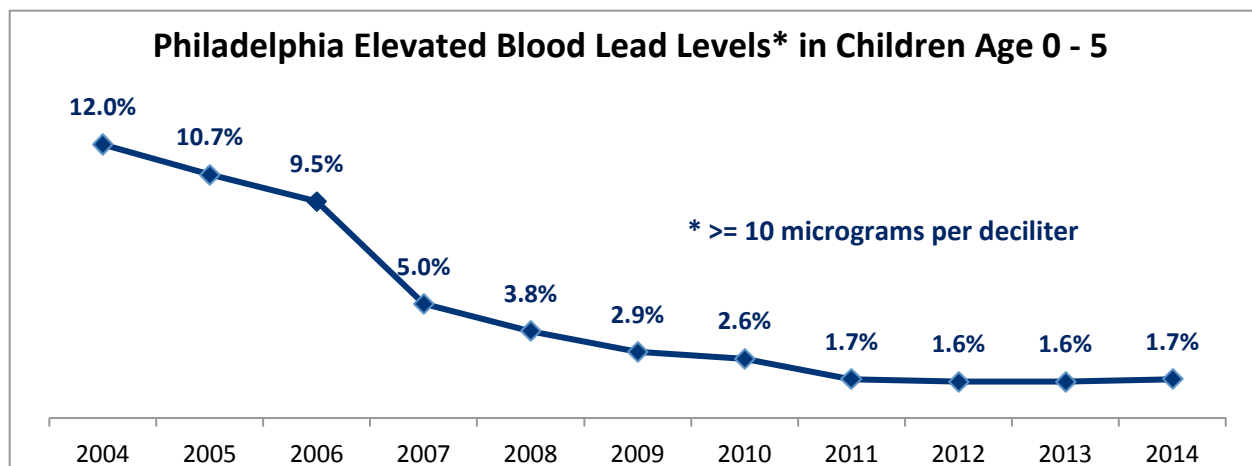
*Division of Disease Control, Philadelphia Department of Public Health, 2013*

Among the city Planning Districts, Central Philadelphia has one of the lowest on-time immunization rates (74.5), a rate that is below the Healthy People 2020 goal.



Source: Division of Disease Control, Philadelphia Department of Public Health, 2013  
4:3:1:3 (DTaP : IPV : MMR : Hib)

**Childhood blood lead levels:** The effects of lead poisoning in children are long term and irreversible. Lead poisoning in children can cause lowered IQ, behavior problems, learning disabilities, and cardiovascular, immune and endocrine problems. The percentage of Philadelphia children ages 0-5 with elevated blood lead has dropped steadily since 2000, from 12% to 1.7% in 2014. Black, non-Hispanic children (3%) are almost three times as likely as Hispanic (1%) and Asian non-Hispanic (1.2%) children to have elevated blood lead levels. It is important to note that these rates are based guidelines that considered lead levels greater than 10 micrograms per deciliter to be high and in need of treatment/care management. Experts now use a reference level of 5 micrograms per deciliter to identify children with high blood lead levels. The new lower value means that more children will likely be identified as having lead exposure allowing parents, doctors, public health officials, and communities to take action earlier to reduce the child's future exposure to lead.

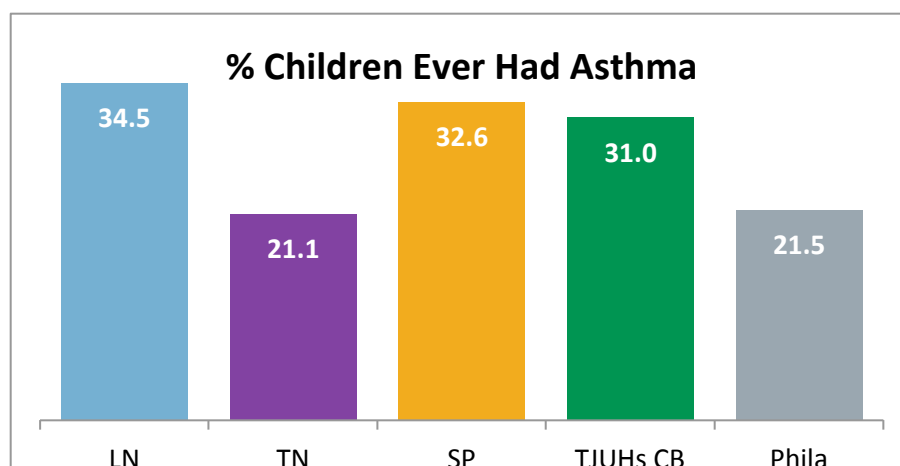


*Division of Disease Control, Philadelphia Department of Public Health*

Lead exposure is frequently due to chipping lead based paint in housing built prior to 1940. In Philadelphia more than 60% of housing was built prior to 1940 compared to less than 20% in the United States. Home remediation is necessary to prevent lead poisoning. Lead is also often found in the soil in urban communities and young children should be encouraged to wash their hands after playing outside. Finally, soil should be tested before growing food. Raised garden beds are frequently used in areas where there is lead and other contamination.

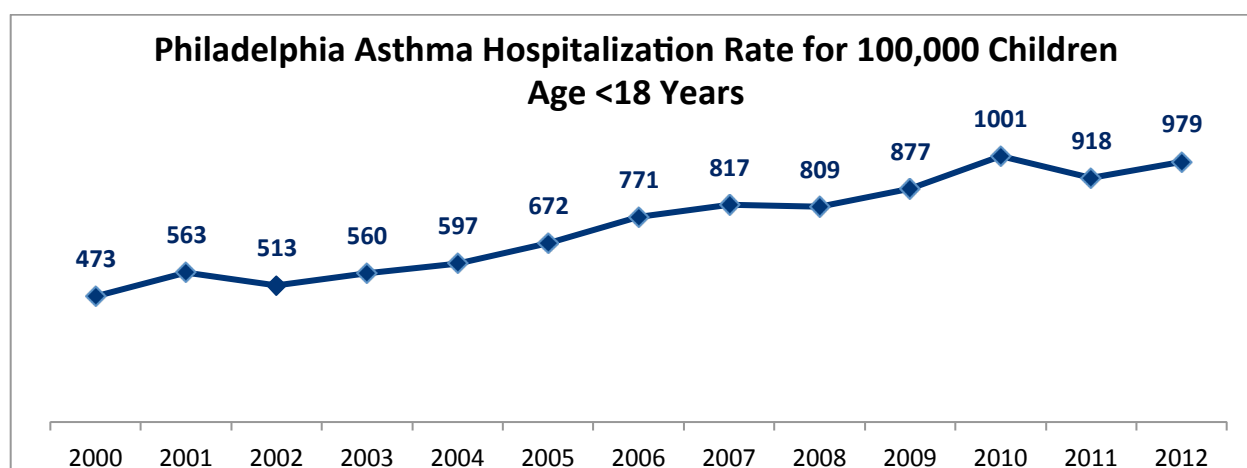
**Asthma:** Asthma affects people of every race, sex, and age. However, significant disparities in asthma morbidity and mortality exist, in particular for low-income and minority populations. Children living in poor housing conditions are more likely to have asthma. Risk factors for asthma include: having a parent with asthma, sensitivity to irritants and allergens, respiratory infections in childhood, and being overweight. According to the 2009 American Housing Survey, 23% of homes in Philadelphia had rodents, 11% had leaks, 10% had open cracks or holes, and 5% had a hole in the roof.<sup>114</sup> These conditions can exacerbate asthma and result in poorer health status, and impact education due to higher rates of school absenteeism.

Although about 1 in 5 children in Philadelphia has ever had asthma, almost one-third of children in TJUHs CB areas have had asthma. Childhood asthma rates in Lower North Philadelphia (34.7%) are the highest of all areas within TJUHs CB area.



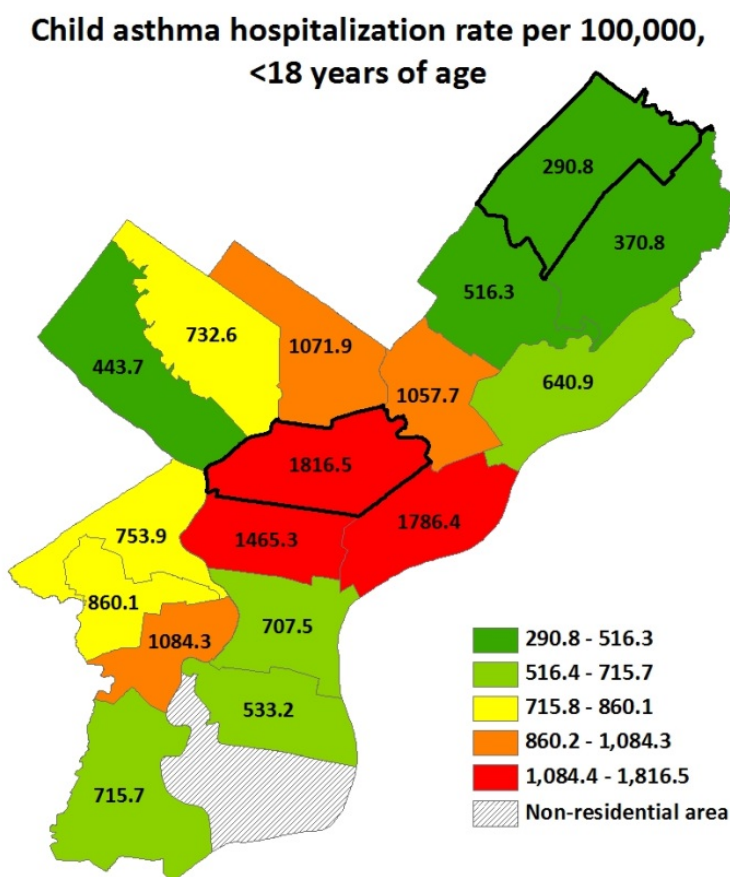
PHMC Household Health Survey 2015

The hospitalization rate for asthma more than doubled between 2000 and 2012 to 979 per 100,000 children under age 18. In 2010 there were almost 10,000 asthma related emergency room visits for children under age 18.<sup>115</sup>



Pennsylvania Cost Containment Council 2012

Among children living in Lower North Philadelphia the asthma rate is 1,465 per 100,000 children, one of the highest in the city.<sup>116</sup>

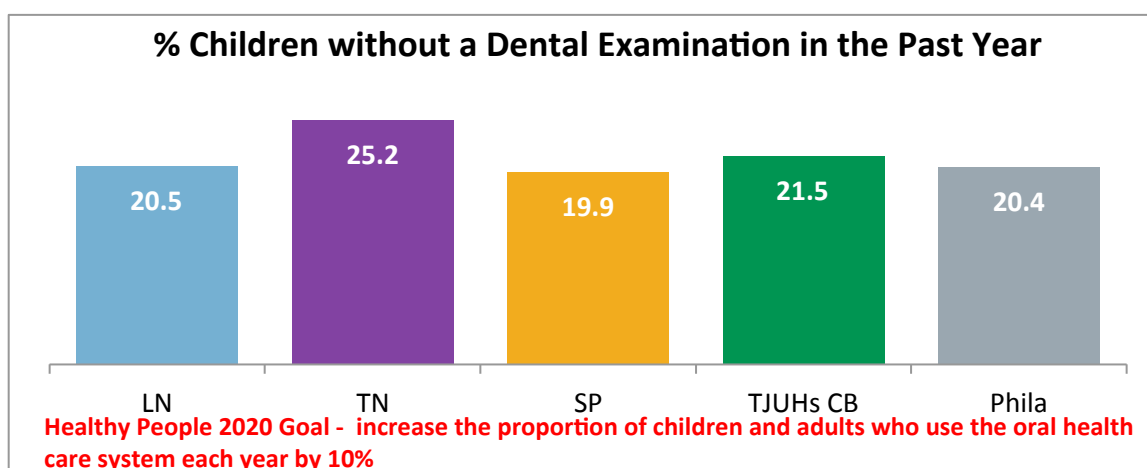


Source: Pennsylvania Health Care Cost Containment Council, 2012

The *Healthy Homes Healthy Kids Program* is a collaborative effort of the Philadelphia Department of Public Health and St. Christopher's Hospital for Children. The program identifies children with severe asthma and then integrates clinical, environmental, and educational strategies to manage the child's asthma, prevent lead poisoning, and address other health and safety issues. A housing assessment conducted between January 2013 and December 2014, in the homes of 160 children with severe asthma, revealed that all of the homes had safety hazards and pests, 81% had mold/moisture issues, and 56% had lead hazards and 69% had allergens. The Healthy Homes Healthy Kids initiative repairs homes as needed (repairs leaks, removes mold and repairs water damage, removes carpeting and refinishes floors, provides integrated pest management and provides weatherization as needed). In addition patients are educated about behavior changes that can reduce the child's exposure to asthma triggers such as tobacco and products with odors. Finally, the Healthy Homes Healthy Kids team and the clinical staff ensure that children and their caregivers understand how to use prescribed medications. The cost for services per unit/family is approximately \$3,500. Outcomes for the program include 70% fewer hospitalizations, 76% fewer ER visits, 62% fewer doctor visits, 53% fewer missed days of school or daycare, and 55% reduction in albuterol use in the past two weeks.<sup>117</sup> Linking social

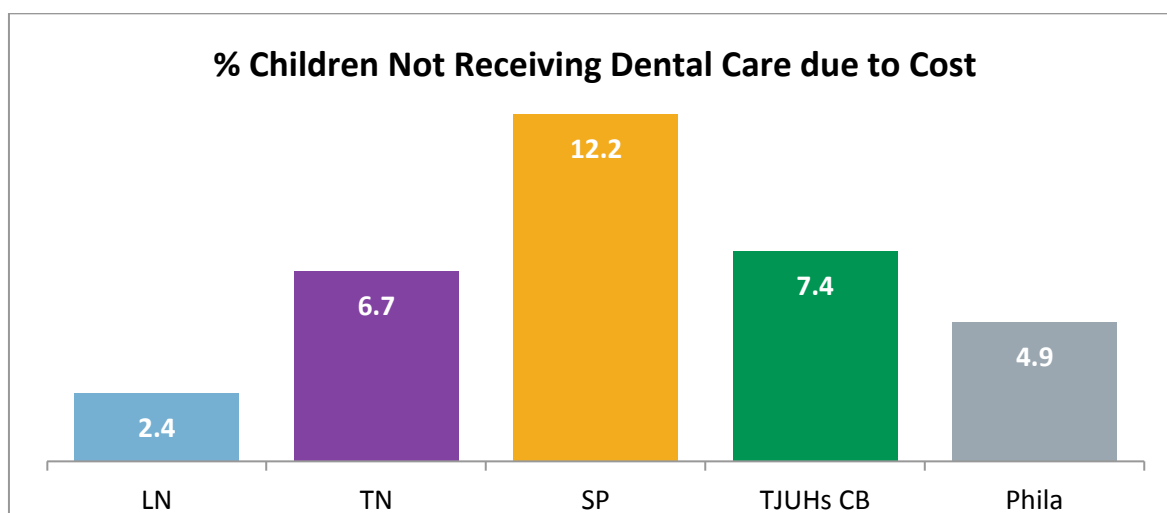
determinants of health, in this case housing, to clinical care treats the whole person and family. Without these linkages the underlying root causes cannot be addressed and patient outcomes suffer.

**Dental care:** One in five children in Philadelphia did not see a dentist in the past year. Children within TJUHs CB area were slightly less likely to have seen a dentist, particularly children living in Transitional neighborhoods where 1 in 4 children did not have dental care in the previous year.



PHMC Household Health Survey 2015

Compared to Philadelphia, cost appears to be of a barrier to dental care in TJUHs CB area, particularly in South Philadelphia.



PHMC Household Health Survey 2015

**Issues, challenges, unmet needs and priorities identified by key informants and focus group participants related to childhood health included:**

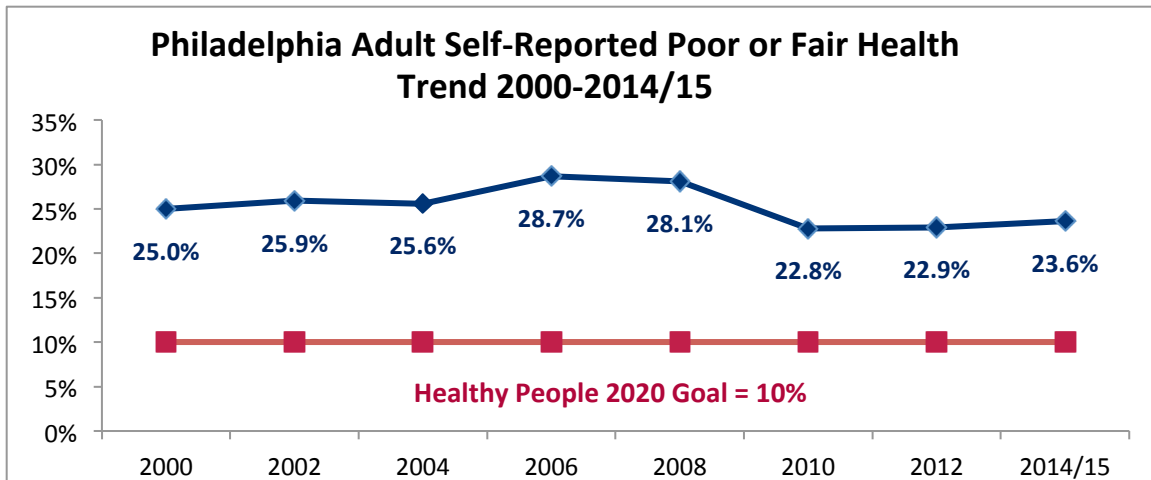
- Major pediatric health issues are asthma, obesity, food insecurity, trauma, poverty (key informant)
- To improve healthy life styles, *"kids need nutrition education"* (focus group)
- *"The focus should be on a healthy school environment. We can make it a healthy learning environment even if reading and math scores are low. Need to take school environment seriously. Want schools to understand it's a coordinated health approach."* (key informant)
- Wellness policy: (1) Each school does an improvement plan; (2) There are 6 questions related to academics. There is interest in proposing a 7th question related to a school environment assessment. It would consider factors like: (key informant)
  - Asthma triggers/school environment
  - Physical activity: playground equipment and safety; structured recess (Playworks)
  - Fundraisers need to be "healthy"
  - "Help kids be healthier learners"
  - X-box in classrooms for movement breaks
- Schools and out of school time programs continue to need assistance/training with behavioral health issues related to trauma and children, working with ADHD children, and access to behavioral health counseling for children and parents (key informant)
- Head Start programs are interested in creating a culture of health, particularly around lifestyle behaviors and policy shifts related to obesity prevention (key informant)
- Advocate for required number of minutes of physical education in schools (key informant)
- Youth need structured, positive opportunities in the community (key informants and focus groups)

**Based on internal and external key informants, focus groups, existing relationships and programs, and secondary data, actions addressing childhood health may include:**

- 1. Provide training for parents, schools, and out of school time staff in trauma informed care, ADHD and mental health first aid for children**
- 2. Provide community-based parenting education programs**
- 3. Talk to school principals and school nurse supervisors about health needs in schools. Partner with schools to address the school health improvement plans. Create healthy culture and environments in schools and Head Start programs that promote healthy eating and physical activity.**
- 4. Support PDPH efforts to pass a school policy that requires a specific number of minutes of physical activity weekly in schools. Work with school Wellness Councils to encourage regular classroom movement breaks and socialized recess.**
- 5. Continue to participate in PDPH *Get Healthy Philly* initiatives**
- 6. Explore potential for increasing structured out of time programs for youth**

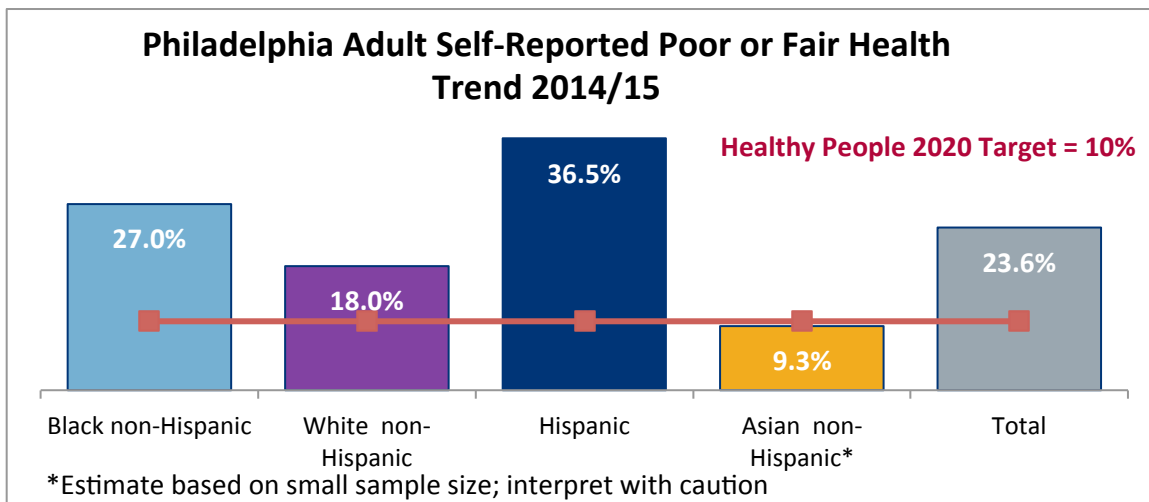
## Morbidity

Philadelphia ranks 67<sup>th</sup> out of the 67 counties in Pennsylvania for morbidity. Nearly 24% of all adults in Philadelphia rate their health as fair or poor compared to 14% in Pennsylvania and the Healthy People 2020 goal of less than 20%. The CDC's CHSI methodology ranks adult overall health status in Philadelphia in the least favorable quartile compared to peer counties.



PHMC Household Health Survey 2015

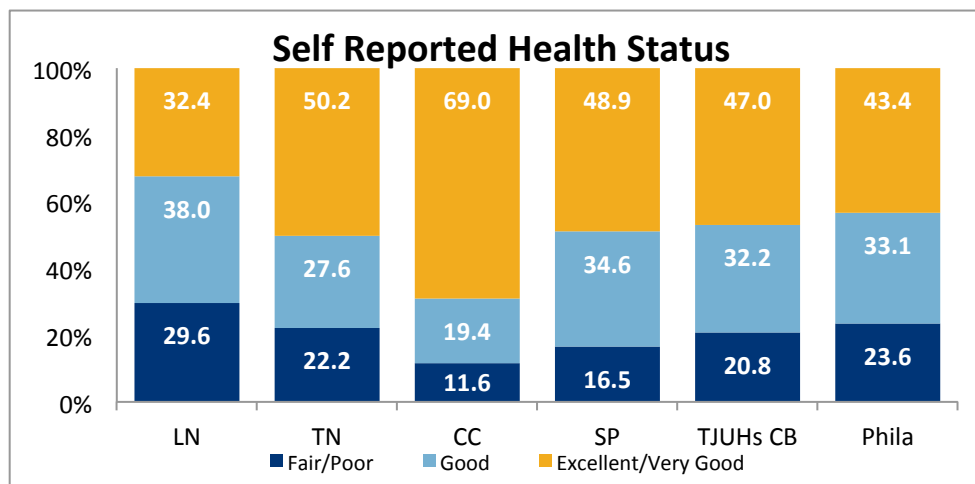
In Philadelphia, Hispanics report the highest prevalence of poor or fair health (36.5%); while White, non-Hispanic individuals and Asians report the lowest prevalence (18.0% and 9.3% respectively).



PHMC Household Health Survey 2015

Adults in Jefferson's CB area are more likely than other Philadelphians to report fair or poor health (24% vs. 22.8%); 35.7% of adults in Lower North Philadelphia report having fair or poor health.





PHMC Household Health Survey 2015

Adults in Philadelphia were more likely to report poor physical health days (average number of physically unhealthy days reported in past 30 days - age-adjusted) than other Pennsylvania residents (4.4 vs. 3.5 respectively) and more poor mental health days (average number of mentally unhealthy days reported in the past 30 days (4.6 days vs. 3.6 days). The national benchmark for poor physical health days is 2.6 and 2.3 for poor mental health days.<sup>68</sup>

Chronic disease management and care coordination was identified by focus group participants and key informant interviews as a community benefit priority. Lack of knowledge about disease prevention, early detection and management was highlighted as needed as well as basic human needs such as food security, housing and employment.

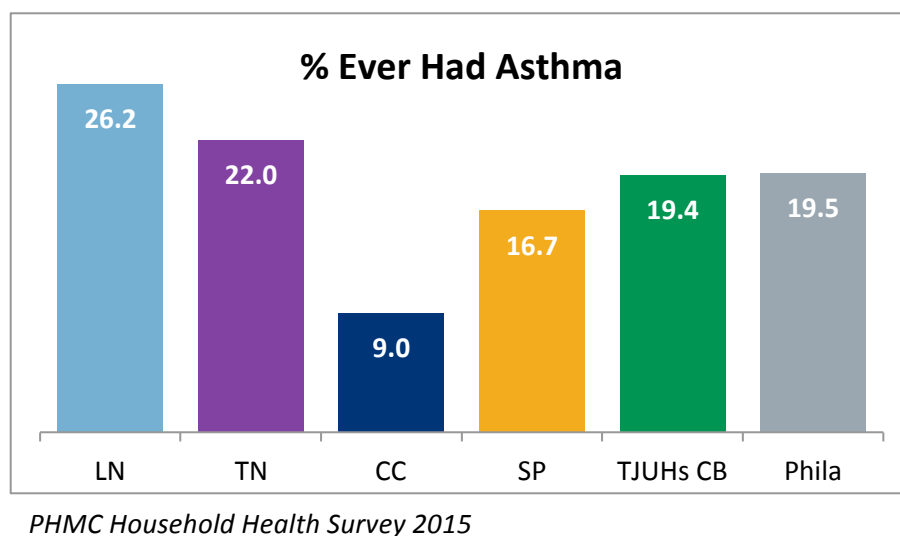
- *"Create culture of health" through advocacy* (key informant)
- *"What impacts health – employment, incarceration, housing, education. Then on top of all that the social dynamic puts stress on anyone. And now we want you to navigate the health system. It's like climbing a mountain and on top low literacy."* (key informant)
- *"This whole system can be overwhelming. People are falling through the cracks."* (key informant)
- *"Health is not a priority for many."* (key informant)
- *"We need health education and screening in community sites such as churches, farmers markets, recreation centers, and schools."* (focus groups)
- *"Corporations are not putting enough resources into choice community and employee wellness programs. Need more culturally responsive chronic disease management. Most of the work being done is food access, nutrition, and physical activity related. We need to increase engagement of the Philadelphia workforce employers in wellness programs for employees and interest employees in participating."* (key informant)
- *"Improve communication with health centers to improve access to medications for low income individuals. While health centers can provide medications for reduced cost, specialty care can't. Administrative issues create burden. There are probably 10 medications that if the Health Department could supply them to specialty care they could*

*dispense them and keep records. This would reduce barriers for low income vulnerable patients." (key informant)*

- *"A fair number of people who are uninsured have poor access to prevention care. By the time they come in they have life threatening conditions. At discharge there is no PCP they can report to except city health center." (key informant)*
- *"We need to create a better partnership with city health centers and FQHCs. We can't schedule appointments for them- there isn't a doctor we can sign off to. So patient shows up and stands in line -just discharged-high risk patients. We need to have a different approach. Maybe we could prioritize them to clinic doctor to be seen." (key informant)*

## ***Asthma***

The adult asthma rate for TJUHs CB area is equivalent to the Philadelphia rate and exceeds the rate in Pennsylvania (12.9%). While almost one in 5 adults in Jefferson's CB areas report having asthma, more than one quarter of adults in Lower North Philadelphia report ever having asthma. The rate in Center City is much lower.

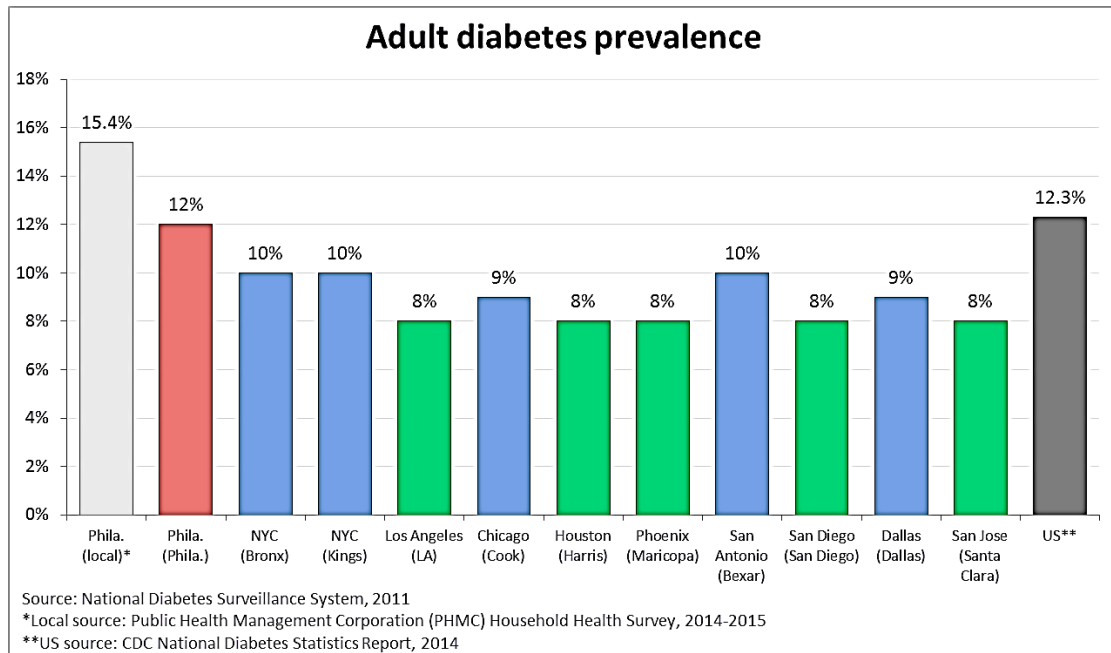


## ***Cardiovascular Disease, Stroke, and Diabetes***

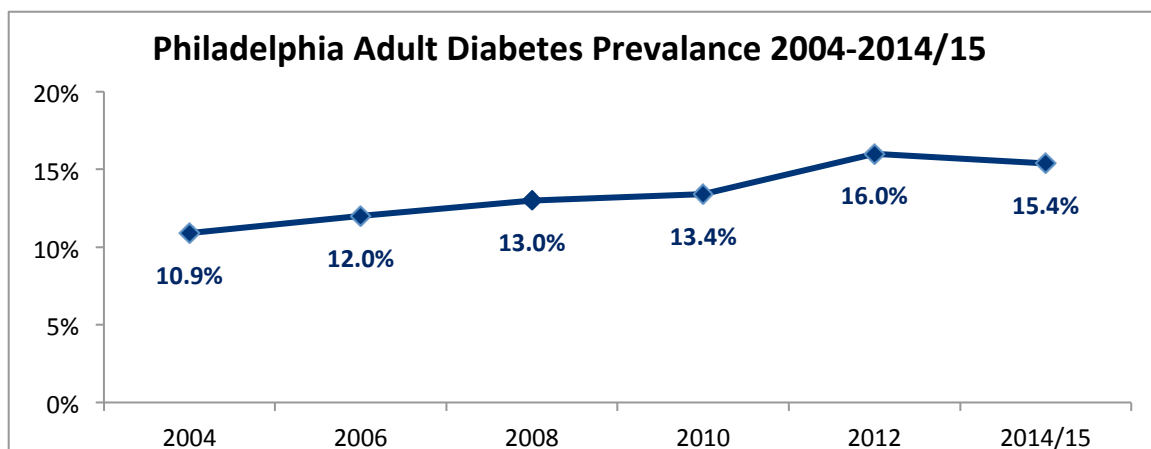
Heart disease, stroke and diabetes are among the top seven causes of mortality in Pennsylvania.<sup>118</sup> Obesity and hypertension are underlying chronic diseases that increase risk of heart attack, stroke, and complications of diabetes. The goal of Healthy People 2020 for heart disease and stroke is to improve cardiovascular health and quality of life through prevention, detection, and treatment of risk factors for heart attack and stroke; early identification and treatment of heart attacks and strokes; and prevention of repeat cardiovascular events. Similarly, the Healthy People 2020 goal for diabetes is to reduce the disease and economic burden and improve the quality of life for all persons who have, or are at risk for, diabetes.

## Diabetes

New federal statistics indicate that fewer cases of diabetes are being diagnosed in the United States: the number of new cases dropped from 1.7 million in 2009 to 1.4 million in 2014.<sup>119</sup> Philadelphia has the highest adult prevalence of diabetes among the largest metropolitan areas of the United States. The CDC's CHSI methodology ranks adult diabetes morbidity in Philadelphia in the least favorable quartile compared to peer counties.

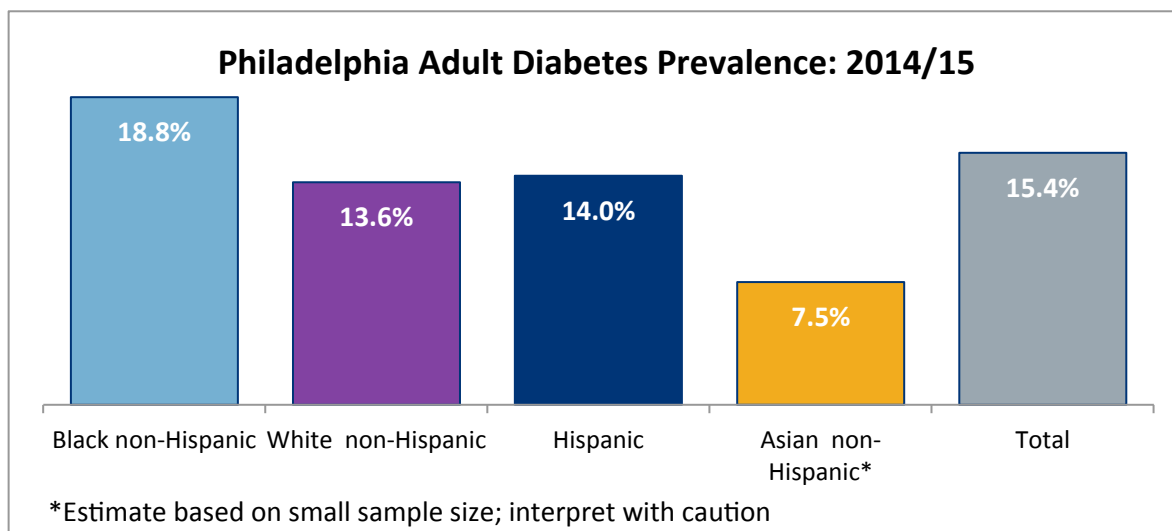


The percentage of adults with diabetes has steadily risen in Philadelphia since 2004 from 10.9% to 15.4% in 2014/15, though there was a slight reduction in the last two years. This decline follows the decrease in the country's diabetes rate. The increase in the prevalence of diabetes is a result of the obesity epidemic, the causes of which are complex and include food insecurity, poverty, and decreased exercise. Only 37% of adults in Philadelphia who have diabetes say they exercise 3 or more times weekly compared to 56% without diabetes.



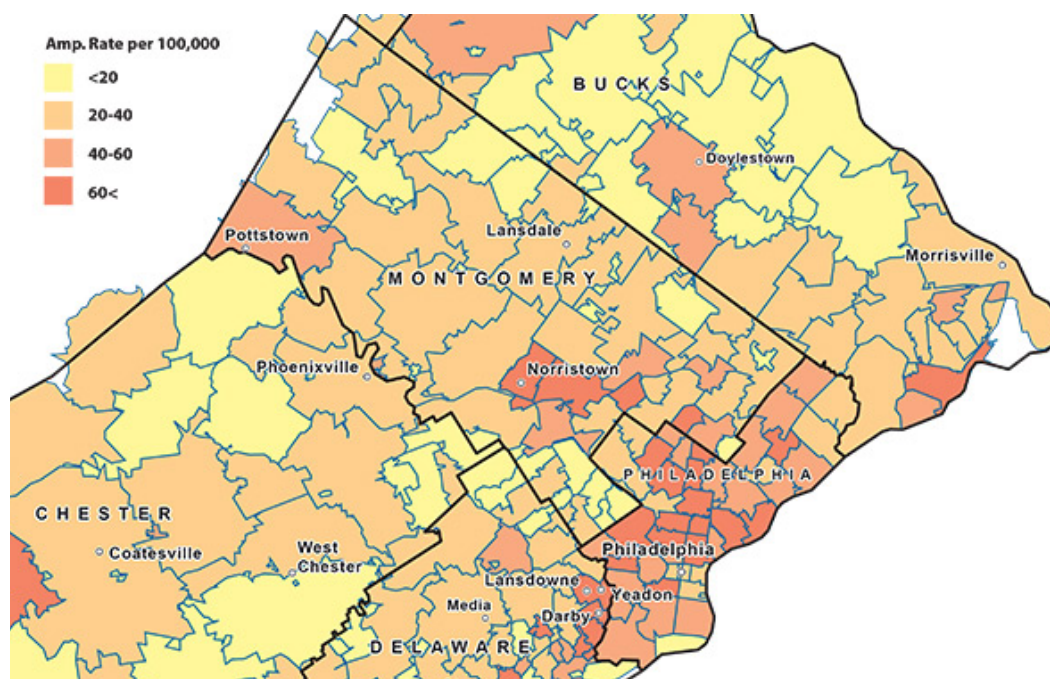
PHMC Household Health Survey 2015

Black non-Hispanic adults in Philadelphia have the highest prevalence of diabetes at 18.8%, and Asian non-Hispanics the lowest at 7.5%.



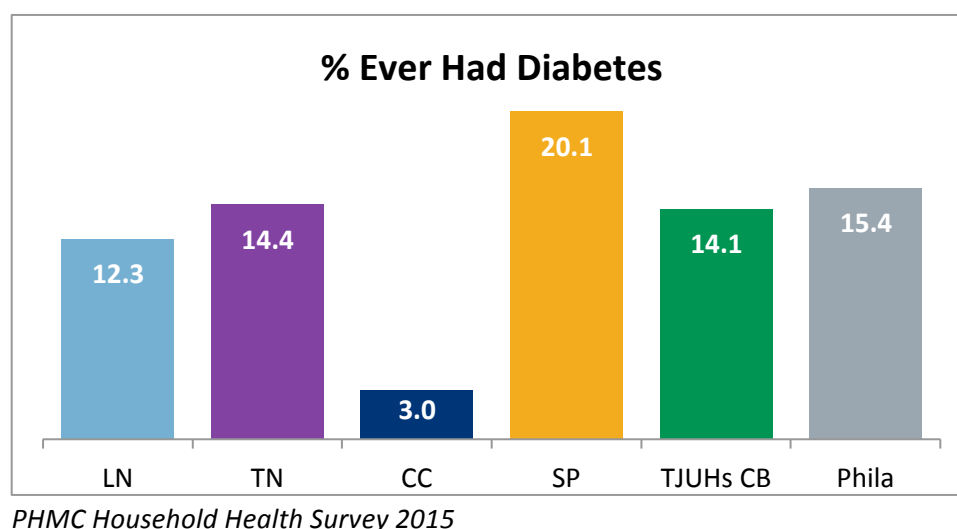
PHMC Household Health Survey 2015

Compounding the higher rates of diabetes among blacks, African Americans in Southeastern Pennsylvania are three times more likely than whites to have lower extremity amputations. *Save Your Soles* is a grassroots program focused on eliminating this disparity. Working with community churches and other groups, *Save Your Soles* teaches the importance of keeping blood sugar under control, taking medications as prescribed, eating healthy foods, and getting regular exercise.<sup>120</sup>



*Save Your Soles Campaign*

In Jefferson's CB areas, 14.1% have been told they have diabetes. Diabetes rates are highest in South Philadelphia and lowest in Center City.



Diabetes education was identified as a priority by multiple key informants including the Philadelphia Department of Public Health and the American Diabetes Association.

Healthy People 2020 objectives for people with diabetes include:

- Increasing the proportion of persons at high risk for diabetes with pre-diabetes who report trying to lose weight to 55%
- Increasing the proportion of persons at high risk for diabetes with pre-diabetes who report increasing their levels of physical activity to 49.1%
- Increasing the proportion of persons with diabetes who receive formal diabetes education to 62.5%
- Increasing the proportion of adults with diabetes who perform self-blood glucose monitoring at least once daily to 70.4%

**Issues, challenges, unmet needs and priorities identified by key informants and focus group participants related to diabetes included:**

- **Collaboration and Coordination**
  - *"Diabetics are readmitted to the hospital. A man had his foot amputated and went to the City Health Center for follow-up. His glucose was 402. All he had in his refrigerator when he was discharged from the hospital was a loaf of bread and mayonnaise."* (key informant)
  - *"We want to collaborate more with others working on diabetes. Diabetes links to heart and kidney disease and we need to link to those areas as well. While collaboration across American Heart Association, American Diabetes Association, etc. happens at national level- it doesn't always occur for community outreach."* (key informant)

- *"PA Department of Aging is implementing a program with Area Agencies on Aging using the Stanford chronic disease self-management program, co-facilitated by a person with diabetes and master trainer."* (key informant)
- *"There is lack of coordination among diabetes self-management education programs (DSME), chronic disease self-management programs, and the diabetes prevention program."* (key informant)
- *"Not enough focus on chronic disease management transitions from inpatient to outpatient."* (key informant)
- *"Need to "empower" pharmacists and educators to inform patients that right now all diabetes education is free."* (key informant)
- *"Need a chronic disease self-management approach. Expand community access to Center for Urban Health, health education and prevention activities. Expand diabetes center/services to focus on diabetes management self-education, nutritional counseling, and screenings and prevention."* (key informant)
- *"Diabetic supplies are costly; insurance often only covers half the cost; the ADA service center can help people defray some of the cost."* (key informant)
- **Transportation** costs of taxi, parking are prohibitive for patients attending DSME classes at TJUHs
  - *"Consider a partnership with Uber or similar transportation alternative. Work with community to help us with transportation. We need partnerships with the community that we are connected to and we need community resources that are easily available at time of discharge from the hospital."* (key informant)
- **Knowledge**
  - *"Chronic disease management – people lack knowledge on how to keep healthy and manage chronic illness...such as diabetes and unhealthy eating. People have difficulty getting medications and glucose strips."* (focus group)
  - *"Diabetes Self- Management Education) for older adults and people with disabilities is needed".* (key informant)

**Based on internal and external key informants, focus groups, existing relationships and programs, and secondary data, actions addressing diabetes may include:**

- 1. Expand and promote community-based DSME and diabetes prevention programs – Center for Urban Health should continue to partner with the YMCA and the Philadelphia Department of Public Health**
- 2. Continue to support diabetes support groups including Divabetic**
- 3. Encourage TJUHs physicians to "prescribe" and refer to these programs**
- 4. Continue expansion of Jefferson Diabetes Center**
- 5. Continue to participate in PDPH *Get Healthy Philly* initiatives**
- 6. Collaborate with the State Health Improvement Plan and City Community Health Improvement Plan around diabetes interventions**

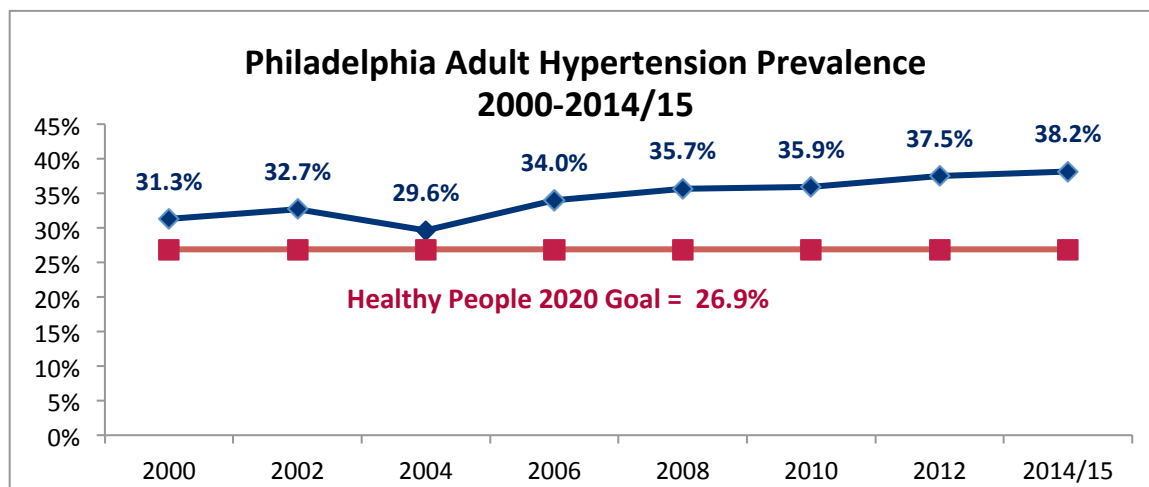
## ***Cardiovascular Disease and Hypertension***

The goal of Healthy People 2020 for Heart Disease and Stroke is to improve cardiovascular health and quality of life through prevention, detection and treatment of risk factors for heart attack and stroke, early identification and treatment of heart attacks and strokes; and prevention of repeat cardiovascular events. The Million Hearts Campaign aims to reduce cardiovascular deaths by 1 million in five years. Key components of Million Hearts are:<sup>121</sup>

- Improving access to effective care
- Improving quality of care for the ABCS of heart health:
  - Aspirin when appropriate
  - Blood pressure control
  - Cholesterol management
  - Smoking cessation
- Focusing clinical attention on the prevention of heart attack and stroke
- Activating the public to lead a heart-healthy lifestyle
- Improving the prescription and adherence to appropriate medications for the ABCS

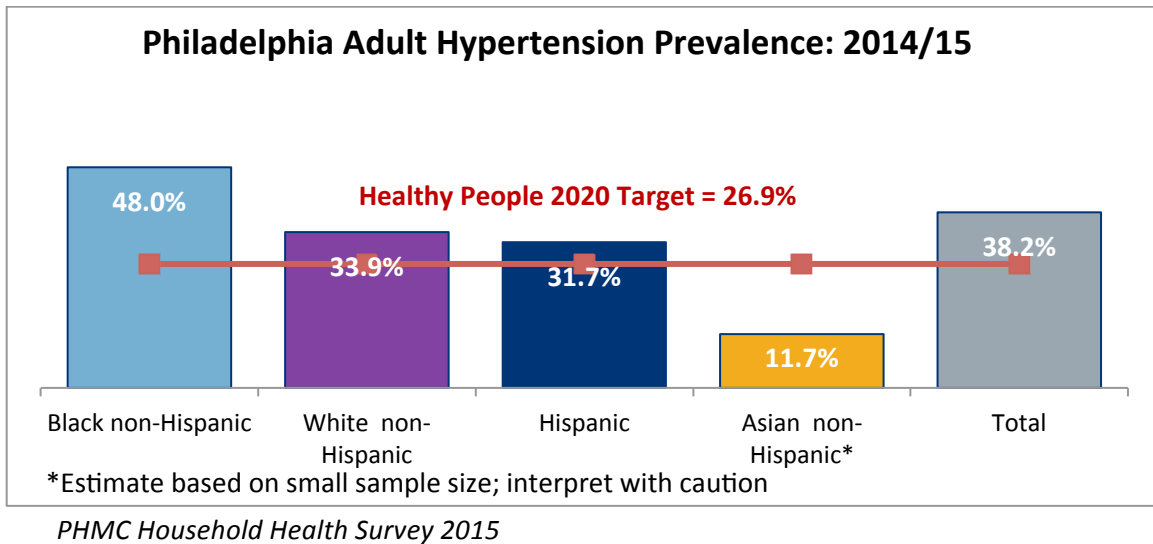
## ***Hypertension***

Hypertension rates have increased in Philadelphia between 2000 and 2014/15, from 31.3% to 38.2%. These rates are above the rate for Pennsylvania (31%) and well above the Healthy People 2020 goal of 26.9%.

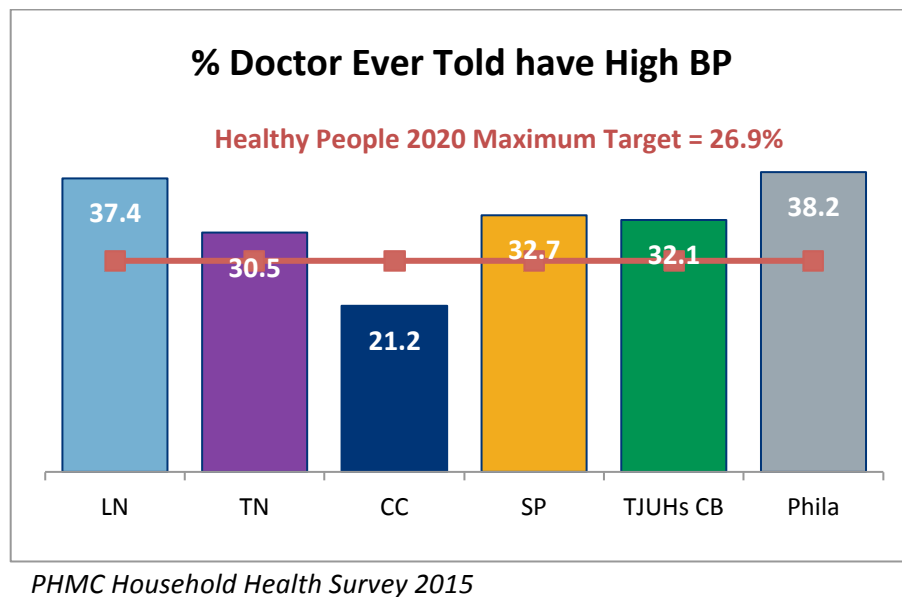


*PHMC Household Health Survey 2015*

Adult hypertensive prevalence is highest in Black non-Hispanics (48.0%), and lowest in the Asian population (11.7%).

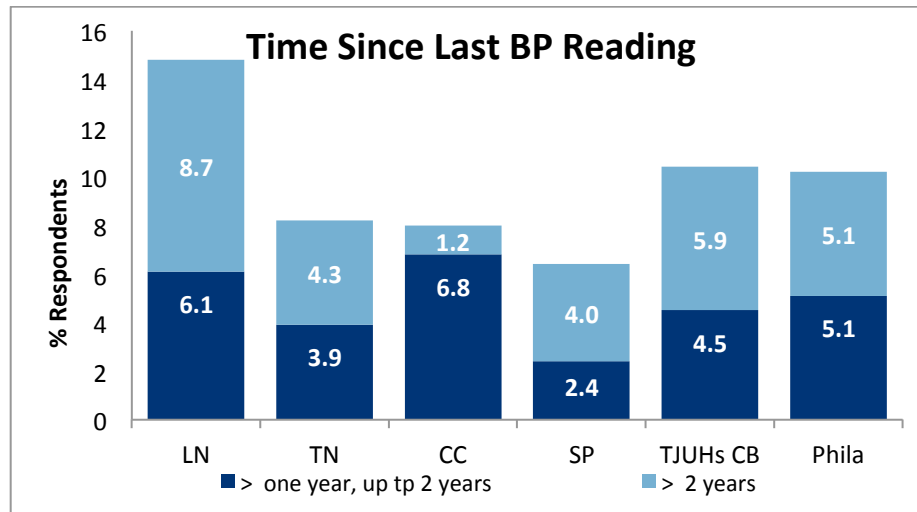


Hypertension prevalence is lower in all TJUHs CB areas relative to the prevalence in Philadelphia; but still higher than the HP 2020 target of 26.9% in all areas except Center City.



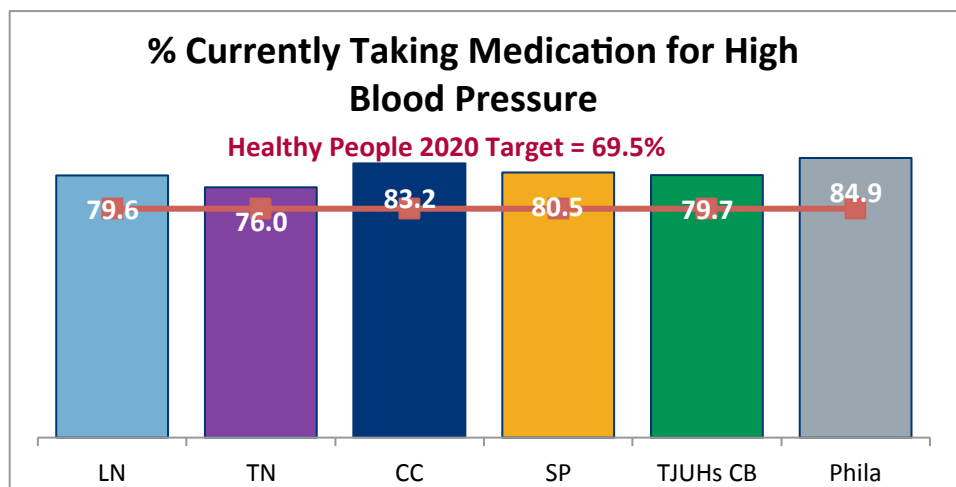
Adults in TJUHs CB areas are slightly more likely not to have had a blood pressure screening in the past two years compared to Philadelphia (5.9% vs. 5.1%). Almost 9% of adults in Lower North Philadelphia reported not having their blood pressure measured in the past two years.





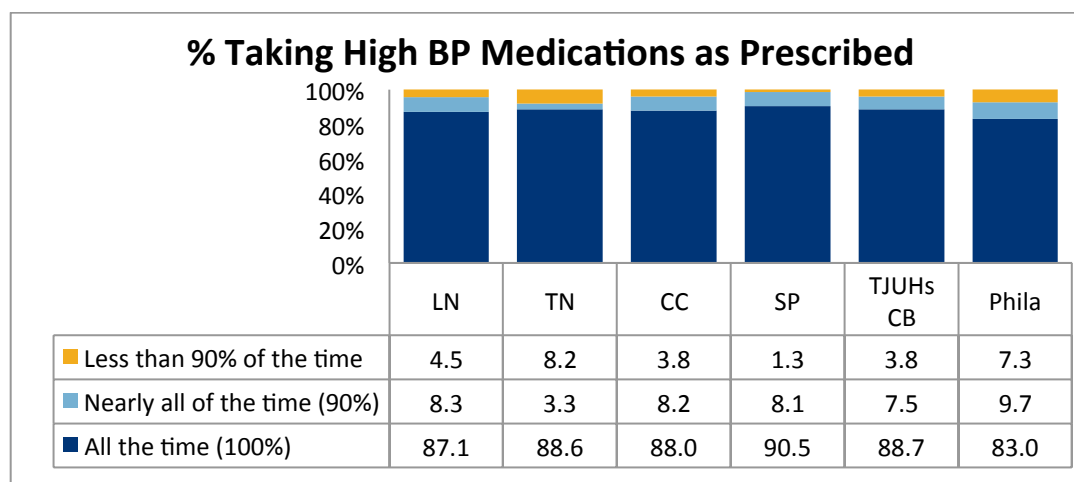
PHMC Household Health Survey 2015

Compared to Philadelphia, fewer adults in all TJUHs CB areas are currently taking medication for high blood pressure, but respondents in all areas report medication adherence above the HP 2020 target.



PHMC Household Health Survey 2015

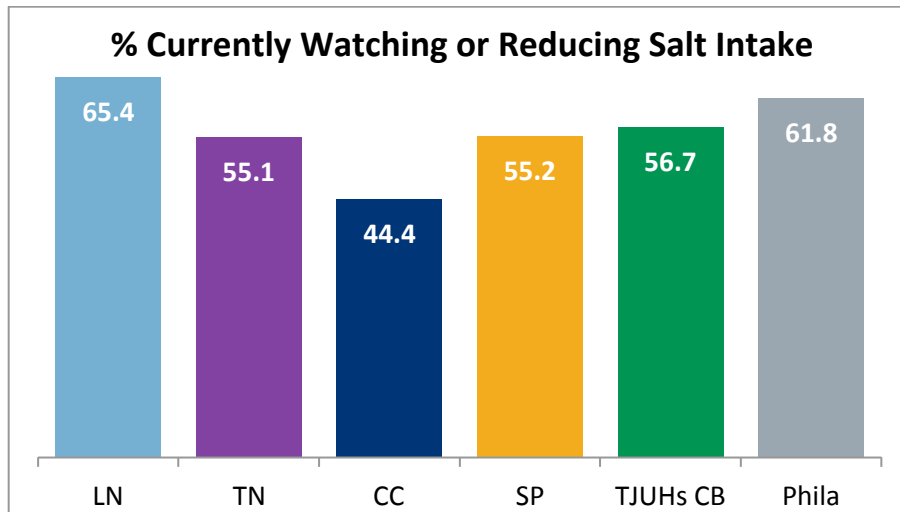
The majority of people with hypertension take their medications as prescribed, although residents in Transitional Neighborhoods are less likely to take their medicine as prescribed.



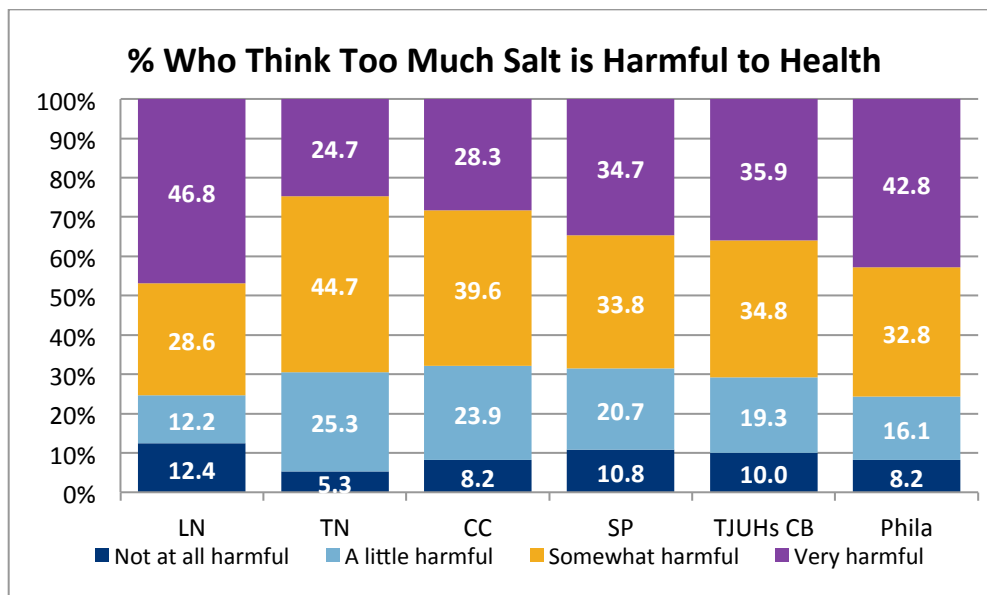
*PHMC Household Health Survey 2015*

Americans get more than 75% of their daily sodium from processed and restaurant foods. As part of a healthy eating pattern, the 2015-2020 Dietary Guidelines for Americans recommend that Americans consume less than 2,300 milligrams of sodium per day.<sup>122</sup> In numerous epidemiologic, clinical, and experimental studies, dietary sodium intake has been linked to higher blood pressure, and a reduction in dietary salt intake has been documented to lower it. In young people, blood pressure remains elevated even after high salt intake is reduced. Older adults, African Americans, and obese individuals are more sensitive to the blood pressure-lowering effects of a decreased salt intake. High salt intake elevates risk of stroke and other conditions.<sup>123</sup> In TJUHs CB area, those reporting watching or reducing their salt intake varies, with almost two thirds in Lower North reporting they are at least aware of their salt intake compared to approximately 55% or less in the other areas.

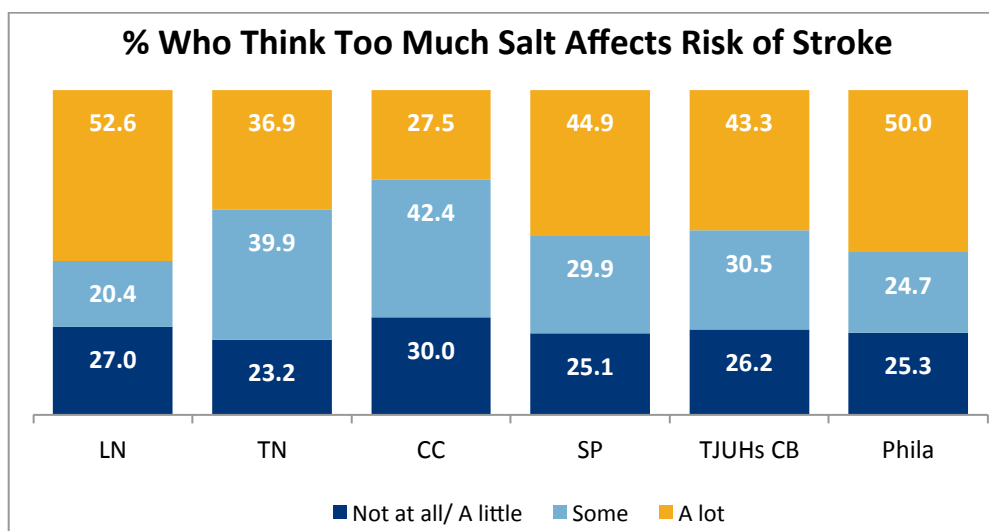
The definition of "too much salt" is left to respondent interpretation. Regardless, views on too much salt vary across TJUHs CB area. Thirty-two percent of residents of Center City think that too much salt is not at all or a little harmful to health. However, Center City also reported the lowest percent with high blood pressure. Lower North respondents reported the highest percent with high blood pressure (37.4%) – 10.5% higher than the Healthy People 2020 target – yet Lower North is the neighborhood that is most likely to be watching or reducing salt intake (65.4%) thinks too much salt is very harmful to health (46.8%), and thinks too much salt highly affects risk of stroke (52.6%).



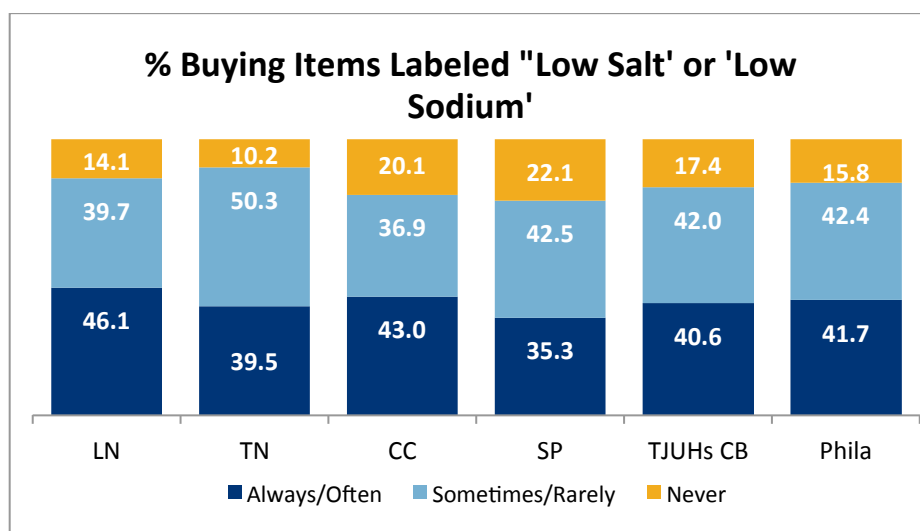
*PHMC Household Health Survey 2015*



*PHMC Household Health Survey 2015*



*PHMC Household Health Survey 2015*



*PHMC Household Health Survey 2015*

Although people may understand the link between high blood pressure and salt intake, they do not always change their behaviors to benefit their health. For example, of those in TJUHs CB area that report high blood pressure, 26.4% rarely/never buy items labeled 'low salt' or 'low sodium'. The complicated interactions between beliefs and behaviors further support the need for education as a means to impact stroke mortality in Philadelphia.

Healthy People 2020 objectives related to hypertension include:

- Reduce the proportion of adults with hypertension to 26.9%
- Increase the proportion of adults aged 20 and older who are aware of the early warning symptoms and signs of a heart attack to 59.3%

- Increase the proportion of adults who have had their blood pressure measured within the past two years and can state whether their blood pressure is high or normal to 92.6%
- Increase the proportion of adults with hypertension who are taking the prescribed medications to lower their blood pressure to 69.5%

**Issues, challenges, unmet needs and priorities identified by key informants and focus group participants related to cardiovascular disease included:**

- **Stroke**
  - *"Once someone has had a stroke how do we deal with the quality of life of survivors when they go home with a disability? How are they managing? Who is caring for them? The community needs help with this. Patient and caregiver support groups for stroke, and brain aneurism support groups are helpful."* (key informant)
  - *"Uninsured and undocumented do not have money for medications (BP, pulmonary). They need assistance with Medicaid applications. They do not have money for canes/walkers. The hospital pays for these things so that patients can leave".* (key informant)
  - Un or underinsured are not able to access care in a timely fashion (key informant)
- **Resources**
  - Healthy Food and Beverage Toolkit and Guidelines (key informant)
  - AHA- Get Health Philly (key informant)
  - Simple Cooking with Heart - put into food banks (key informant)
- **Awareness**
  - Raising awareness about hypertension, high cholesterol, heart disease, stroke and kidney disease was cited as a priority by focus groups and key informants.
  - *Many people are unaware they have hypertension* (key informant)
  - Need for community based screening with follow-up and for a database to track participants and connect them to primary care (key informant)
  - *"Need to increase awareness about the link of smoking, diabetes and hypertension to stroke."* (key informant)
- **Treatment**
  - *"Those with hypertension are often undertreated."* (key informant)
  - The need for chronic disease management programs was identified as a priority (focus groups and key informants)
- **Risk Factors**
  - Little understanding of the link between smoking, hypertension, and stroke
  - Smoking prevalence is alarmingly high (key informant)
  - Access to healthy (low sodium) foods in corner stores and food cupboards is limited (focus group)
  - Need more access to low cost or free weight management, physical activity, and smoking cessation programs (focus group)
- **Language**
  - Language barriers limit cardiovascular and stroke health education and treatment (key informant)

Based on internal and external key informants, focus groups, existing relationships and programs, and secondary data, actions addressing cardiovascular disease may include:

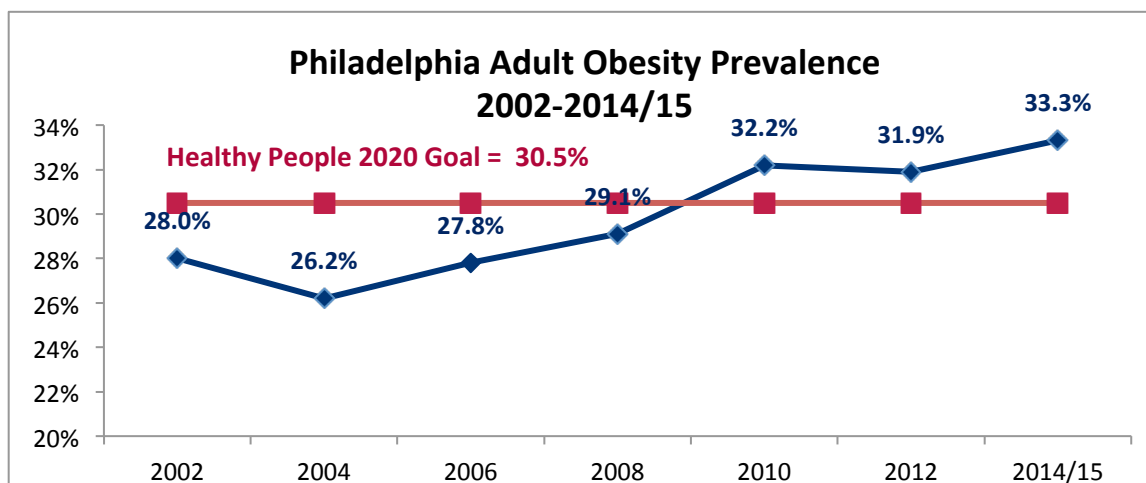
1. Partner with the PDPH in Million Hearts Initiative
2. Partner with AHA 360 campaign<sup>55</sup>, *Get to Goal*, and Power to End Stroke program
3. Link existing stroke screening programs at TJUHs to target neighborhoods
4. Develop database to track blood pressure screening participants and close communication loop with providers
5. Support the Athlete Health Organization
6. Screen and refer all smokers to the Pennsylvania Quit Line (FAX to QUIT)
7. Raise awareness about signs and symptoms of heart attack and stroke
8. Increase access to chronic disease management programs
9. Continue to support the collaboration with the Food Trust – *Heart Smarts*
10. Continue to participate in PDPH *Get Healthy Philly* initiatives

### ***Obesity and Nutrition Education***

In the United States, almost 35% of adults are obese, and in Pennsylvania, the self-reported obesity rate (based on self-reported height and weight) in 2014 was 30.2%.<sup>124</sup> Diet and body weight have been shown to be related to overweight/obesity, malnutrition, iron deficiency anemia, heart disease, high blood pressure, dyslipidemia, Type 2 diabetes, osteoporosis, asthma, and some cancers. Increases in obesity related diseases are projected to be significant.<sup>125</sup>

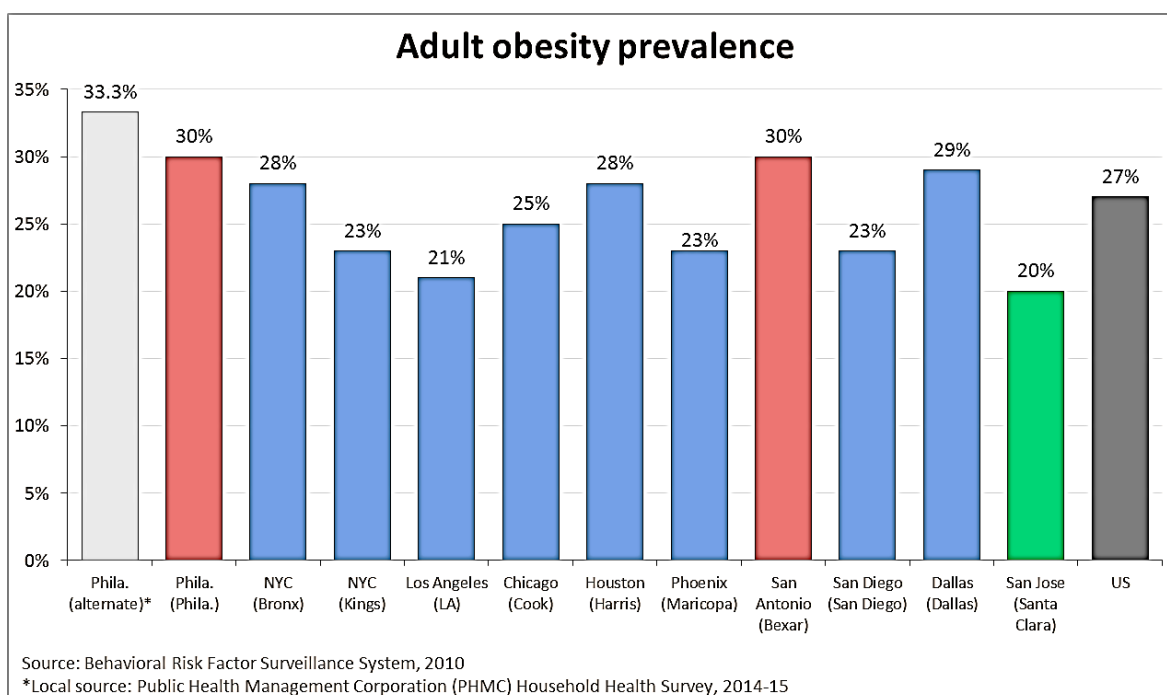
Obesity Related Diseases in Pennsylvania			
	2010 Cases	2030 Projection	%Change
Heart disease	892,129	3,964,312	344%
Obesity related cancers	227,588	553,041	143%
Diabetes	1,135,646	1,731,248	52%
Hypertension	2,752,209	3,483,650	27%

Like obesity rates in the United States, adult obesity rates in Philadelphia have increased between 2002 and 2014/15 and are above the Healthy People 2020 benchmark for the nation.

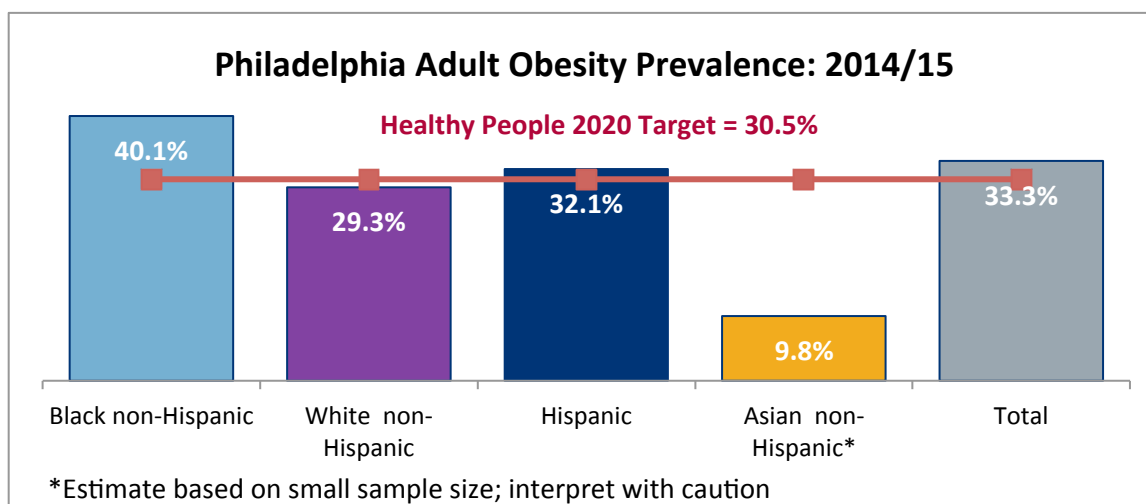


*PHMC Household Health Survey 2015*

Over the years, Philadelphia has been labeled a city where people are fat and out of shape. In fact, at one time Philadelphia had the dubious honor of being the “fattest city in the United States.” Since 2002, Philadelphia has made substantial efforts to address obesity through multiple coalitions that have worked to improve access to healthy, affordable food and access to safe places for physical activity. Despite these initiatives, Philadelphia ranks the highest in adult obesity prevalence among major metropolitan areas in the United States.

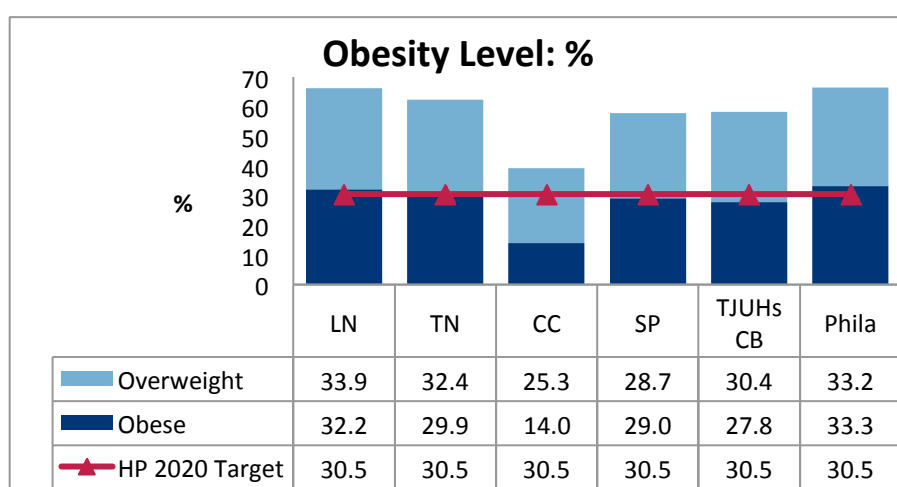


Obesity prevalence is the highest in the Black, non-Hispanics population (40.1%), and lowest among Asian, non-Hispanics (9.8%).



PHMC Household Health Survey 2015

The obesity rate in Jefferson's CB areas (27.8%) is lower than the city and below the Healthy People 2020 goal of 30.5%. However, 32% of adults in Lower North Philadelphia are obese. Center City has the lowest obesity rate (14%). In addition, 30.4% of adults in Jefferson's CB areas are overweight. The rate of overweight adults ranges from 33.9 % in Lower North Philadelphia to 25.3% in Center City. Overall, 58.2% of adults in TJUHs CB area are overweight or obese compared to 66.5% in Philadelphia.



PHMC Household Health Survey 2015



The Healthy People 2020 objectives related to obesity and nutrition education include:

- Increase the proportion of worksites that offer nutrition or weight management classes or counseling
- Increase the proportion of adults who are at a healthy weight to 33.9%
- Reduce the proportion of adults who are obese to 30.5%
- Reduce the proportion of children and adolescents who are considered obese to 14.5%
- Increase the proportion of physician office visits made by adult patients who are obese that include counseling or education related to weight reduction, nutrition or physical activity to 31.8%

**Issues, challenges, unmet needs and priorities identified by key informants and focus group participants related to obesity included:**

- **Increase awareness**
  - More health information and screening is needed (focus groups and key informants)
  - *"We need to communicate that all behaviors related to obesity affects health, diabetes, and cancer. We need a communication strategy with the City. We need to increase awareness about obesity and other behaviors that increase risk for all major diseases."* (key informant)
  - *"Greatest health need is obesity. Nutrition is number one priority, followed by lack of physical activity and the need for support group for adults with chronic disease. We need affordable physical activity programs for adults under age 60."* (key informant)
- **Increase physical activity**
  - Lack of access to affordable recreational facilities particularly for adults (focus groups)
- **Improve access to healthy, affordable food**
  - Affordable healthy grocers/markets was identified as a priority (focus groups and key informants)
  - *"Food access report- getting worse - 15+ supermarkets closed" (PRIORITY)* (key informant)
  - *"Lack of access to healthy food options in neighborhoods."* (focus group)
  - *"There are limited health resources and information for non-English speaking populations in the 19125 community including markets with healthy food options."* (focus group)
  - *"I would say there are not enough resources for people to buy healthier, fresher foods like fruits and vegetables. There are probably a handful of fruit stands or vegetable stands in South Philly, I would say 7th and Reed area or 9th and Reed area, but I don't ever see anything like that in my neighborhood."* (focus group)
  - *"Mothers lack access to healthy food, don't know how to cook, physical activity is not part of everyday lives. Don't know what 'real food' is."* (focus group)
  - *"Health and food are not separate issues. If you don't have the right food your health condition gets worse, you need to connect the two/"* (key informant)

- **Improve access to weight management programs**
  - Lack of affordable weight management programs (key informant)
  - Lack of awareness about nutrition programs available in the community (key informant)
  - Limited recreational facilities in Lower North Philadelphia (focus group)
  - Nutritional Counseling - not done well for patients or available in cardiology. Need nutrition education in group sessions. (key informant)
  - Need to work with obese women pre- and post- pregnancy and with their kids. (key informant)
  - *"Need for education, especially for younger kids to prevent obesity. The key is really to prevent rather than treat. The problem is that often parents are obese and passing on their habits to their children."* (focus group)
  - *"Parents need education too, because they don't realize that obesity can kill them. They eat a lot of fast food, don't cook, and lack of time to prepare healthy meals."* (focus group)
  - *"Maybe if we had nutrition or cooking classes because we really need to show people, not just tell them; we tell patients the same thing over and over."* (focus group)
  - *"I think education is lacking...it doesn't work to just tell patients what they need to do. They need structured classes and ongoing programs for support. There used to be a community center that people used for these things, but it was just converted to a school."* (focus group)
  - *"A lot of people will say that they would rather buy something that's non-healthy because it's more affordable, when actually, if they would educate themselves on how important the healthy aspect is long term, they would maybe not mind spending extra to buy something healthy or use more healthier choices."* (focus group)
- **Continue to promote breastfeeding**
  - *"Need a huge culture shift to increase breastfeeding particularly among African American women. Poorer women need to see breastfeeding as part of their culture. OBs need to discuss breastfeeding early and often with pregnant women. Lactation support is needed in hospitals and in the community. This type of support is spotty for poor women. Philly WIC could do more locally like in other parts of the country to promote breastfeeding. Philadelphia had one lactation consultant for 15,000 women. More are training now. Women at WIC are saying they are using formula just in case breastfeeding problems occur."* (key informant)

**Based on internal and external key informants, focus groups, existing relationships and programs, and secondary data, actions addressing obesity may include:**

- 1. Link TJUHs dietitians and health educators to community education programs**
- 2. Provide chronic disease management and nutrition programs in community sites**
- 3. Continue to support efforts to enhance physical activity opportunities in South Philadelphia**
- 4. Continue to support efforts to change vacant lots into productive land use such as community gardens**

- 5. Promote walking clubs in collaboration with the YMCA and senior centers**
- 6. Support PDPH efforts to pass a school policy that requires a specific number of minutes of physical activity weekly in schools. Work with school Wellness Councils to encourage regular classroom movement breaks and socialized recess**
- 7. In collaboration with PDPH, School Wellness Councils, and others, support school food reform through policy and behavioral changes.**
- 8. Create a central place to promote nutrition, physical activity, weight management, and other wellness programs**
- 9. Continue to support healthy vending machine options, the farmers market, and the PDPH Healthy Hospital initiative at Jefferson**
- 10. Continue to pursue *Baby Friendly Hospital* status**
- 11. Continue to participate in PDPH *Get Healthy Philly* initiatives**

## ***Mental Health***

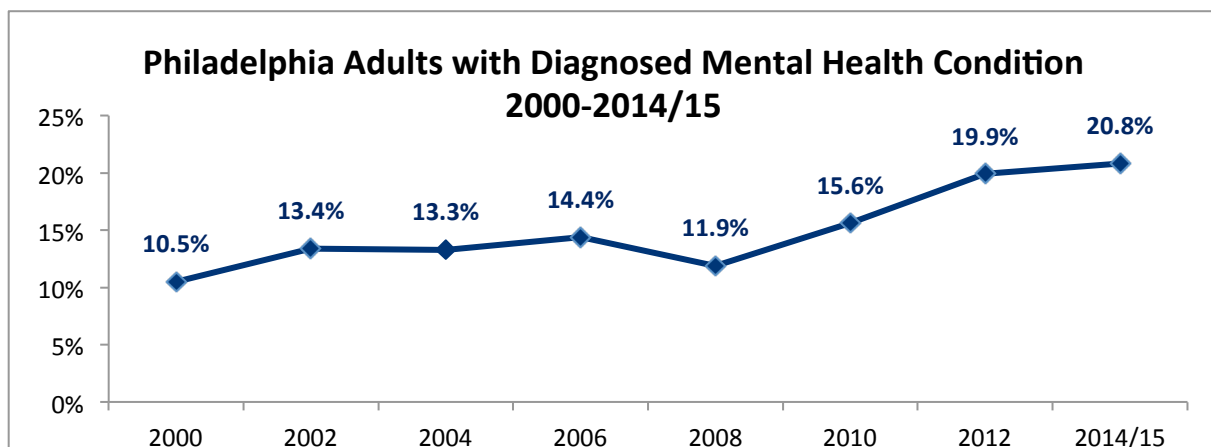
*“The community is psychiatric desert.”* (key informant)

Mental and physical healthcare are inter-related. Mental health plays a major role in people’s ability to maintain good physical health. However, mental illness, such as depression and anxiety, can limit the ability to integrate health-promoting behaviors into one’s life. Conversely, physical health issues, such as chronic disease, can have a serious impact on mental health and may inhibit full participation in treatment and recovery.

Healthy People 2020 objectives related to mental health include:<sup>126</sup>

- Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral to 87%
- Increase the proportion of adults with mental disorders who receive treatment to 72.3%
- Increase the proportion of adults aged 18 years and older with major depressive episodes (MDEs) who receive treatment to 75.9%
- Increase the proportion of primary care physicians who screen adults aged 19 years and older for depression during office visits to 2.4%
- Increase the proportion of homeless adults with mental health problems who receive mental health services to 41%

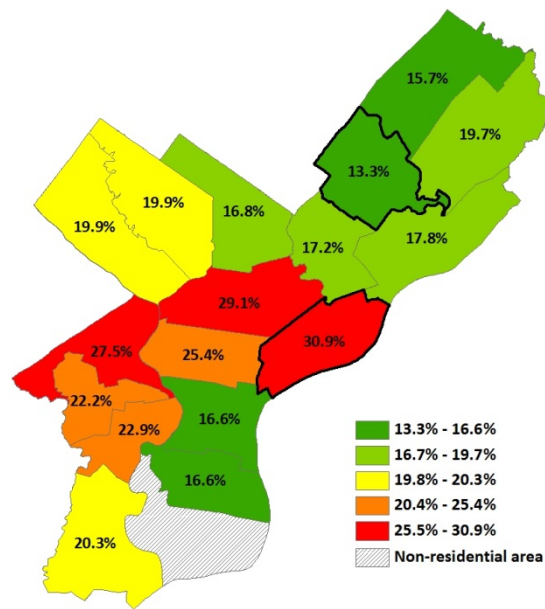
Just under 21% of all adults in Philadelphia have been diagnosed with a mental health condition. Since 2000, the percentage of adults diagnosed with a mental condition nearly doubled.



*PHMC Household Health Survey 2015*

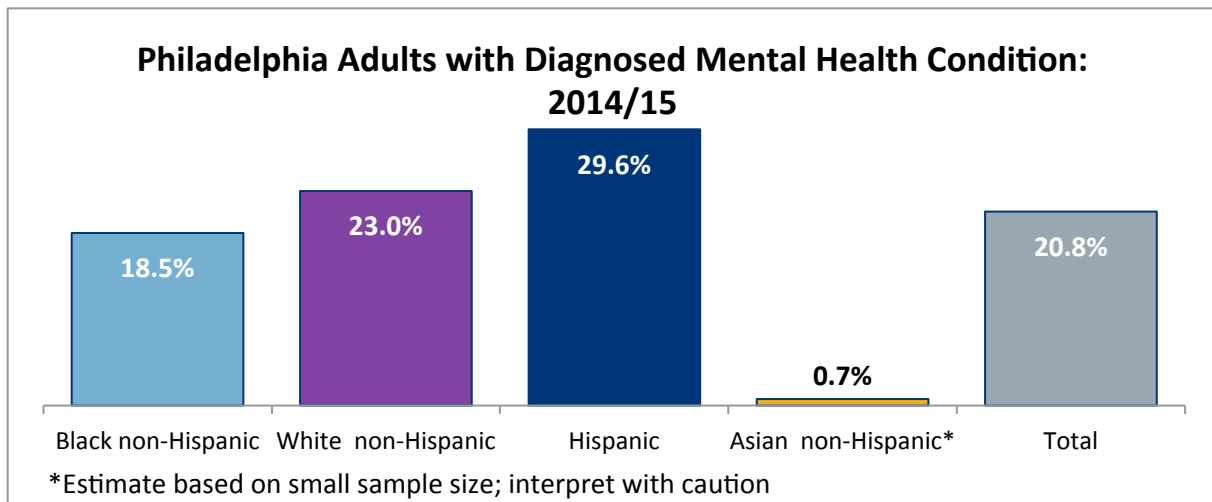
Mental health condition diagnoses rates vary greatly across Philadelphia.

### Adults with diagnosed mental health condition



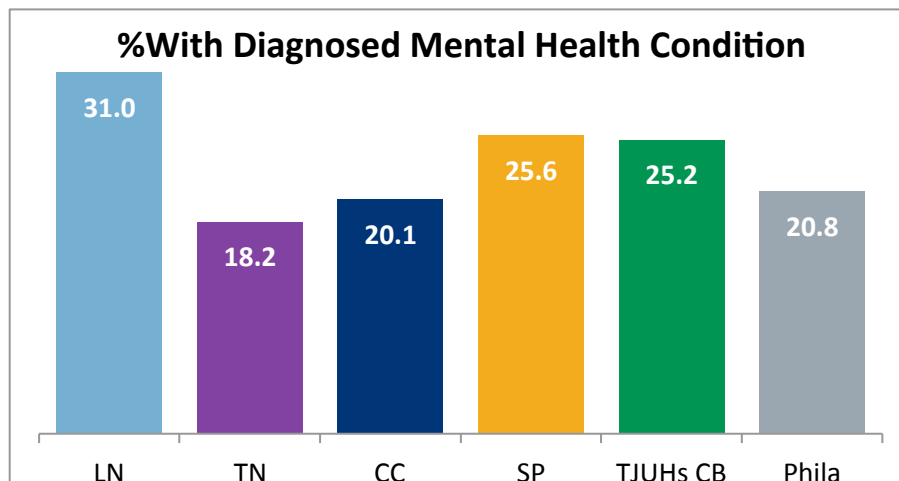
Source: Public Health Management Corporation (PHMC) Household Health Survey, 2012

Hispanics have the highest prevalence of adults with a diagnosed mental health condition, followed by White-non Hispanic and Black non-Hispanics.



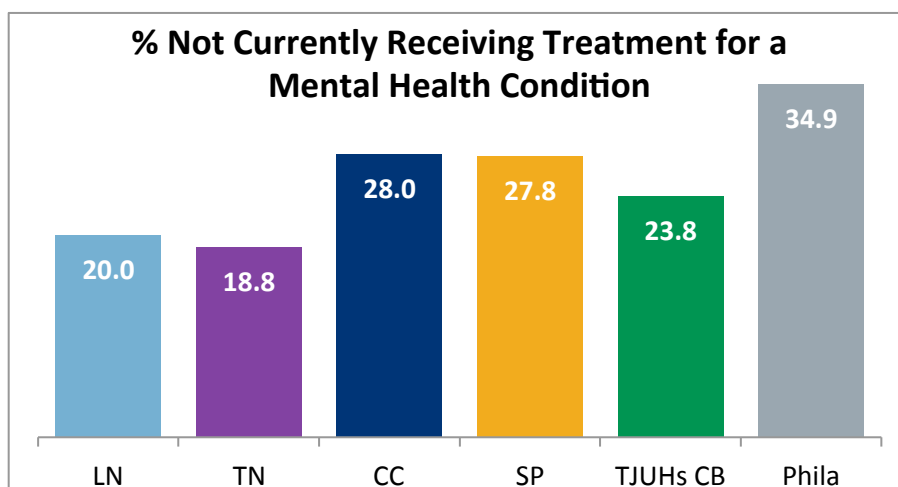
PHMC Household Health Survey 2015

The rate of people in TJUHs CB areas that report having been diagnosed with a mental health condition is higher than in Philadelphia. Residents living in Lower North Philadelphia report the highest rates, with 31% diagnosed with a mental health condition.



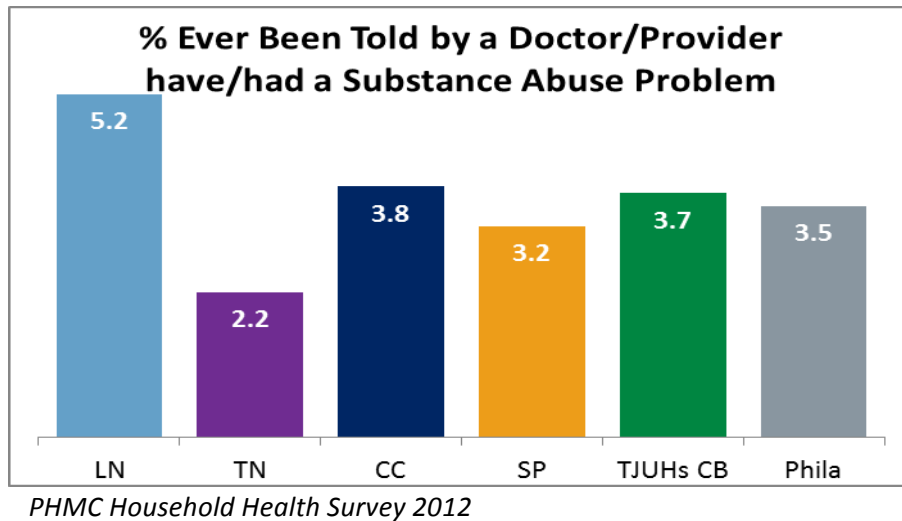
PHMC Household Health Survey 2015

Almost a quarter of those with a mental health diagnosis in TJUHs CB areas report they are not receiving treatment for their condition.



PHMC Household Health Survey 2015

**Substance Abuse:** According to 2012 data (the most recent data available), residents of TJUHs CB areas are slightly more likely than Philadelphians overall to have been told by a doctor or health provider that they have a substance abuse problem (3.5% vs. 3.7%). Adults living in Lower North Philadelphia and Center City report the highest rates of substance abuse (5.2% and 3.8% respectively).

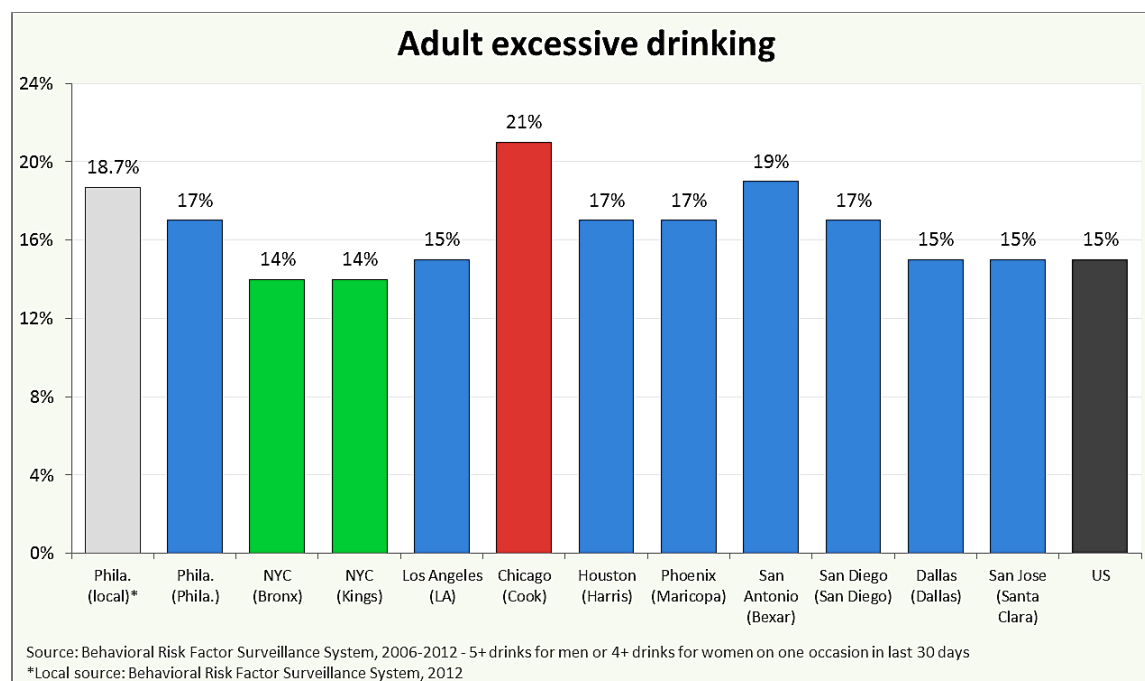


Most drugs of abuse can alter a person's thinking and judgment, leading to health risks, including addiction, driving while under the influence of drugs, infectious disease, interpersonal violence, pregnancy and if pregnant harm to an unborn baby. Substance abuse can have a major impact on individuals, their families, and communities and contributes to costly social, physical, mental, and public health problems. Abuse of tobacco, alcohol, and illicit drugs is costly to our Nation, with an annual price tag of \$700 billion in costs related to crime, lost work productivity and health care.<sup>127,128,129,130</sup>

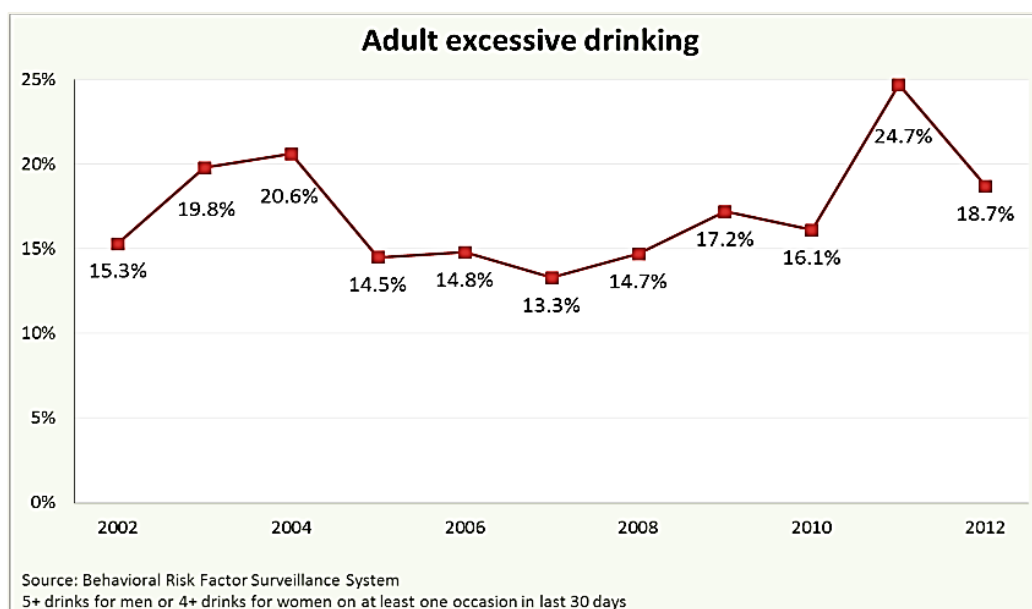
The goals of Healthy People 2020 related to substance abuse include:<sup>131</sup>

- Reduce the proportion of adolescents reporting use of alcohol or any illicit drugs during the past 30 days, Target: 16.6 percent
- Reduce the proportion of adolescents reporting use of marijuana during the past 30 days. Target 6.0 percent
- Reduce the proportion of adults reporting use of any illicit drug during the past 30 days. Target: 7.1 percent
- Reduce the past-year nonmedical use of pain relievers
- Reduce the past-year nonmedical use of tranquilizers
- Reduce the past-year nonmedical use of any psychotherapeutic drug (including pain relievers, tranquilizers, stimulants, and sedatives). Target: 5.5 percent
- Reduce the proportion of persons engaging in binge drinking during the past month—adolescents aged 12 to 17 years. Target: 8.6 percent
- Reduce the proportion of persons engaging in binge drinking during the past 30 days—adults aged 18 years and older. Target: 24.4 percent

Compared to its peer metropolitan areas, Philadelphia has the third highest rate of excessive use of alcohol. Only Chicago and San Antonio have higher rates.

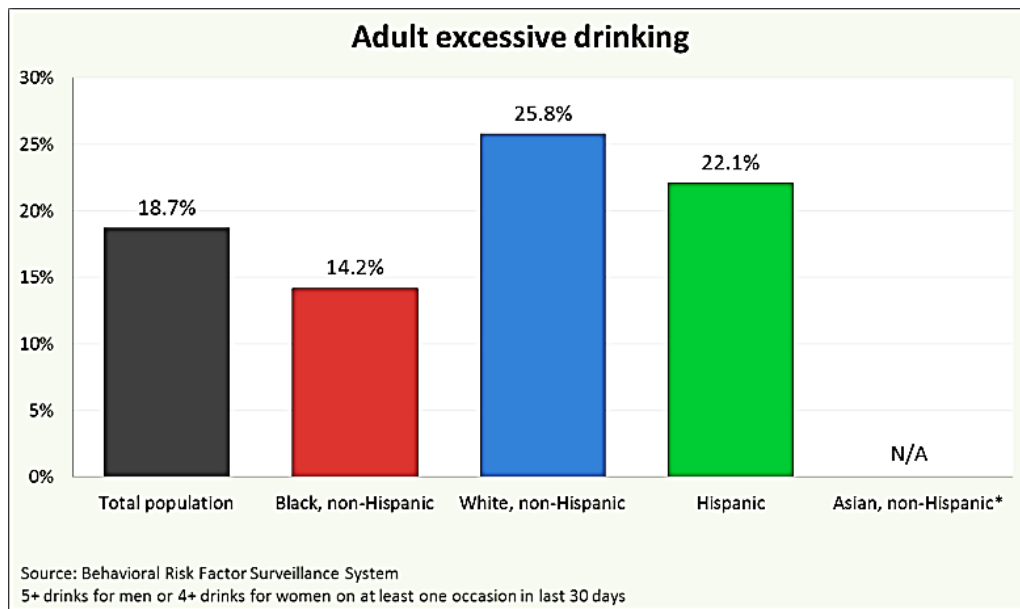


Excessive use of alcohol has increased since 2002 among Philadelphia adults from 15.3% to 18.7% in 2012; however, there has been considerable fluctuation in excessive alcohol use during this timeframe.

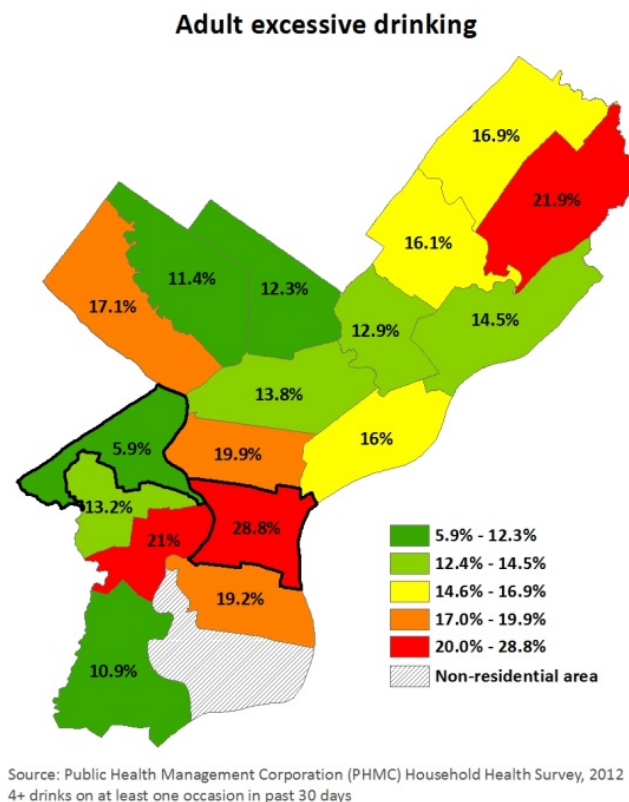


White non-Hispanic (25.8%) and Hispanic (22.1%) individuals have the highest rates of excessive drinking while Black non-Hispanics have the lowest rate (14.2%)

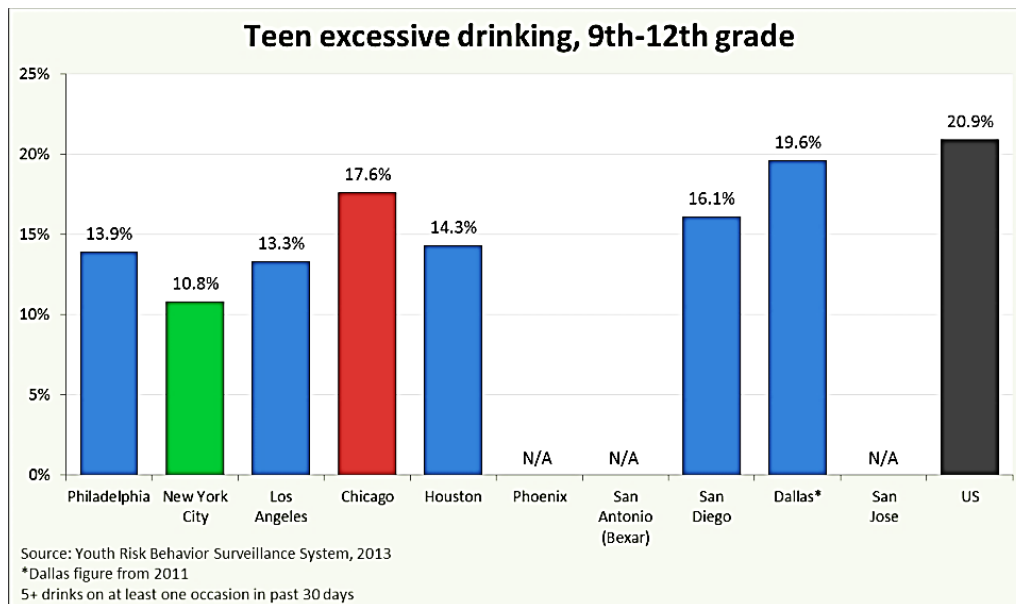




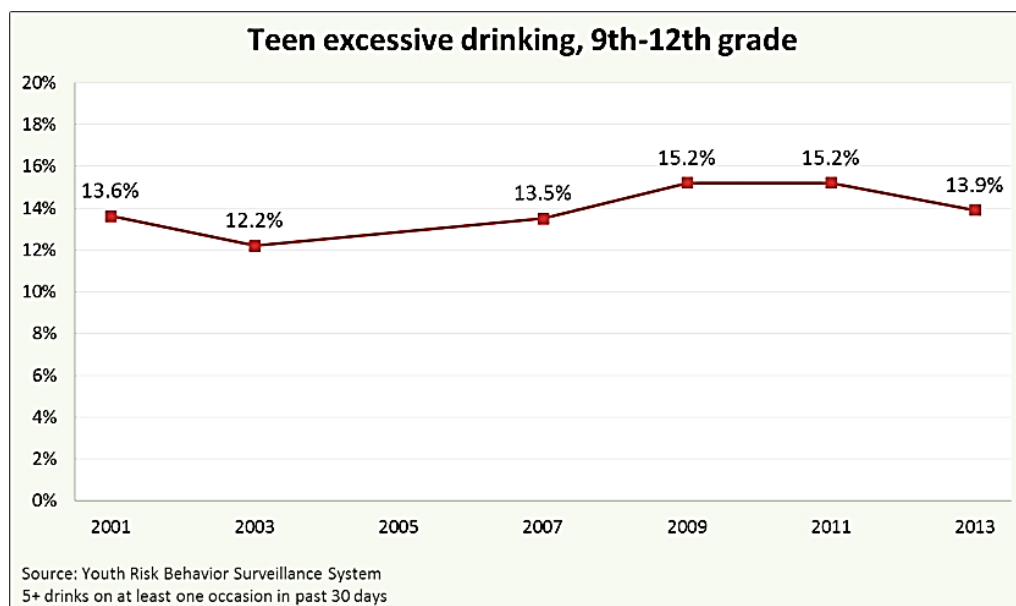
TJUHs CB area has some of the highest rates of excessive alcohol use in Philadelphia. In Central Philadelphia almost 30% of adults report excessive alcohol use, the highest rate in the City. Almost 1 in five individuals in Lower North and South Philadelphia also report excessive use of alcohol.



Excessive drinking by 9<sup>th</sup>-12 graders is less problematic in Philadelphia compared to peer metropolitan areas and the United States.



The rate of excessive drinking has not changed dramatically between 2001 and 2013 (13.6% vs. 13.9%). White non-Hispanic adolescents are most likely to report excessive drinking (24%), followed by Hispanics (16.1%), Black non-Hispanic (10.7%) and Asians non-Hispanic (7.1%).



According to the National Drug Early Warning System (NDEWS) 2015 Sentinel Community Site Profile for Philadelphia, substance use continues to be a public Health problem in Philadelphia. In 2014, the Mayor of Philadelphia signed legislation that decriminalized the possession and public consumption of marijuana. The bill levies fines of \$25 on people

possessing up to 30 grams, and \$100 for smoking it in public. When asked about drug use in the past month, 10.9% of all Philadelphians aged 12 or older indicated they used marijuana (128,588 people) and 4.2% used an illicit drug other than marijuana (53,000 people). Almost 63,000 people indicated they used pain killers for non-medical use in the past year. More than 150,000 people reported dependence on or abusing illicit drugs or alcohol in the past year. Admissions to substance abuse treatment programs increased steadily between 2010 (7,513 admissions) and 2014 (8,363 admissions). In 2014, alcohol (29.6%), marijuana (22%) and heroin (21.1%) accounted for the majority of admissions to substance abuse treatment programs.<sup>132</sup>

### Self-Reported Substance Use Behaviors among Person in Philadelphia 2010-2012

Substance Use Behaviors	Philadelphia County				
	Age 12-17	Age 18-25	Age 26+	Total ages 12+	
	Estimated %	Estimated %	Estimated %	Estimated %	Estimated #
Used in Past Month					
Binge alcohol	6.9	42.4	27.6	28.44	358,884
Marijuana	7.8	23.6	7.3	10.19	128,588
Use of illicit drug other than marijuana	3.7	6.3	3.8	4.2	53,000
Used in Past Year					
Marijuana	14.2	37.1	12.2	unavailable	unavailable
Cocaine	0.5	4.1	2.9	2.93	36,974
Non-medical use of pain relievers	5.4	9.0	4.0	4.99	62,969
Dependence or abuse in past year					
Illicit drugs or alcohol	7.8	20.6	10.3	11.9	150,166
Alcohol	4.0	14.8	8.8	9.46	119,376
Illicit drugs	3.4	7.9	3.5	4.28	54,009

*NDEWS Coordinating Center from data provided by the substance Abuse and Mental Health Services Administration (SAMSHA), Substate Estimates of Substance Use and Detailed Tables. 95% Confidence Interval. Annual averages Based on 2010, 2011 and 2012 NSDUHS*

The Philadelphia Fire Department Emergency Medical Services (EMS) reported 11,745 responses in 2014 (more than 800 per month) for overdoses or accidental poisoning.

Philadelphia has the highest rate of drug overdoses in Pennsylvania, nearly 42 people per 100,000. In 2014 there were 652 overdose deaths in Philadelphia and toxicology tests performed on 635 cases. Test results showed the following drugs were present in intoxication death cases: morphine/heroin (350 deaths; 55%); cocaine (273 deaths; 43%); fentanyl (100 deaths; 15.7%) and oxycodone (93 deaths; 14.6%). Alcohol in the presence of other drugs was found in 125 cases. Multiple drugs were found in many of the intoxication deaths.<sup>133</sup>

Data from the Medical Examiner's Office for 2014- H1 2015, shows that five 5 zip codes in TJUHs CB area are among the top ten zip codes for resident deaths confirmed to be due to alcohol and/or drug intoxication. Zip codes in TJUHs CB area are highlighted.

Deaths due to Alcohol and/or Drug Intoxication confirmed by the Medical Examiner's Office 2014-H1 2015					
ZIP code	Count of intoxication deaths by decedent resident zip code during H1 2015	Rank	ZIP code	Count of intoxication deaths by decedent resident zip code during 2014	Rank
19134	19	1	19124	42	1
19136	17	2	19134	41	2
unknown	15	3	unknown	38	3
19124	14	4	19140	30	4
19132	14	5	19136	26	5
19104	13	6	19148	25	6
19121	13	7	19144	24	7
19135	13	8	19145	21	8
19148	12	9	19120	18	9
19145	11	10	19135	18	10
			19143	18	10

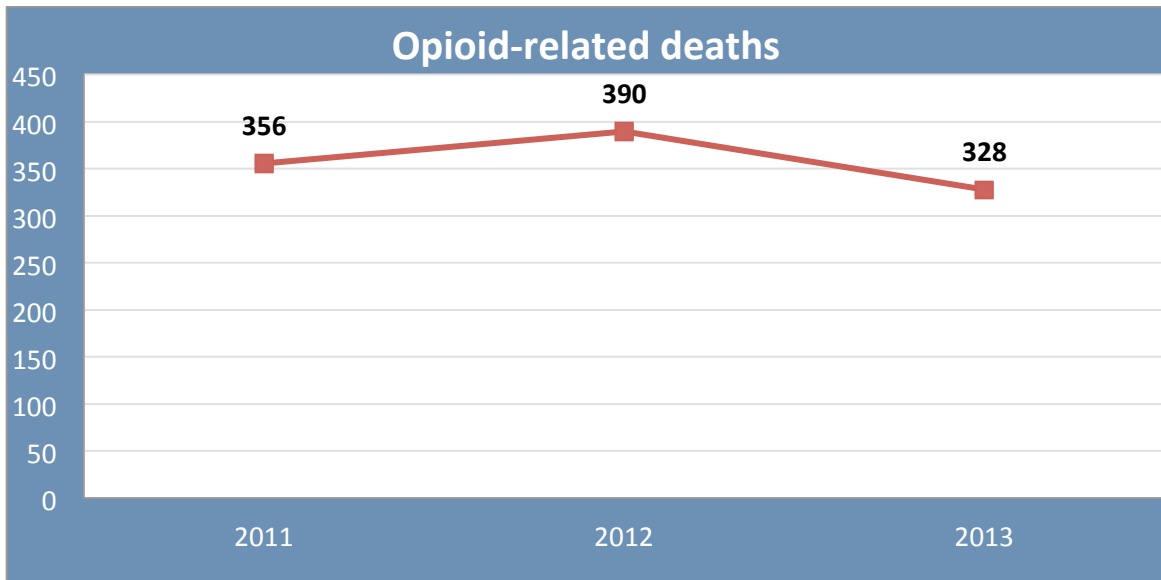
*Philadelphia Medical Examiner's Office for 2014- H1 2015*

In 2014, 900,000 people in the United States reported using heroin in the past year. Opioids include heroin as well as powerful pain relievers available legally by prescription, such as oxycodone (OxyContin®), hydrocodone (Vicodin®), codeine, morphine, fentanyl, and many others. Opioids can be safe, but are frequently misused (taken in a different way or in a greater quantity than prescribed, or taken without a doctor's prescription). Regular use—even as prescribed by a doctor—can produce dependence, and when misused or abused, opioid pain relievers can lead to fatal overdose.<sup>134,135</sup> From 1991 to 2011, there was a near tripling of opioid prescriptions dispensed by U.S. pharmacies: from 76 million to 219 million prescriptions. Opioid-related deaths nearly tripled over the same time period.<sup>136</sup>

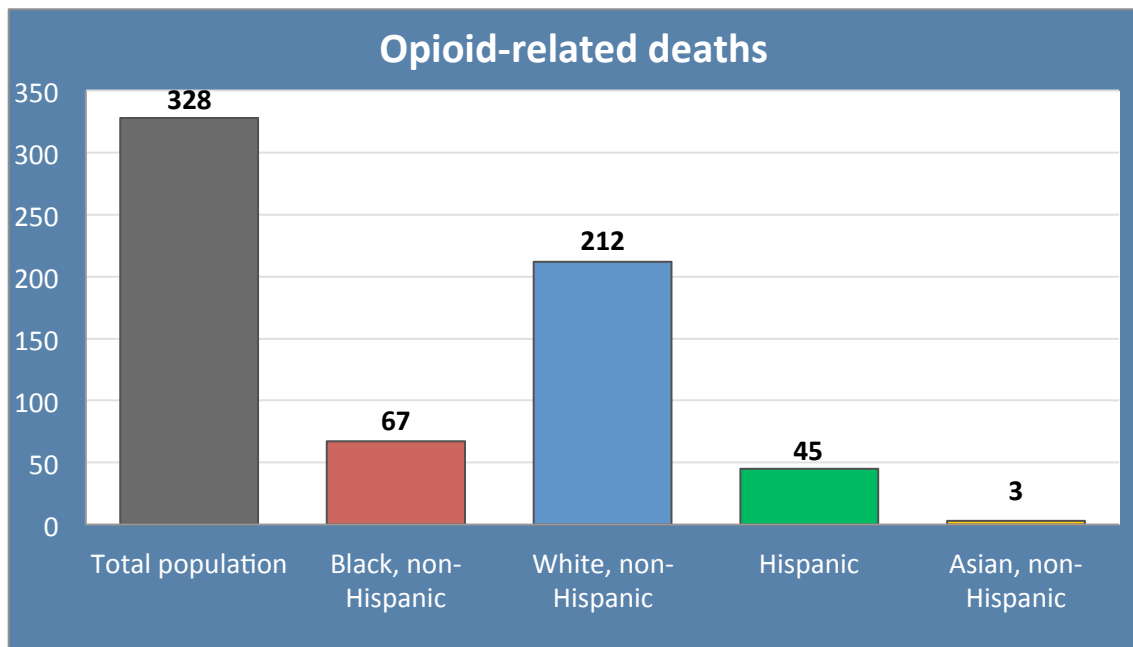
Frequent prescription opioid users and those diagnosed with dependence or abuse of prescription opioids are more likely to switch to heroin; dependence on or abuse of prescription opioids has been associated with a 40-fold increased risk of dependence on or abuse of heroin.<sup>137</sup>

According to the CDC, there were 10,574 heroin overdose deaths in the United States in 2014, more than a five-fold increase in the heroin death rate between 2002 and 2014.<sup>134,135</sup>

Between 2011 and 2013, 1,074 people died from an opioid related death. In 2013, 64.6% of all deaths related to opioid use were among non-Hispanic Whites.



*Source: Medical Examiner's Office, Philadelphia Department of Public Health, 2013*  
*Data are a total number not a rate*



*Source: Medical Examiner's Office, Philadelphia Department of Public Health, 2013*  
*Data are a total number not a rate*

To combat the intertwined problems of prescription opioid misuse and heroin use, in March of 2015 the Secretary of Health and Human Services announced the Secretary's Opioid Initiative. This initiative focuses on three priority areas that tackle the opioid crisis.<sup>138</sup>

- **Providing training and educational resources, including updated prescriber guidelines, to assist health professionals in making informed prescribing decisions** and address the over-prescribing of opioids.
- **Increasing use of naloxone**, as well as continuing to support the development and distribution of the life-saving drug, to help reduce the number of deaths associated with prescription opioid and heroin overdose.
- **Expanding the use of Medication-Assisted Treatment (MAT)**, a comprehensive way to address the needs of individuals that combines the use of medication with counseling and behavioral therapies to treat substance use disorders.

*“Overdoses don’t discriminate based on race, gender or economic status. Prescription drug, opioid and heroin have created victims in all walks of life in our city and throughout the Nation” (District Attorney Seth Williams – announces pilot program with police to safely dispose of prescription drugs in Philadelphia, January 20, 2016).*

On January 20, 2016, Philadelphia District Attorney, Seth Williams, launched a new pilot program in six Philadelphia Police districts to promote safe and anonymous disposal of unwanted prescription drugs as a means to reduce heroin abuse in Philadelphia. The “Lock Box” program will be initiated in the 1<sup>st</sup>, 15<sup>th</sup>, 19<sup>th</sup>, 22<sup>nd</sup>, 25<sup>th</sup>, and 35<sup>th</sup> Police districts.

Mental Health issues for Older Adults are discussed in the Special Population section.

**Issues, challenges, unmet needs and priorities identified by key informants and focus group participants related to mental health include:**

***“The community is psychiatric desert.”***

- **Collaboration**
  - Need to improve collaboration between emergency departments, residential facilities and psychiatric facilities when a patient is involuntarily committed to the hospital. (key informant)
    - Need to identify what else is happening with this person (ex: traumatic brain injury vs. mental illness) in the emergency department.
    - Patients often lack a state ID, therefore access to patient information isn’t possible if the patient is unresponsive
    - Need to address other patient health issues at same time.
  - Need better communication between mental and physical health providers. Could communicate through HER (key informant)

- The behavioral health and physical health systems in Philadelphia are large, complex, siloed and lack cross-sectorial communication. (key informant)
- Need co-located health and behavioral health services (key informant)
- **Access to Care:**
  - Mental Illness - hospital needs to support mental illness safety net organizations.
  - Hospitals should help get more psych services into the community (key informant)
  - Schools need a better more timely way to respond to mental health needs. Child with anxiety in a charter school- saw the school psychologist.- Mom didn't understand what the child needed and waited two months to get assistance (she talked to her pediatrician). Need in-school psychologists- These children do poorly in school without access to behavioral health
  - Behavioral Health for Kids: Lack of access to HHS (services not provided in timely way) (key informant)
  - *Need outpatient psych particularly after discharge from the hospital. The community struggling with mental illness- Are there Community Centers that deal with this? Is there a better way to identify and deal with health and behavioral health? You can make the diagnosis in the hospital and start the patient on meds (in-patient Psych), but why start if there isn't follow through?* (key informant)
- **Insurance**
  - Uninsured face barriers to mental health services, including not wanting to use public services. The Council for Relationships provides mental health care for low income people including the uninsured and underinsured. (key informant)
  - *Challenged by referrals to psych due to lack of insurance for outpatients* (key informant)
- **Interpretation**
  - Use of the language line to address mental health issues is problematic. Language line interpretation for mental health issues is seen as lacking context and sensitivity. (key informant)
  - *While clients go to therapy, when interpretation is needed therapy often falls apart* (key informant)
  - *Interpretation is a major issue. Refugees don't follow through with treatments plans/ medication therapy. Interpreters for mental health issues have been available at TJUHs. However, interpreters can be unreliable; that is, there may not be an interpreter available who speaks a needed language or dialect.* (key informant)
  - *It's difficult to address mental health issues via telephonic translation. Interpreters may be rejected because you don't share these things outside of family, Having an in-person professional interpreter is preferable (phone may be rejected). Needs to be throughout health care, not just between doctor and patient interaction.* (key informant)
- **Cultural Issues and Stigma**
  - *What's needed? Mental health services for immigrants and refugees - a westernized approach is not always effective.* There are multiple cultural issues related to mental health screening, diagnosis and treatment in the community, particularly among refugee and immigrant populations

- *Refugees need mental health services but don't 'want' a referral. Language access is not available. Need more 'art' music, movement therapy rather than basic counseling. Mental health is not discussed in refugee communities. (key informant)*
- *Sense of inferiority- just to ask for help is hard (key informant)*
- *Mental health has a big stigma in Asian community. Talking about it is taboo; and they do not believe in counseling (key informant)*
  - *People in the community are afraid to speak their mind. This is a big barrier, due to Khmer Rouge. They need a trusted person to help them*
    - *After building trust, the NSC Case manager gets the refugee client to try behavior health services. The counseling can still go badly. Client was asked- "why are you here" at each visit- she stopped going because she felt they were not "hearing" her. (key informant)*
- *Stigma/reluctance to go to VA for mental health concerns due to fear it will limit future employment (key informant)*
- **Depression**
  - *Underdiagnoses of depression, particularly in older women, pregnant women and refugees*
  - *Depression among pregnant women is a problem as is bi-polar diagnosis. Access to care for these women is also an issue. It's very difficult for people with behavioral health issues to get regular care. People on SSI (mental health disabled) are less likely to be on treatments or medications. Pregnant women with mental health issues may also have poor housing, children, lack food, etc. No one service provider can care for all their needs. They need in home health therapy since they have barriers to getting to services. Medicaid won't cover all costs. MCC is trying to make in home services cost effective but currently is not economically feasible. There is fragmentation, lack of service coordination and all needed services are not available. (key informant)*
  - *There is no money to get to care/appointments and some (women) have had a negative experience with therapists. The system is extraordinarily fragmented. People may have 6 to 12 service providers in their lives and none of them meet all their client's needs. There is no coordination. Everyone recognizes it's a train wreck about to happen and no one can do anything to stop it (key informant).*
- **Drug Use**
  - **Opioid use**
    - *We are in the midst of a heroin resurgence like we have never seen. Heroin is seen as a safer lifestyle than crack cocaine because it isn't gang or violence related (key informant)*
    - *Seeing a lot more heroin, both in ED visits and in the community. Seeing it across all ages. A lot of people are taking pain pills. It gets more difficult to get the scripts and then they turn to heroin because it's cheaper (key informant)*
    - *Seems to be related to underlying mental health issues (depression, anxiety issues, underlying problems that manifest as drug addiction)*



- *Drugs are accessible- if person is in an accident and prescribed opiates for pain- increases the likelihood of heroin use. Heroin is only \$5 a bag. (key informant)*
- *Drugs in home- instead of buying food for children, using it on drugs (focus group)*
- *10-15% of opioid users will become addicted. Heroin is more addictive. (key informant)*
- **Treatment access and barriers**
  - *Individual and group counseling and case management are required weekly to stay in drug replacement program (about 9 hours). Obstacles to staying in treatment are inadequate childcare, healthcare, mental health care and transportation. (key informant)*
  - *If a client has a 3 year old and no money then it's hard to get that person to attend. Then you may have to throw them out of the program since they can't participate in therapy. During Christmas break their kids aren't in school and they have no one to watch them. They can't go to the required therapy. (key informant)*
  - *The current methadone treatment census is 405 (used to be 50-75 daily). No one else is offering replacement therapy in South Philadelphia. DBHIDS would like us to increase the census but we can't expand in current physical space. (key informant)*
  - *Institutionalized poverty - Only about 20% of clients work. If a client makes too much money then they aren't eligible for MA. If they aren't on MA then the replacement therapy (methadone) will cost them \$100 per week. (key informant)*
  - *Addictions among the refugee community are common. Services aren't available particularly for non-English speakers/refugees (key informant)*
- **Programmatic needs**
  - *Need co-located services (key informant)*
  - *Create a Family Wellness Center culture where services are co-located. (Vocational training) how to look for a job), psycho-therapy, replacement therapy, parenting education, quality childcare services. (key informant)*
  - *Hold separate services for newly addicted young individuals, separate from older patients. Younger clients don't respect older clients. Older clients don't feel their opinions are valued. (key informant)*
  - *Need high quality services co-located with health care (family medicine) West of Broad and South of Washington Avenue. (key informant)*
  - *Drug overdose- need outpatient support services to decrease re-admissions (key informant)*
  - *We would like to screen refugees for substance abuse and would like providers to screen. We need a tool to use (key informant)*
  - *Need increased access to Narcan*
  - *Need to use evidence-based practice - In 2015, Thomas Jefferson University's Department of Family and Community Medicine received a three year grant from SAMSHA to initiate screening, brief intervention*

and referral to treatment SBIRT training into health professional student education to improve screening rates for substance abuse.

○ **Social environment**

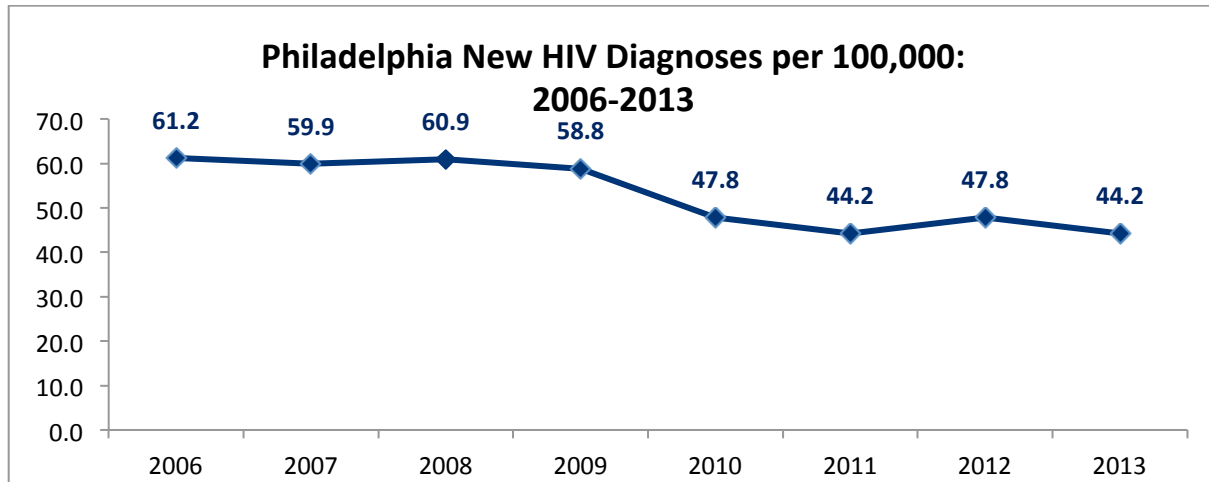
- *It's interesting because they're at the clinic down here between 9th and 10th and market. I only know from my patients because we treat the methadone clinic. Popeye's used to be the big thing- they all used to hang out at Popeye's where the drug dealers stay. Now the Gallery's closed down they're all at McDonalds. The bus driver doesn't even let me off at 9th, he lets me off a little bit at the corner cause you have these men who are nodding off.*(focus group)
- *I feel like we have that clinic down on Girard at 7th, I feel like the Girard-MFL stop becomes a nodding corner, and it becomes really sad and they don't know what to do.* (focus group)
- Need to continue collaboration with South Philadelphia Prevention Coalition through the Drug Free Communities grant

**Based on internal and external key informants, focus groups, existing relationships and programs, and secondary data, actions addressing mental health may include:**

- 1. Cultural competence training for mental health and primary care providers**
- 2. Improve mental health language access and services for non-English speakers**
- 3. Support mental health services that are culturally acceptable and community based**
- 4. Continue to coordinate training for community based organizations in *Trauma Informed Care*, working with children with ADHD and managing behavior/anger management of children and adolescents**
- 5. Improve access to and raise awareness among providers and community organizations about mental health resources**
- 6. Collaborate with the State Health Improvement Plan and City Community Health Improvement Plan related to mental health issues**
- 7. Continue to provide Mental Health First Aid training in partnership with the Department of Behavioral Health and Intellectual Disabilities (DBHIDS)**
- 8. Partner with Police Departments in removing unused drugs safely through the Lock Box program. Raise awareness among health care providers and the community about the program.**
- 9. Explore potential for co-locating services**
- 10. Increase access to Narcan**
- 11. Continue partnership with the South Philadelphia Prevention Coalition through the Drug Free Communities grant**
- 12. Initiate screening, brief intervention and referral to treatment SBIRT training into health professional student education**

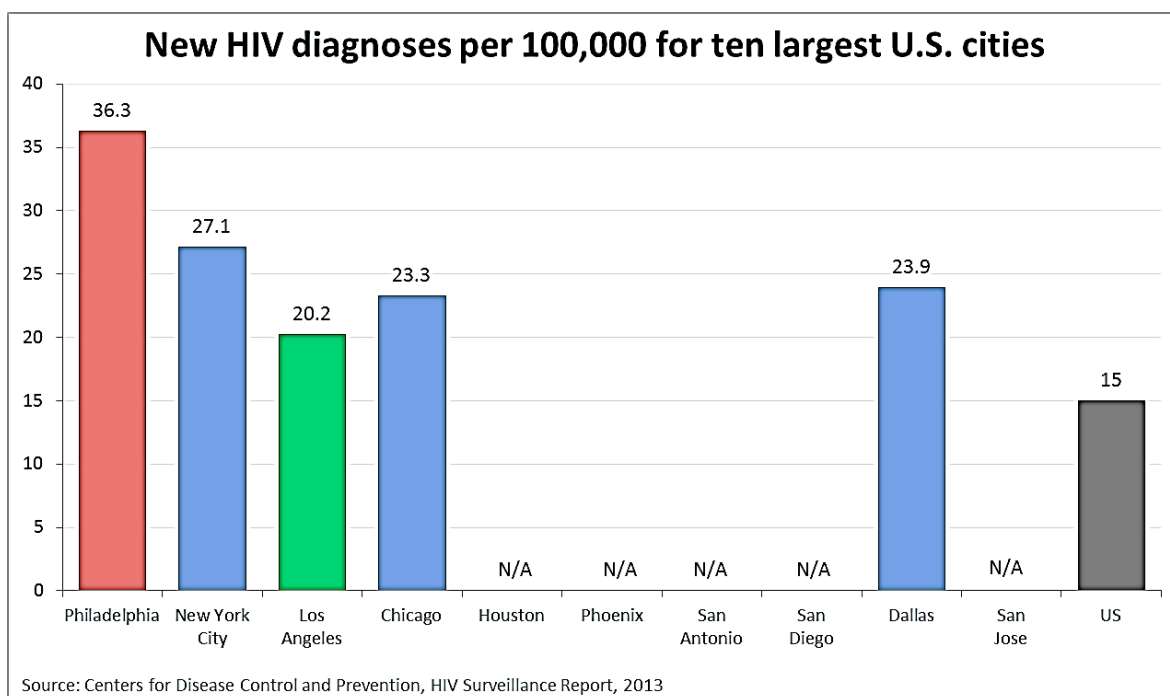
## ***HIV Status***

The HIV epidemic in the United States continues to be a major public health crisis. An estimated 1.1 million Americans are living with HIV, and 1 out of 5 people with HIV do not know they have it. HIV continues to spread, leading to about 56,000 new HIV infections each year.<sup>139</sup> In Philadelphia, there has been a significant decline in the number of new HIV diagnoses since 2006.

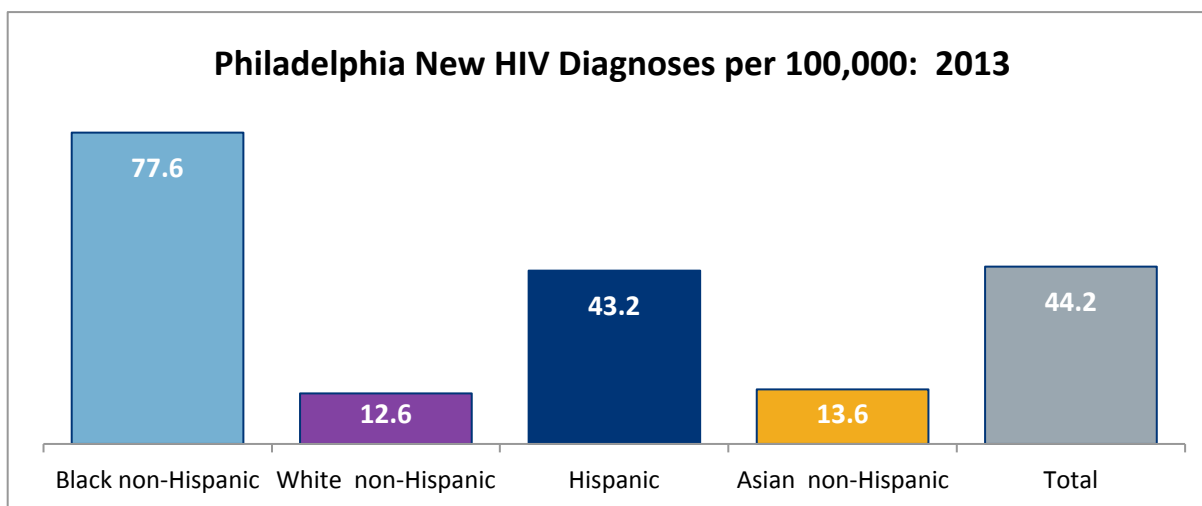


*AIDS Activities Coordinating Office, Philadelphia Department of Public Health*

Despite this decline, Philadelphia has the highest new HIV diagnoses rate per 100,000 of the ten largest cities in the United States.

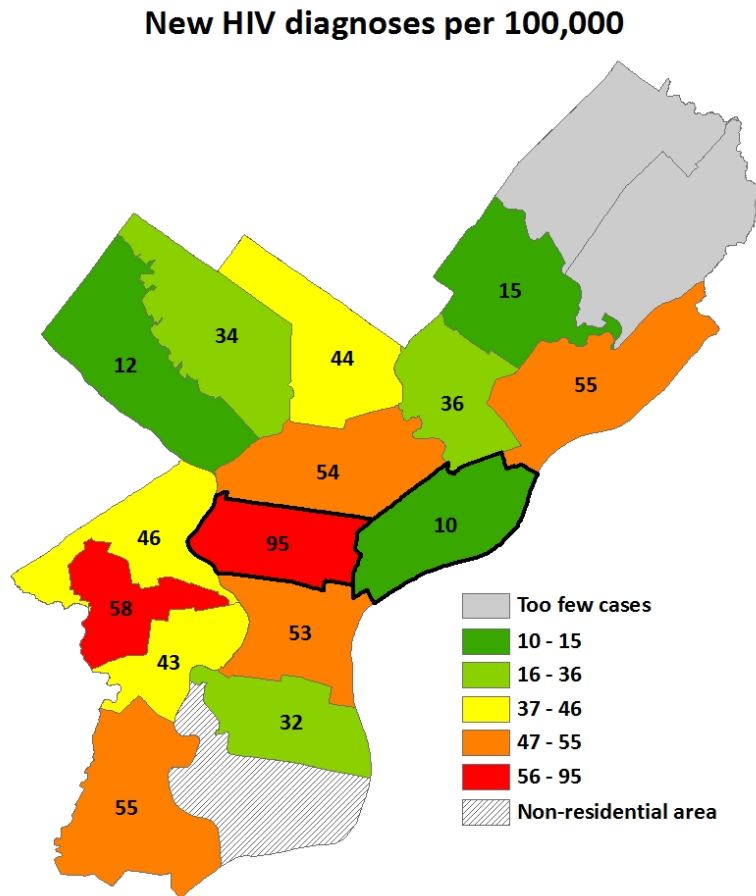


Black non-Hispanics are six times more likely to have a new diagnoses of HIV than non-Hispanic Whites and Asians, and nearly twice as likely as Hispanics.



*AIDS Activities Coordinating Office, Philadelphia Department of Public Health*

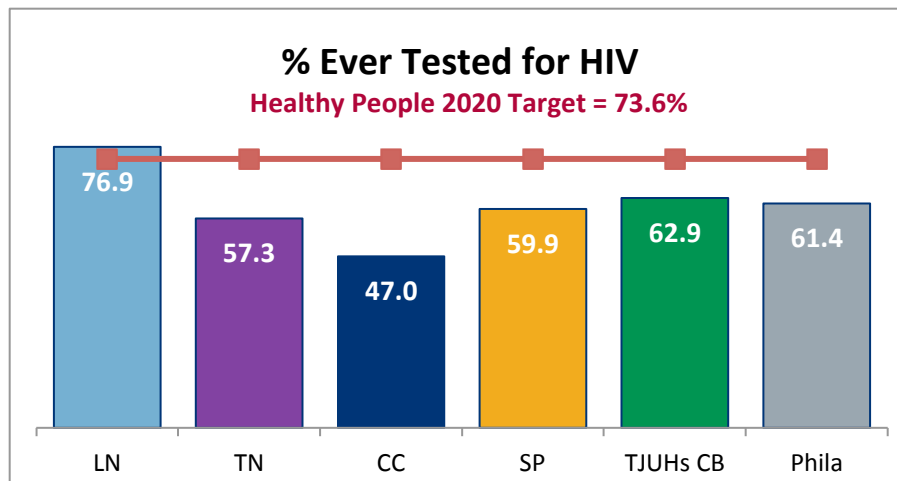
Consequently, location of new HIV diagnoses reflects the racial/ethnic composition of the population.



Source: AIDS Activities Coordinating Office, Philadelphia Department of Public Health, 2013

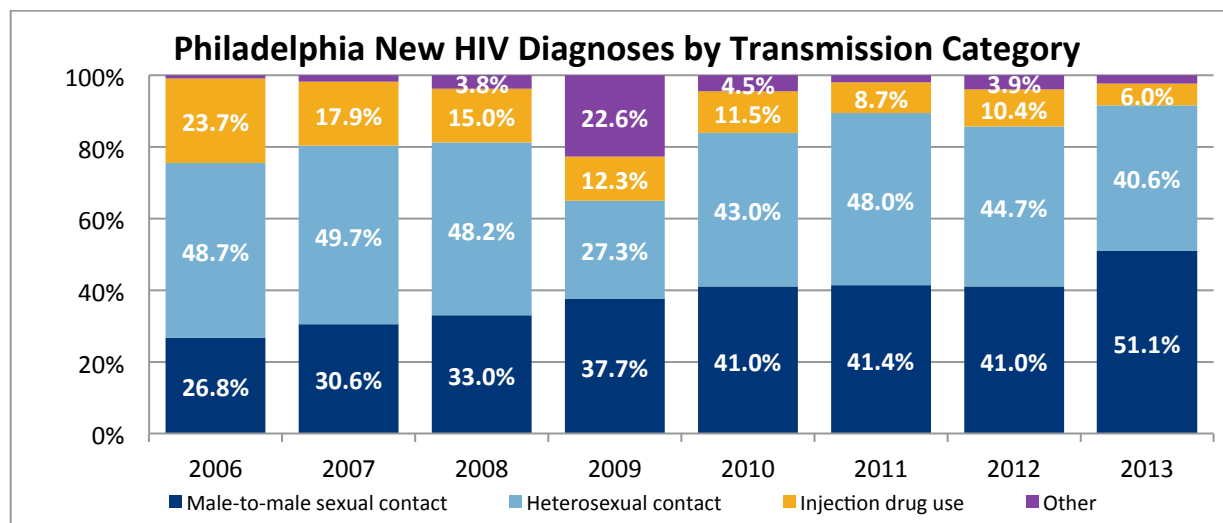
According to data provided by the Office of Addiction Services/Department of Behavioral Health and Intellectual Disability Services (DBHIDS), the planning analysis sections in Philadelphia with the highest rates of people living with HIV are in Center City (19102, 19103, 19106, 19107), Lower North Philadelphia (19121, 19122, 19123, 19130), and Upper North Philadelphia (19132, 19133 and 19140). All but one of these zip codes is in TJUHs CB area.

Residents living in TJUHs CB areas are slightly more likely than Philadelphians to have been tested for HIV. Only adults in Lower North Philadelphia have been screened for HIV at a rate that exceeds the Healthy People 2020 goal. The screening rate in Center City is lower than 50%, which is especially concerning since a large population of vulnerable gay men reside there. TJUH's Emergency Department provides rapid screening tests for HIV.



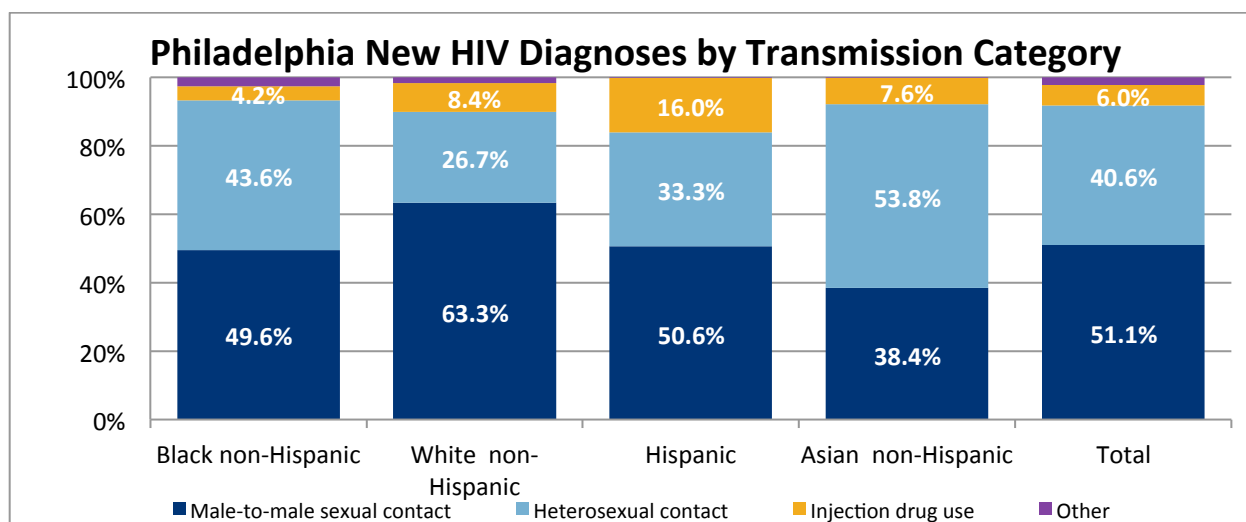
PHMC Household Health Survey 2015

In Philadelphia in 2013, the most common mode of HIV transmission is male-to-male sexual (MSM) contact (51.1%) followed by heterosexual contact (40.6%). In most prior years, heterosexual contact was the most frequent means of transmission.



AIDS Activities Coordinating Office, Philadelphia Department of Public Health

HIV is more likely to be transmitted by MSM among White non-Hispanics compared to Black non-Hispanics (63% vs. 50%). Heterosexual transmission is least common among White non-Hispanics.



AIDS Activities Coordinating Office, Philadelphia Department of Public Health

**Issues, challenges, unmet needs and priorities identified by key informants and focus group participants related to HIV include:**

- *"P.R.E.P – pre-exposure prophylaxis for gay/bi men. PREP was Approved 1 ½ years ago and today about 500 men are on PREP. To date, no one on PREP has gotten HIV yet. PREP is a pill (Trevada.) There are still side effects like kidney problems. It works well with men who are very sexually active. There are some that believe that this gives you permission to have sex. Need to make PREP more accessible in community setting like a storefront in Wash West. This is particularly important for outreach to Black men (who may have high viral loads and not know it)." (key informant)*

**Based on internal and external key informants, focus groups, existing relationships and programs, and secondary data, actions addressing HIV may include:**

1. Raise awareness about PREP and expand its availability in community settings
2. Continue rapid HIV screening in the emergency department

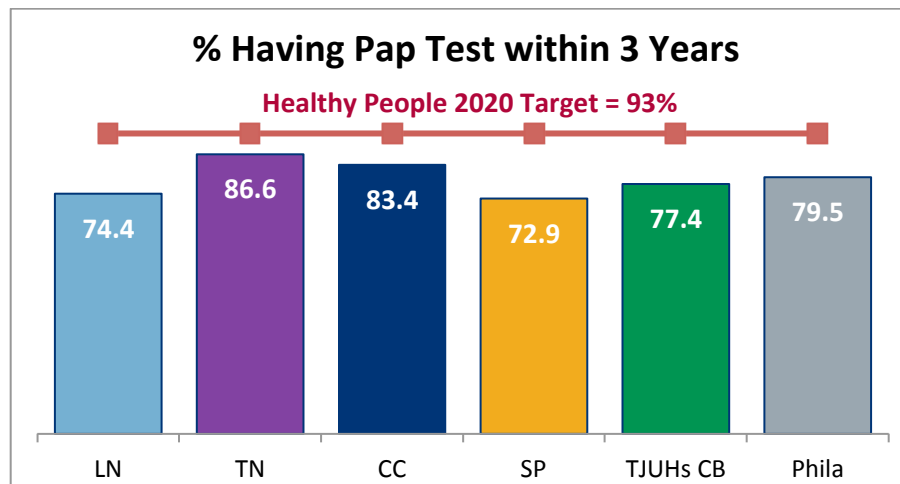
## ***Preventive Care and Early Detection of Disease***

People who have a regular health care provider are more likely to have better health outcomes. Having a regular source of care can help reduce health disparities and costs and increase preventive health screenings. This is key to detecting signs/symptoms that are precursors to disease and to detecting disease earlier when it is often more treatable.

### ***Cancer***

Lack of health insurance and low socio-economic status are factors most related to disparities in cancer incidence and death.

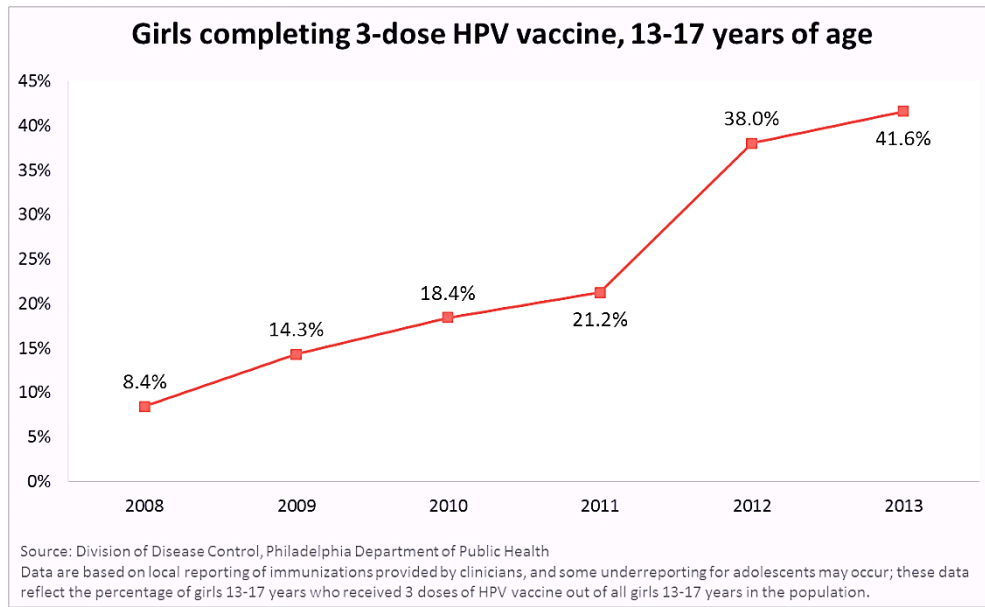
The percentage of women in Philadelphia and in TJUHs CB area who were screened for cervical cancer in the past three years was well below the Healthy People 2020 goal of 93%. Women in TJUHs CB area are slightly less likely to have had a PAP smear in the past three years (77.4%) than were women in Philadelphia (79.5%). Women living in Transitional Neighborhoods were most likely to have been screened for cervical cancer and women in Lower North Philadelphia and South Philadelphia were least likely to have been screened (74.4% and 72.9% respectively).



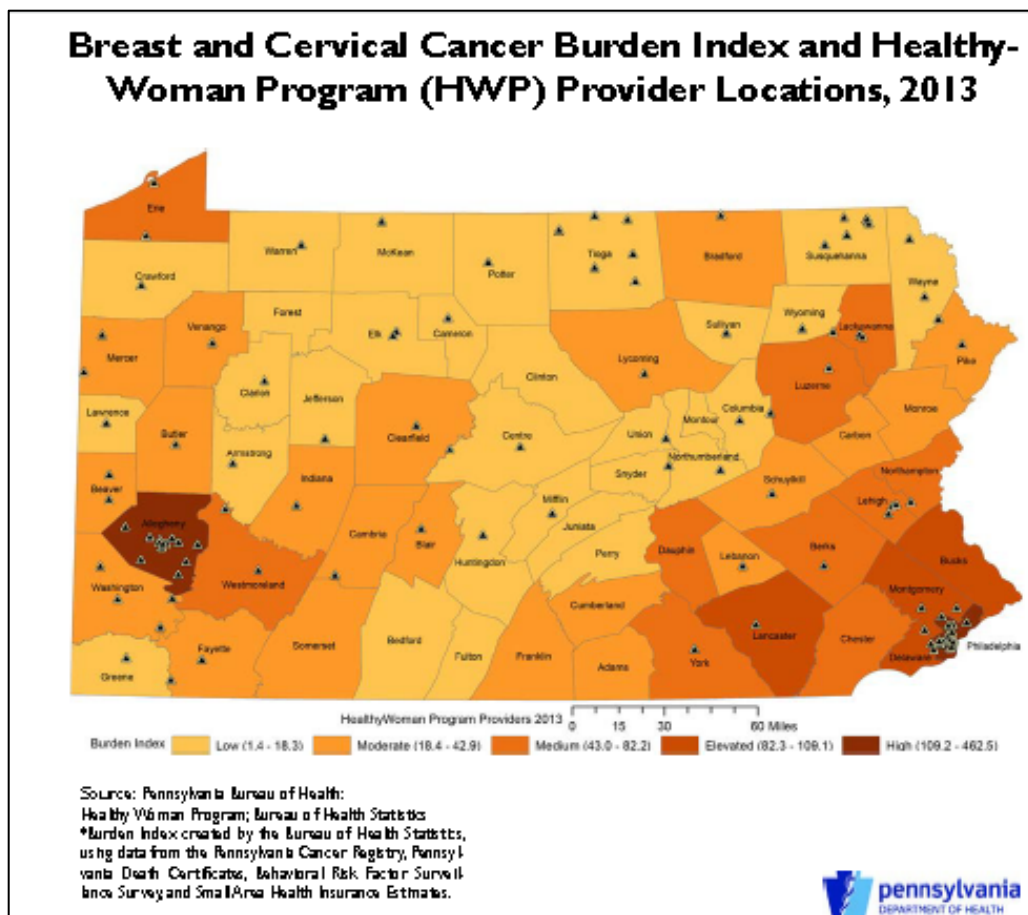
*PHMC Household Health Survey 2015*

Human Papilloma Virus can cause cervical and other cancers including cancer of the vulva, vagina, penis, or anus. It can also cause cancer in the back of the throat, including the base of the tongue and tonsils (oropharyngeal cancer). Completion rates in 2014 for HPV vaccine among girls in Philadelphia aged 13-17 was 59.3 and exceeds the state rate (46.7) and that national completion rate (39.7%).

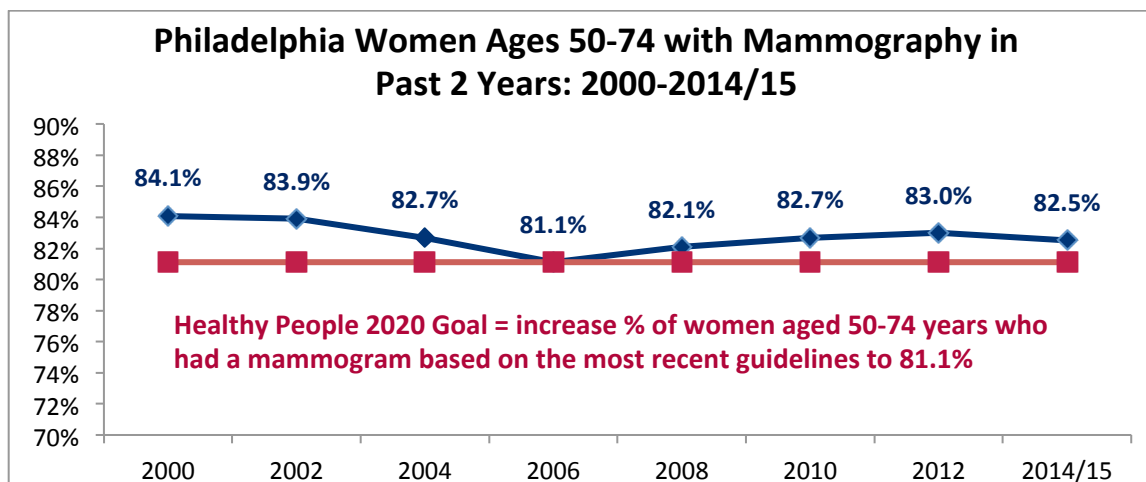




Breast cancer is the second most common type of cancer for women in the United States<sup>140</sup> and accounts for one-third of all cancer deaths in females in Pennsylvania.<sup>141</sup> Philadelphia is one of the two counties with the highest breast and cervical cancer burden in the state. Pennsylvania sponsors two programs to assist women with these cancers and Jefferson and Methodist Hospitals participate with both: the Healthy Woman Program and the Breast Cancer and Cervical Cancer Prevention and Treatment Program. These programs assist un- and under-insured women with low incomes to obtain cervical and breast cancer screening and assist women in getting treatment if they are diagnosed with cancer.

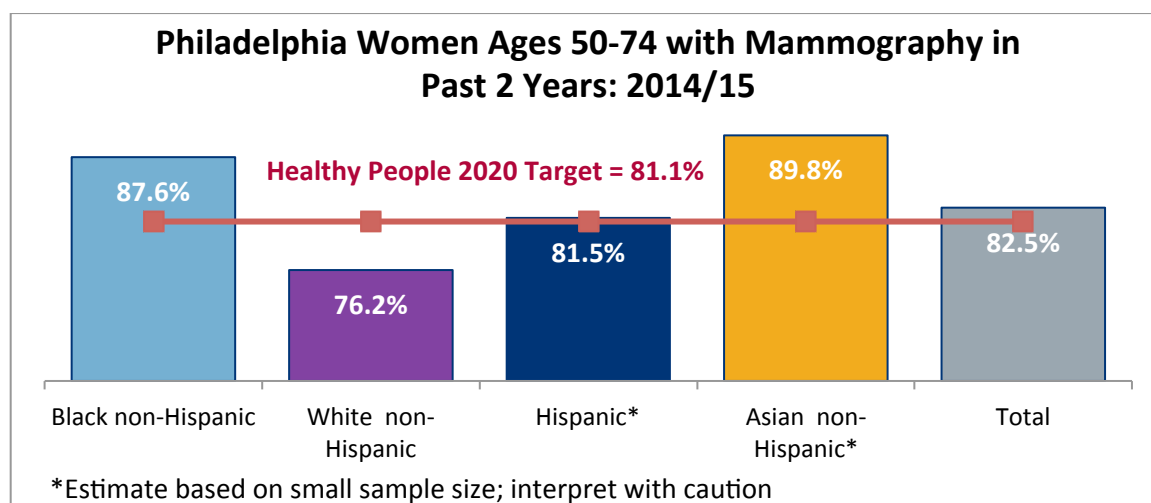


The Healthy People 2020 goal for women aged 50-74 who had a mammogram based on the most recent guidelines is 81.1%. In Philadelphia, the prevalence of women ages 50-74 with mammography screenings in the past 2 years has remained nearly constant since 2000 and exceeds the Healthy People 2020 goal.



*PHMC Household Health Surveys*

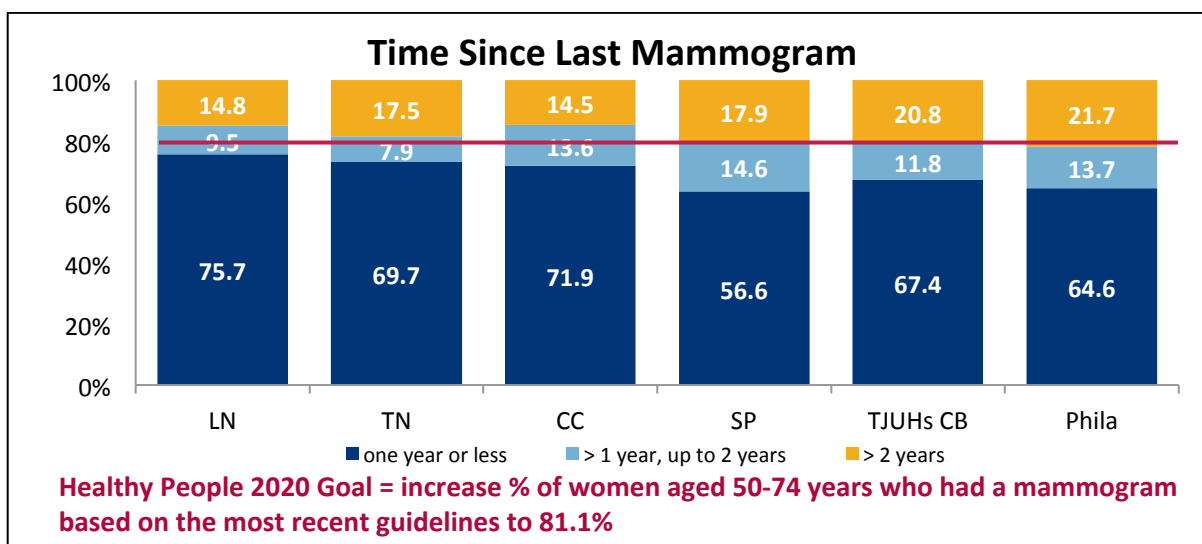
In Philadelphia, there are differences in the percentages of women aged 50-74 who have had a mammogram. Asian, non-Hispanic and Black non-Hispanic women are most likely to have had a mammogram within the past 2 years, and non-Hispanic White women are least likely. This speaks well for breast screening efforts to reach minority women, but highlights a need to ensure white non-Hispanic women also reach the screening goals.



*PHMC Household Health Survey 2015*

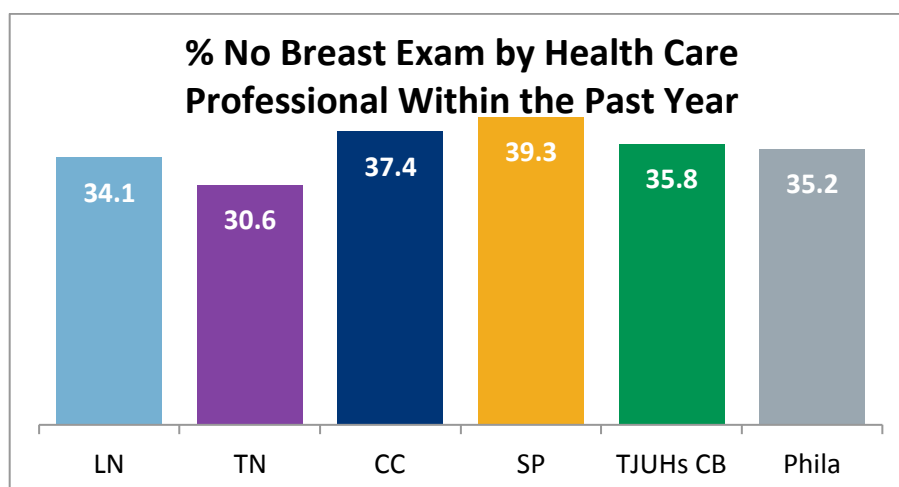
Women in both TJUHs CB area and Philadelphia are close to achieving the Healthy People 2020 goal (79.2% and 78.3% respectively). Women in Lower North Philadelphia exceeded the

Healthy People 2020 goal (85.2%) and women South Philadelphia had the lowest mammography rate (71.2%).



*PHMC Household Health Survey 2015*

Compared to women in Philadelphia, women in TJUHs CB neighborhoods were slightly less likely to have had a breast exam by a professional in the past year. In addition to having the lowest mammography rate in the TJUHs CB area, women in South Philadelphia were least likely to have a breast exam by a health care professional within the past year.

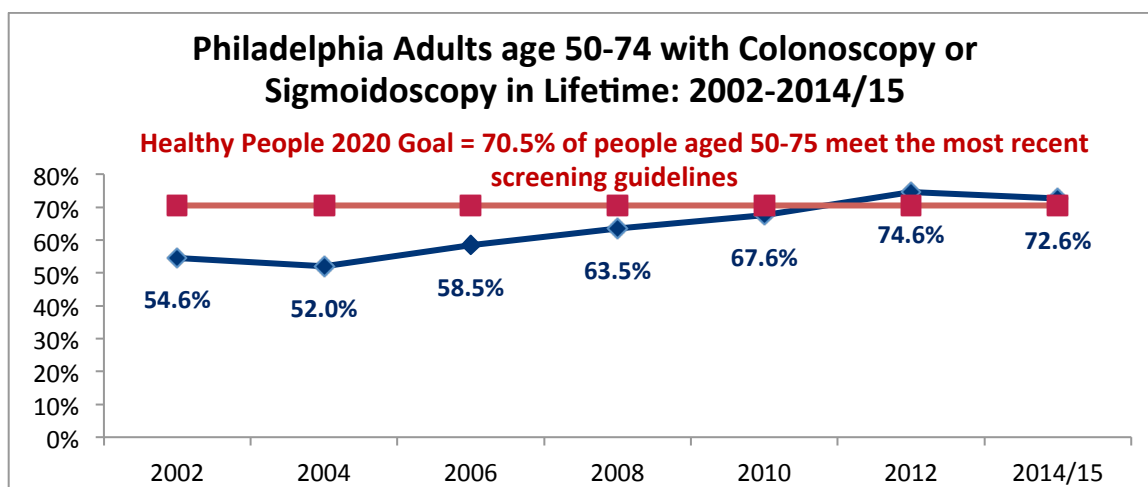


*PHMC Household Health Survey 2015*

### ***Colon Cancer***

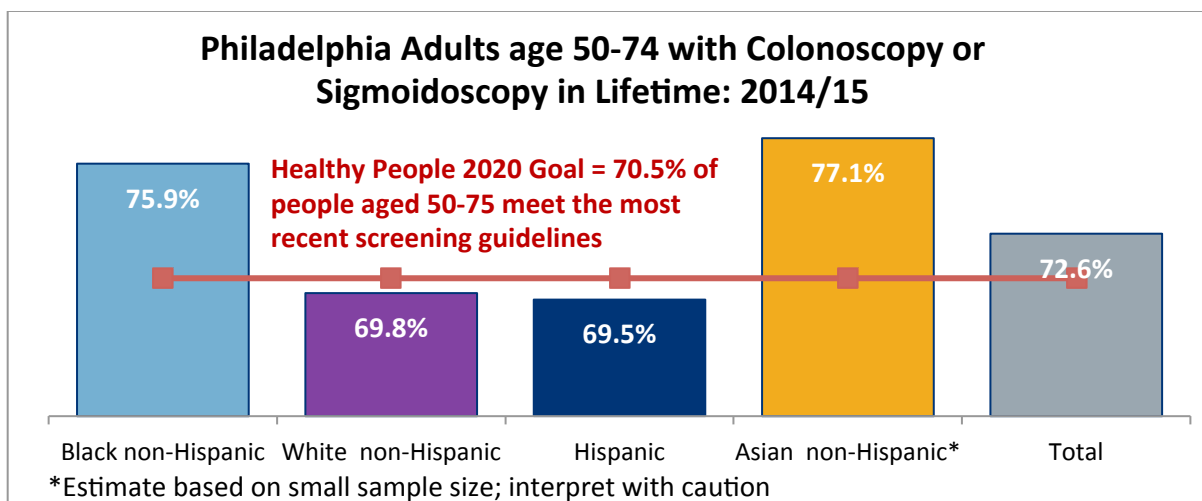
The Healthy People 2020 target for colon cancer screening is for 70.5% of people aged 50-75 to meet the most recent screening guidelines.

In Philadelphia, the percentage of adults with colonoscopy or sigmoidoscopy in a lifetime increased significantly, but declined slightly since 2012.



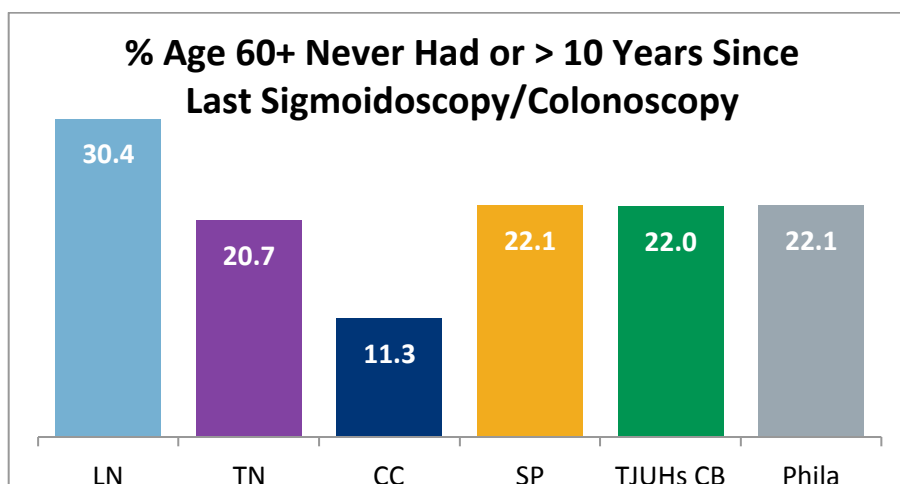
PHMC Household Health Surveys

There are racial/ethnic differences in the percentage of adults in Philadelphia who had a colonoscopy or sigmoidoscopy in their lifetime.



PHMC Household Health Survey 2015

In Philadelphia and TJUHs CB area, 22% of adults aged 60+ have never or not had a colonoscopy/sigmoidoscopy in 10 or more years. Center City residents are most likely to have had colon cancer screening and residents of Lower North Philadelphia are least likely to have had this screening.



*PHMC Household Health Survey 2015*

The Healthy People 2020 objectives for cancer reflect the importance of promoting evidence-based screening for cervical (PAP), colorectal (fecal occult blood testing, sigmoidoscopy, or colonoscopy) and breast cancer (mammography). These objectives are to:

- Increase the proportion of women aged 21-65 who receive a cervical cancer screening based on the most recent most recent guidelines to 93%
- Increase the proportion of adults aged 50-75 who receive a colorectal cancer screening based on the most recent guidelines to 70.5%
- Increase the proportion of women aged 50-74 who receive a breast cancer screening based on the most recent guidelines to 81.1%

**Issues, challenges, unmet needs and priorities identified by key informants and focus group participants related to preventive health screening included:**

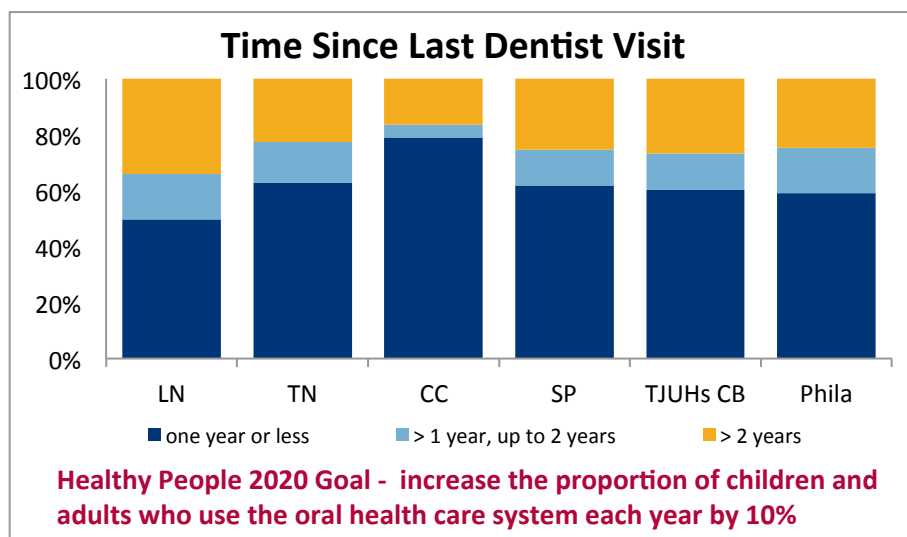
- **Cancer**
  - Need to raise awareness about the link between obesity and cancer (key informant)
  - Need to raise awareness of screening and treatment resources among Jefferson primary care providers and the community (focus group)
  - Need to raise awareness about the cultural barriers to cancer screening (key informant)

Based on internal and external key informants, focus groups, existing relationships and programs, and secondary data, actions addressing preventive health screenings may include:

1. Encouraging colorectal screening at community venues
2. Utilizing existing screening resources such NBCFF, Komen, Healthy Women 40+ program for breast and cervical cancer screening
3. Raising community and TJUH health care provider awareness about the Pennsylvania Breast and Cervical Cancer Prevention and Treatment program.
4. Distribute the breast cancer photonovelas more widely

### ***Dental Care***

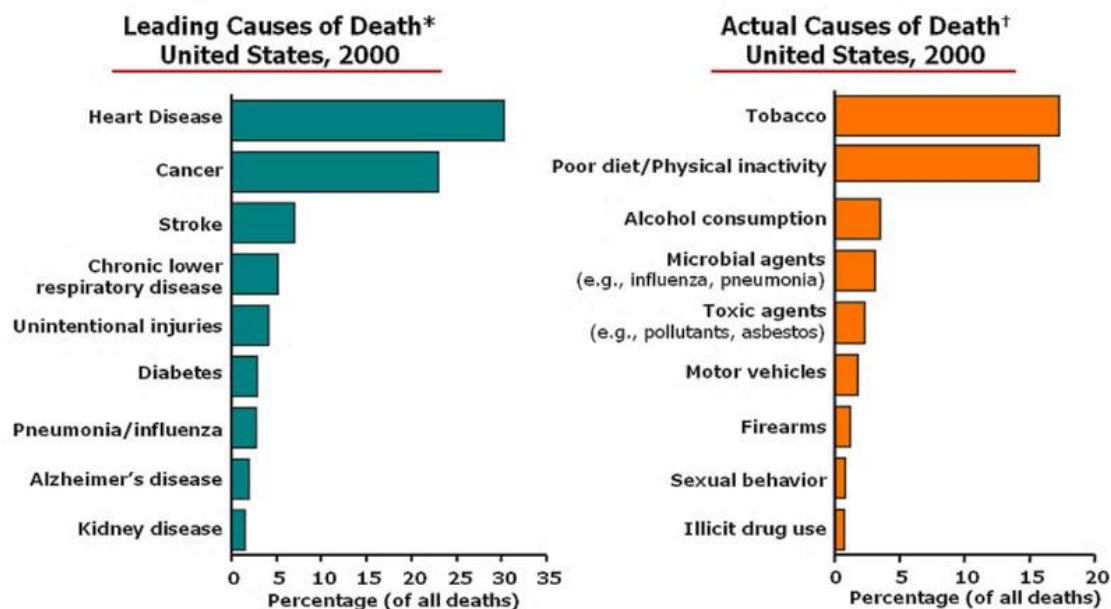
Forty percent of TJUHs CB area residents and Philadelphians did not see a dentist in the past year. Approximately 1 in 4 adults in Philadelphia (24.7%) and TJUHs CB area (26.8%) has not seen a dentist in more than 2 years. Center City residents obtain dental care more regularly than residents of other TJUHs CB areas. Fewer residents from Lower North Philadelphia received dental care within the past 2 years.



*PHMC Household Health Survey 2015*

## Health Behaviors

The figure below depicts the leading reported causes and actual causes of death in the United States at the turn of the century - tobacco, poor diet, alcohol and lack of physical activity.<sup>142,143</sup> Heart disease and cancer are still the two leading causes of death in the United States and Philadelphia. Many of the leading causes of death are attributable to health behaviors such as tobacco use, physical inactivity, and poor diet. Counseling for these health behaviors and policy changes to create a healthier environment and improved access to healthy affordable food are keys to improving health in the United States and Philadelphia.



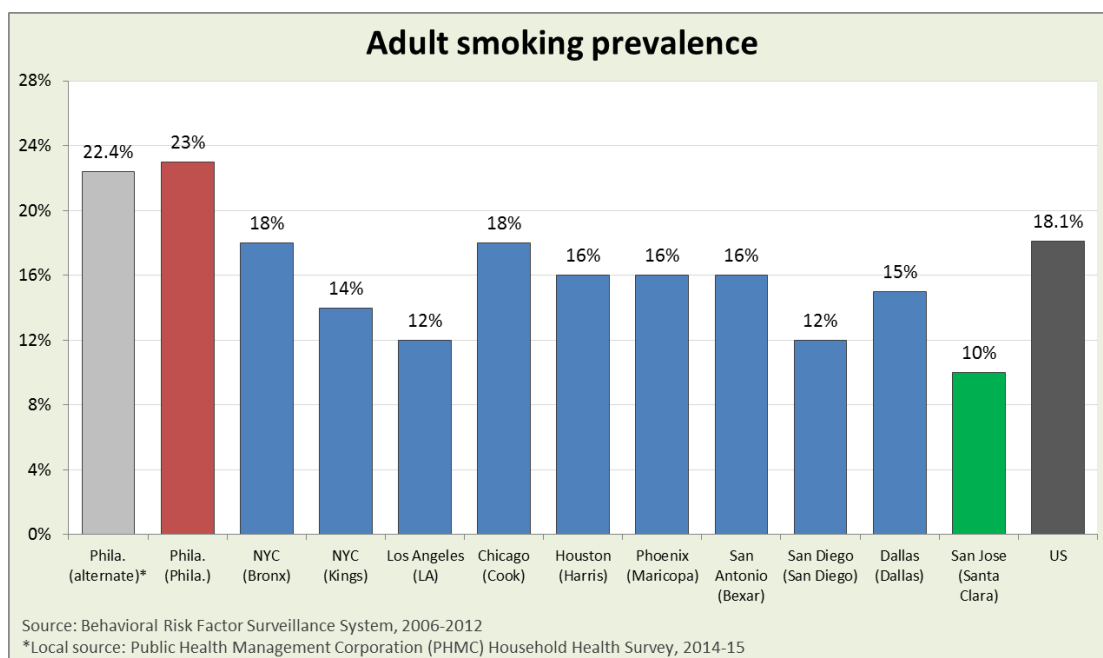
\* Minifio AM, Arias E, Kochanek KD, Murphy SL, Smith BL. Deaths: final data for 2000. National Vital Statistics Reports 2002; 50(15):1-120.  
 † Mokdad AH, Marks JS, Stroup DF, Gerberding JL. Actual causes of death in the United States, 2000. JAMA. 2004;291(10):1238-1246.

Philadelphia has been steadily working to reduce smoking rates and improve access to healthy affordable foods and safe places for physical activity. The Philadelphia Department of Public Health (PDPH), Health Promotion Council, The Food Trust, School District of Philadelphia and many others have worked to improve school food, create new farmers markets, improve food choices in corner stores, and pass legislation, such as the menu-labeling act. However, much more needs to be accomplished to reduce tobacco use and obesity rates and their associated diseases in the City. The following describes the current health behaviors of adults in Philadelphia.

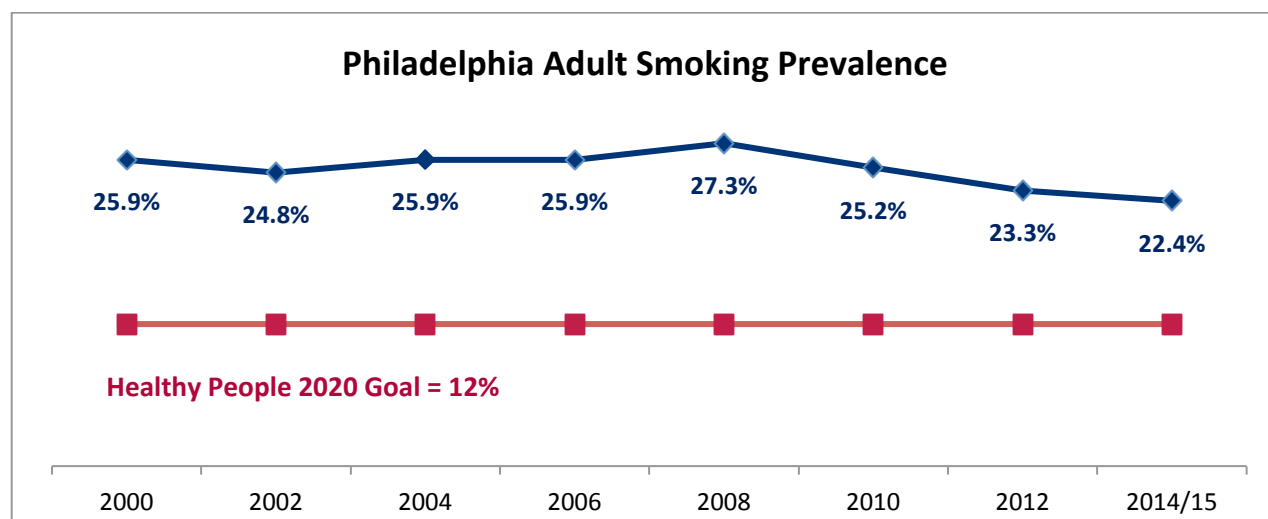
### Tobacco Use

Tobacco use is the single most preventable cause of death and disease in the United States. Smoking causes cancer, heart disease, stroke, lung diseases, diabetes, and chronic obstructive pulmonary disease (COPD). Tobacco use costs the U.S. more than \$300 billion annually in direct medical expenses and lost productivity and over \$600 million in Philadelphia.<sup>144,145</sup> Philadelphia has more tobacco retailers per capita than in any large city except Washington, D.C.<sup>146</sup>

Among major peer cities, Philadelphia's adult smoking prevalence is the second highest at 22.4%.



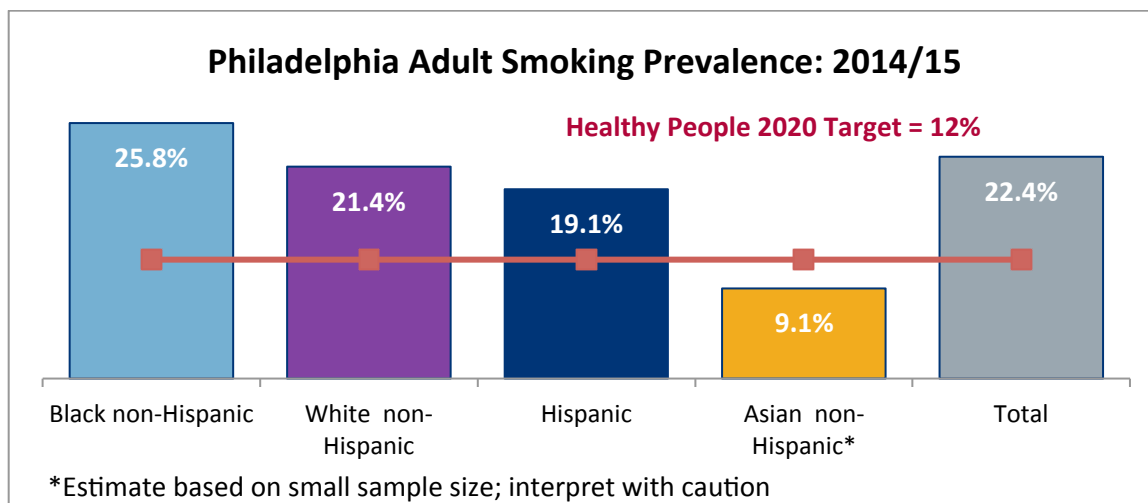
Over the past 15 years, smoking prevalence has declined slightly from a high of 25.9% to 22.4%. This rate is almost twice the Healthy People 2020 target of 12%.



*PHMC Household Health Survey 2015*

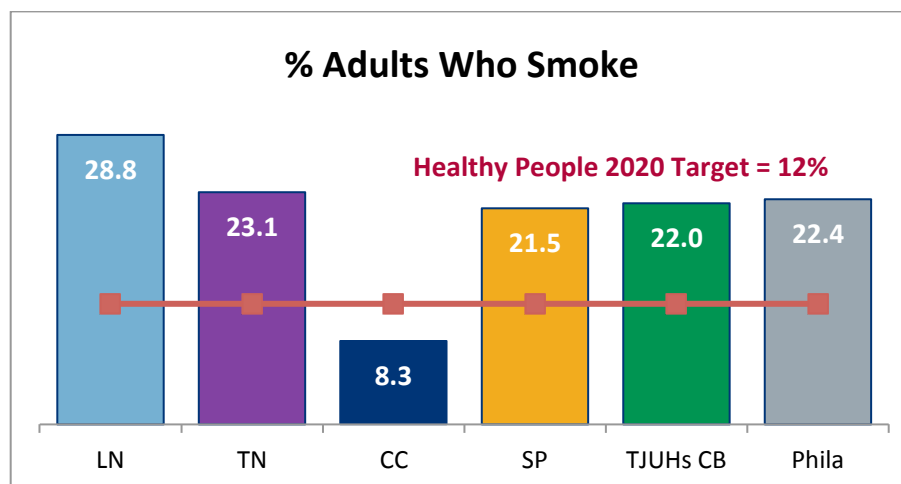
In Philadelphia, adult smoking prevalence is highest among Black-non Hispanics (25.8%) and lowest in Asian non-Hispanics (9.1%). Nearly 29% of those living below 200% FPL smoke compared to 16.8% of those living above 200% FPL.





*PHMC Household Health Survey 2015*

Smoking rates in Philadelphia and in TJUHs CB area are similar. Residents of Lower North Philadelphia reported the highest smoking rate and Center City is the only neighborhood in TJUHs CB area where the smoking rate is below the Healthy People 2020 target.



*PHMC Household Health Survey 2015*

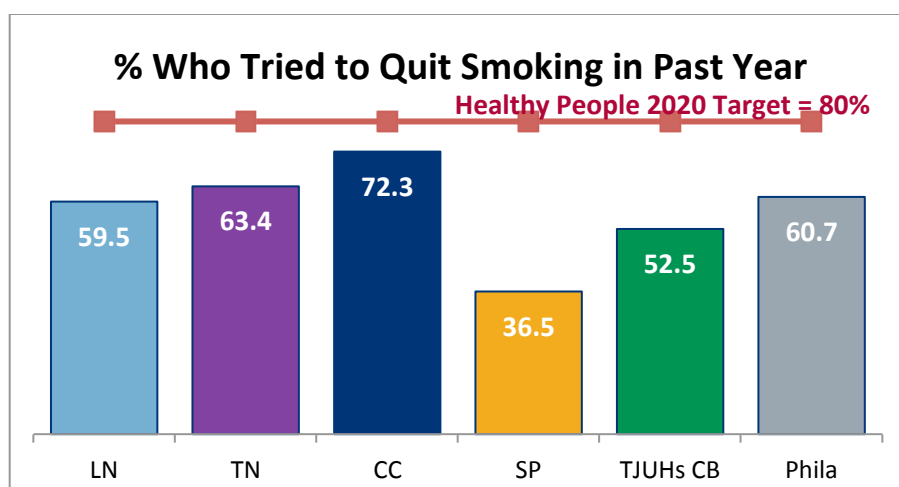
As of January 1, 2014, the Affordable Care Act requires most insurance plans to cover quit smoking services. In addition, there are free smoking cessation resources available at the state (PA QUIT Line and Fax to Quit programs) and local level (smoking cessation programs are offered by the PDPH). The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards requires identifying smoking status of patients and helping them develop a plan to quit. In October 2014, lawmakers passed a \$2 per pack tax on cigarettes sold in Philadelphia, increasing the average price from \$5.85 to \$7.85. The tax increase and continued tobacco control activities could lead to 40,000 fewer adult smokers.<sup>147</sup> Since 2014, smoke-free policies expanded to all City-owned parks, 19 inpatient behavioral health agencies, and all Philadelphia Housing Authority (PHA) properties. In addition, City Council legislation prohibited the use of e-cigarettes in indoor spaces. As an academic medical center and leader in

the health care community, Jefferson recognizes that smoking is a health hazard. As of July 1, 2014 Jefferson adopted a policy for the maintenance of a tobacco-free environment and a tobacco-free hiring policy. All tobacco use is prohibited on the Jefferson Campus.

Get Healthy Philly, a Philadelphia Department of Public Health public health initiative, partners with government agencies, community based organizations, and academic institutions to change policies, systems, and environments that reduce exposure to secondhand smoke, limit access to tobacco products, assist smokers to quit, and change tobacco prices and community norms.<sup>148</sup> Examples of strategies planned by Get Healthy Philly to accomplish this include:

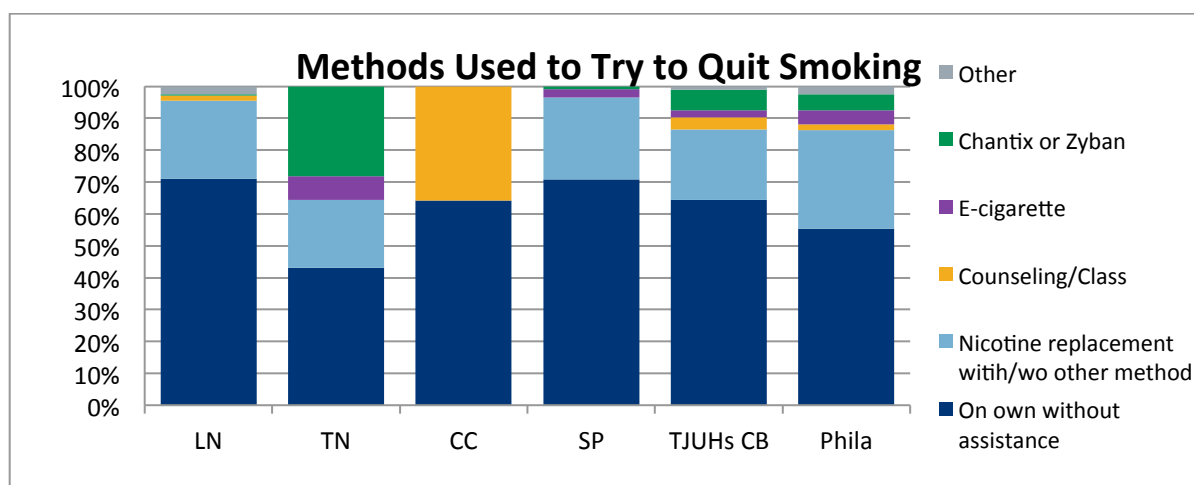
- Decrease youth smoking initiation and increase quit attempts by restricting access to existing and emerging tobacco products
- Decrease exposure to secondhand smoke by expanding smoke-free policies to additional outdoor municipal spaces, educational settings, and public housing communities
- Work with youth leaders and wellness champions to promote tobacco control activities in school
- Recognize retailers that voluntarily discontinue tobacco sales and reduce tobacco marketing and advertising
- Increase the capacity of behavioral and physical health providers to provide tobacco dependence treatment through organizational change initiatives
- Increase the number of mid-to large-sized employers in Philadelphia and the region that implement value-based insurance design for smoking, hypertension, and high cholesterol
- Continue mass media messaging about secondhand smoke and quitting smoking
- Expand smoke-free policies to one additional university/college and implement tobacco-free policy for all acute inpatient behavioral health treatment settings
- Explore ways to discourage use of non-cigarette tobacco products such as cigars, pipe tobacco, and smokeless tobacco
- Assess compliance of hookah and cigar bars with Clean Indoor Air Law exemption requirements
- Continue to promote and recognize tobacco-free retailers locally and nationally
- Promoting smoke-free homes
- Increase enforcement of current policies and penalties for retailers who sell tobacco products to minors
- Implement a public health program to improve the ability of primary care providers to assist patients in quitting smoking

In TJUHs CB areas, the percentage who tried to quit smoking in the past year was highest in Center City and lowest in South Philadelphia. Cessation efforts in all CB areas are below HP2020 goal of 80% attempting to quit smoking.



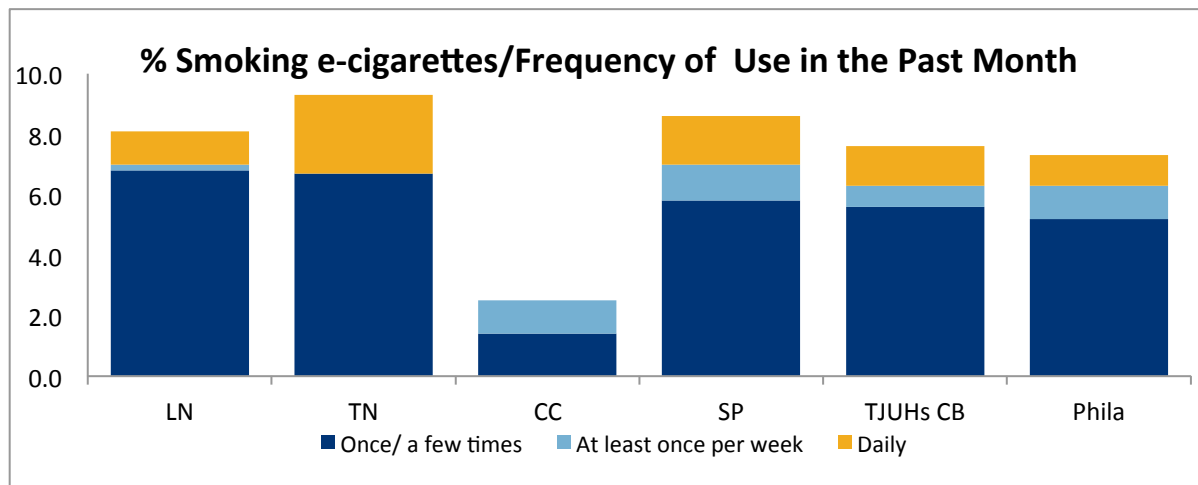
*PHMC Household Health Survey 2015*

Methods to stop smoking vary widely across TJUHs CB areas. In all areas, the majority of the methods are “on own, without assistance”. Counseling or a class is much more common in Center City, while Chantix/Zyban more common in Transitional Neighborhoods.



*PHMC Household Health Survey 2015*

The use of e-cigarettes is low in Philadelphia, but use varies across neighborhoods.



*PHMC Household Health Survey 2015*

Healthy People 2020 objectives related to smoking cessation include:

- Reduce cigarette smoking by adults to 12%
- Increase smoking cessation attempts by adults to 80%
- Increase recent smoking cessation success by adult smokers to 8% and adolescent smokers to 64%
- Increase tobacco screening in office-based ambulatory care setting to 68.6%
- Increase tobacco screening in hospital ambulatory care setting to 66.2%
- Increase tobacco cessation counseling in office-based ambulatory care settings to 21.1%
- Increase tobacco cessation counseling in hospital ambulatory care settings to 24.9%

**Based on internal and external key informants, focus groups, existing relationships and programs, and secondary data, actions addressing smoking cessation may include:**

1. Refer smokers to [www.smokefreephilly.org](http://www.smokefreephilly.org) for resources such as how to find a Quit Coach, information about treatments, talking to your doctor and quit tips.
2. Refer smokers to the PA Quit Line and encourage health care providers to participate in the State's FAX to Quit program.
3. Refer smokers to [www.facebook.com/smokefreephilly](https://www.facebook.com/smokefreephilly) for smoking cessation support from an on-line community.
4. Refer smokers to PDPH free community based quit-smoking classes. Classes are now available in Spanish and Chinese.
5. Promote a continuing medical education module on improving COPD outcomes (major focus on smoking cessation) to physicians (15 CME credits)
6. Enforce TJU/TJUH smoke-free campus policy
7. Support PDPH policy efforts to reduce tobacco use in Philadelphia
8. Screen all inpatient and outpatients
9. Encourage private insurers to cover smoking cessation and nicotine patches/ drugs.

## ***Physical Activity***

Regular physical activity is important to reducing overweight and obesity rates and is shown to lower adults' risk of early death, coronary heart disease, stroke, high blood pressure, Type 2 diabetes, breast and colon cancer, falls, and depression. Among youth and adolescents, regular physical activity improves bone health, improves cardiorespiratory and muscular fitness, decreases body fat levels, and helps to reduce symptoms of depression. Even small increases in physical activity have been associated with benefits to health. People who are more physically active are more likely to have higher education levels, income, self-efficacy, support from others, access to exercise/recreational facilities they find to be satisfactory, and live in neighborhoods that are perceived to be safe. Advancing age, low income, lack of time, lack of motivation, perception of poor health, overweight/obesity, and being disabled negatively impact physical activity. Healthy People 2020 supports a multi-disciplined approach to addressing physical inactivity. These approaches include expanding traditional partnerships (schools, health care, recreational organizations such as the YMCA and biking coalitions) to include non-traditional partners such as transportation, zoning, streets departments (sidewalks, street crossings), parks and recreation departments, and city planning. Policies that promote physical activity in schools, workplaces, and childcare as well as improvements to the environment that support physical activity are needed.<sup>149</sup>

Philadelphia has been strategically working to improve the environment to increase opportunities for safe places for physical activity (See the Social Determinants section on the *Built Environment*). The PDPH, through *Get Healthy Philly*, plans to continue its efforts to enhance opportunities for safe physical activity by:

- connecting street and trail networks for walking and biking
- implementing low-cost safety improvements to high-risk intersections and corridors
- offering structured, quality physical activity in recreation center after-school programs<sup>150</sup>

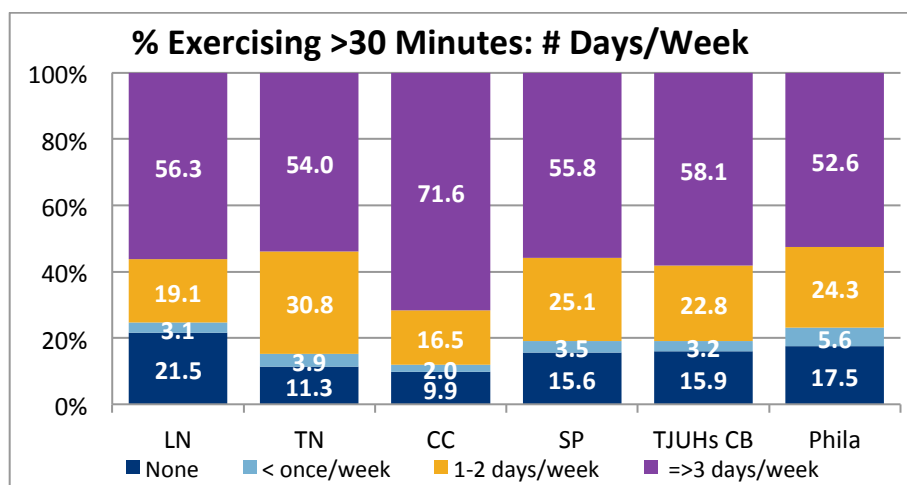
Between 2010 and 2012, 171 schools initiated Wellness Councils to improve school food and opportunities for physical education. Socialized recess and classroom movement breaks were implemented in many schools.

Through the Philadelphia Urban Food and Fitness Alliance (PUFFA), TJUH was active in helping the community surrounding Mifflin Square Park in South Philadelphia revitalize its park and increase park utilization. Although PUFFA has ended, the Friends of Mifflin Square Park has continued these efforts and provides an opportunity for Jefferson to continue its participation.

Furthermore, the largest employers in Philadelphia, the City of Philadelphia, colleges and universities, and healthcare institutions are engaging in wellness programs. For example, Jefferson has initiated a worksite wellness program to encourage healthy lifestyles among its more than 15,000 employees, many of whom live in the communities that are part of the TJUHs CB area. The worksite wellness program will address strategies for increasing physical activity among employees.

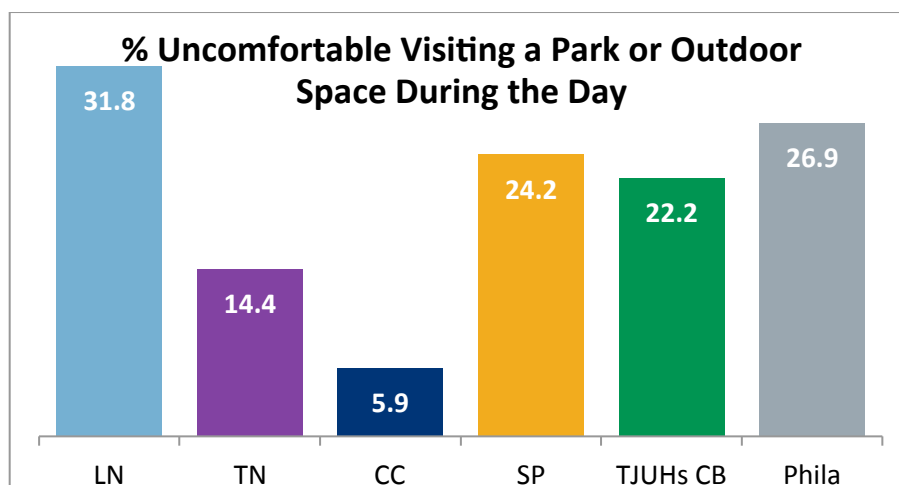
In Philadelphia, more than half of adults do not get the recommended daily amount of physical activity. In TJUHs CB areas, 58.1% of adults exercise regularly (3 or more times weekly for at

least 30 minutes). Center City residents are much more likely to exercise three or more times weekly. In Philadelphia, 23.1% of residents exercise less than once per week or not at all. Almost a quarter of adults in Lower North are physically active less than once weekly.



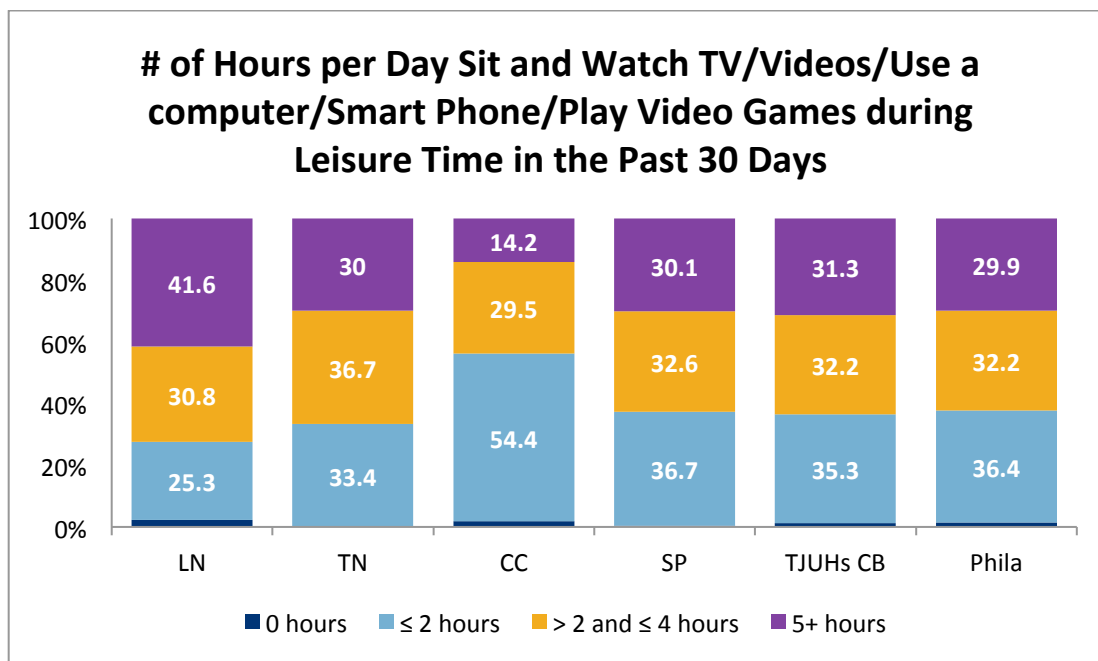
*PHMC Household Health Survey 2015*

Exercise may be correlated with feeling safe outside. More residents of Lower North Philadelphia do not exercise or exercise less than once a week and also report the highest rate of feeling uncomfortable being in an outdoor space or park during the day. Conversely, residents of Center City who report the highest rate of exercising 3 times per week or more, also report the highest rate of feeling comfortable in outdoor space during the day (94.1%).



*PHMC Household Health Survey 2015*

Adults living in Lower North Philadelphia are more likely than residents in TJUHs CB area and Philadelphia to report frequent sedentary indoor activities: watching TV and videos, using a computer/smart phone, and playing video games for 5+ hours daily (40%, 30% and 30% respectively).



*PHMC Household Health Survey 2015*

Healthy People 2020 include the following objectives:

- Increase the proportion of adults who participate in moderate aerobic physical activity for 150 minutes per week to 47.9%
- Increase the proportion of adolescents who meet the current federal guidelines for physical aerobic activity to 31.6%
- Increase the proportion of public and private schools that require daily physical education in elementary schools to 4.2%; in middle schools to 8.6%; and high schools to 2.3%
- Increase the proportion of adolescents who participate in daily school physical education to 36.6%
- Increase the proportion of school districts that require regularly scheduled elementary school recess to 62.8%
- Increase the proportion of youth/adolescents who view television, videos or play video games for no more than 2 hours daily. The target for children age 2-5 is no more than 83.2%; for ages 6-14 to no more than 86.8%; and the proportion of adolescents in grades 9-12 to no more than 73.9%.
- Increase the number of states with licensing regulations for physical activity provided in child care
- Increase the proportion of the nation's public and private schools that provide access to their physical activity spaces and facilities for all persons outside of normal school hours (that is, before and after the school day, on weekends, and during summer and other vacations) to 31.7%
- Increase the proportion of physician office visits that include counseling or education related to physical activity for children and adults to 8.7%
- Increase legislative policies for the built environment that enhance access to and availability of physical activity opportunities

**Issues, challenges, unmet needs and priorities identified by key informants and focus group participants related to being physically active included:**

- **Lack of fitness facilities** in communities that are safe and affordable
  - *There is not a senior center in the neighborhood – there is no place for older adults to be physically active. They would like a place to go where you can learn to exercise safely* (focus group)
  - *In addition, some South Philadelphia youth do not use the YMCA because of safety concerns (walking through certain neighborhoods is perceived as dangerous)* (key informant).
  - *City working at a systems level but not programmatic level; for example bike lanes are great but not as important to people in North. Philadelphia* (key informant)
- **Lack safe places for recreation**
  - *No recreation facility currently available- water department plans to put in green infrastructure* (key informant)
  - *Lack of green space- but plethora of vacant land/ spaces* (key informant)
  - *Neighborhood is dirty* (focus group)
  - *I see one issue, which is the immobility or lack of activity of the population. And talking with friends and colleagues who live in these areas, one of the major barriers is the lack of the sense of safety ... I did a similar program with the Singapore government and we did programs with teaching people how to walk, how to race walk, putting in lights to the surrounding area, and to create walking paths and trees and so forth.* (focus group)
  - *Priority: I think it would be really nice, for the people who are afraid to go out by themselves to do any kind of walking or exercise, to have, to advance a group on Sunday afternoon. We are going to walk from here to here, anyone that would like to do that is more than welcome to come, and then people can get together and all walk together* (focus group)



**Based on internal and external key informants, focus groups, existing relationships and programs, and secondary data, actions addressing physical activity may include:**

- 1. Support school Wellness Councils in TJUHs CB areas**
- 2. Continue to support the Friends of Mifflin Square Park efforts to improve the park and playground facility and increase park utilization by the diverse surrounding community**
- 3. Assist the PDPH in assessing parks/playgrounds in TJUHs CB area**
- 4. Encourage physical activity among TJUHs employees through the worksite wellness initiative. Work with TJU to initiate similar policies and strategies for its employees.**
- 5. Partner with the YMCA to initiate walking programs and exercise programs in the community**
- 6. Work with adults and youth to reduce screen time**
- 7. More school and community physical activity opportunities for youth and older adults.**
- 8. See recommendation for obesity**

### ***Healthy Diet***

As mentioned previously, obesity is a major cause for concern both nationally and in Philadelphia (see morbidity section on obesity). Among counties containing one of the largest U.S. cities, Philadelphia County has the highest prevalence of obesity, hypertension, and heart disease and the second highest prevalence of diabetes.<sup>63</sup> Interventions to address a healthier diet should include improving nutrition knowledge/attitudes and skills of individuals, and increasing access to healthy and affordable food through systems and policy changes and access to food assistance programs. For example, retail venues that sell healthier food can impact diet and nutrition. Low income communities may have less access to healthier food choices. Marketing also has a major influence on people's food choices.<sup>151</sup>

Healthy People 2020 objectives related to healthier diet and access to healthy food include:

- Increase the proportion of schools that offer nutritious foods and beverages outside of school meals
- Increase the proportion of schools that do not sell or offer calorically sweetened beverages
- Increase the proportion of schools districts that require schools to make fruits and vegetables available whenever other foods are offered or sold
- Increase the number of states that have nutrition standards for food and beverages provided to school aged children in childcare

To address the problem of obesity and poor nutrition leading to preventable illness and death in individuals, families, and communities, the Pennsylvania State Health Improvement Plan has identified a goal to increase opportunities for access to and consumption of healthy foods and beverages. The City of Philadelphia's Community Health Improvement Plan details three strategic priority areas – access to care; chronic disease related to poor diet and physical

inactivity; and behavioral health. The chronic disease goals related to poor diet and physical inactivity include:

- Increase access to healthy foods
- Increase physical activity among children and adults
- Further integrate nutrition and physical activity promotion in clinical practice
- Reduce consumption of sugar sweetened beverages through advocacy for taxes and regulation on sizing of sugar sweetened beverages
- Create and sustain healthy food bonus incentives programs through SNAP and WIC
- Work with childcare licensing agencies to develop and implement official standards related to nutrition and physical activity

Since 2004, Philadelphia has been strategically addressing healthier dietary choices through nutrition education and access to healthy, affordable food. Led by the PDPH (*Get Healthy Philly*), the School District of Philadelphia, the Food Trust, Health Promotion Council and the Philadelphia Urban Food and Fitness Alliance (PUFFA), these efforts:

- eliminated sugar beverages in schools
- mandated nutrition education in schools
- initiated Farm to School programs to increase fresh fruits and vegetables in school lunch programs
- created a Healthy Corner Store initiative
- increased the number of supermarkets in low income communities
- increased the number of farmers markets in low income communities
- involved youth in improving school food
- revised twenty day cycle menus with recipes that meet USDA Nutrition guidelines for pre-plate and full service programs
- expanded the USDA Meal program in recreation center after-school programs
- encouraged schools to remove junk food from classrooms and school fundraisers
- incentivized SNAP (food stamps) in the Philly Bucks program
- implemented social marketing campaigns to change community norms about sugary drink consumption

Due to the efforts of the Food Trust and PDPH, Philadelphia now boasts the largest network of healthy corner stores in the U.S. Ten new farmers markets were created in low income communities, including several in TJUHs CB areas. The largest improvements in walkability to healthy food in high poverty neighborhoods (availability of healthy food within 0.5 miles) occurred in the Lower North, Upper North, and South Philadelphia Planning Districts.<sup>152</sup> In addition, some schools are interested creating school gardens and garden clubs.<sup>153</sup>

*Get Healthy Philly* will continue its efforts and partnerships to promote healthy eating in the following ways:<sup>153</sup>

- incentivizing healthy food sales through zoning and planning
- offering free/low cost breakfast through breakfast carts in schools

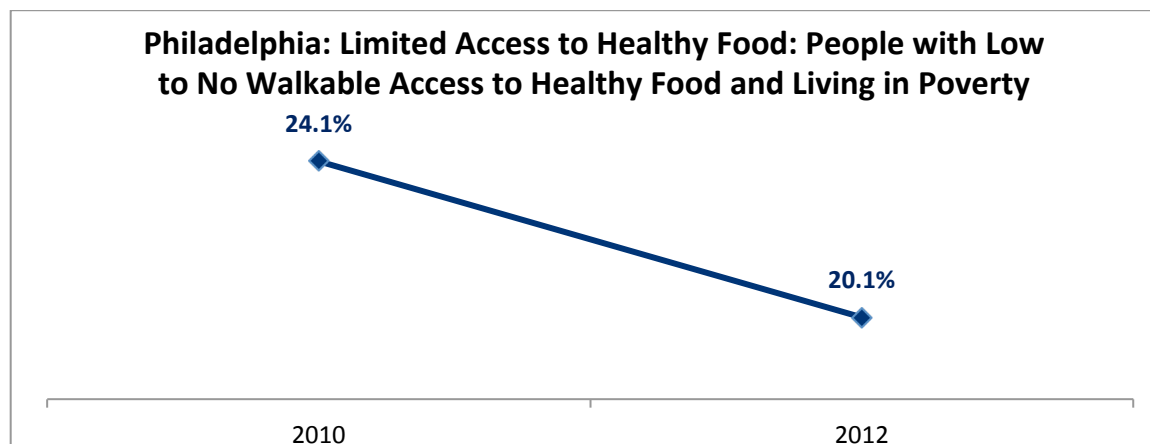
- offering the USDA meal program in recreation centers
- implementing food and fitness standards in afterschool programs
- encouraging healthier food and beverage vending options in work place settings
- enforcing the menu labeling law
- maintaining support for the Healthy Corner Store Initiative
- promoting breastfeeding in birthing hospitals
- continuing the Philly Bucks program in 10 low income communities
- continuing to improve the nutritional quality and taste of school food
- reducing sodium content of foods sold in 200 Chinese take-out restaurants
- implementing a certification program for corner stores to incentivize healthier food choices and decrease promotion and availability of sugary drinks, junk food, and tobacco
- develop a healthy supermarket policy to incentivize healthier food choices and decrease promotion and availability of sugary drinks, junk food and tobacco

TJUHs are active in improving access to healthy, affordable food and:

- initiated an on-campus farmers market
- initiated a CSA for employees
- serves as a Winter Harvest site
- increased locally grown fruits and vegetables at the hospital's Atrium cafeteria
- implemented a healthy vending machine initiative on campus

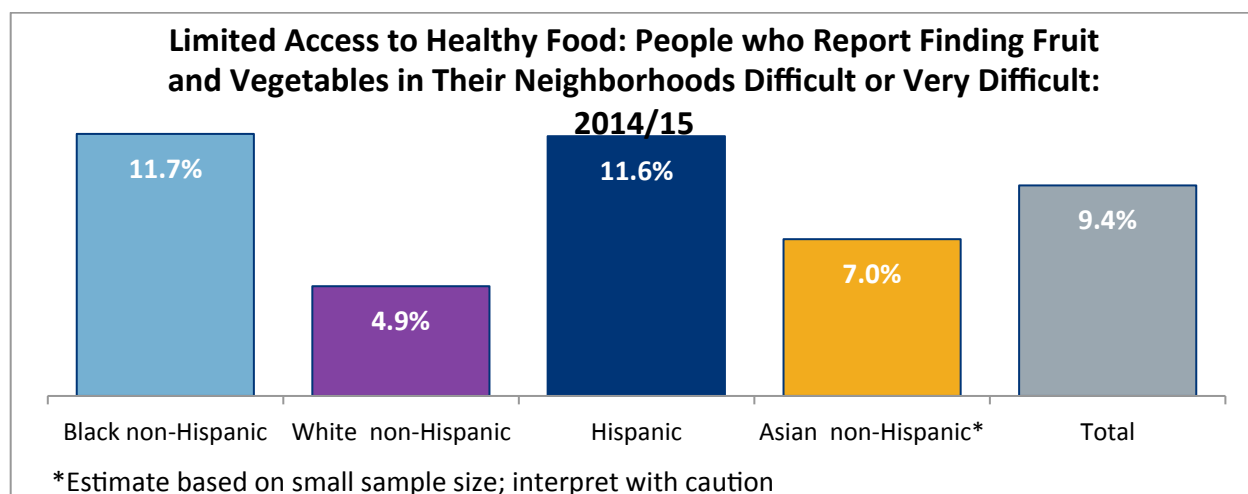
The Food Trust and TJUHs Center for Urban Health expanded the *Heart Smarts* program to provide blood pressure, height and weight screening, and health education at eight of their “Super” Healthy Corner Stores that receive conversions.

In Philadelphia, from 2010-2012, there has been a modest decline in the percentage of individuals with limited access to healthy food.



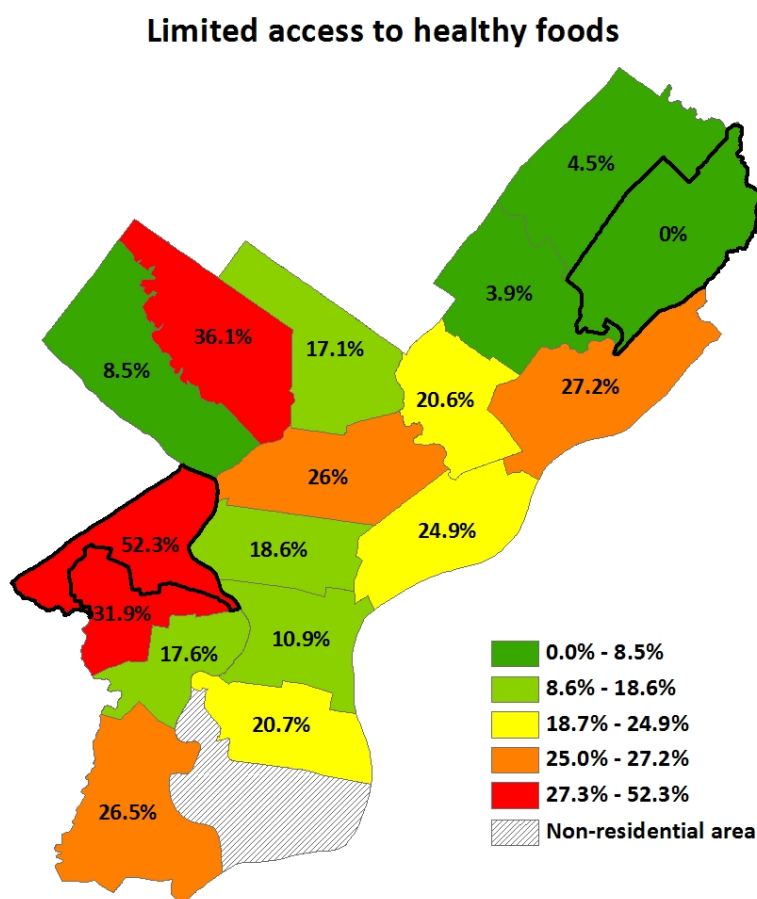
*Get Healthy Philly, PDPH*

Black non-Hispanic and Hispanic Philadelphians are most likely to have limited access to healthy food.



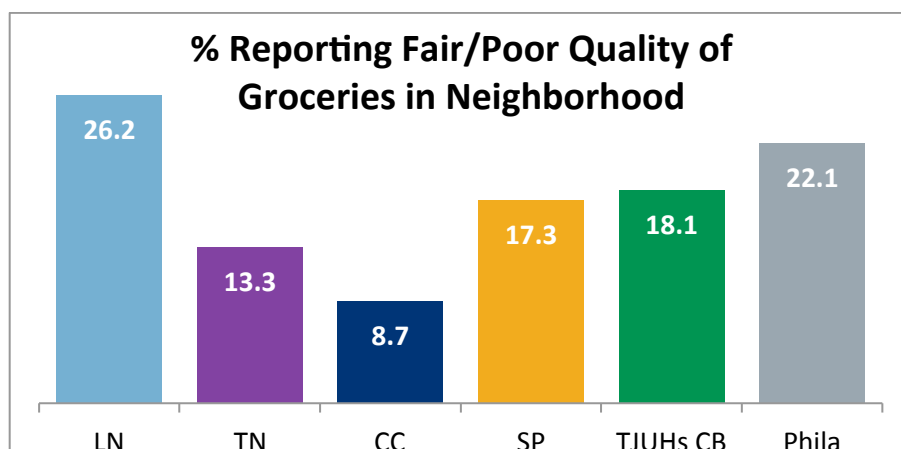
PHMC Household Health Survey 2015

Limited healthy food access, defined as low to no walkable access and high poverty, varies by neighborhood. Within TJUHs CB areas, South Philadelphia residents have the most hardship.



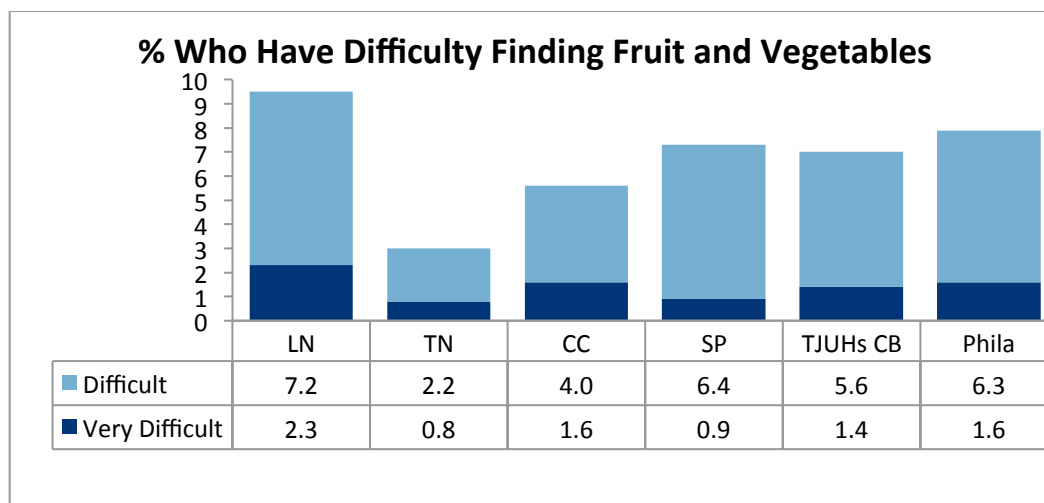
Source: Get Healthy Philly, Philadelphia Department of Public Health, 2012  
Low to no walkable access and high poverty

The quality of food is still a concern in some neighborhoods in TJUHs CB area, particularly in Lower North Philadelphia where 26.2 % of adults report fair or poor food quality.



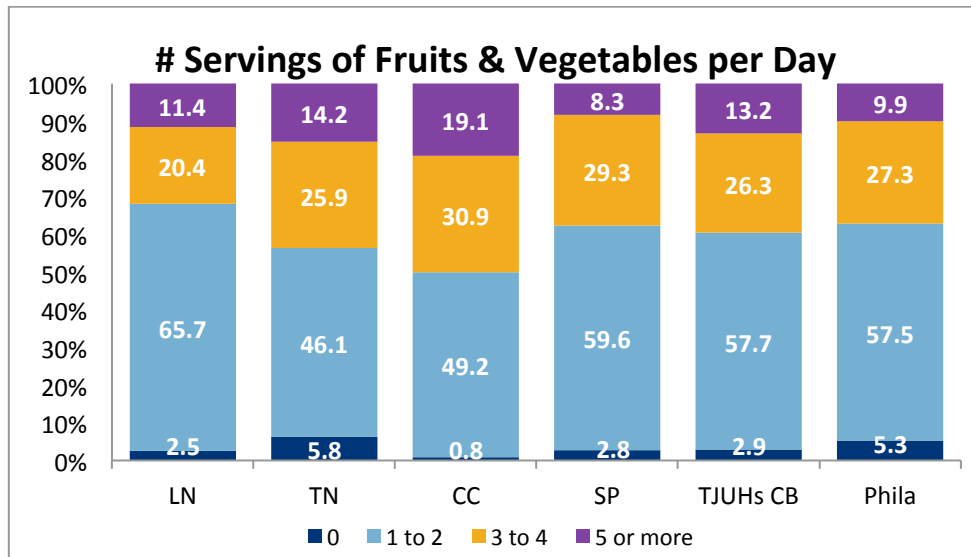
*PHMC Household Health Survey 2015*

Almost one in ten residents in Lower North Philadelphia report difficulty finding fruit and vegetables in their neighborhood, a rate higher than TJUHs CB areas and Philadelphia.



*PHMC Household Health Survey 2015*

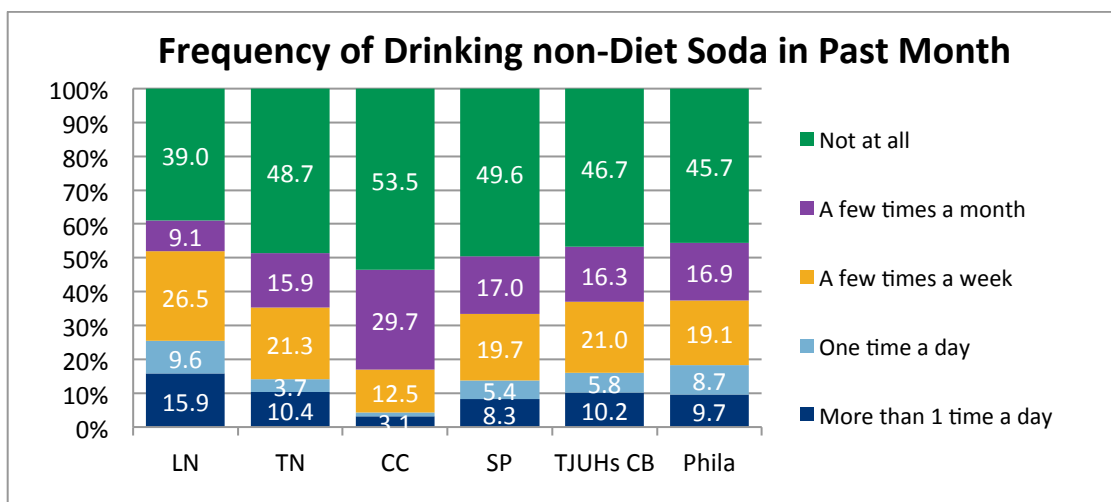
Sixty-eight percent of people living in Lower North Philadelphia say they eat less than three servings of fruit and vegetables daily compared to 62.4% of South Philadelphia residents, 51.9% of Transitional Neighborhood residents, and 50% of Center City residents. Residents of Center City are almost twice as likely to eat five or more servings of fruits and vegetable daily compared to TJUHs CB area as a whole.



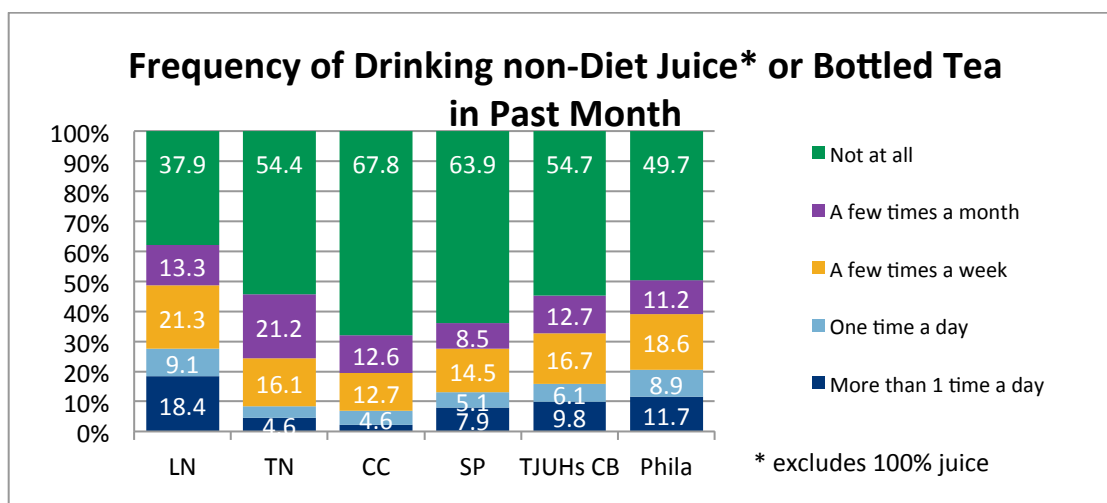
*PHMC Household Health Survey 2015*

Philadelphia has tried, but failed to pass legislation to tax beverages with added sugar. The Philadelphia branch of the American Heart Association supports passage of this legislation as do many others organizations.

In Philadelphia 18.4% of adults report having one or more non-diet sodas daily and 20.6% have non-diet juice and/or bottled tea one or more times daily. In TJUHs CB area 16% report drinking 1 or more non-diet sodas daily. While only 12.5% of adult residents in Center City drink soda a few times a week, 26.5% of Lower North Philadelphia, 21.3% of Transitional Neighborhood, and 19.7% of South Philadelphia adults consume non-diet sodas a few times a week.

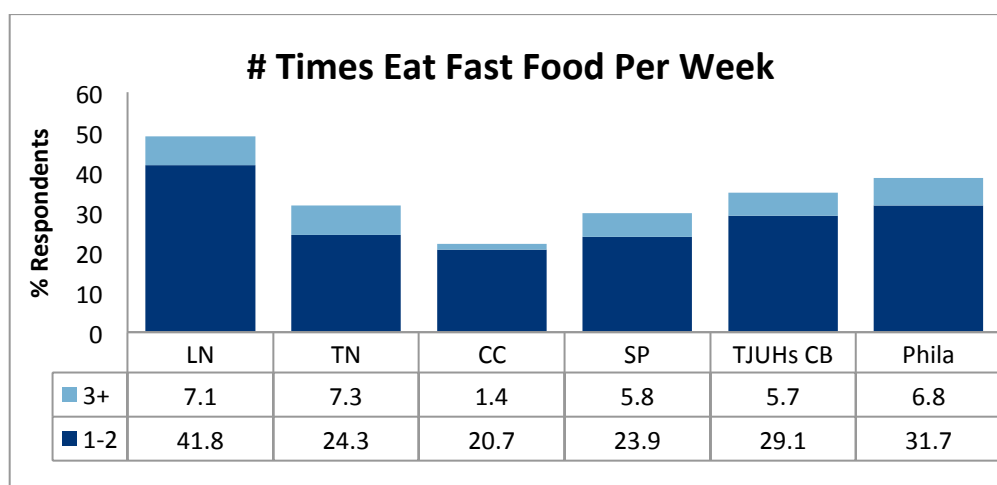


*PHMC Household Health Survey 2015*



PHMC Household Health Survey 2015

Adults in Lower North Philadelphia are also more likely to eat food from a fast food restaurant compared to adults in Philadelphia and TJUHs CB area. Seven percent of Lower North Philadelphia and Transitional Neighbor residents ate fast food 3 or more times in the previous week, a rate slightly higher than Philadelphia.



PHMC Household Health Survey 2015

The table below provides information on poverty (<200% FPL) and race/ethnicity related to healthy eating in Philadelphia. Overall, poverty (<200% FPL) and race/ethnicity appear to negatively impact healthy eating lifestyles.

### Healthy Eating Behaviors by Poverty and Race/Ethnicity in Philadelphia

	< 200% FPL	> 200% FPL	White non-Latino	Black non-Latino	Latino	Asian
Ate less than 3 servings of fruit/vegetables daily in past week	70.1%	56.7%	57.6%	64.1%	77.1%	64.4%
Difficult/very difficult to find fruit in neighborhood	10.5%	5.7%	4%	10.7%	12.4%	3.1%
Had fast food 3+ times per week	8.1%	5.6%	5.1%	8.2%	8.5%	2.7%
Had soda and/or juice daily	40.6%	23.8%	22.7%	39.4%	41.3%	19.7%

PHMC Household Health Survey 2015

### Issues, challenges, unmet needs and priorities identified by key informants and focus group participants related to healthy eating included:

- **Nutrition education**
  - *Philadelphia has done a great job with childhood obesity- we need to continue efforts* (Key informant interview)
  - *Need to learn to prepare healthy food and shop economically*(Key informant)
  - *Prevention is a difficult concept for folks...motivating people is really difficult* (key informant).
  - *Provide healthy eating initiatives (taste testing and nutrition education). Provide healthy meal options in cafeterias and at meetings.*(focus group)
  - *Some people don't know how to cook healthy foods* (focus group)
  - *There is a farmers market at the prison (19<sup>th</sup> and Parish). This is a good place to do programs and screening* (focus group)
- **Advocating for a sugar beverage tax legislation**
- **Improve access to healthy, affordable food**
  - The need for affordable healthy grocers/markets was identified as a priority by focus groups and key informants
  - *Food access report- getting worse - 15+ supermarkets closed (PRIORITY)*(key informant)
  - *Need innovative ways to get healthy food to people* (focus group)
  - *Need to figure out how to get supermarkets into the city* (key informant)
  - *Lack of access to healthy food options in neighborhoods* (focus group)
  - *There are limited health resources and information for non-English speaking populations in the 19125 community including markets with healthy food options* (focus group)
  - *"I would say there are not enough resources for people to buy healthier, fresher foods like fruits and vegetables. There are probably a handful of fruit stands or vegetable stands in South Philly, I would say 7th and Reed area or 9th and Reed area, but I don't ever see anything like that in my neighborhood."* (focus group)



- *Mothers lack access to healthy food, don't know how to cook, physical activity is not part of everyday lives. Don't know what "real food" is. (focus group)*
- *Health and food are not separate issues. If you don't have the right food your health condition gets worse, you need to connect the two (key informant)*

**Based on internal and external key informants, focus groups, existing relationships and programs, and secondary data, actions addressing healthy eating may include:**

- 1. Add health screenings and health promotion to corner store offerings in collaboration with Food Trust. Align nutrition and health promotion programs with the Food Trust Farmers Markets and corner stores as well as Wellness Councils.**
- 2. Provide nutrition education at day care centers, churches, farmers markets, community gardens, playgrounds, Philadelphia Housing Authority, Steven Klein Wellness Center (places where people gather).**
- 3. Support gardening efforts**
- 4. Raise awareness about farmers markets, and other venues for healthy food among health care providers and community organizations**
- 5. See recommendations for obesity**

### ***Health Behaviors of Adolescents***

The information provided in this section is based on the School District of Philadelphia Action Plan v3.0 dated March 4, 2015<sup>154</sup> and the 2013 Youth Behavior Risk Survey (YBRS) as part of the CDC's Youth Risk Behavior Surveillance System (YRBSS).<sup>155</sup> This data is being used because it is self-reported by youth, not their parents and is therefore more likely to represent actual behaviors of adolescents in Philadelphia.

The leading causes of illness and death among adolescents and young adults are largely preventable. During adolescence, behavioral patterns are established that can affect their current health status and impact their risk for developing chronic diseases in adulthood. Social and environmental factors such as family, friends, school, neighborhood, and social norms can support or challenge adolescent's health and well-being. Addressing the positive development of young people facilitates their adoption of healthy behaviors and helps to ensure a healthy and productive future adult population.

Healthy People 2020 objectives for adolescents include:

- Increase the proportion of adolescents who have had a wellness checkup in the past 12 months to 75.6%
- Increase the proportion of adolescents who participate in extracurricular and/or out-of-school activities to 90.6%
- Increase the proportion of students who graduate with a regular diploma 4 years after starting 9th grade to 82.4%
- Decrease school absenteeism among adolescents due to illness or injury

- Reduce the proportion of students who report using alcohol or any illicit drug in the past 30 days to 16.6%.
- Reduce the proportion of adolescents who have been offered, sold, or given an illegal drug on school property to 20.4%
- Increase the proportion of middle and high schools that prohibit harassment based on a student's sexual orientation or gender identity to 92.2%
- Reduce the percent of adolescents aged 12 to 19 years who are considered obese to 16.1%
- Increase fruit and vegetable consumption
- Reduce the percent of adolescents in grades 9 through 12 who smoked cigarettes in the past 30 days to 16%
- Increase the percent of adolescents who meet the current physical activity guidelines for aerobic physical activity to 31.6%
- Increase the percent of adolescents in grades 9 through 12 who viewed television, videos, or played video games for no more than 2 hours a day to 73.9%
- Increase the percent of adolescents in grades 9 through 12 who used a computer or played computer games outside of school (for non-school work) for no more than 2 hours a day to 82.6%
- Reduce the percent of students in grades 9 through 12 who reported that they engaged in physical fighting in the previous 12 months to 28.4%
- Reduce the percent of students in grades 9 through 12 who reported that they were bullied on school property in the previous 12 months to 17.9%
- Reduce the percent of students in grades 9 through 12 who reported that they carried weapons on school property during the past 30 days to 4.6%
- Increase the percent of motor vehicle drivers and right-front seat passengers that used safety belts to 92%

The YRBS provides data about health-risk behaviors among 9<sup>th</sup> to 12<sup>th</sup> grade public school students in Philadelphia. The YRBS is conducted every two years to approximately 1,500 high school students from 29 randomly selected public schools in Philadelphia. In 2013, 94% of the randomly selected high schools and 78% of the randomly selected students in grades 9 to 12 voluntarily agreed to participate in the survey, allowing data to be weighted such that it is representative of all 9<sup>th</sup> – 12<sup>th</sup> grade students throughout the School District of Philadelphia. The prevalence of health risk behaviors self-reported by Philadelphia high school students during the 2013 administration of the YRBS are summarized below. Behaviors that have met the HP2020 objectives are bolded.<sup>155</sup>

### **Tobacco Use**

- **7.5% of students report being current smokers**, down from a high of 35% in 1999
- **10.3% of students report current use tobacco (cigarettes, smokeless tobacco, or cigars)**
- 6.9% of students reported smoking at least one cigarette every day for 30 days
- 8.3% of students reported initiation of smoking before age 13
- 41.9% of students reported lifetime smoking, down from 76% in 1991

## Alcohol Use

- 33.1% of students reported alcohol use within the last 30 days
- 13.9% of students reported binge drinking
- 18.6% of students reported drinking alcohol before age 13
- 64.6% of students reported lifetime alcohol use

## Use of other drugs

- 25.1% of students reported current marijuana use
- 44.6% of students reported lifetime marijuana use
- Use of heroin (1.8%), methamphetamines (2.8%), ecstasy (4.1%), cocaine (3.1%), and use of steroids without prescription (3.4%) remains infrequent
- 11.4% of students reported taking prescription drugs without a prescription
- 25.1% of students reported being offered or sold drugs on school property

## Body Weight, Nutrition and Physical Activity

- 14.6% of students are classified as obese based on self-reported height and weight
- 18.1% are classified as overweight based on self-reported height and weight
- 6.7% of students reported not eating fruit or drinking 100% fruit juices in the past week
- 10.5% of students reported not eating vegetables in the past week
- 23.7% reported daily consumption of non-diet soda
- 21.9% reported zero days of  $\geq 60$  minutes of physical activity in the past week
- 40.5% watched three hours or more of TV daily
- 46.7% played video or computer games or used a computer three or more hours per day

## Safety and Violence

- 25% never or rarely wore seat belts
- 92.9% of students report never or rarely wearing a bicycle helmet while riding a bike
- **2.9% carried a weapon on school grounds**
- 35.4% were in a physical fight during the last year, down 6.6% from 2011
- 6.5% stayed home from school within the past year due to safety concerns
- **13.3% reported being bullied at school**
- 8.1% reported being bullied electronically
- 13% considered suicide
- 10% reported a suicide attempt within the last year

## Sexual Activity

- 61% report ever having sexual intercourse in 2011, no data available for 2013
- 11.1% report becoming sexually active prior to age 13
- *Among sexually active students:*
  - 42.2% used a condom during last sexual intercourse, down from 60% in 2011

- Used birth control pills (14.9%), IUD (0.3%), shot, patch or birth control ring (5.6%)
- 20.8% did not use any method to prevent pregnancy
- 21.7% reported use of alcohol and/or other drugs prior to last sexual intercourse

Compared to students in 20 other urban jurisdictions, a higher percentage of Philadelphia high school students reported: being in a physical fight, having sexual intercourse before age 13 for the first time, having sexual intercourse with four or more persons during their life, not using any method to prevent pregnancy, and not eating vegetables in the past week. In response to these and other statistics, city health officials put condom dispensers in 22 high schools. The aim is to reduce the incidence of sexually transmitted diseases and unplanned pregnancies.

**Issues, challenges, unmet needs and priorities identified by key informants and focus group participants related to healthy behaviors and adolescents included:**

- **Increased access to constructive activities**
  - *Young people need constructive things to do. Several of the community centers have closed and as a result kids don't have enough constructive things to do* (key informant)
  - *There is a lack of community programs, services, facilities, positive role models for teens resulting in teens engaged in non-directed activities in 19122 and 19133. It's a breeding ground for trouble... they are involved in fighting* (focus group)
  - *Raise awareness about community programs* (focus group)
- **Mental and behavioral health issues**
  - Resources are needed for teens to address (1) conflict and anger management training for teens; (2) mental and behavioral health issues (key informant)
- **Mentoring and investment in positive activities**
  - Adolescents could benefit from mentoring (key informant)
  - *Help youth without parental support understand how they are going to "make it." Kids don't believe in anything anymore* (focus group)
  - *Work with schools to train teens as "peer educators" as part of their required community service* (key informant)

**Based on internal and external key informants, focus groups, existing relationships and programs, and secondary data, actions addressing adolescent healthy behaviors may include:**

- 1. Engaging with the Philadelphia School District's Office of Strategic Partnerships**
- 2. Working with School Wellness Councils in target neighborhoods**
- 3. Linking pregnant teens to the Maternity Care Coalition services**
- 4. Referring youth who smoke to PA QUIT line**
- 5. Increasing youth access to constructive, positive activities in the community**
- 6. Training youth as peer health educators**
- 7. Training bilingual youth as medical interpreters**

- 8. Linking youth to workforce pipe line for health professions**
- 9. Addressing bullying and anger management**

## Special Populations

### *Older Adults*

Older adults are among the fastest growing age groups, and the first “baby boomers” (adults born between 1946 and 1964) began turning 65 in 2011. Older adults are at high risk for developing chronic illnesses and related disabilities including diabetes mellitus, arthritis, congestive heart failure and dementia and may lose the ability to live independently at home. Illness, chronic disease, and injury can create physical and mental health limitations in older adults, affecting their ability to remain at home. Regular physical activity is a protective factor for such declines. While most adults want to age in place and remain in their homes for as long as possible, the supports they need to do so may not be available. Caregivers are often family members or friends who volunteer and may not be prepared for the stressors of caregiving. Elder abuse by a caregiver has unfortunately become more common with up to 2 million older adults affected.<sup>156</sup>

The Healthy People 2020 objectives on older adults focus on:

- Increased adherence to a core set of Clinical Preventive services
- Increased older adult confidence in managing chronic health conditions
- Increased utilization of diabetes self-management programs (target: 2.4%)
- Increased physical activity among those with mild cognitive impairment
- Increased proportion of the healthcare workforce with geriatric certification (target: physicians 3%; psychiatrists 4.7%; registered nurses 1.5%; physical therapist 0.7%; registered dietitians 0.33%)
- Reducing ED visits due to falls (target: 4,711.6 ED visits per 100,000 due to falls among older adults)

Philadelphia Corporation for Aging (PCA)<sup>157</sup> is a non-profit organization established in 1973 to serve as the Area Agency on Aging (AAA) for Philadelphia. PCA is required by the Pennsylvania Department of Aging (PDA) to produce an Area Plan for Aging Services every four years. For the years 2012-2016, PDA established five priority themes: Innovation for Services; Communities to Age and Live Well; Revitalization and Re-architecting of Services; Promotion of Health and Wellbeing; and Effective and Responsive Management.

In developing the Area Plan for Aging Services, PCA took into consideration both the PDA’s priorities and the following key factors which impact the delivery of services:

**Population trends:** Philadelphia’s seniors experience high rates of poverty and as a result have difficulty paying life’s basic necessities such as housing and food. The number of older Philadelphians suffering from poverty, hunger, and chronic illness will continue to grow. The population of foreign-born and non-English-speaking elders is also increasing, placing new demands on service providers for interpretation, translation, and cultural sensitivity.

**Changes in the cityscape:** Growing awareness of the needs of the elderly on the part of city government and planners will have some positive impacts, such as improved walkability, better access to parks and green spaces and improvements to the zoning and building codes to increase visitability in newly constructed homes.

**Development of new models:** Innovative initiatives to enable Philadelphians to age in place are gaining momentum. These include co-housing, Villages, and Naturally Occurring Retirement Community Supportive Service Programs (NORC SSP).

**Funding levels:** Unfortunately, at the same time the needs and numbers of older Philadelphians are increasing, the funding for services is effectively decreasing. Flat funding combined with increased operating costs, has eroded the capacity of the aging network to provide services. Flat funding has contributed to the closing of five senior centers and six satellite meal sites, reducing the number of seniors served from 33,000 to 20,000. The Options program for in-home care currently has a waiting list of more than 1,000 people.

PCA's Strategic Plan 2012-2016 emphasizes four general categories for further attention:

- 1) ***Supporting a system of aging services:*** Addressing the **sustainability** of the aging network remains a critical issue and is expected to become even more challenging.
- 2) ***Serving the Frail Elderly:*** Providing services for frail older adults who wish to remain in their homes will continue to be a challenge in the next four years.
- 3) ***Improving Access:*** Building **awareness** of, and increasing access to, **information** and services remains a high priority for stakeholders. The availability of **transportation** has a major impact on the ability of seniors to access services. **Technology** will increase in importance to the delivery of information and services to seniors. More affordable technology and increased access to technology for seniors are both issues. In Philadelphia, only 50% of older adults use computers in some way.
- 4) ***Strengthening Neighborhoods:*** The overall elements constituting an Age-friendly city, strongly affect the well-being of older adults. These elements include:
  - a. **Trust** in neighbors gives many a feeling of community, but not all neighborhoods have a sense of community.
  - b. **Crime** prevents seniors from using the neighborhood.
  - c. **Safety** in the physical environment (better street lights, slower lights at crosswalks, repairing broken sidewalks), is both necessary to reduce crime and to create a more accessible neighborhood for everyone.
  - d. **Food access** is a neighborhood problem. In order for a neighborhood to support seniors, seniors need to be able to access food.
  - e. Availability of **housing and housing repairs** is of critical importance to maintaining older Philadelphians remaining in the neighborhood. Many would like to downsize but can't find available, affordable, accessible units.

In addition to PCA, in 2012 the Mayor's Office of Policy, Planning and Development conducted an assessment of the City of Philadelphia in response to the World Health Organization's Global Age-Friendly Cities initiative. The plan lays out how Philadelphia must meet the needs of a growing senior population to ensure they can stay in their homes and communities, become more engaged in their neighborhoods, and continue to live with respect and dignity. The Mayor's Commission on Aging is another example of Philadelphia's commitment to its oldest citizens and their ability to age in place.

## Older Adult Demographics

In TJUHs CB area there are more than 53,000 people over the age of sixty-five. The majority of older adults (65+) live in South Philadelphia (23,478 people).

Age	Lower North	Transitional Neighborhoods	Center City	South Philadelphia	Total CB Area
60+	15.27%	16.54%	20.45%	18.68%	17.58
	18,920	11,040	11,688	32,843	74,491
65+	10.44%	11.79%	15.72%	13.35%	12.58%
	12,939	7,868	8,988	23,478	53,273
75+	4.27%	4.93%	7.17%	5.84%	5.42%
	5,288	3,287	4,100	10,275	22,950

*Census 2010 with Truven Projections for 2016*

The percentage of older adults aged 60+ living in TJUHs CB areas varies across zip codes from about 12% in 19107 (Center City) to almost 25% in 19103 and 19106 also in Center City. Twenty percent of residents in zip codes 19145 and 19148 in South Philadelphia are over age sixty. The highest rates of adults over age 75 are in zip codes 19103 (10%) and 19102 (7.1%), both in Center City. Over the next five years, the projected population growth of adults aged 60 and older is expected to increase by 16% or more in zip codes 19107, 19123, 19125 and 19121.

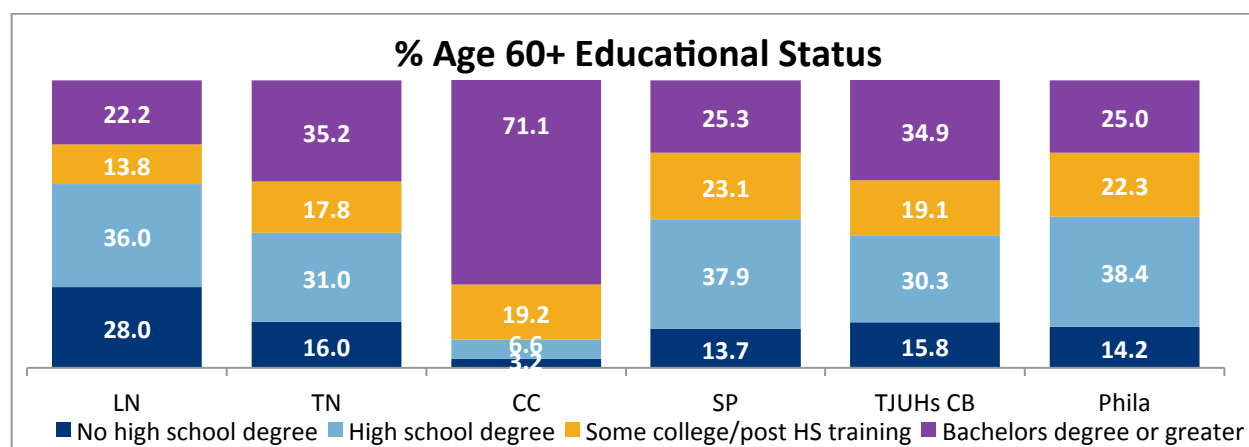
Zip	# (%) aged 60 Plus	# (%) aged 65 Plus	# (%) aged 75 Plus	% Population Growth Age 60+ Predicted 2015-2020
Center City				
19102	959 (18.44)	749 (14.40)	368 (7.08)	7.2
19103	5,810 (24.59)	4,720 (19.98)	2,348 (9.94)	7.1
19106	2,993 (24.52)	2,169 (17.77)	851 (6.97)	10.9
19107	1,926 (11.94)	1,350 (8.37)	533 (3.31)	16.0
Transitional Neighborhoods				
19123	2,443 (15.24)	1,739 (10.85)	744 (4.64)	16.8
19125	3,796 (15.69)	2,600 (10.75)	984 (4.07)	16.1
19130	4,801 (18.11)	3,529 (13.31)	1,559 (5.88)	13.0
Lower North Philadelphia				
19121	5,331 (13.67)	3,600 (9.23)	1,499 (3.84)	17.7
19122	2,985 (13.07)	2,188 (9.58)	943 (4.13)	11.5
19132	6,844 (19.13)	4,661 (13.03)	1,963 (5.49)	12.3
19133	3,760 (14.30)	2,490 (9.47)	883 (3.36)	15.8
South Philadelphia				
19145	9,916 (20.11)	7,188 (6.65)	3,280 (6.65)	11.7
19146	5,974 (16.20)	4,084 (11.08)	1,690 (4.58)	13.9
19147	6,595 (17.20)	4,698 (12.25)	1,877 (4.90)	12.9
19148	10,358 (20.19)	7,508 (14.64)	3,428 (6.68)	10.7

*Census 2010 with Truven Projections for 2016*



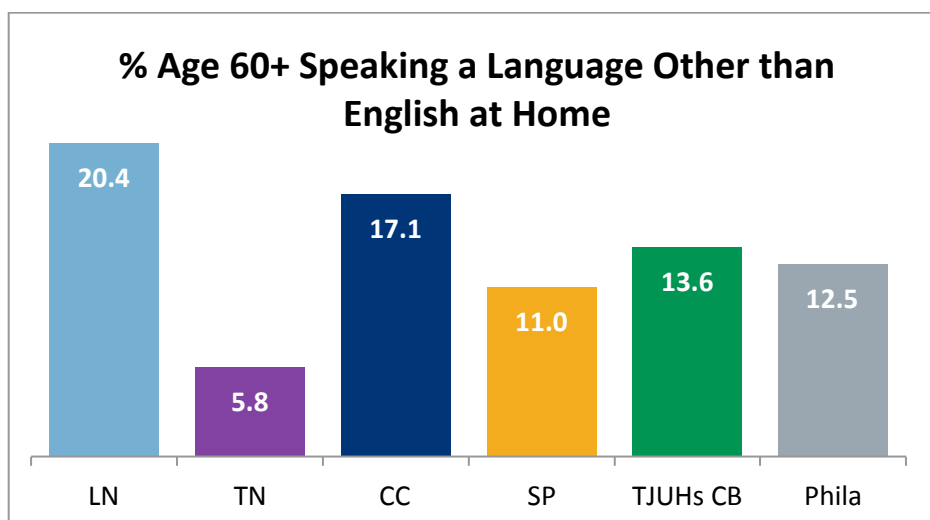
**Gender:** In Philadelphia, 59% of older adults (aged 60+) are female compared to 50% in TJUHs CB area. No significant changes in the gender distribution of older persons are expected in the near future. That means that most very old, very poor, and very frail Philadelphia elders will continue to be women.

**Education and health literacy:** Twenty-six percent (14%) of older adults in Philadelphia have less than a high school education. Within TJUHs CB area, slightly more than 15% of older adults did not graduate from high school and in Lower North Philadelphia more than one in four older adults (28%) lack a high school diploma. The reading level of older adults is becoming more critical as the amount of information provided via the Internet and other electronic sources increases. As people age, they suffer from more chronic illnesses, require more medications, and have more hospitalizations. The ability to read prescriptions and understand written discharge plans is a challenge for those less literate or unable to read English. Older adults are proportionately more likely to have below basic health literacy scores than any other age group. Almost two-fifths (39%) of people aged 75 and over have a health literacy level of below basic compared with 23% of people aged 65-74 and 13% of people aged 50-64.<sup>158</sup> People with lower health literacy are at greater risk for hospital readmissions, longer length of stay, medication errors, and non-adherence to treatment guidelines and medical test preparation.



*PHMC Household Health Survey 2015*

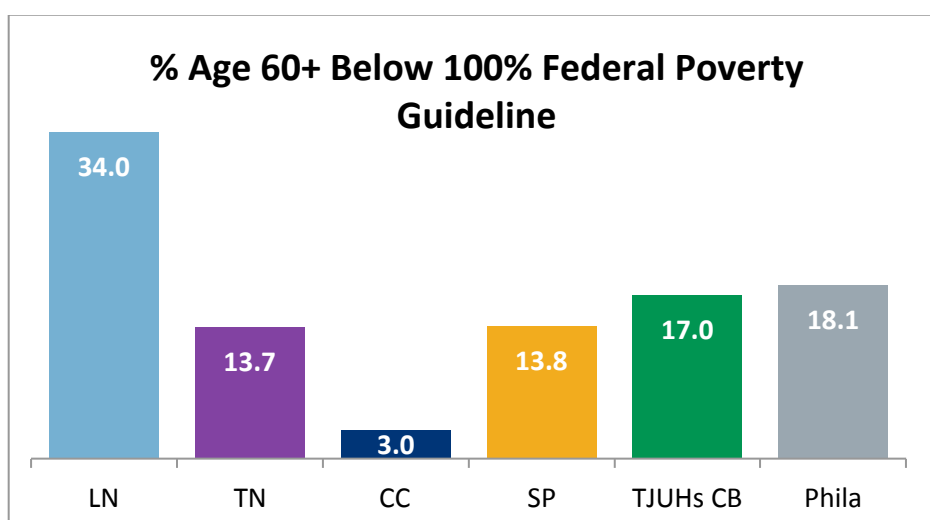
In addition, about 1 of every 8 older adults in TJUHs CB area speaks a language other than English at home. Lack of English proficiency creates additional health literacy obstacles and can impact care.



*PHMC Household Health Survey 2015*

**Living arrangement:** Thirty-nine percent (39%) of older Philadelphians live in one-person households (37% in TJUHs CB area). As more of these older adults live into very old age, it is likely there will be fewer co-resident caregivers. This may lead to greater reliance on the formal aging care system for assistance. Older adults in TJUHs CB area are slightly more likely to be married or living with a partner (44.3%) compared to Philadelphia (40.3%).

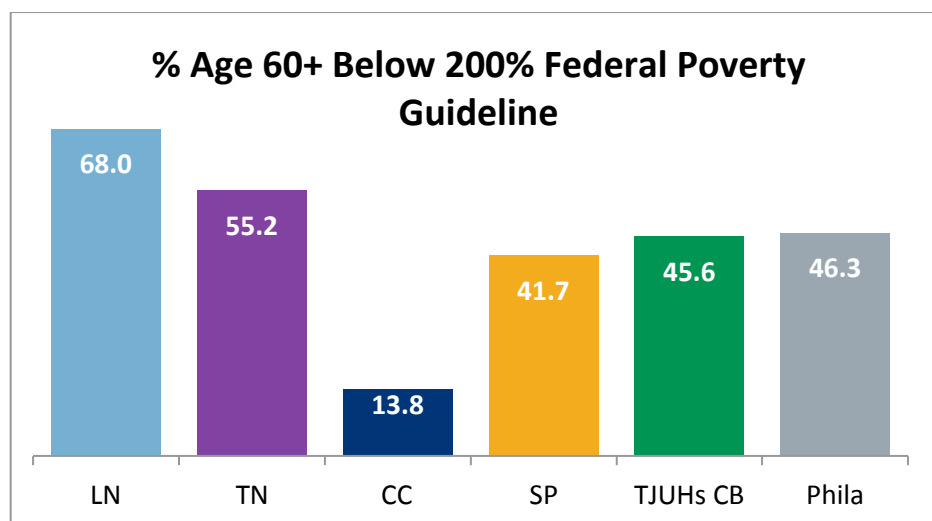
**Income:** According to the Public Health Management Corporations' 2015 Household Health Survey, 18% of older adults in Philadelphia live below 100% of the Federal Poverty Level (FPL) and 46% live below 200% of the poverty level. In TJUHs CB area these rates are 17% and 45.6% respectively. More than one-third of older adult residents in Lower North Philadelphia live below 100% FPL.



*PHMC Household Health Survey 2015*

The rates of older adults living below 200% of poverty vary across TJUHs CB areas with the highest rate in Lower North Philadelphia (68%), followed by 55.2% in the Transitional

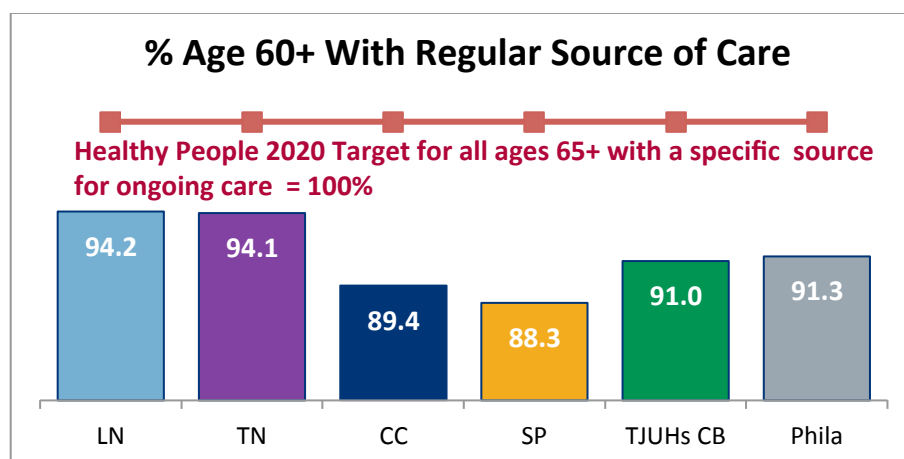
Neighborhoods, 41.7% in South Philadelphia and 13.8% in Center City. Research shows that 200% FPL is a more appropriate measure of functional poverty. To qualify for programs that assist low income older adults, an individual's income is often required to be below 100% poverty. This means that many older adults who are deemed "functionally poor" will not be eligible for these services. This will place additional demands on the aging services care system for older adults.



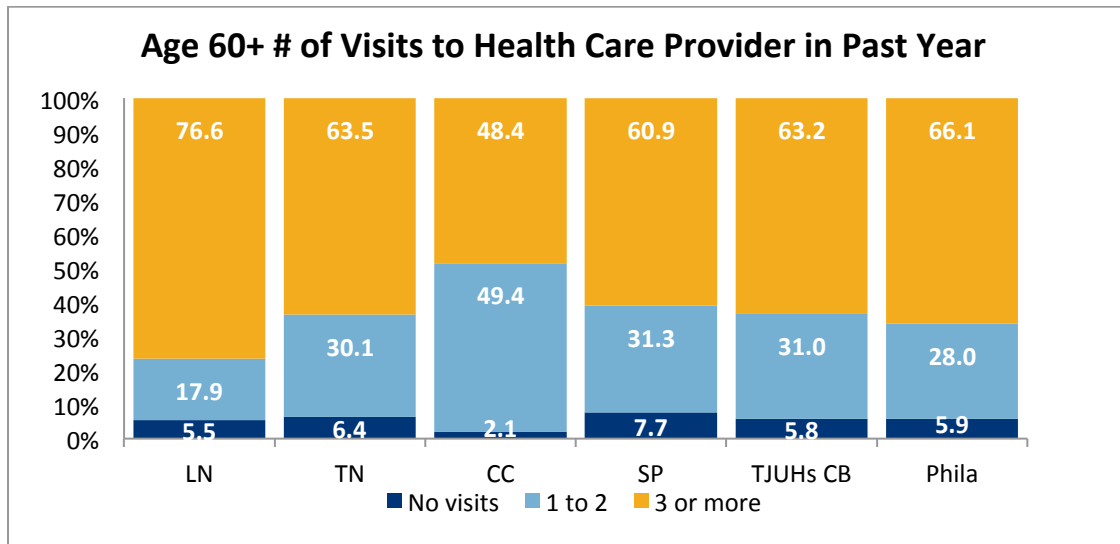
*PHMC Household Health Survey 2015*

## Health Care Access

Almost all older adults in Philadelphia and TJUHs CB area report having a regular source of care and the majority in TJUHs CB area (63.2%) saw their doctor three or more times in the previous year. Very few adults (less than 6%) living in Philadelphia and TJUHs CB area did not see a doctor in the past year. However, the Healthy People 2020 goal for regular source of care has not been achieved.

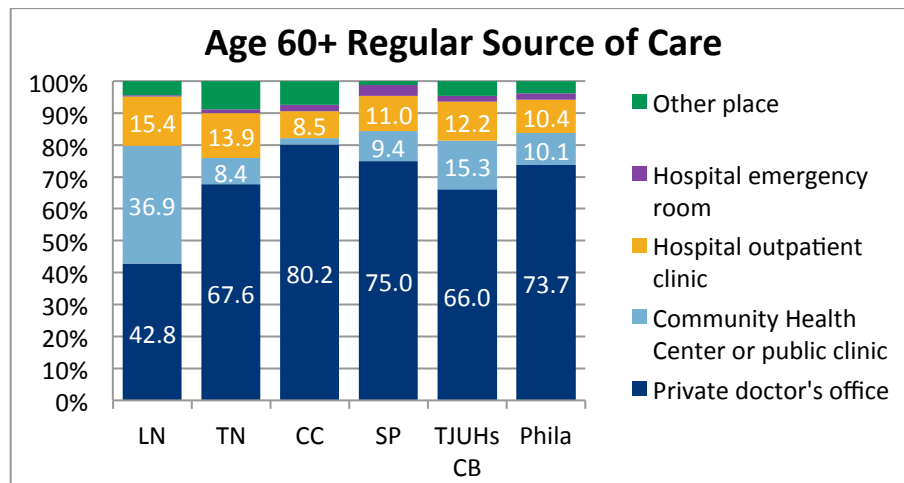


*PHMC Household Health Survey 2015*



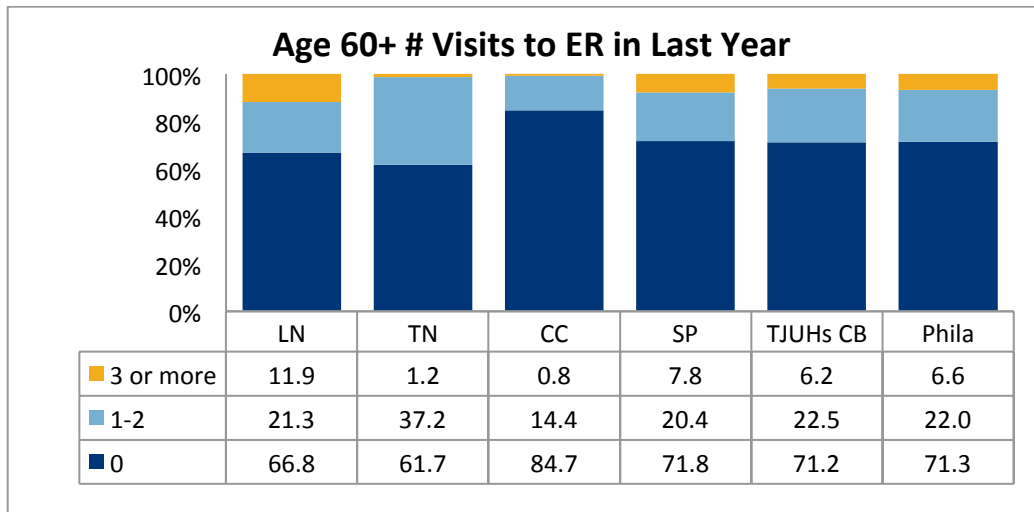
*PHMC Household Health Survey 2015*

The majority of older adults in TJUHs CB area receive care in a private doctor's office. Residents in Lower North Philadelphia were more likely to receive care in a community health center or public clinic than were others in Philadelphia or TJUHs CB area.



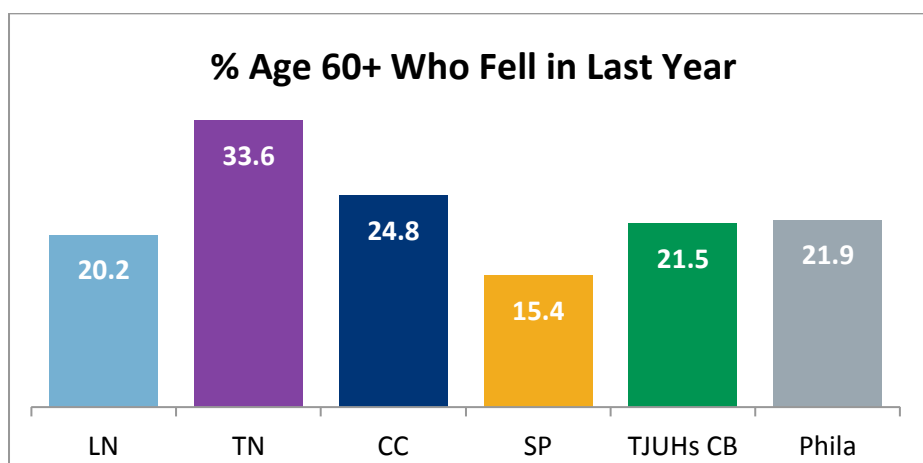
*PHMC Household Health Survey 2015*

Use of the emergency department (ED) in the past year was similar for Philadelphia and TJUHs CB area with 29% of all older adults using the ED at least once. The highest rate of ED utilization was among older adults living in the Transitional Neighborhoods (38.4%) followed by Lower North Philadelphia (33.2%). Older adults in Center City were least likely to have used the ED (15.2%). Older adults in Lower North Philadelphia were almost twice as likely to have had 3 or more visits to the ED compared to Philadelphia and TJUHs CB area.



*PHMC Household Health Survey 2015*

TJUHs emergency department data for 2013 indicates that falls are the number one type of ED visit related to trauma. Among those aged 65 and older, 84% of ED trauma visits are due to falls. Almost 22% of older adults in TJUHs CB area and Philadelphia reported falling in the past year. The rate of falls among older adults in Center City and the Transitional Neighborhoods is 25% and 33% respectively. In 2012 the median charges for unintentional falls was approximately \$50,000.<sup>41</sup> Clearly, fall prevention is needed to help seniors age in place and reduce falls which can be devastating to their health and quality of life. The Center for Injury Prevention Research at Jefferson is addressing falls prevention. The Philadelphia Planning Commission is also working on injury prevention. The District Plan for South Philadelphia (June 2015) has a focus on pedestrian safety particularly for older adults. Walkability for seniors includes manageable intersections, safety from bicyclists, continuous wheelchair friendly sidewalks, and bus transit shelters. Walkability to popular senior destinations such as senior centers and parks are the priority.

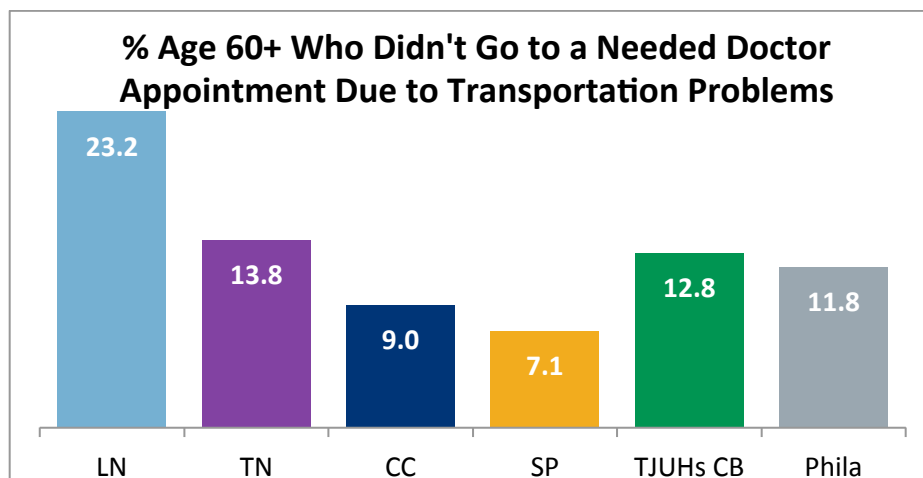


*PHMC Household Health Survey 2015*

According to the 2012 PHMC Household Health Survey, the lack of access to transportation for seniors is significant:

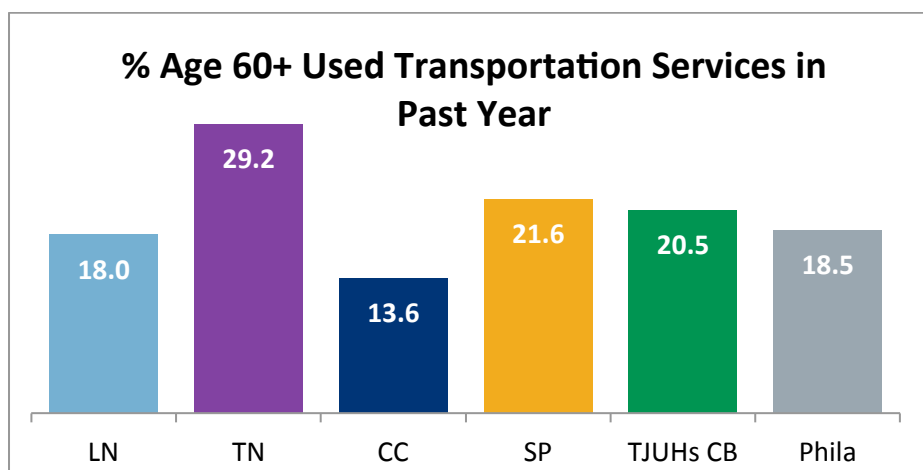
- 55% of low-income seniors in the city do not have access to an automobile in their household.
- 46% of seniors who report at least one ADL or IADL disability do not have access to an automobile in their household.
- 42% of seniors, who speak English poorly or not at all, reported not having an automobile in their household.

Almost 13% percent of adults aged 60+ in TJUHs CB area reported cancelling a doctor's appointment because of transportation problems. In lower North Philadelphia almost one in four adults cancelled a doctor appointment due to transportation.

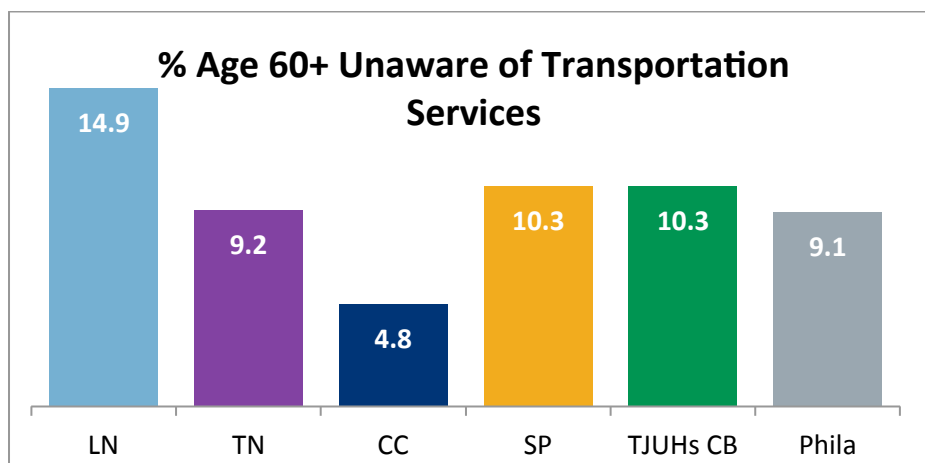


*PHMC Household Health Survey 2015*

On average 20% of older adults in Philadelphia use transportation services; however, approximately 10% are unaware of transportation services.

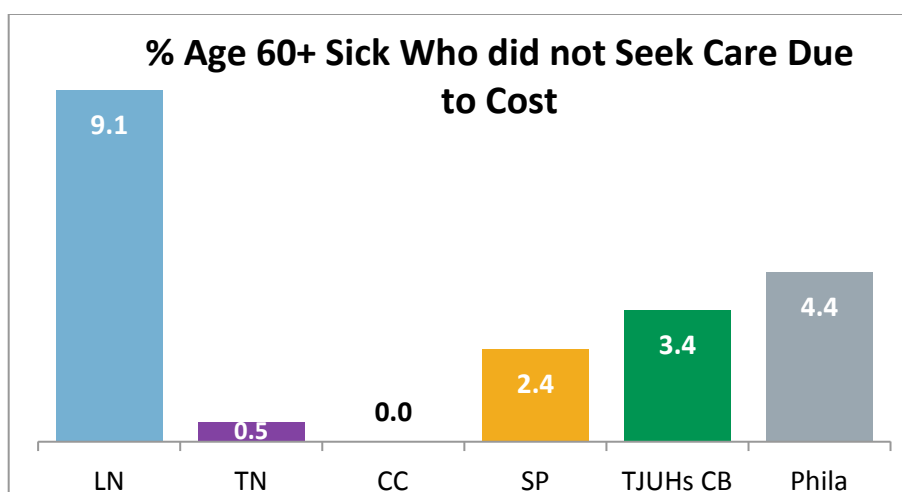


*PHMC Household Health Survey 2015*



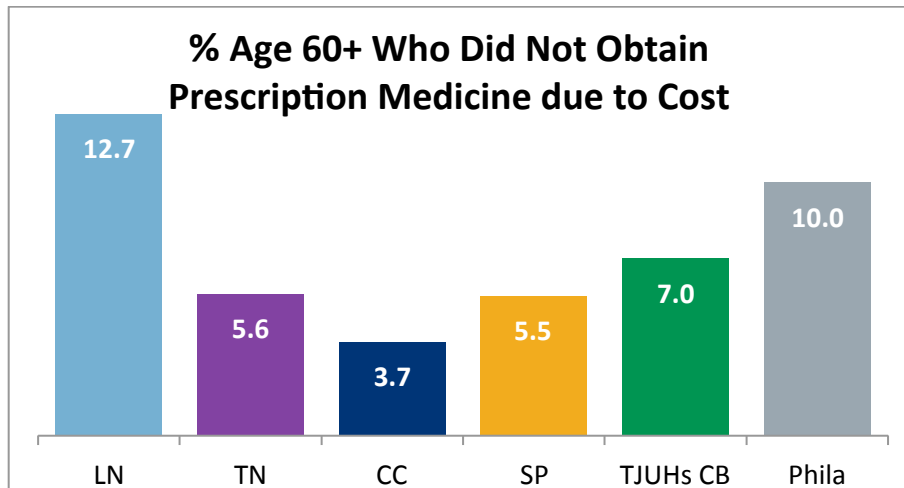
*PHMC Household Health Survey 2015*

Cost of health care and medications was also problematic for some older adults in TJUHs CB area. Almost 10% of older adults in North Philadelphia did not see a doctor when they were sick due to cost, more than twice the rate in Philadelphia (9.1 vs. 4.4).

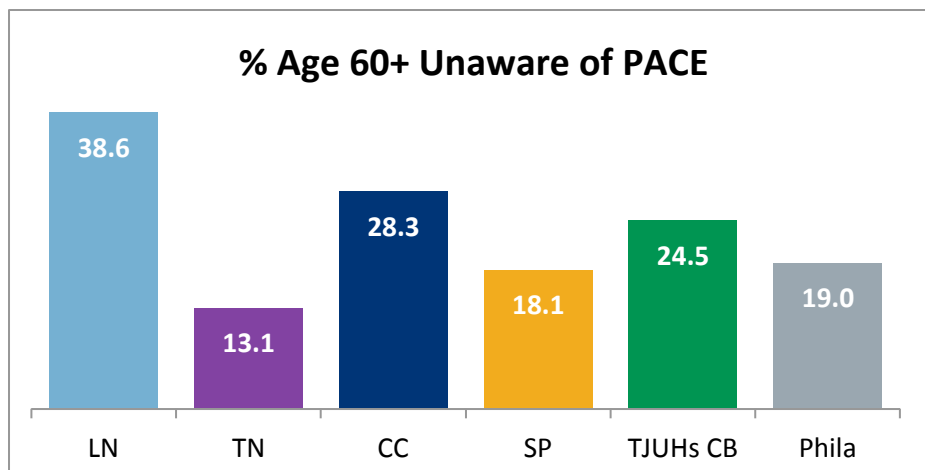


*PHMC Household Health Survey 2015*

The percentage of older adults in TJUHs CB area with prescription coverage exceeds the rate in Philadelphia (89%), except in South Philadelphia (86%). Approximately 1 in 10 adults in Philadelphia did not purchase needed medication due to cost; in TJUHs CB area 7% of older adults reported not obtaining needed medications due to cost. Nearly one in four older adults in Jefferson's CB area (24.5%) was not aware of PACE. Older adults in Lower North Philadelphia are most likely not to have had a prescription filled due to cost and least likely to be aware of PACE.



*PHMC Household Health Survey 2015*



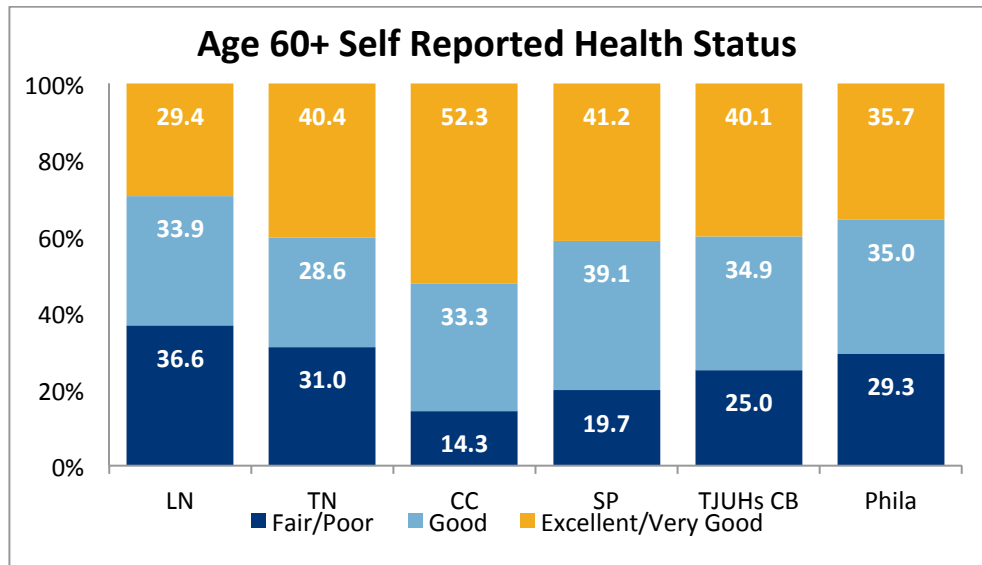
*PHMC Household Health Survey 2015*

## Health Status

Health status data for older adults is from the PHMC Household Health Survey conducted in 2015.

With the exception Lower North Philadelphia, older adults in TJUHs CB areas are more likely to rate their health as very good or excellent compared to Philadelphia. However, nearly one-third of older adults in Lower North Philadelphia and the Transitional Neighborhoods rate their health as fair or poor which exceeds the rate for Philadelphia.

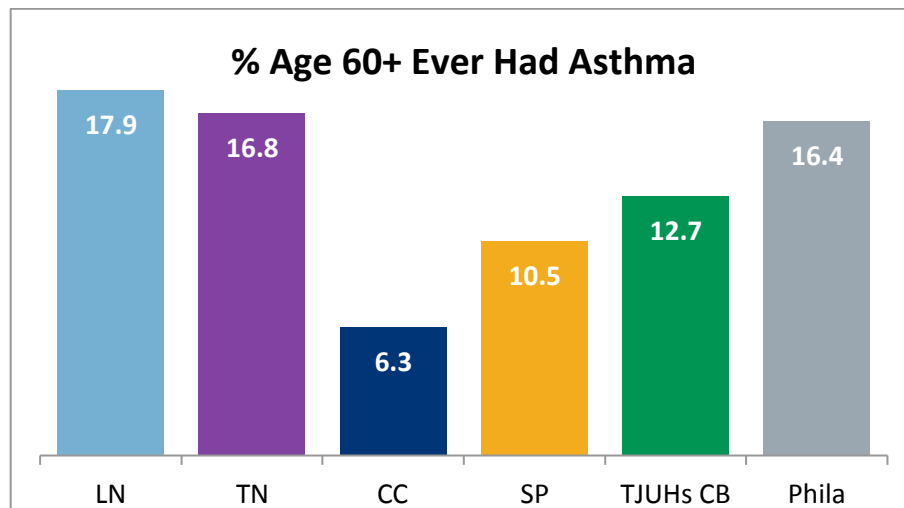




*PHMC Household Health Survey 2015*

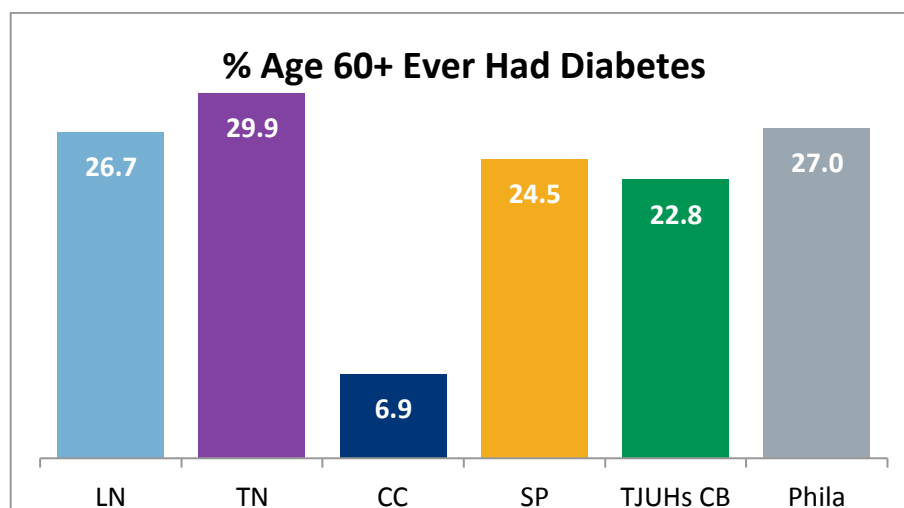
### ***Chronic Disease***

Overall, older adults in TJUHs CB area are less likely to report having asthma compared to Philadelphia.



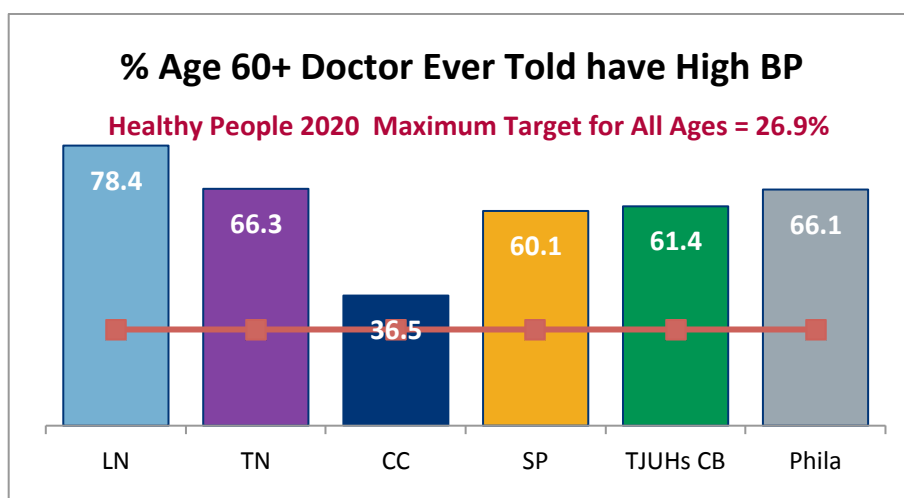
*PHMC Household Health Survey 2015*

On average, one in four older adults in Philadelphia and TJUHs CB area report having been told they have diabetes. However rates vary across TJUHs CB area with only 6.9% of older adults in Center City reporting diabetes compared to almost 30% in The Transitional Neighborhoods.



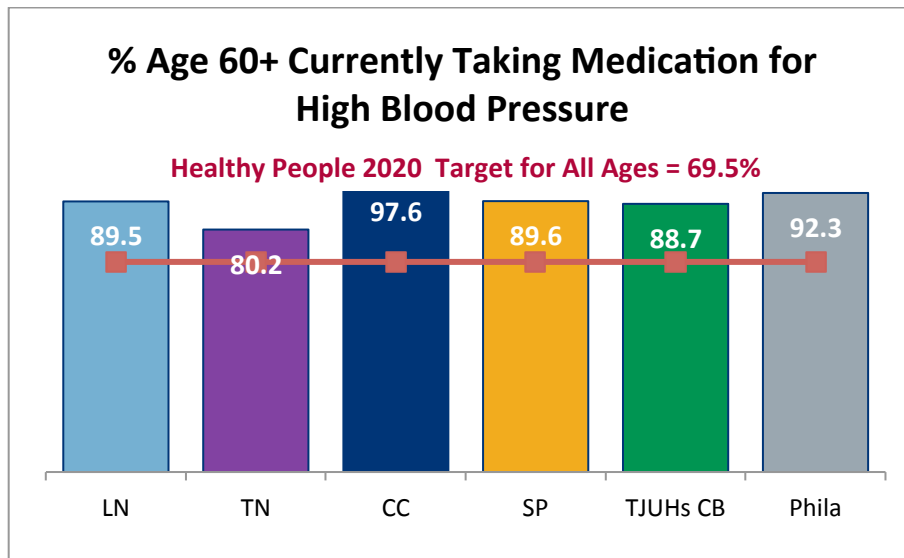
*PHMC Household Health Survey 2015*

The national benchmark for hypertension is that no more than 26.9% of adults will report having high blood pressure. Nearly two-thirds of older adults in TJUHs CB area and in Philadelphia report having high blood pressure. In Lower North Philadelphia almost 80% of all older adults say they have been told their blood pressure is high.

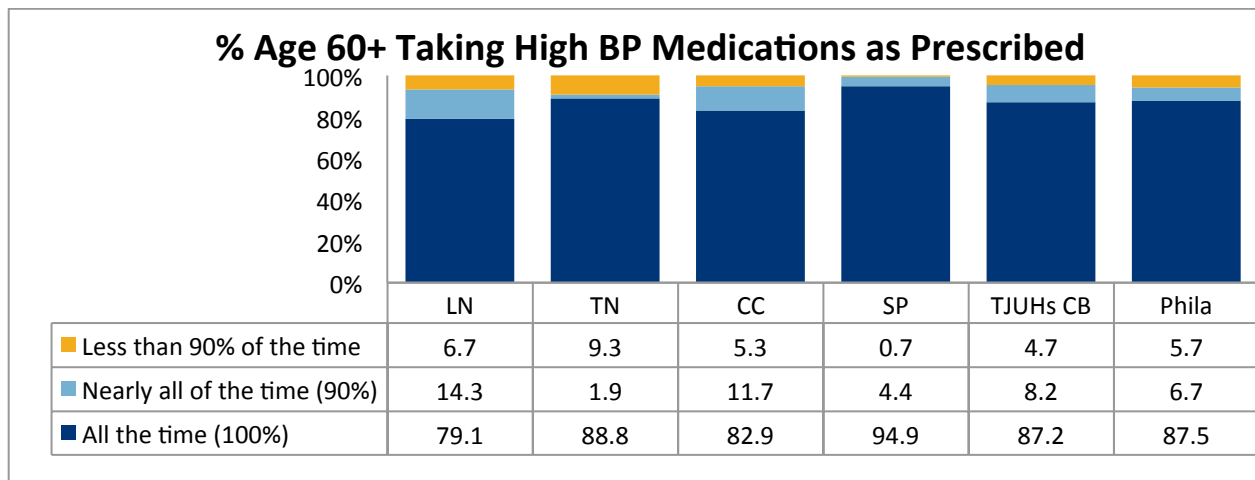


*PHMC Household Health Survey 2015*

Of those older adults with high blood pressure, most are taking hypertension medication and at a rate that exceeds the Healthy People 2020 goal. Almost all people on blood pressure medications indicate they are taking it as prescribed.

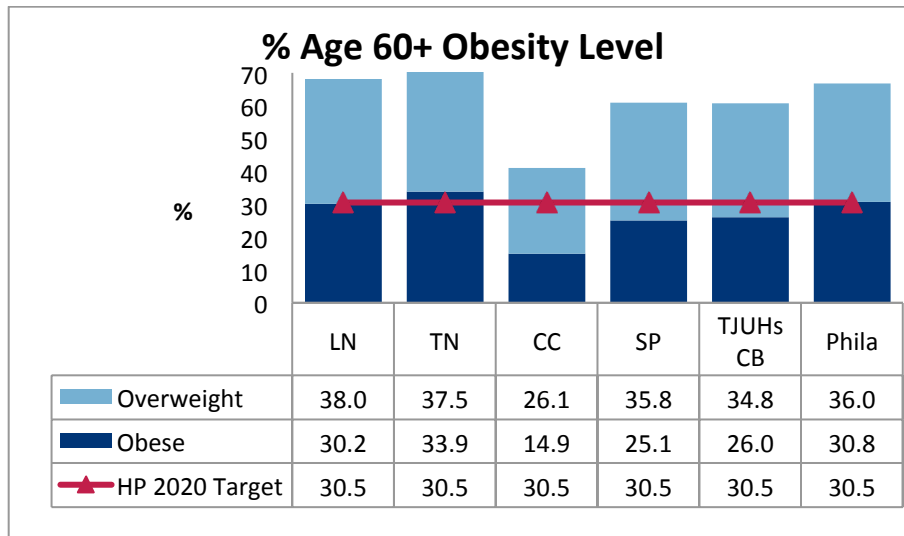


*PHMC Household Health Survey 2015*



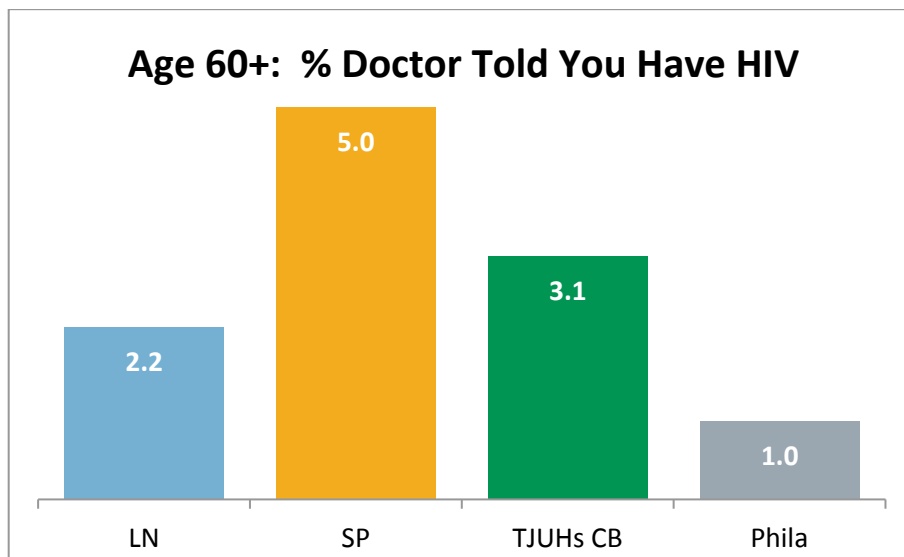
*PHMC Household Health Survey 2015*

Obesity is an underlying cause of hypertension, heart disease, cancer, asthma and diabetes. Rates of obesity among older adults in Jefferson's CB area are somewhat better than those in Philadelphia (26% vs. 30.8%). With the exception of the Transitional neighborhood, all TJUHs CB areas have met the Healthy People goal for obesity of less than 30.5%. Nevertheless, the rate for overweight/obese older adults is about 70% in the Transitional Neighborhoods and Lower North Philadelphia compared to 41% in Center City. The lower obesity rate in Center City may also partially explain lower rates of diabetes and hypertension in this area.



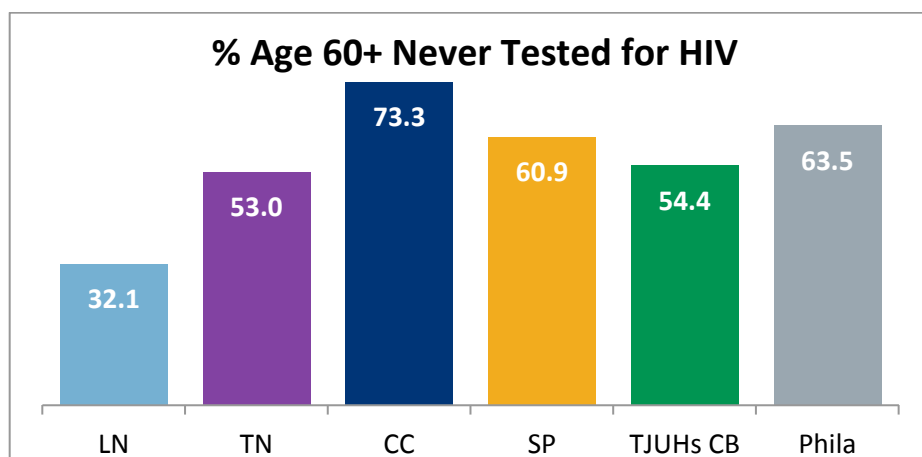
*PHMC Household Health Survey 2015*

HIV is a growing concern among older adults. According to the Public Health Management Corporation's Household Health Survey for 2012 (the latest data available), the rate of HIV among older adults in South Philadelphia is five times the rate in Philadelphia (5% vs. 1%).



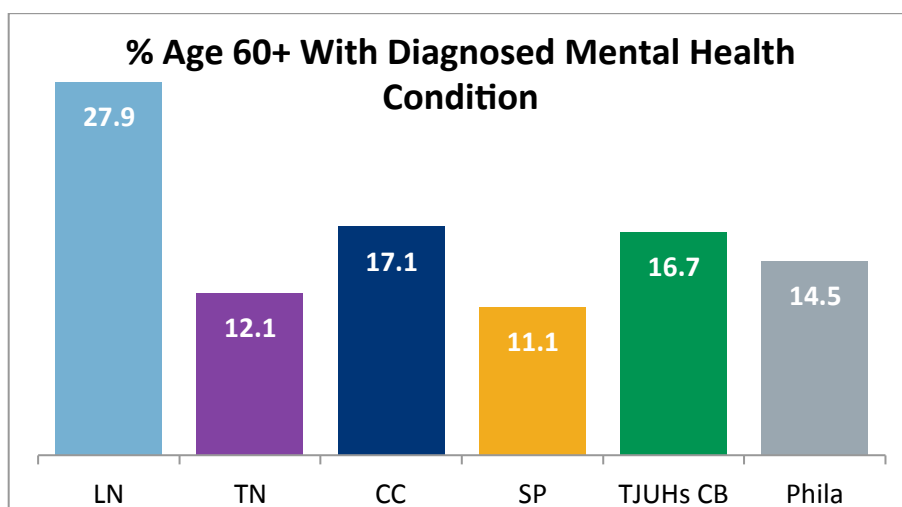
*PHMC Household Health Survey 2012*

Most older adults have never been tested for HIV (54.4% in Jefferson's CB area, 60.9% in South Philadelphia, 73.3% in Center City and 63.5% in Philadelphia). Older adults in Lower North Philadelphia were most likely to have been screening for HIV. HIV screening in the older adult population may be warranted.



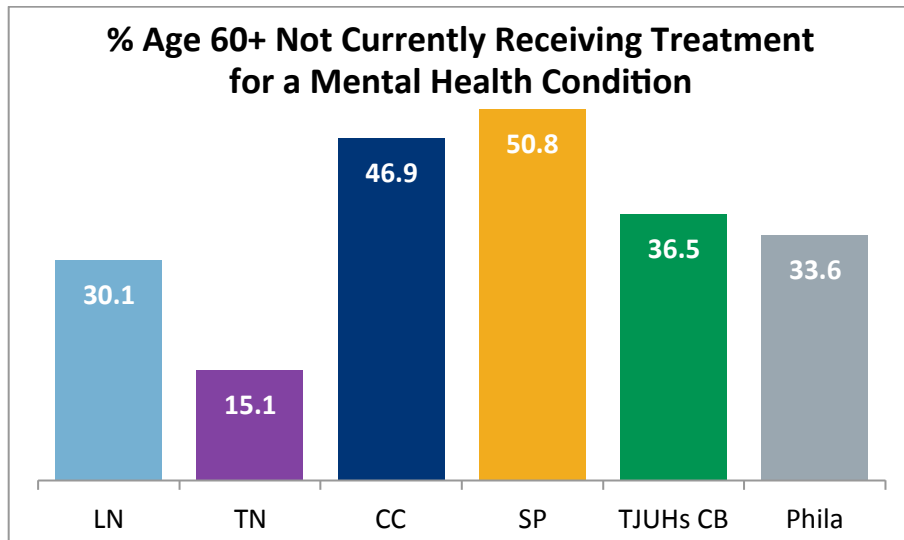
*PHMC Household Health Survey 2015*

Older adults in Jefferson's CB are more likely to have a diagnosed mental health condition compared to Philadelphia (16.7% compared to 14.5%). In Lower North Philadelphia 28% of older adults report having been diagnosed with a mental health condition.



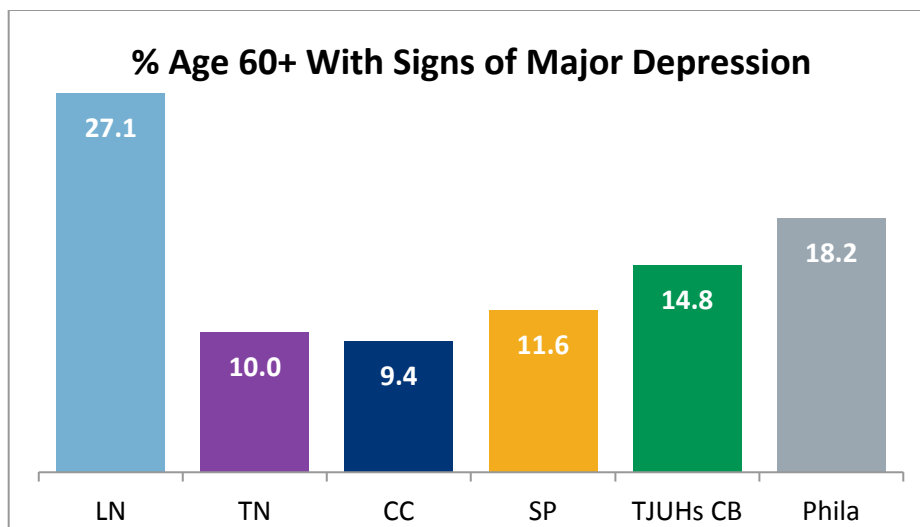
*PHMC Household Health Survey 2015*

However, 36.5% of older adults with a mental health condition are not currently receiving care for their condition compared to 33.6% of Philadelphia. The rate of those receiving treatment compares even less favorably in Center City (47%) and in South Philadelphia where more than 50% of those with a mental health condition are not receiving treatment.



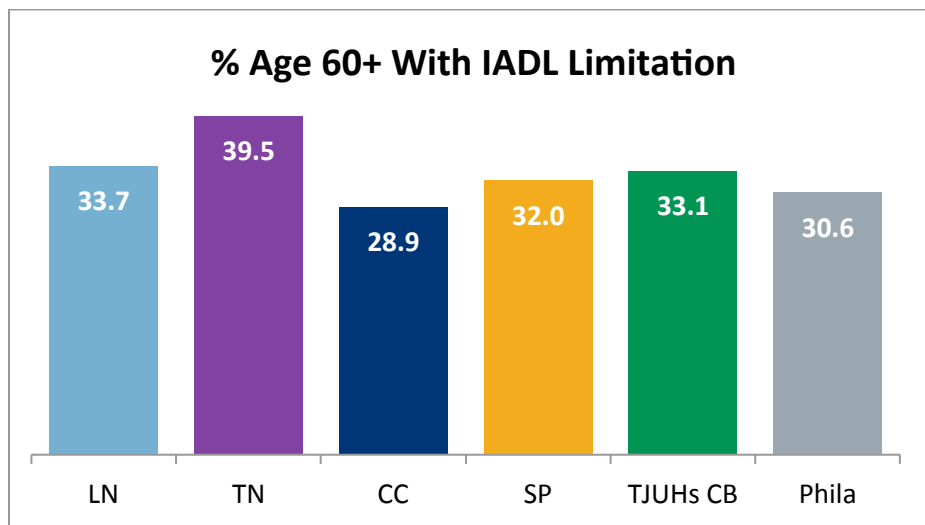
*PHMC Household Health Survey 2015*

More than one in four older adults in Lower North Philadelphia has signs of major depression compared to 18% in Philadelphia and less than 12% in TJUH's other community benefit areas. The inability of the formal aging system to respond to mental health issues is a barrier to serving the older adult population.



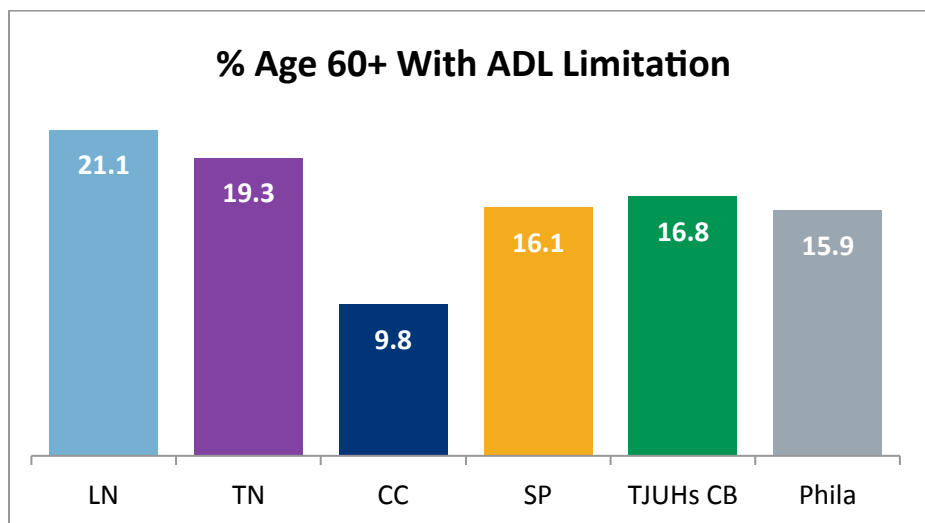
*PHMC Household Health Survey 2015*

Ethnic minority background and income are associated with risk for functional health impairments, and the combination of poverty and ethnic minority background appears to increase that risk. Three out of 10 older adults in Philadelphia have an instrumental activity of daily living (IADL) that limits their everyday functioning. This rate is lower than that of TJUHs CB area (33.1%), South Philadelphia (32%), Transitional Neighborhoods (39.5%) and Lower North Philadelphia (33.7%).



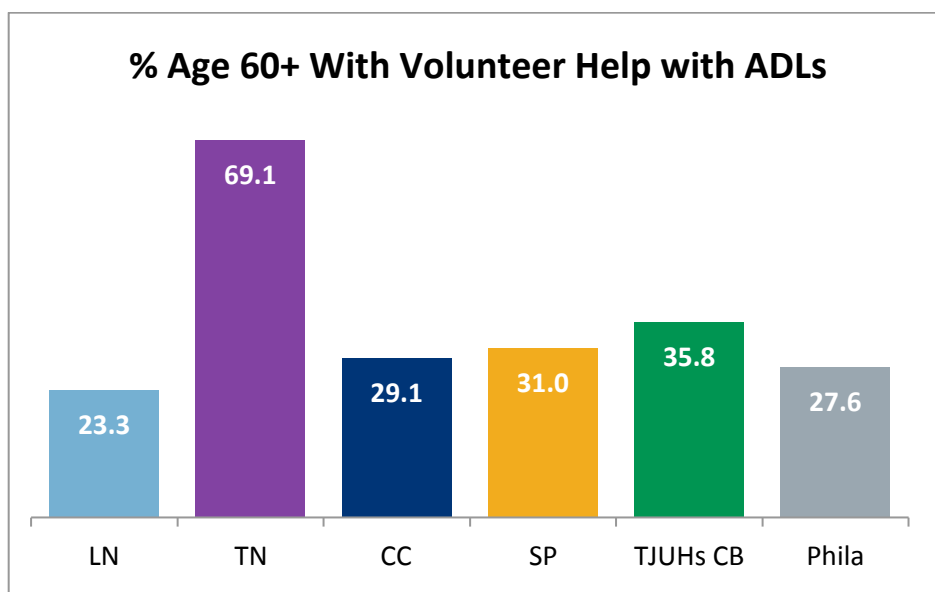
*PHMC Household Health Survey 2015*

Seventeen percent of older adults in TJUHs CB area have at least one activity of daily living (ADL) that limits their functioning.



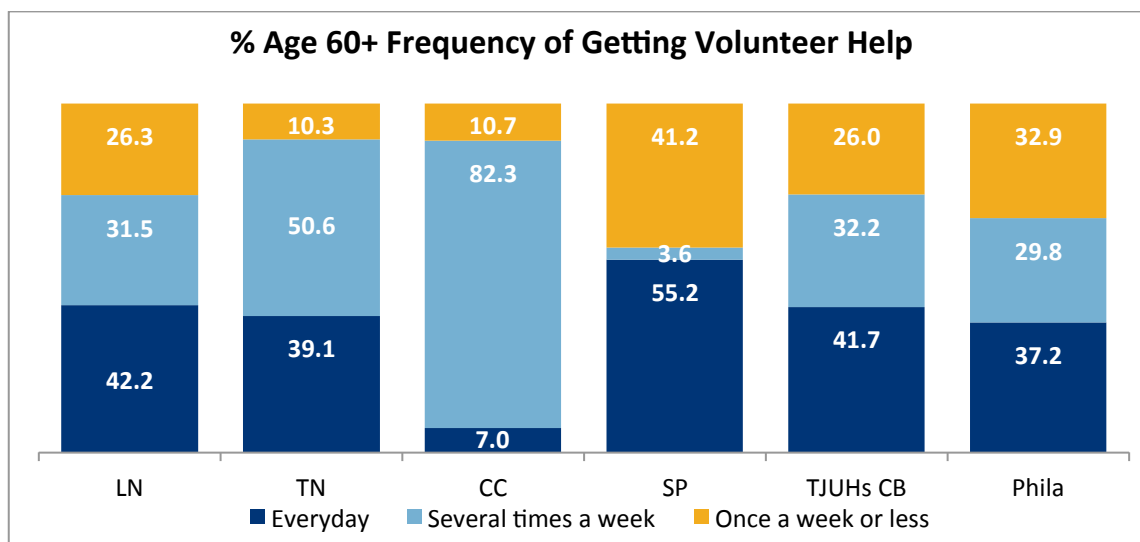
*PHMC Household Health Survey 2015*

While Lower North Philadelphia has the highest rate of individuals with ADLs, they are least likely to be receiving assistance from volunteers such as family and friends with activities of daily living needs. On the other hand, nearly 70% of older adults in Transitional Neighborhoods are receiving assistance with ADLs. This is more than twice the ADL assistance rate for Philadelphia and other TJUH CB areas.



*PHMC Household Health Survey 2015*

Of those getting volunteer help for IADLs or ADLs, more than 40% in TJUHs CB area receive help on a daily basis.



*PHMC Household Health Survey 2015*

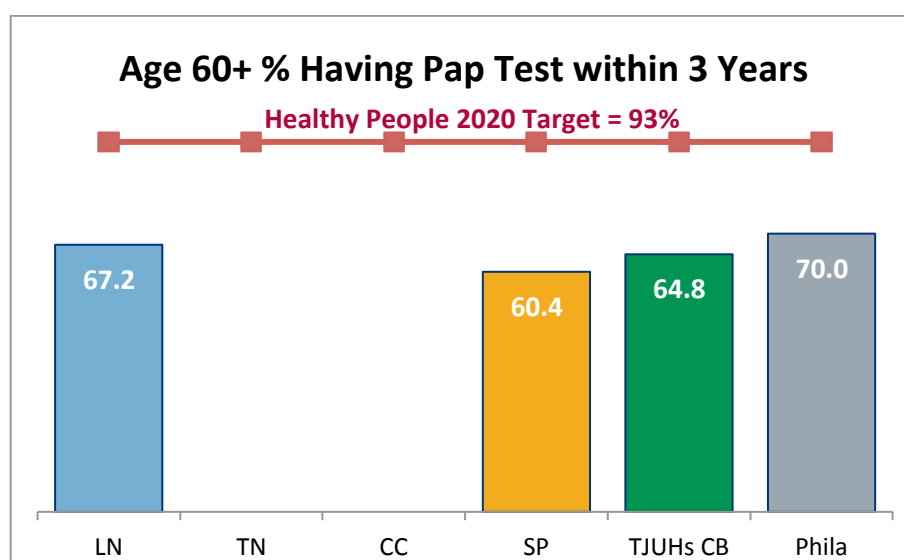
In Pennsylvania in 2013, people with any disability/limitation (includes cognitive, mobility, vision, self-care and independent living disabilities) when compared to people without no limitations, were more likely to be obese (42.4% vs. 25.9%), smoke (35.8% vs. 19.1%), and not to have seen a doctor due to cost (24.5% vs. 10.2%). They are also more likely to have fallen in the past 12 months (45% vs. 19.6%), have high blood pressure (43.3% vs. 26.7%), and



depression (42.2% vs. 12.4%). Rates of arthritis, asthma, diabetes, stroke, cancer and COPD are also on average 2 to 3 times the rate found among those without limitations.<sup>159</sup>

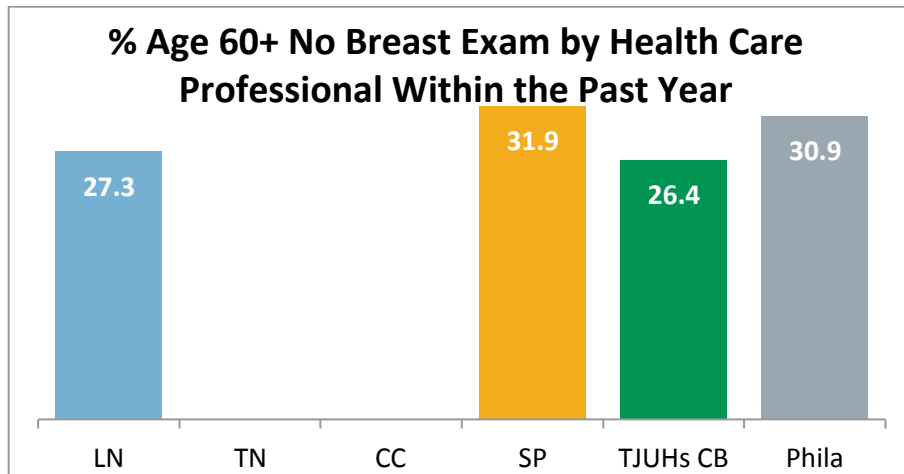
### ***Preventive Health Care Services***

The rate of women in TJUHs CB area who report having had a PAP test in the past three years is well below the Healthy People 2020 goal of 93% and is an area for improvement. Women over age 60 in Jefferson's CB were slightly less likely to have had a PAP test in the previous three years than were women in Philadelphia (64.8% compared to 70%). Older adult women living in South Philadelphia were the least likely to have had a PAP test done in the past three years (60.4%). The sample size for Center City and the Transitional Neighborhoods was too small for inclusion.



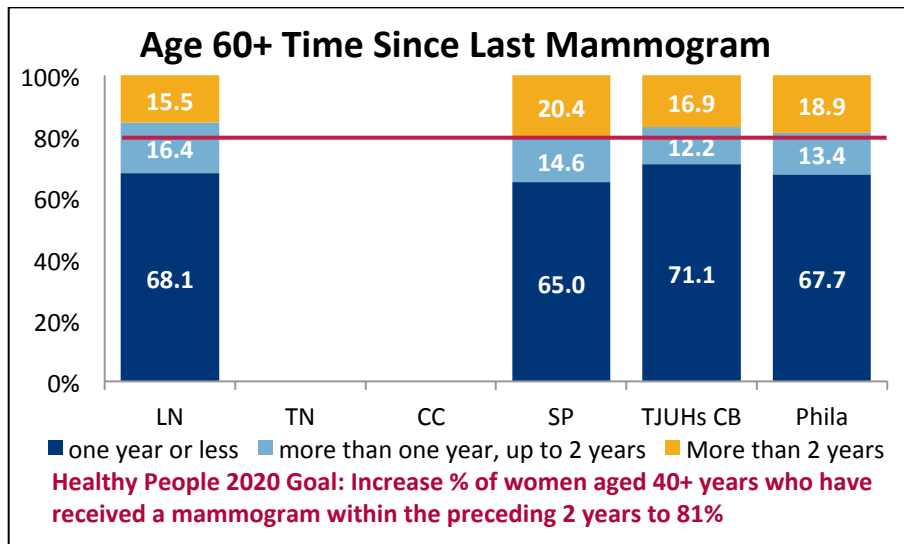
*PHMC Household Health Survey 2015*

Compared to older adult women in Philadelphia, women in TJUHs CB areas are more likely to have had a clinical breast exam in the past year, with the exception of women in South Philadelphia. Only 68.1 % of South Philadelphia women aged 60+ had a breast exam in the prior year compared to 73.6% of older women in TJUHs CB area and 69.1% of older women in Philadelphia. However, the rate in South Philadelphia has improved since 2013 (56 % vs. 68.1%). The sample size for Center City and the Transitional Neighborhoods was too small for inclusion.



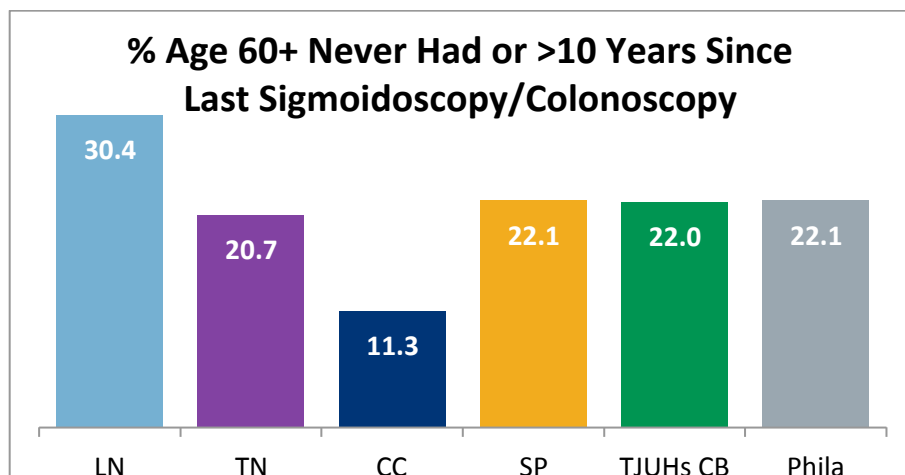
*PHMC Household Health Survey 2015*

This trend continues for mammograms. Older adult women in South Philadelphia were least likely to have had a mammogram in the previous year (65% vs 67.7%) and least likely to have had a mammogram in the past two years (79.6%). However, South Philadelphia's annual mammography rate has improved since 2013 (57.9% vs. 65%). With the exception of South Philadelphia, mammography rates meet or exceed the Healthy People 2020 goal of 81%. These findings suggest that health care providers need to recommend preventive screening to their older patients living in South Philadelphia. The sample size for Center City and the Transitional Neighborhoods was too small for inclusion.



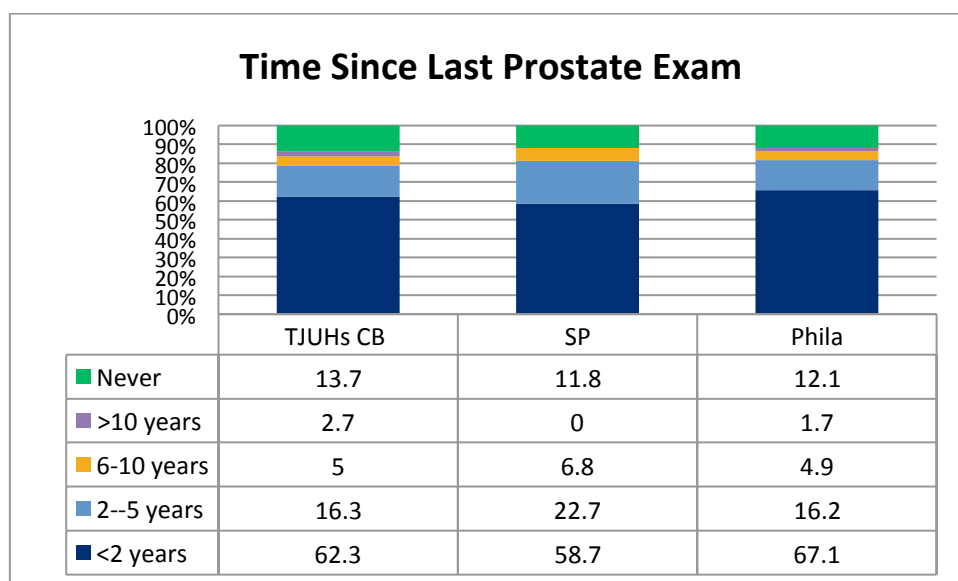
*PHMC Household Health Survey 2015*

Older adults in North Philadelphia were also less likely to have had a colonoscopy in the past 10 years compared to adults in in TJUHs CB area and all of Philadelphia (69.9% vs. 78% and 77.9% respectively).



*PHMC Household Health Survey 2015*

Older adult males in Jefferson's CB area were less likely than other men in Philadelphia to have had a prostate exam in the past year (48.2% vs. 55.7%). More than 16% of older adult males in TJUHs CB area have not had a prostate exam in the past 10 years or have never had an exam compared to 13.8 % in Philadelphia. The sample size for Center City, Lower North Philadelphia and the Transitional Neighborhoods was too small for inclusion.

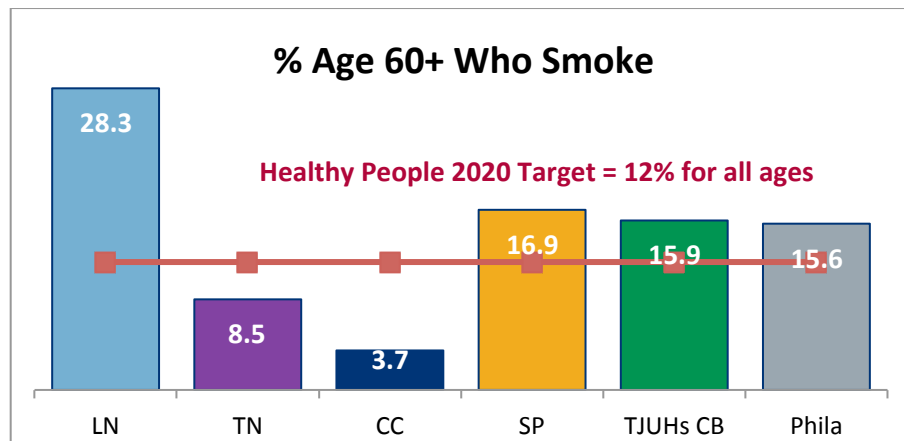


*PHMC Household Health Survey 2015*

## Health Behaviors

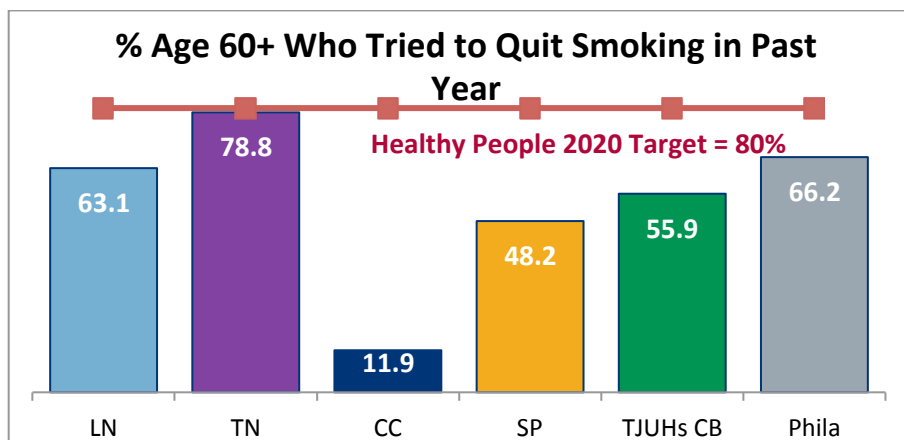
### Tobacco Use

Approximately one in six older adults in Jefferson's CB area smoke (15.9%) compared to 19.5% in 2012. The rate in Lower North Philadelphia (28.3%) is the highest in TJUHs CB area is more than twice the goal for Healthy People 2020 (12%).



*PHMC Household Health Survey 2015*

Older adult smokers in Jefferson's CB area, with the exception of the Transitional Neighborhoods, were less likely to have tried to quit smoking compared to Philadelphia (55.9% vs. 66.2%). Physicians and other health care providers should refer patients to state and local free programs including FAX to QUIT and the Pennsylvania QUIT line to increase quit attempts by smokers.

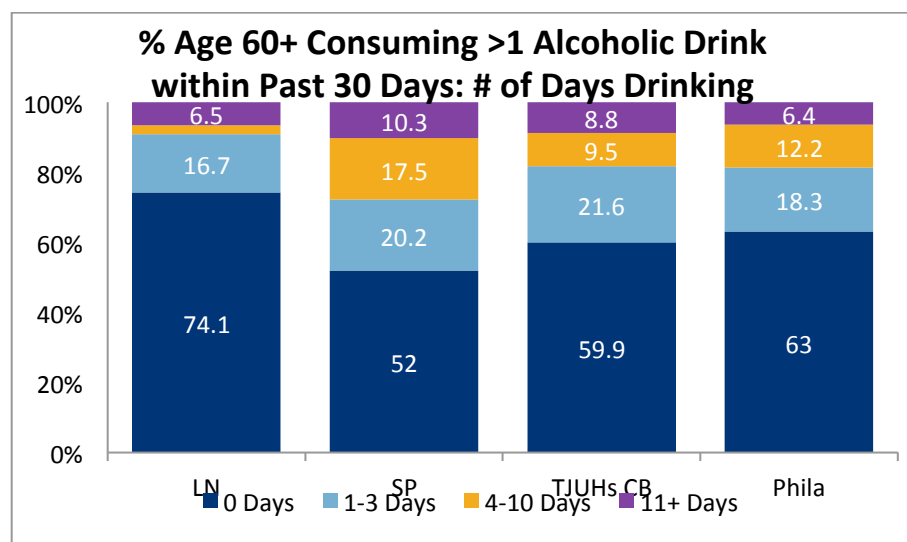


*PHMC Household Health Survey 2015*

## Alcohol Use

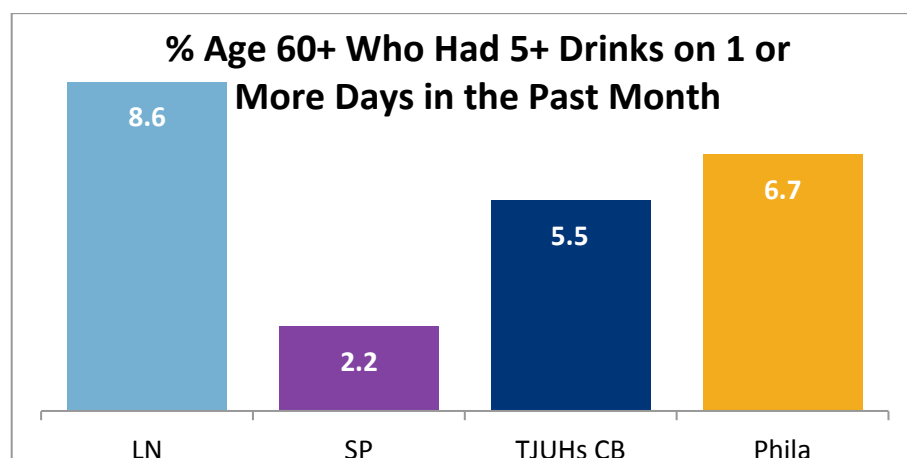
The most prevalent substance abuse problem among older adults is alcohol misuse. Aging increases sensitivity to both alcohol and drugs. Misuse of alcohol, with or without other drugs, can impact cognitive impairment, exacerbate existing health conditions, and increase risk of unintentional injuries such as falls. Loss of a loved one, social isolation, and pain can trigger increased use of alcohol. Health care providers should be skilled in recognizing and addressing symptoms of substance use among the elderly.

In 2012, the most recent data available, older adults in TJUHs CB area were more likely to have 2 or more drinks on 11 or more days in the past month than were older adults in Philadelphia (8.8% vs. 6.4%) and 10.3% of older adults in South Philadelphia consumed this amount of alcohol.



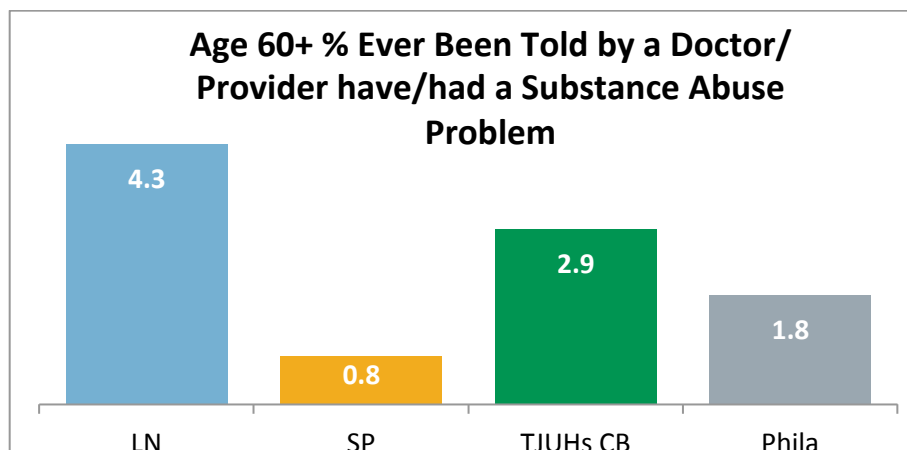
*PHMC Household Health Survey 2012*

Binge drinking (5 or more drinks on any one day) was more common in Lower North Philadelphia (8.6%) compared to 5.5% in Jefferson's CB area and 6.7% in Philadelphia.



*PHMC Household Health Survey 2012*

Given the high rate of chronic disease among older adults, alcohol use could be problematic among older adults who are taking medications. Compared to Philadelphia, older adults in Jefferson's CB area are more likely to have been told they have a substance abuse problem particularly those living in Lower North Philadelphia (1.8%, 2.9% and 4.3% respectively).



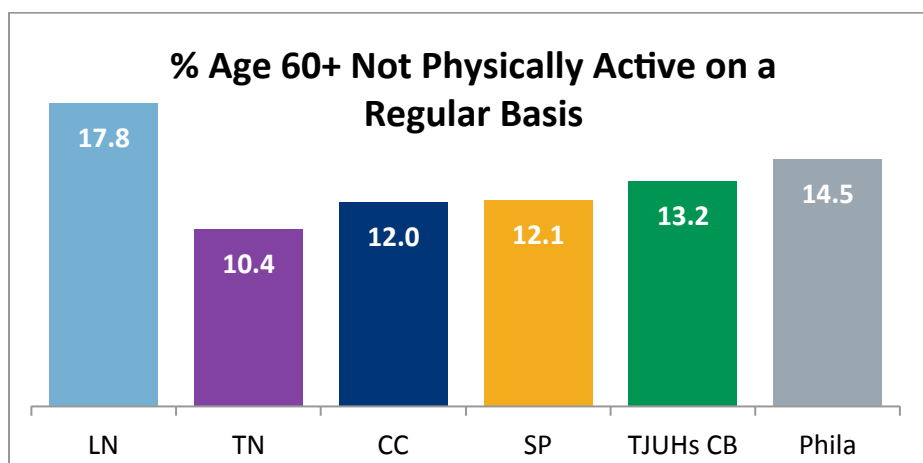
*PHMC Household Health Survey 2012*

## Physical Activity

Physical activity is important to healthy aging. It maintains muscle strength, bone density, helps to prevent weight gain and reduces stress and depression. Perceived lack of safety can limit physical activity and isolate older adults aging in place in the community. According to the 2012-2016 Area Plan developed by Philadelphia Corporation for Aging (PCA), a majority of older Philadelphians do not use the city's many parks or recreation facilities.

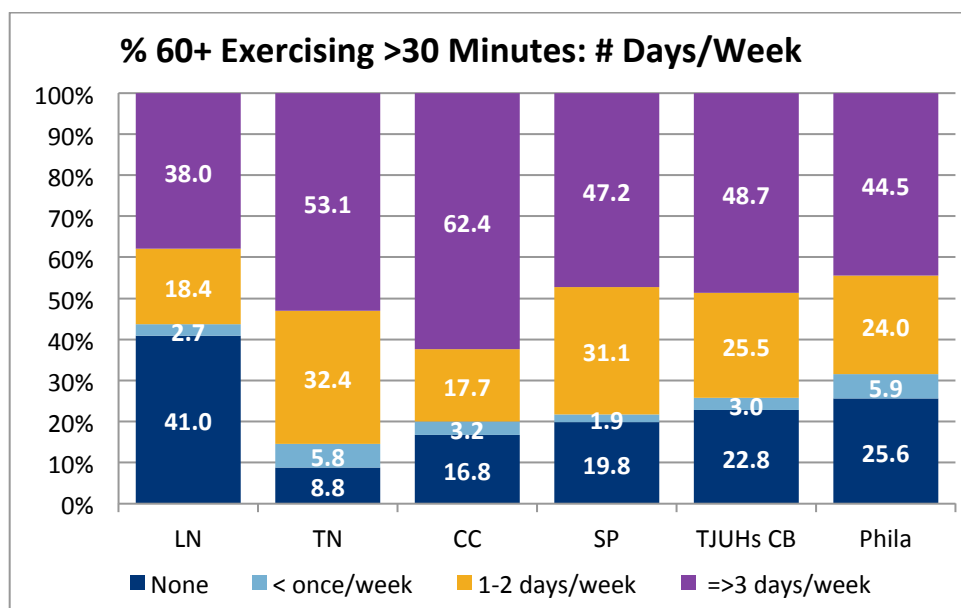
*“In most cases the older adult lives near one but chooses not to use it. When surveyed, older adults said that they would like to use city parks more often but were concerned about safety (too much crime, too many cars, too many bikes) and the lack of amenities (bathrooms and benches). Concerns about safe and accessible transportation to-and-from parks are another reason older adults are reluctant to use parks. When seniors use the city's public spaces, they gain an opportunity to become engaged in the community, which combats isolation and helps build social capital.”*

Almost 87% of older adults say they are physically active on a regular basis. The rate of regular physical activity reported by older adults in TJUHs CB area ranges from a low of 82% (Lower North Philadelphia) to almost 90% in the Transitional Neighborhoods.



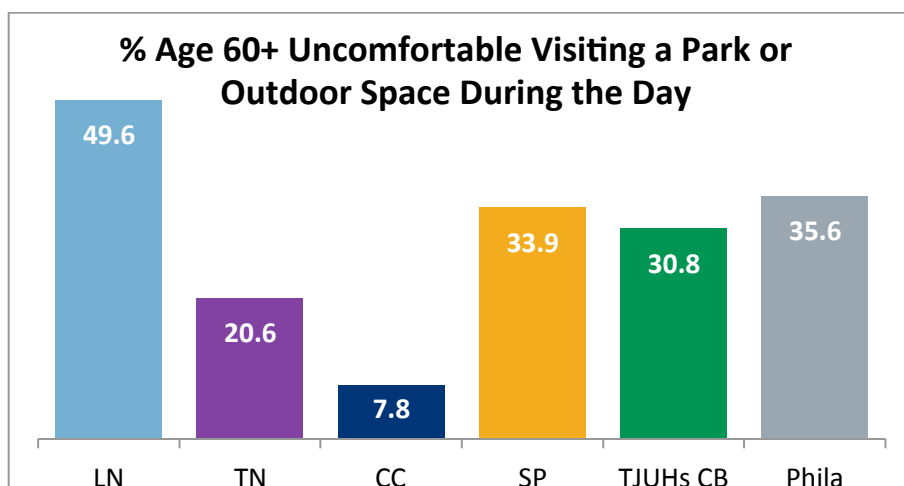
*PHMC Household Health Survey 2015*

While the majority of older adults report being physically active, slightly less than half of all older adults living in TJUHs CB area report exercising for at least 30 minutes for three or more days per week. Compared to other neighborhoods in TJUHs CB area, older adults in Lower North Philadelphia are more likely not to have been physically active even once weekly (43.7%) compared to 31.5% in Philadelphia and 25.8% in TJUHs CB area.



*PHMC Household Health Survey 2015*

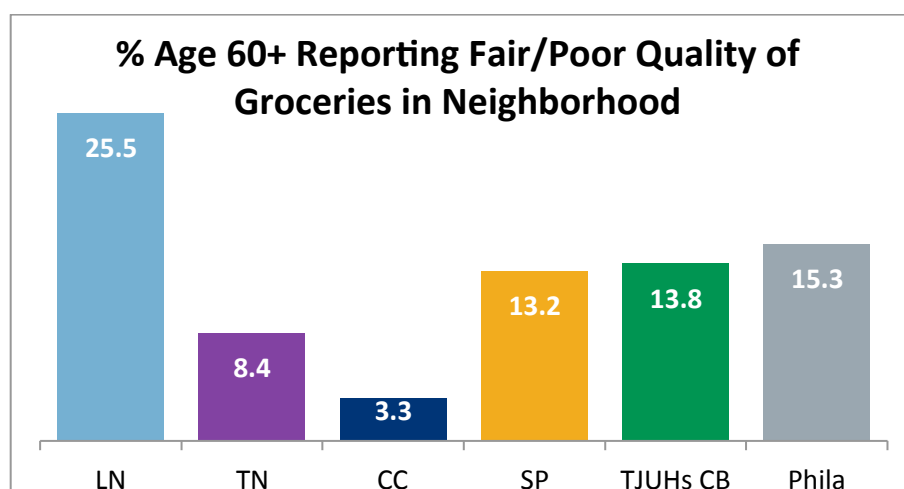
Inactivity in Lower North Philadelphia may correspond to being more uncomfortable visiting a park or outdoor space during the day compared to Philadelphia older adults. Almost half of Lower North Philadelphia older adults indicated discomfort in visiting a park or outdoor space in 2015 (an increase from 40.3% in 2012). Older adults living in Center City have the highest exercise rates (at least 3 times weekly for at least 30 minutes) and also report the least discomfort in visiting a park of outdoor space during the day (7.8%).



*PHMC Household Health Survey 2015*

### **Nutrition and Food Access**

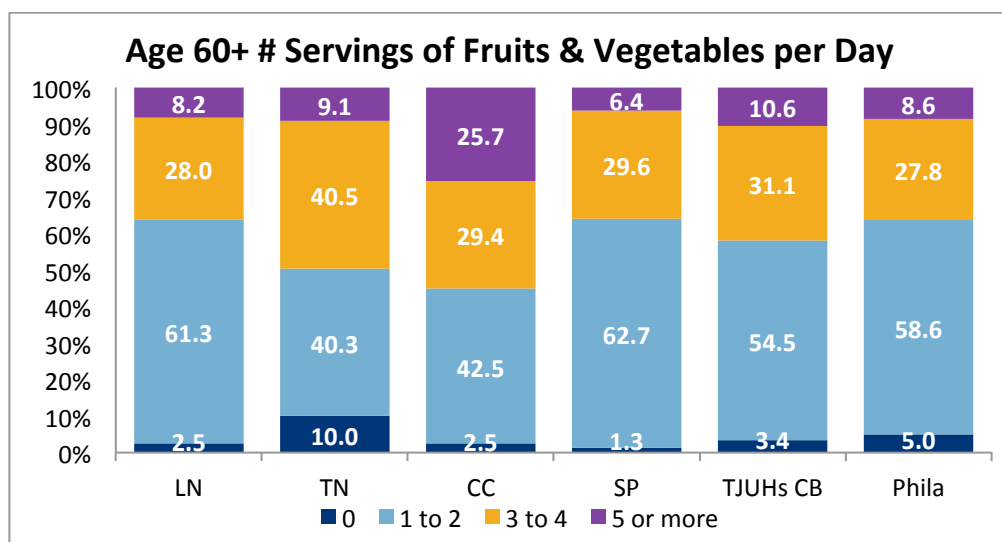
Sixty-one percent of older adults in Jefferson's CB area are overweight or obese. Access to healthy affordable food can play a role in the overall health of seniors. Almost 14% of adults in Jefferson's CB area say the quality of food in their neighborhood is fair or poor and for those in Lower North Philadelphia more than 25% find this to be the case.



*PHMC Household Health Survey 2015*

Overall, 50% of older adults in Center City and Transitional Neighborhoods report eating at least three servings of fruits and vegetables daily which exceeds Philadelphia's overall rate of 36.4%. However, almost 2 out of 3 older adults in South and Lower North Philadelphia eat less than 3 servings of fruits and vegetables daily. Center City residents are most likely to report difficulty in getting fresh fruit and vegetables (11.9%) compared to the other community benefit areas (less than 8%).





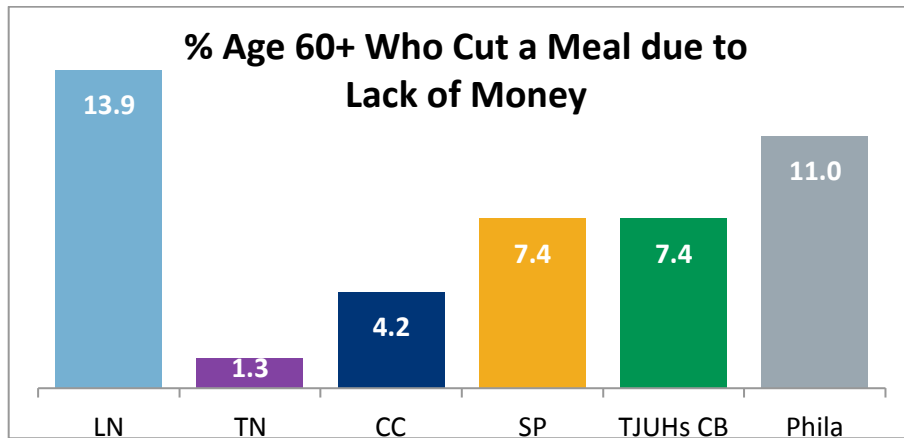
*PHMC Household Health Survey 2015*

**Food Security:** Between 2001 and 2012, the percentage of food insecure older adults increased 65% in the United States and the number of food insecure older adults increased 130%.<sup>160</sup> In 2014, 9% of households in the United States with seniors aged 65 and older experienced food insecurity.<sup>161</sup> Food insecure seniors are at increased risk for chronic health conditions, even when controlling for other factors such as income:

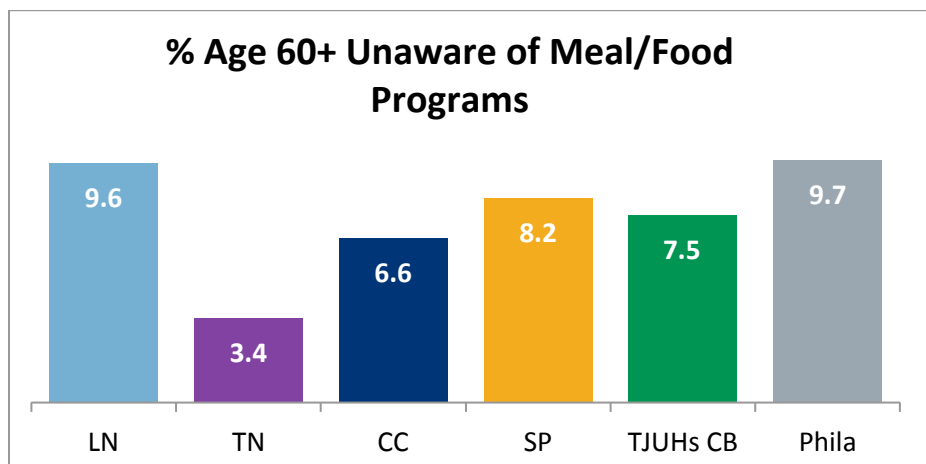
- 60% more likely to experience depression
- 53% more likely to report a heart attack
- 52% more likely to develop asthma
- 40% more likely to report and experience of congestive heart failure

Food insecure older adults are more likely to have lower intake of vital nutrients (iron and protein) in their diets compared to the food secure. Persistent food insecurity among older adults is associated with higher levels of medication non-adherence due to cost.<sup>162</sup> Food insecure older adults report tradeoffs between paying for food and utilities (60%), housing (49%), transportation (58%) and medical care (63%).<sup>163</sup>

It is important to note that one in seven older adults (13.9%) in Lower North Philadelphia cut a meal in the past month due to lack of money. This is a sign of food insecurity. Older adults in TJUHs CB area were slightly more likely than others in Philadelphia to be aware of a meal/food assistance program (92.5% vs. 90.3%).

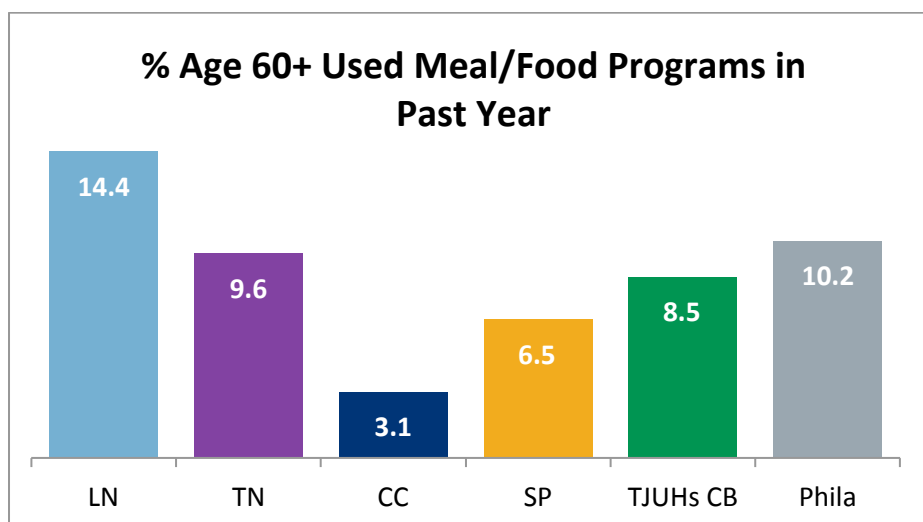


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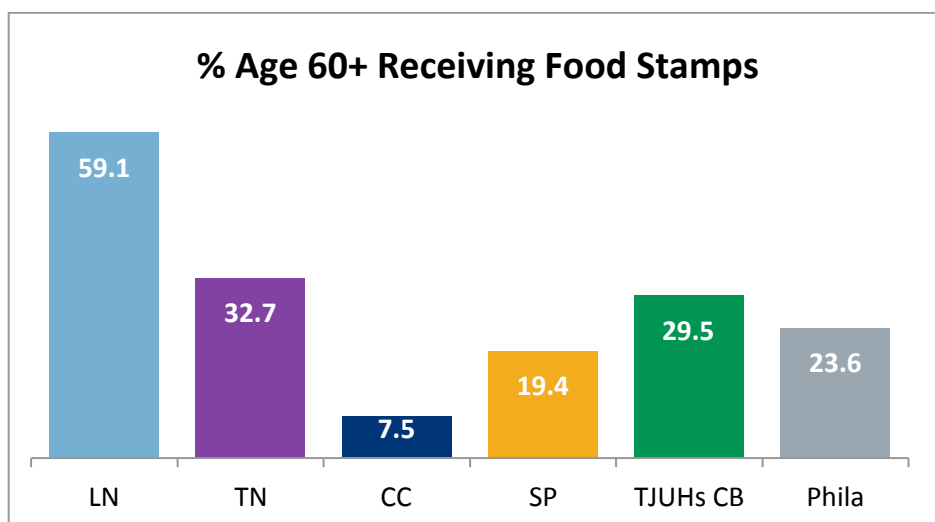


*PHMC Household Health Survey 2015*

Older adults in Lower North Philadelphia were more likely to report having used a meal or food program in the past year compared to all other TJUH CB areas and Philadelphia. They were also twice as likely to report receiving food stamps compared to TJUHs CB area and Philadelphia.

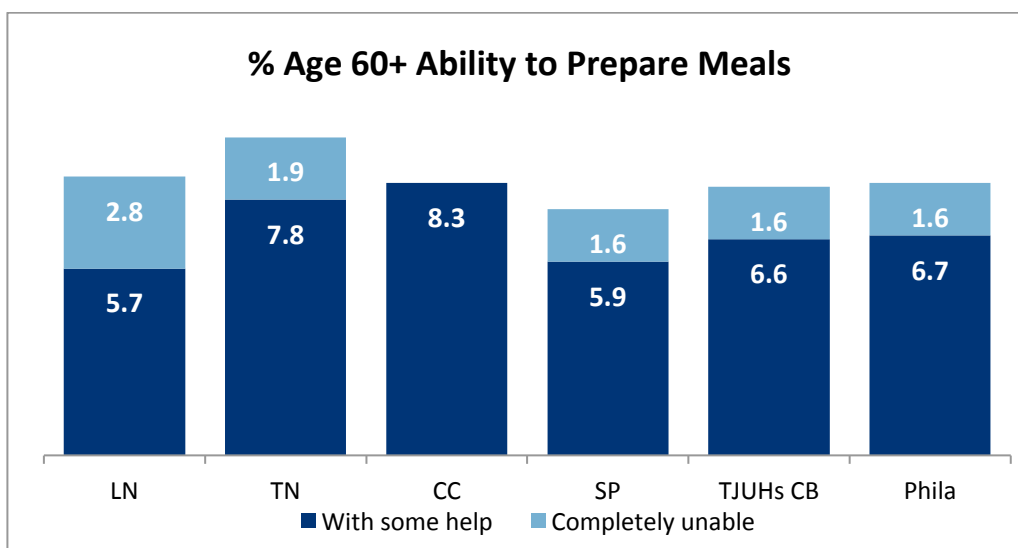


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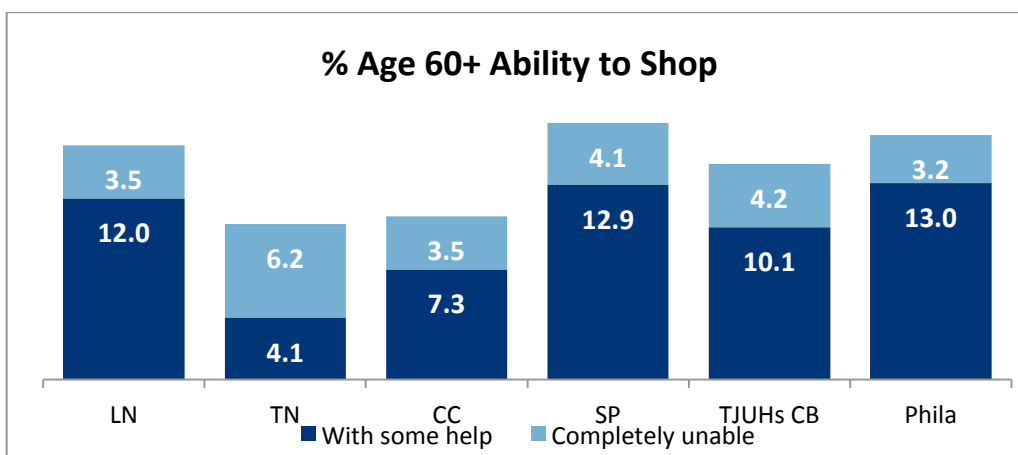


*PHMC Household Health Survey 2015*

Food security can also be impacted by mobility limitations that are more frequent among older adults. Slightly more than 8% of older adults in TJUHs CB area and Philadelphia are unable to prepare meals or require some assistance with this task. In addition, 13% of all Philadelphians are unable to shop. Seventeen percent of older adults in South Philadelphia and 15.5% in Lower North Philadelphia are either unable to shop or need assistance with this activity. Health care providers should screen for food insecurity, ability to prepare food and the need for assistance with shopping and refer to community based organizations addressing food assistance as appropriate.



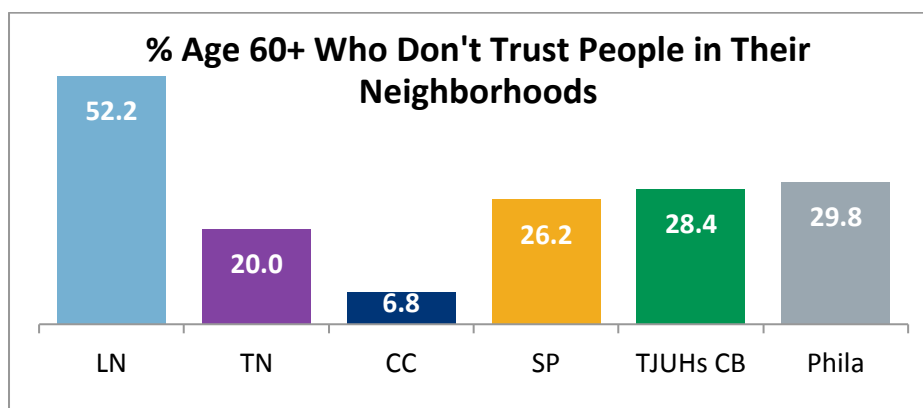
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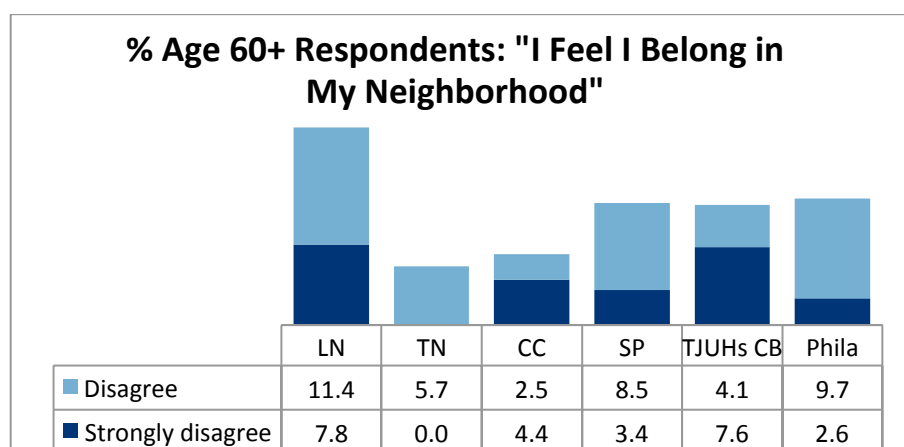
## Social Connectedness

Feeling you are connected to the community is important to prevent isolation and depression among seniors. Social networks are protective factors for health and wellness. While almost 70% of older adults in Philadelphia and TJUHs say they trust people in their neighborhood, the rates for trust vary greatly across neighborhoods with 48% of Lower North Philadelphia's older adults reporting they trust their neighbors to almost 93% of older adults in Center City. Lack of trust can limit one's ability to extend relationships that improve social connectedness and access to services.



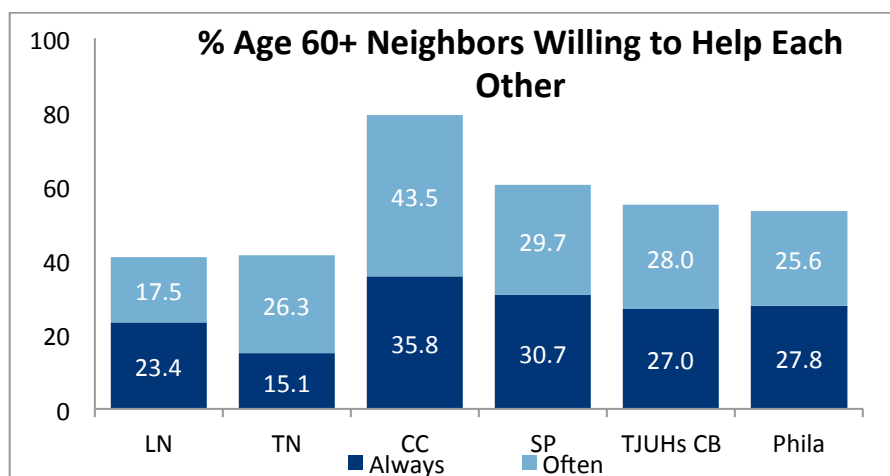
PHMC Household Health Survey 2015

The majority of older adults in TJUHs CB (88.3%) and Philadelphia (87.7%) indicate they *feel they belong in their neighborhood*. Nearly 20% of older adults living in Lower North Philadelphia disagree or strongly disagree with the statement “I feel I belong in my neighborhood”.



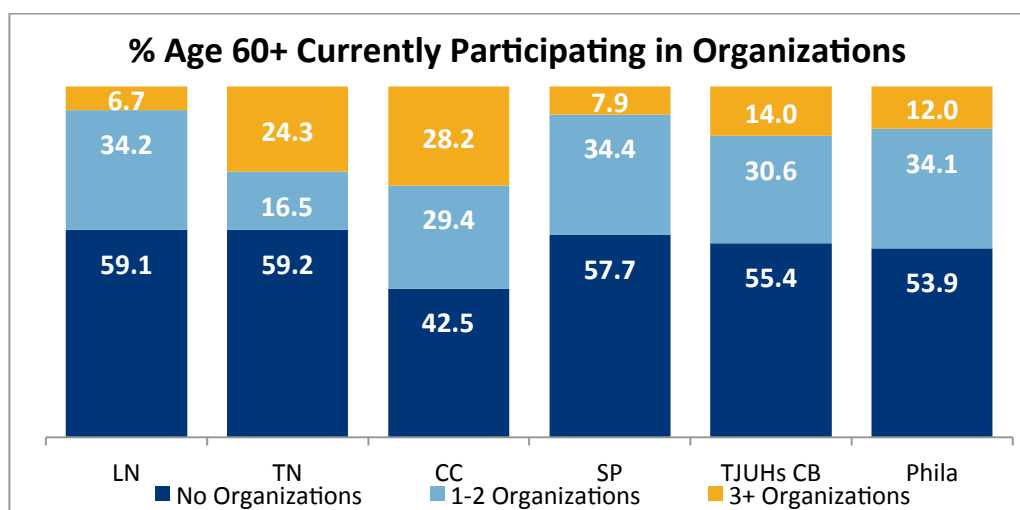
PHMC Household Health Survey 2015

Neighborhoods with high trust where people feel they belong may be more likely to help others in their neighborhood. While 55% of older adults in TJUHs CB area report that neighbors are always or often willing to help each other, rates in Lower North (40.9%) and Transitional Neighborhoods (41.4%) reflect less willingness to assist a neighbor.



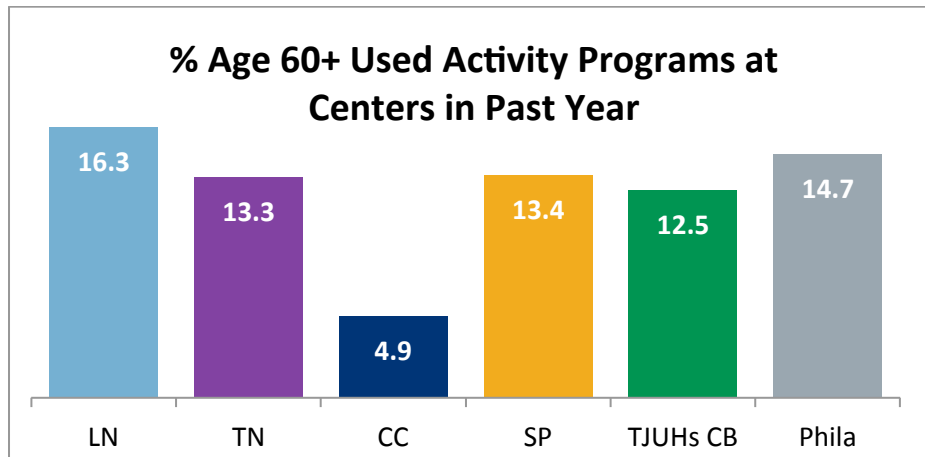
*PHMC Household Health Survey 2015*

Almost 45% of older adults in Jefferson's CB area and 46.1% in Philadelphia currently participate in at least one organization. Older adults in Center City and the Transitional Neighborhoods are twice as likely to participate in three or more organizations compared to Philadelphia (12%) and TJUHs CB area (14%).

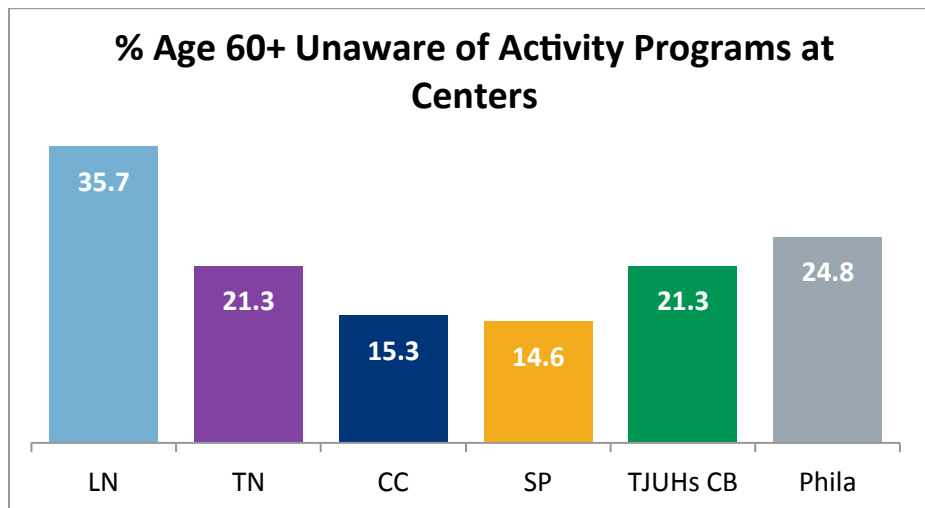


*PHMC Household Health Survey 2015*

Overall, the rate of older adults in TJUHs CB area who attended a program at a community and/or senior center was lower compared to Philadelphia (12.5% vs. 14.7%). Older adults in Lower North Philadelphia were most likely to take advantage of these programs (16.3%) compared to only 4.9% in Center City. More than 20% in TJUHs CB area are unaware of programs at these Centers. Raising awareness about these community programs could help older adults gain valuable information and provide an opportunity for socialization.

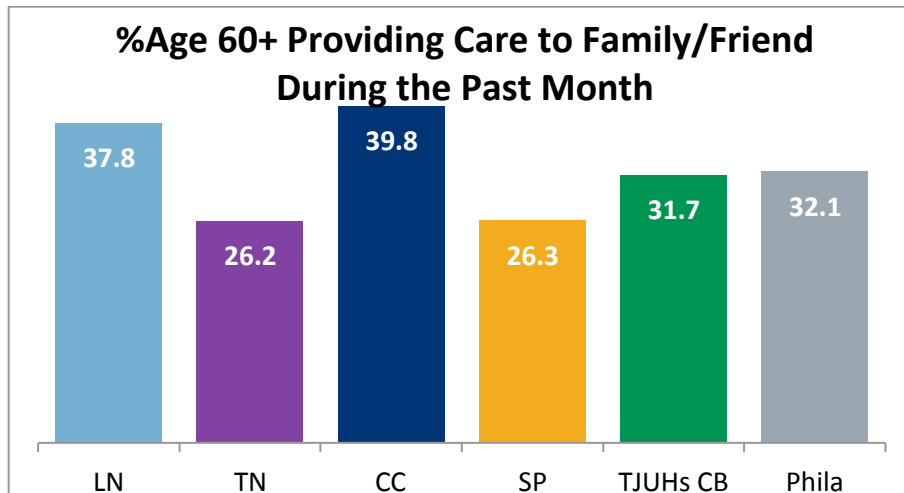


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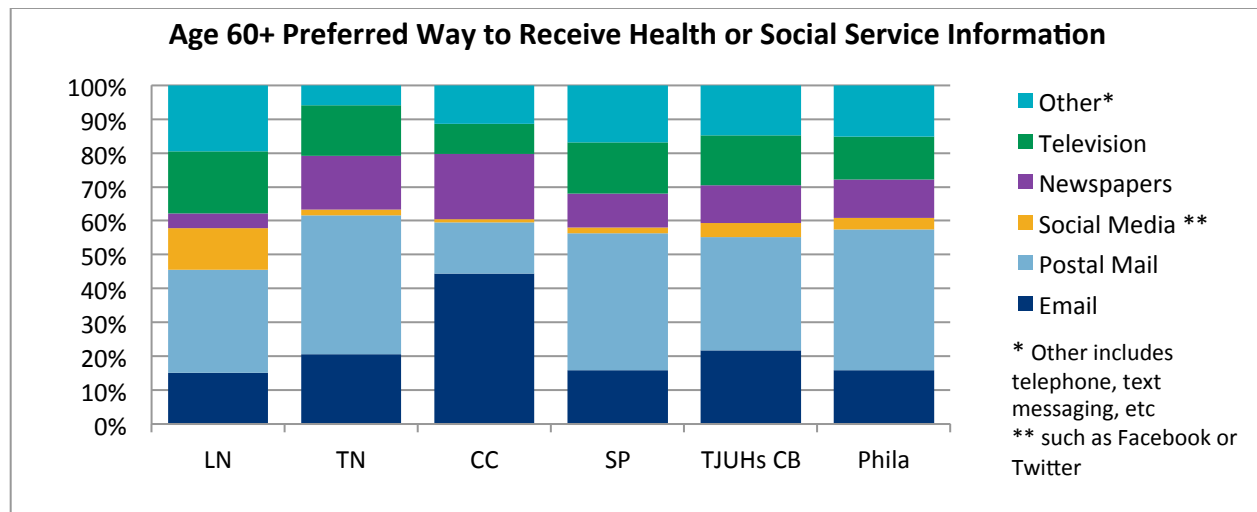
*PHMC Household Health Survey 2015*

Finally, nearly one-third of older adults in TJUHs CB areas say they are caring for a family member or friend; in Center City this is true for almost 40% of older adults. This may reflect a need for caregiver supports such as training and respite care.



*PHMC Household Health Survey 2015*

In order to raise awareness about health and social services programs available in the community it's important to understand the best way to promote information among older adults. Preferences vary across neighborhoods. Postal mail continues to be the preferred method of communication in most neighborhoods except for Center City where email is preferred.



*PHMC Household Health Survey 2015*

## Housing

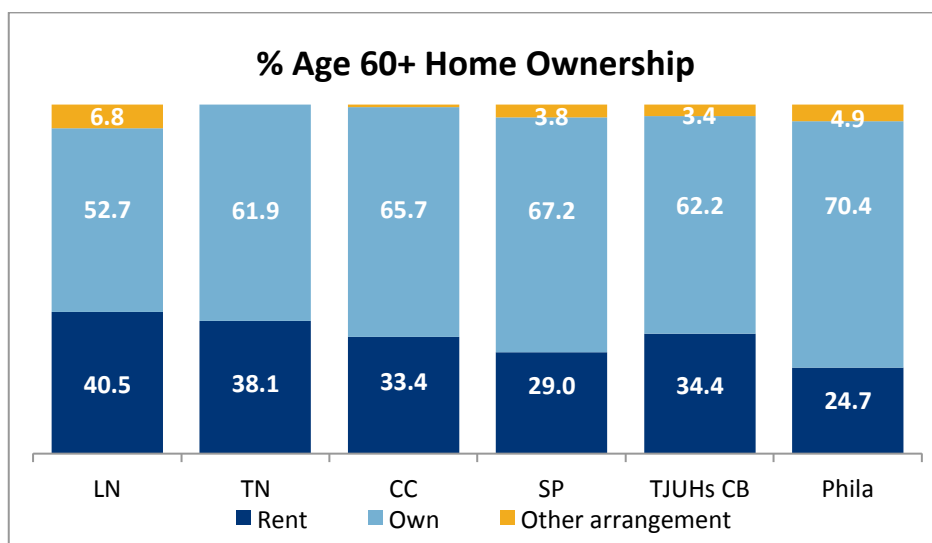
Stable, affordable housing is central to the health of individuals, families and communities. Affordable housing leaves individuals and families with more money to spend on other necessities, such as nutritious food and health care. Stable, affordable housing also provides mental health benefits due to reduced stress related to housing concerns. According to the Center for disease Control and Prevention, not being able to remain in one's home or neighborhood (housing displacement) exacerbates existing health inequalities. Low income people, women and



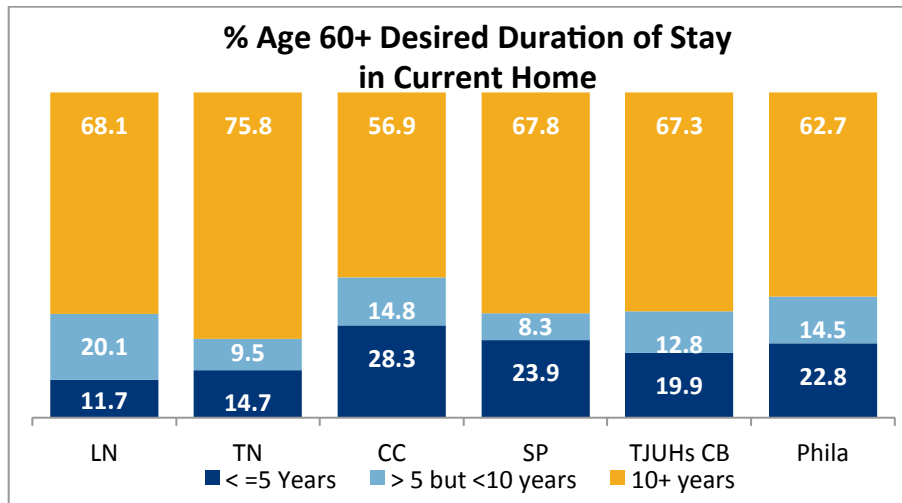
children, communities of color and the elderly are disproportionately affected.<sup>164</sup> Rising housing costs can result in cutting back on necessities, moving to poorer quality housing, moving multiple times, homelessness and disruption of social networks and social cohesion.<sup>165</sup>

Gentrification is occurring in several of TJUHs CB areas. These neighborhoods experience increased rents and taxes as a result of gentrification and can cause housing displacement of long-term renters and home owners who may no longer be able to afford to live in the neighborhood. In Philadelphia, rowhouses provide affordable home ownership opportunities for low income individual; an asset not available in most cities in the United States. However, these rowhouses are deteriorating due to age and owner's inability to maintain them. Thirty-eight percent of owner occupied homes in Philadelphia in 2012 were owned by households making less than \$35,000. Many older adults in Philadelphia are faced with home repairs that are not possible due to low fixed incomes.

For elders who want to age in place, remaining in their homes for as long as possible is important emotionally and economically. Older homes in Philadelphia have stairs and are often multiple dwellings. Having a home entrance on the first floor is often not possible. These barriers affect seniors' ability to take care of basic needs and to participate fully in the community without modifications. In TJUHs CB area 62% of older adults own their own home and two-thirds of these adults hope to remain in their home for ten or more years.

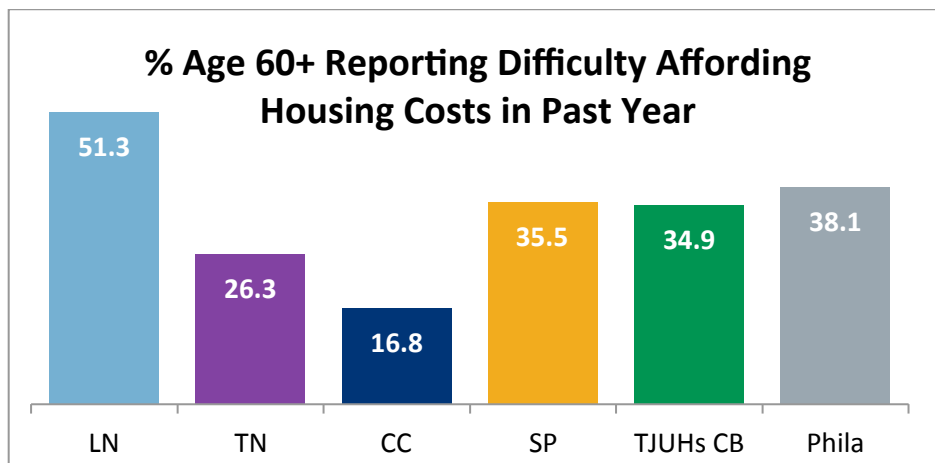


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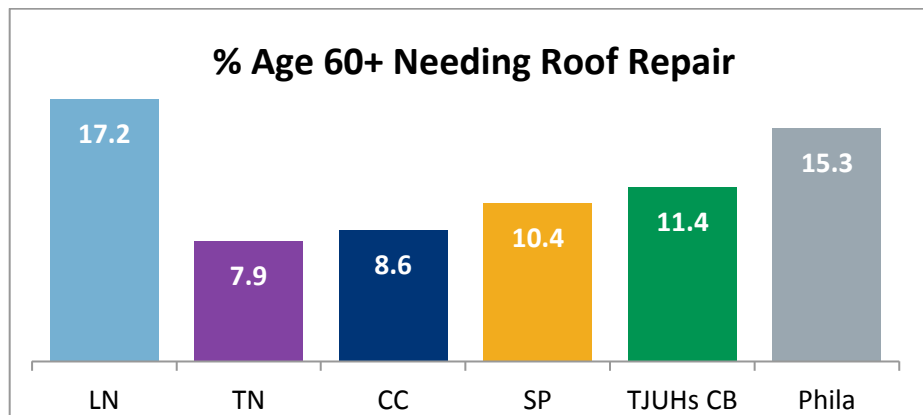
*PHMC Household Health Survey 2015*

Similar to national trends, older adults are having a difficult time affording housing costs. More than a third of older adults in TJUHs CB area had difficulty affording housing costs in the past year. In Lower North Philadelphia half of older adults reported difficulty affording their housing.

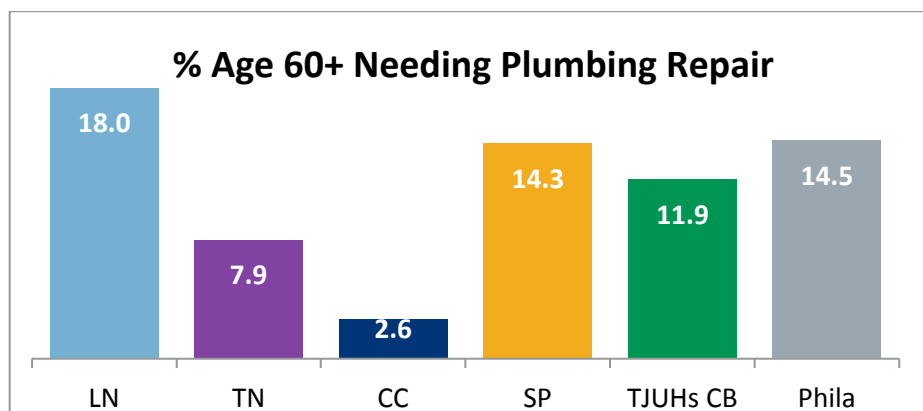


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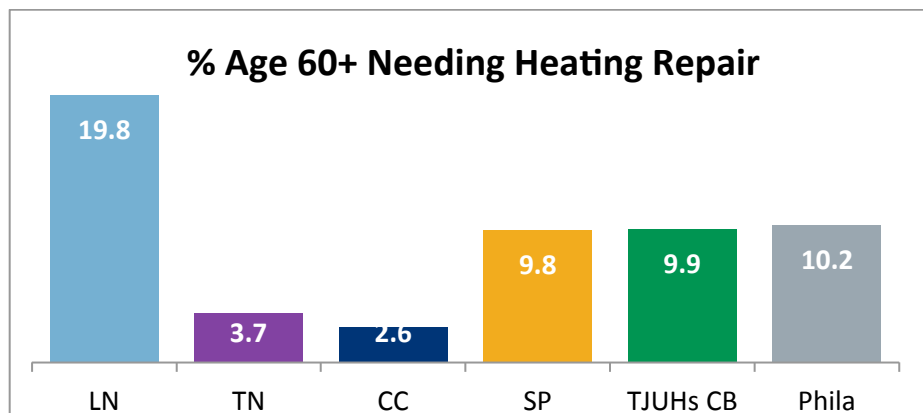
Older adults in TJUHs CB area are experiencing the need for home repairs. Almost one in 8 older home owners need their roof or plumbing repaired and about 10% of older adults need their heating system repaired. Between 17% to almost 20% of older adults living in Lower North Philadelphia report their home needs roof, plumbing or heating repairs.



*PHMC Household Health Survey 2015*

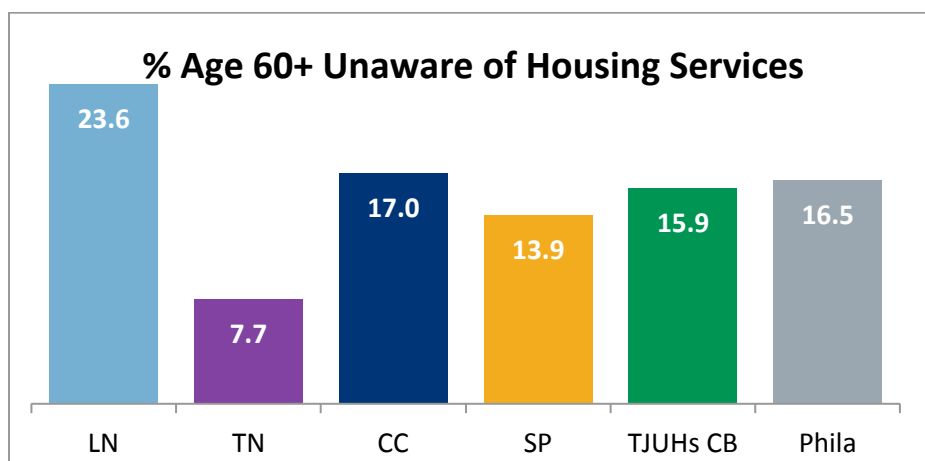


*PHMC Household Health Survey 2015*



*PHMC Household Health Survey 2015*

Despite needing housing repairs and affordable housing, many older adults are unaware of available housing services—particularly in Lower North Philadelphia where the need for repairs is high—but only 23.6% were not aware of these services. Overall 16.5% of older adults in Philadelphia lack awareness about housing services.



*PHMC Household Health Survey 2015*

The Healthy Rowhouse Initiative, Philadelphia Association of Community Development Corporations, Philadelphia Corporation for Aging, and Philadelphia Housing Authority, among others, are addressing affordable housing in Philadelphia including home repairs, and co-locating health care and social services in low-income housing.

**Issues, challenges, unmet needs and priorities identified by key informants and focus group participants related to older adults included:**

- **Well Elderly**
  - Need opportunities for socialization and places where they can be physically active safely such as community gardens
  - Need to understand what the well elderly need to stay in their homes as long as possible
  - Consider collaboration with Healthy Homes initiative
  - Older adults not using “free” wellness visit
  - Need older adult health education (HIV, healthy aging, elder abuse)
  - “Increase community norms of ‘respect for elder’ and ‘respecting aging’”
  - *Tap into Healthy Aging - Pilates, Nutrition, Wellness... Increase availability of activities that are meaningful*
- **Communication**
  - It’s harder for older people to use over-the-phone interpreters. An in-person interpreter would be preferred. Use technology like Skype
  - Consider communication and technology needs of older adults. Use tablets such as the iPad or large smart phones if using technology is necessary. Need to design technology for older adults
  - Health literacy/language – ensure that oral communication and written materials as well as websites are designed for an older adult

- **Care Coordination**

- *Need to ask people what they need and take into account their abilities. Hearing and walking differ across people. It's important to look at and consider their functional disability vs. diagnostic (disease) and the impact on quality of life.*
- *Lack of coordinated care across health system and CBOs – There is limited communication between PCA and primary care providers. Improved coordination between community based organizations like PCA and health care would be helpful in care management.*
- *Lack of knowledge of providers about community/neighborhood resources available to support discharged patients*
  - *Senior centers- center social workers would like to work with hospitals around discharge planning, particularly for high utilizers. Funding to support prevention and case management of high utilizers is needed to support this.*
  - *At discharge we should ask all adults if they are caring for an older adult to identify if assistance might be needed to help the patient and the older adult for whom they are the caregiver.*
  - *Some older adults may not get needed care or procedures because they are caring for someone else or have a pet. Need to screen for this.*
  - *Need to address the needs of elderly without caregivers. Once you are out of the hospital, who cares for you?*
- *Create “JeffCares” volunteer group and collaborate with faith-based institutions, senior housing, senior centers and others to assist older adults with chores and services needed so they can age in place safely (snow shoveling, minor home repairs such as railings, changing batteries in smoke detectors, delivering medications from the pharmacy, etc.)*
- *Medication adherence - There are older adults who refuse to take medications. What can they do to regulate themselves without medication?*
  - *Limited income: people stop medications and don't see doctor because they need to pay for housing first*
  - *Work with doctors to be more effective in follow-up with medicines, also less expensive medications*
  - *Improve medication and treatment adherence through collective/collaborative interventions that increase understanding of what patient needs to do*
- *Mental health resources for older adults exist but are limited*
- *Co-located health and social services in low income older adult housing is desired. Older adults in low income housing may have difficulty scheduling appointments...Our residents have high rates of diabetes, asthma, cardiovascular disease and need education to help them learn to manage the disease. Programs in low income housing would be beneficial.*
- *Access to Social services: “Some people who don't have family caregivers may not get social services”*
  - *Overwhelming for older adults to do themselves or they are unable to do and there is limited social work available to assist older adults*

- Older adults may not reach out because they want to remain in their home
  - *“Home nursing, PT, OT – a lot of referrals are made to them but they don’t communicate back about what they find”*
  - Care providers make geriatric assessment plans but Jefferson nursing, PT, OT don’t go out to the home to see home conditions. Need home visits.
- *Once someone has had a stroke how do we deal with the quality of life of survivors when they go home with a disability? How are they managing?- Who is caring for them?*
- There is a need for care managers in the community
- Need more assistance with non-English speaking residents (refugees) to navigate the system. *While our agency has been doing this, we are now understaffed so we can’t physically escort any longer.*
- **Social Isolation**
  - *Elder care and other resources for elderly: many elderly live alone and need help in home and with meeting basic needs e.g., grocery shopping, getting and taking medication, getting to physicians. Family members are busy with their own lives*
  - *In this community family and older adults live near each other. There is support, but elders are aging in place and cared for by their aging children. Some may be isolated (shut-ins) and need geriatric care, home care and have difficulty traveling*
  - *The hospital has a volunteer visiting program for those without families. We should consider something similar for those who are aging in place and isolated.*
  - Decrease isolation *“it just mounts”*
  - Build social networks to assist older adults: *“How do we harness and use talents and skills and make them more part of fabric of community?”*
  - Connect young and older people (intergenerational programming)
    - Create Barter system to help meet needs of elders and younger adults
  - Support services – *social support network for older adults who are in better health but need meds pick-up, etc.*
- **Interpersonal Violence**
  - *An older adult or disabled person is dependent on spouse for food, shelter income, etc., therefore, can’t leave. Caregivers withholding medications key informant*
- **Pain Management**
  - Need a holistic way to address pain management that includes Non-medical approaches such as Mindfulness meditation
  - Conduct research on the impact of mindfulness meditation and yoga (non-medical approaches) on chronic pain management among the urban complex Medicaid population.
  - Focus on decreasing opiate use in the population and improving functional ability

- **End of Life care - Palliative Care and Hospice and Advance Directives**
  - Lack of understanding of palliative care and hospice. Need for community education about these topics (focus – faith based for all ages)
  - Need to raise awareness among care providers and the community about end of life issues
  - Need to understand the cultural beliefs associated with end of life
- **Care Giver Support**
  - Caregiver education and support- need support groups for caregivers- *Caregivers need help and support to deal with stress*
  - *Build cultural competence around dealing with grief- both community and patient-loss.*
  - Provide support for patients w/ dementia- when families face this it throws things into chaos
  - Caregivers need support, education, respite – *“not enough support for them – can become depressed – We should help loved ones get health care at same time as patients. Create appointments that see patient's caregiver “dyads”*
    - Hold Dyadic visit- (caregiver and person with dementia get their care at the same time)
- **Transportation to offices and hospital**
  - *The elderly need help getting to the doctor, getting groceries, getting medications. They need support in the home so they can remain in their homes*
  - *Transportation is a priority; Southeastern Pennsylvania Transportation Authority (SEPTA) has Customized Community Transportation (CCT) Connect and the majority of the time it works well, but we are getting complaints about long waiting times for the van. Also, bus shelters and benches are needed to support elderly taking public transportation. The City is starting to address this.*
    - Logisticare - Medicaid – Some caregivers/patients may not know about CCT Logisticare. Completing the paperwork for CCT is problematic. It's difficult for some families to complete the application and work with CCT
    - Patients can wait 4 to 6 hours to be picked up after an appointment. Sometimes patients may be on the bus for almost two hours. Need to raise awareness about other transportation services such as Home Helpers.
    - *CCT will drop the rider off and leave them not checking to see if they are safe (to stay on schedule). Frail elderly may be left out in cold if needed paperwork was not completed.*
    - *“I leave at 6:30 and my patient is still in the waiting room waiting for CCT”*
  - Access issues to the subway. Lack of elevators
  - Non-English speakers can have problems taking buses. Raise awareness that SEPTA is free for people aged 65+ and that *Travel Trainers* help people learn how to use public transportation. Increase awareness of this federally funded program by the National Center for Mobility

- Train SEPTA and CCT drivers on needs of elderly (ramps, canes, cognitive impairment, mental health issues)
  - Uber was discussed as option by several people and is being used at different locations (some hospitals use already; Sarasota Memorial Hospital uses Uber) City Life clinic takes people to and from doctor appointments.
    - Penn's Village has contract with Uber: \$5 flat fee for those who qualify to doctor appointments
    - Shuttle vans suggested as a way to get people to appointments
  - Cost of transportation can be a barrier
  - *CCT won't pick you up if you have bed bugs. This prevents older adults from seeing doctor*
- **Education**
    - Dementia Friendly Cities – businesses and those who work with seniors in the community need training to help those with dementia
    - Cultural competence training for health care providers working with older adults
  - **Food insecurity** (see section on food access and security)
    - Families needing assistance are often headed by a grandparent - *"Invisible hunger"*
    - *Long wait lists for Meals on Wheels is a barrier*
    - *Sometimes older adults share their food with their pets. Raise awareness about food programs for pets*
  - **Age Friendly Housing**
    - *Not enough housing available for people with a disability. Housing stock that is accessible is not held for people with disabilities.*
    - Adaptive modification housing program has funding but is oversubscribed. Wait time for housing assistance is long.
  - **Fall Prevention**
    - *Fear of falling causes elders not to want to move. This then actually increases their risk of falling; we need to keep people safe at home by minimizing their risk of falls. Mild cognitive impairment and medications can increase risk of falls in the elderly. We need to assess fall risk more regularly and do home adaptations to reduce falls. (focus group)*
    - Fear of falling prevents seniors from taking public transportation.
      - *You have to actually be able to get your hand above your head to hold the pole. I don't know why they're made that way. They're so high. I have to get on my tippy toes to be able to hold it securely (In response to fear of falling among older adults). (focus group)*
      - *I take the bus to work and its drives me crazy that people don't get up for older people that get on the bus. It drives me crazy.(focus group)*
      - *A lot of elderly people are scared to fall. Bus rides can be kind of very scary, very crowded. Elderly people are scared to get on a bus and take the chance of falling or have to stand up. I've never seen anyone fall, but I*



*can see it being a deterrent for elderly people. I can see them saying “I can’t take the bus because it’s too difficult to sit down or get to a seat safely. (focus group)*

- Support citywide “give up your seat for elderly campaign”
- Increase awareness about safer ride times to ride SEPTA (e.g. 10-2 as safe ride time)
- Physician practices could try to schedule more appointments for elderly during safer times to travel (10-2). *Telemedicine and home visit appointments need to occur to prevent falls/trauma in the elderly. Need to see what the patient is taking at home (medications that might impair cognitive functioning, over medication and drug interactions).*
- *#1 reason people come to Home Helpers is falls*
- Community training: *We need to know what exists already, and how can we improve training. Senior Centers do an education class once a year; could we do fall prevention education programs more often in Senior Centers?*
- Consider screening older adults for fall risk during an ED visit
- Create safer environments for older adults (review the National center for Mobility recommendations). Work with the City Planning Department on pedestrian safety for older adults in South Philadelphia.
- Explore integrating orthopedic trauma services with geriatric practices.
- Increase osteoporosis screening and coordinate with Abington.
- Fall prevention should include: (1) Education of elderly community about falls (2) Long term medication management and monitoring- (long term management) (3) Balance, coordination, and exercise programs in the community (4) Home assessment and modification.
  - Clearly define multi-disciplinary teams to get out in community who address elderly issues and provide in-home falls assessments (OT/PT/pharmacy students, medical students/ other students)
  - Conduct medication reviews

## • **Aging Services and Resources**

- Need to increase awareness about resources/services available to assist older adults and their caregivers with disease management, behavioral health issues, safety concerns, housing, food security, etc. (the Aging Network; pharmacy vital signs card; PCA Aging Helpline provides assistance in 22 languages)
- Need to centralize information so that it is available to community organizations, community residents and caregivers, and health care.
- *...we used to have community centers around but there is a terrible lack of community centers ... You could go in when you had a question about something health related...But if you had the community center and you could say this is what I got going on, someone can research an organization that would get them free mammograms or a limit, or something health related that would cost them very little. I guess if we had a representative from Jefferson that can partner with, ...I’m an AARP member...So I would say, if you had a representative of Jefferson that could reach out to organizations like AARP or Allegheny West is a big organization in 19132...So I would say if you guys, if we could have an employee*

*that's familiar with those types of things, that could be there one or two days a week, if Jefferson would allow, that you could reach out to the community...*

- *I think one of the things you mentioned earlier is how can employees be more effective in helping. And I think that one of the things is us becoming more aware and knowledgeable about what resources are there. A lot of times, if we're living in our neighborhood we can be a resource to our community members, to where those community resources are and how to obtain those. We need to be more knowledgeable about how to navigate the system for the other people who might not know*

**Based on internal and external key informants, focus groups, existing relationships and programs, and secondary data, actions addressing older adults may include:**

- 1. Continue to participate in the South Philadelphia Aging Collective, which consists of organizations serving older adults, to address needs of seniors.**
- 2. Develop care coordination initiatives with Practice Design and Care Coordination team and community organizations**
- 3. Tie Community Health Workers to hospital discharge and opportunities for care coordination with Practice Design and Care Coordination team and community based organizations.**
- 4. Transportation – Explore transportation options to and from hospital for appointments**
- 5. Explore strategies to address older adults concerns about using public transportation such as enforcing giving up seats to seniors, training for SEPTA and CCT about the needs of the elderly and promoting 10 to 2 as preferred appointment times when older adults can use public transportation more safely.**
- 6. Food security - Screen patients for food security at discharge. When signing patients up for MA, also sign them up for food stamps. For patients screening positive, refer to community food assistance programs**
- 7. Educate seniors about fall prevention, chronic disease management and healthy lifestyles. Coordinate with TJUHs Departments already doing education, fall prevention, and screening programs for older adults, such as the Center for Injury Prevention Research, the Institute for Healthy Aging and Supportive Care, JHN Stroke Screening, TJU Nursing, Breast Screening Program, Nurse Magnet program, Pharmacy, Physical Therapy, etc.**
- 8. In partnership with Methodist and the South Philadelphia Aging Collective conduct an assessment of the health and social needs for aging in place for south Philadelphia older adults**
- 9. Provide home visiting for isolated seniors**
- 10. Initiate programs that support caregivers to reduce stress and burnout**
- 11. Educate the community about Palliative Care and Hospice and distribute Hospice Photonovel when available**
- 12. Raise awareness about opportunities for socialization and physical activity**

- 13. Develop a more coordinated approach to increasing awareness about health and social services/resources available for older adults and their caregivers**
- 14. Coordinate employee volunteer opportunities to provide needed assistance to older adults in TJUHs CB area. Partner with community based organizations including Block Captains, community centers, PCA and faith-based institutions.**
- 15. Provide cultural competence training for health care providers and community organizations serving older adults on the needs of LGBT older adults, older adults with cognitive impairment/dementia, ageism, language assistance, health literacy**
- 16. Address communication needs of older adults pertaining to use of technology, health literacy and language translation.**
- 17. Address use of pain medications (opiates) among older adults and support efforts for appropriate disposal of unused medications.**

## ***Immigrants and Refugees***

The Greater Philadelphia region's immigrants and refugees account for 9% of the area's current population. In Philadelphia 12.7% of city residents are foreign born. These immigrants and refugees come from around the world and most have arrived in our region since 1990. Within this immigrant and refugee population are many recent arrivals with even greater vulnerabilities: some seeking asylum or without current status, those with limited English proficiency, and many experiencing health challenges, creating barriers to daily functioning. Philadelphia is one of 200 cities nationwide known as a "sanctuary city," which means a mayoral Executive Order bars Philadelphia police and prison officials from cooperating with Immigration and Customs Enforcement (ICE) agents. More than 2,000 refugees resettled in Philadelphia in the past few years, 200 Syrian refugees are expected in the coming 12 months.

### **Background**

Multiple studies measure disparities, evaluate obstacles, and suggest approaches to improving the health and well-being of immigrant and refugee populations. The following are findings from some of these reports.

A 2015 National Academies Press document, *The Integration of Immigrants into American Society*,<sup>166</sup> reports that immigrants are at a distinct disadvantage compared to the native-born when it comes to receiving adequate and appropriate care to meet their preventive and medical health needs. This finding extends the research on undocumented immigrants, who were found to be less likely than native-born or other immigrants to have a usual source of care, visit a medical professional in an outpatient setting, use mental health services, or receive dental care. The ACA should improve this situation for lawfully present immigrants and naturalized citizens, but the undocumented are specifically excluded from all coverage under the ACA. In addition, the undocumented are not entitled to any nonemergency care in U.S. hospitals. Legal status therefore restricts access to health care, which may have detrimental effects for all immigrants' health. Per capita health care spending is lower for all immigrants, including the undocumented, than it is for the native-born.

Despite its importance, the report documents that insurance coverage is not the sole barrier to access to health care for immigrants. Hospitals, clinics, and community health centers may not have the appropriate staffing and capabilities to adequately communicate and serve some immigrant groups. Costs for health care including medication are high, and immigrants, especially those without health insurance coverage, may not have the resources to pay these costs. Some immigrants may work at multiple jobs just to pay for their daily living expenses and are unable to find time to seek care for their health problems. Many immigrants may not speak English or may not speak it well enough to negotiate access to needed health services. Language barriers can also limit knowledge about community services and reduce effective communication between patient and care provider.

Despite the large and growing immigrant and refugee population in Philadelphia and the region, these groups face numerous barriers to obtaining health insurance to get the care they need including language access, lack of linguistically accessible materials and lack of understanding

about the ACA Marketplace, low-incomes, lack of employer coverage, lack of existing coverage, lack of sources of care, and high demand for services at agencies that require increased resources to meet the increased needs of the community.

According to Migration Policy Institute's 2013 report on Health Care for Immigrant Families,<sup>167</sup> low-income immigrant families are twice as likely to lack health insurance coverage as their citizen counterparts. Beyond access to insurance coverage, immigrants are significantly less likely to identify a regular source of primary care. Additionally, some of the most well-known regular sources of primary care among immigrant communities in Philadelphia, the City Health Centers, are incredibly overburdened with wait times of up to 10 months for an initial new patient visit. Furthermore, patients and families often face language barriers when they attempt to access care. The process of calling to make an appointment in a foreign language may present a seemingly insurmountable barrier to care. These factors create high hurdles for clients to overcome, resulting in many forgoing needed care, overusing emergency rooms, and increasing the burden of adjustment to life in Philadelphia.

In a study of Primary Health-Care Delivery Gaps Among Medically Underserved Asian American and Pacific Islander (AAPI) Populations, Philadelphia had the lowest MUAC index score (28.4) among the 20 counties studied with AAPI populations greater than 10,000, indicating the least access to primary care. A MUAC index is based on the Medically Underserved Area concept but has been adapted to provide a method appropriately tailored to capture the underserved AAPI population. The authors conclude that the MUACs identified clearly lack adequate primary care and other community services to support underserved AAPIs. Additional health center resources and culturally competent primary care providers are needed to adequately serve this population.<sup>168</sup>

The Department of Health and Human Service's Office of Minority Health January 2012 Report - *Integrated Care for Asian American, Native Hawaiian and Pacific Islander Communities – A Blueprint for Action*<sup>169</sup> states that disparities exist in quality of care for Asian American, Native Hawaiian, and Pacific Islanders (AANHPI) that is a detriment to the overall health and mental health of their communities, and that integrated care must take a public health approach, be holistic, work across the life span, include prevention and early intervention, and be person-centered, strength-based, and recovery-focused.

National health surveys such as National Health Interview Surveys (NHIS) and Behavioral Risk Factor Surveillance System (BRFSS) are the preferred methods of gathering information about the health of the population. In 2004, Public Health Management Corporation (PHMC) oversampled the Asian community in Philadelphia to gain a better understanding of their health needs. However, this survey was not conducted in any of the Asian languages. Therefore, only Asian residents who spoke English well enough to do a 30 minute survey and had a telephone could participate. In 2007, the Southeast Asian Mutual Assistance Association Coalition (SEAMAAC) conducted a community-based health survey (CBHS) of Southeast Asians in South Philadelphia. This survey was conducted in native languages by trained SEAMAAC staff that are trusted by the community.<sup>170</sup>

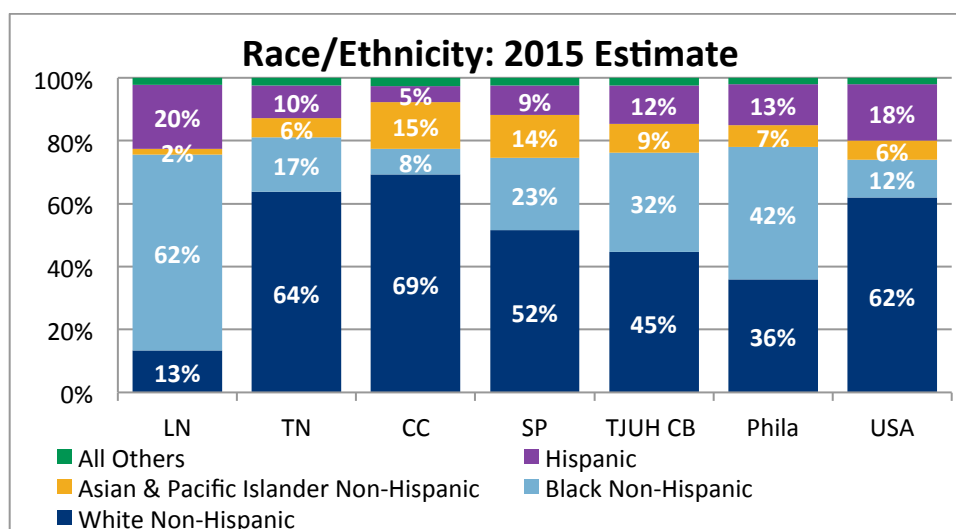
Significant differences were found between the standard community health survey (SCHS) conducted by PHMC and the CBHS conducted by SEAMAAC. Participants from the CBHS conducted by SEAMAAC reported: higher rates of poverty (50.5%) and non-citizenship (57.2%), limited English proficiency (94.3% speak a language other than English at home; 2.4% say their main language is English and 22% speak no English), low rates of employment (56%), lack of education (43% did not graduate from high school), and lack of health insurance (48%). The top five reasons reported as to why the respondent did not have insurance were:

- Not eligible due to health or other problems (58.2%)
- Could not afford/too expensive (13.5%)
- Employer did not offer (11.8%)
- Respondent was “healthy” (3.8%)
- Lost public program (Medicaid/Medicare) coverage (2.9%)

The findings demonstrate that there are a number of socioeconomic and health access issues in Philadelphia’s Southeast Asian community that were understated or unrecognized by the SCHS. Efforts must also be made to continue comprehensive research on this underrepresented population.<sup>170</sup>

## Demographics

The 2010 Census reports 177,423 foreign-born residents in Philadelphia, including 74,000 foreign-born Asian immigrants and refugees,<sup>171</sup> an estimated 50,000 African and Caribbean immigrants and refugees,<sup>172</sup> and 53,000 from Latin America.<sup>172</sup> TJUHs CB area encompasses some of the most diverse communities in Philadelphia, particularly the Asian community. The percentage of foreign born residents ranges from 1.2% in zip code 19132 (Lower North west of Broad St.) to 20.5% in zip codes 19102 (Center City west) and 19148 (South Philadelphia east of Broad St.), and 22.3% in Center City–Washington Square West/Chinatown.



*Census 2010 with Truven Projections for 2015*

Including US-born and foreign-born, there are nearly 110,000 Asian Americans in the City of Philadelphia, including 32,773 Chinese, 16,268 Vietnamese, 9,912 Cambodians, 2,222 Indonesians, and 1,350 Laotians.<sup>173</sup> From 2008 through 2013, 713 refugees from Burma and 1,086 refugees from Bhutan (total 1,799) were resettled in Philadelphia.<sup>174</sup> Many of these refugees resettled in South Philadelphia. As of 2015, organizations working with resettlement estimate there are more than 1,000 Burmese and almost 2,000 Bhutanese refugees living in South Philadelphia. Additionally, approximately 250 newly arrived refugees resettle in Northeast Philadelphia each year, joining over 2,000 who have arrived in the last five years. These refugees come from Iraq, Bhutan, Eritrea, Sudan and Democratic Republic of Congo.<sup>173</sup>

Philadelphia is now home to one of the largest new African and Caribbean immigrant communities in the United States. Southwest Philadelphia is known as “Little Africa” where 10,000 African immigrants represent 11% of its population. According to the 2010 Census, between 2000 and 2010 the African (many from Ghana, Ethiopia, Liberia, Nigeria, and Sierra Leone) population of Southwest Philadelphia tripled.<sup>175</sup> Almost 29,500 Africans and more than 24,200 Caribbean natives reside in Philadelphia. This includes a growing Malian, Ivorian and Senegalese community in Southwest Philadelphia. Additionally, an estimated 30,000 Haitian immigrants reside in North, Northeast, and West Philadelphia.<sup>176</sup>

The Asian community in Philadelphia represents about 7.0 % of the total population. Approximately 39,000 Asian individuals live in TJUHs CB area. Within TJUHs CB area, the majority of Asian residents live in South Philadelphia (25%, estimated 24,500 individuals) and 15% in Center City (estimated- 8,375). The Asian community in Center City is predominantly of Chinese descent, while in South Philadelphia residents include immigrants from Vietnam, Cambodia, Laos, Indonesia, as well as newly resettled refugees from Burma, Nepal and Bhutan. In the next five years, the Asian community is expected to increase by 8%.<sup>8</sup>

In Philadelphia, 26% of Asians live below the poverty level; 47% are low income; 47% have limited English proficiency; 70% aged 25+ have a high school education or GED; and approximately 90,000 (82%) speak an Asian or Pacific Island language at home. Chinese and Vietnamese Americans have significantly higher rates of limited English proficiency (LEP) than all other racial and ethnic groups (61% and 58% respectively). More than 4 in 5 Asian American seniors in Philadelphia have LEP.<sup>173</sup>

The Hispanic community, predominantly from Mexico, Puerto Rico, and Central America, make up 9% of the population of South Philadelphia. Of these, 24% do not “speak English well” or “not at all.” Fifteen percent of individuals between the ages of 18-59 have incomes below the poverty level, and 36% are uninsured. According to the Philadelphia Department of Public Health, indicators for which Hispanics have the poorest health outcomes include self-reported poor or fair health, unemployment, poverty, childhood obesity, teen births, forgoing care due to cost, colon cancer screening, and adult mental health. In the next five years the Hispanic population in South Philadelphia is expected to increase by 30%.<sup>8</sup>

Many restaurant workers from Mexico and Latin America reside in South Philadelphia. The Restaurant Opportunities Council (ROC) reports that the restaurant and food service sector is the largest sector of the American economy. Currently 10 million people work in this sector and

Philadelphia is the nation's 5<sup>th</sup> largest restaurant industry with 140,000 workers. Half of the workers are women and people of color and at least 40% of the workers in the industry are undocumented immigrants. The median wage in the industry is \$16,000 per year. The "tipped wage" in Pennsylvania is \$2.83/hour. The Department of Labor recently reported that of the 10 lowest paid jobs in the nation, five of those lowest paid jobs are in restaurants.<sup>177</sup>

ROC finds a high rate of work place injuries among restaurant workers, yet:

- 90% of workers in this sector lack the option of getting health care through their employer
- 93% do not have paid sick leave
- 65% of them report handling or serving food while sick.

There has been an increase in the access to health care among ROC's members in the last year as many fresh out of college restaurant workers are able to stay on their parent's health care due to the Affordable Care Act. The people that will likely not have health care are young adults 26 years old and older without children and undocumented immigrants.

## Jefferson Involvement

The Department of Family and Community Medicine (DFCM) provides care to refugees in its Center for Refugee Health. Since 2007, The Center has provided health care services to over 1,400 refugees with over 5,000 office visits. Jefferson Department of Family and Community Medicine is committed to not only provide services to this population, but to use the opportunity to train family medicine residents and medical students. Refugee health care training, composed of clinical experiences and didactic lectures, is taught during all three years of family medicine residency.

The Center for Refugee Health has seen over 1,400 newly arrived refugees to date. There was a decline in 2015 because of the Keystone First cap on new patients seen at Jefferson.

Year	# Refugees
2008	77
2009	104
2010	173
2011	236
2012	242
2013	245
2014	196
2105	133



The major countries of origin of refugee patients seen at Jefferson are:

Country of Origin	# Refugees
Bhutan/Nepal	391 (28%)
Iraq	385 (27%)
Myanmar	259 (18%)
Eritrea/Ethiopia	83 (6%)
Congo	54 (4%)

Almost half of the refugees seen at the Center reside in South Philadelphia (highlighted):

Zip Code	% Refugees
19148	44%
19149	17%
19111	8%
19142	4%
19147	3%

Refugee Health Partners (RHP) was founded in the spring of 2007 by Thomas Jefferson University medical students and participation is open to students from all of its health professions colleges. The student-run organization was launched in response to a growing need to provide care for a burgeoning refugee population in Philadelphia. During the initial years, RHP initiated community outreach programs including partnerships with newly arriving refugee families to help them assimilate by organizing flu clinics, health fairs, health education classes, and picnics with refugee communities.

DFCM and RHP are founding members of the Philadelphia Refugee Health Collaborative (PRHC), which is a regional coalition consisting of Philadelphia's three refugee resettlement agencies and eight refugee health clinics. The core mission of the Collaborative is *to create an equitable and sustainable system of refugee health care in the Philadelphia region that ensures a consistently high standard of care for all newly arrived refugees and supports their long-term health and resettlement*. Each year, PRHC provides domestic health screenings, primary care (including newborn, pediatrics, adult medicine, geriatric, obstetric and gynecologic care), and access to laboratory, imaging, and subspecialty services to 800 newly arrived refugees. PRHC also provides ongoing primary care and women's health services to established refugee patients.

The Philadelphia Refugee Mental Health Collaborative (PRMHC) is a group of resettlement agencies, mental health providers, physicians, and arts organizations working to link refugees in Philadelphia to culturally and linguistically appropriate mental health care. TJUH, a member of the collaborative, provides assistance with research to better understand the needs of refugees as they transition to their new lives in Philadelphia. The PRMHC hopes to strengthen ethnic communities and increase receiving health providers' capacity to work with new communities using culturally-resonant methods. The PRMHC was founded in 2011 and is led by Lutheran Children and Family Service. The PRMHC uses a person-first, trauma-informed, approach to help families process past exposure to violence and current resettlement stress through therapy

referrals, educational empowerment, support groups and community-building arts projects. Programming uses a holistic and wellness-focused model to promote resilience and preserve the cultural assets of new refugee communities. Through a partnership with The City of Philadelphia's Mural Arts Project public and community arts program *Southeast by Southeast*, the program operates out of a reclaimed storefront community center in Southeast Philadelphia. Philadelphia Refugee Mental Health Collaborative Project priorities include:

- Cultural preservation
- Community-based arts
- Clinical art therapy
- Health and service provider training
- Network building
- Research and advocacy
- Community building
- Screening and referrals
- Support for community leaders

## **Elderly Refugees**

A recent study identified the life issues that cause resettled elderly refugees to experience stress and determine the types of programs they need to improve their quality of life. A convenience sample of 6 Iraqi and 6 Bhutanese refugees age 60 and above, who had been resettled in the past 3 years, were interviewed in their homes in Philadelphia. The interviewer explored five domains: 1) demographics; 2) health and functional status; 3) social roles and activities; 4) sources of stress since immigrating to the U.S; and 5) knowledge of and access to programs for seniors. Language barriers, difficulty managing health conditions, and mobility issues emerged as the most significant problems among participants. Investigators determined that these challenges lead to two larger, overarching issues, including chronic dependency on family members and social isolation. Based on participants' responses, key informant interviews, and previous research, recommendations for resettlement agencies were generated and include community-based services, such as a senior center for regular programming, the specialization of English as a Second Language (ESL), health education classes, and the use of community health workers. Recommended immediate next steps involve strengthening partnerships between resettlement agencies and the aging services network in Philadelphia, cultural competence training for providers, and future research involving the caregivers of elderly refugees.<sup>178</sup>

**Issues, challenges, unmet needs and priorities identified by key informants and focus group participants related to refugee and immigrant health included:**

**Also refer to Section of Culture and Language**

- **Demographics**
  - Undocumented immigrants are a challenge (key informant)
  - Undercounting of immigrant population in census

- *"Refugees and immigrants don't like to participate in the census. They fear 'politically linked activities' and they think the census taker is 'working for government' and can't be trusted." (key informant)*
- Undocumented Mexican community is large. Mexican consulate helps coordinate health services (key informant)
- Syrian refugees expected to arrive in a few months (key informant)
- **Hispanics** (key informants)
  - Congreso de Latinos Unidos has case managers who can help clients with special needs (HIV, kid with special needs) and they can accompany to doctor's visits
  - Health Partners and Keystone First are trying to put their CHWs into primary care to help their patients
  - Insurance: Mostly Health Partners insurance - 20% Medicare; 60% MA; decreasing uninsured/undocumented; 15% private; most go to Temple, St. Christopher's and Episcopal
  - Tu Ojos – *your eyes* (at Episcopal Hospital)
- **Access**
  - **Health system**
    - *"Look at needs of undocumented community. How do you create a continuum of care using a patchwork of services (government, CBOs, health providers, etc.)? It really forces us to change how we provide services. We need to improve access and equality of care." (key informant)*
    - *"Immigrants are many more steps behind in taking care of their health. Many individuals have complex health issues deep rooted in poverty. This has to go beyond health and address education, safety, and security." (key informant)*
    - *"Insurance navigation- need help with understanding their insurance. What is covered, what is not by their insurance, what do terms mean, Who can help guide this? Can someone in doctor office do this? What hospitals and specific providers are in plan? What medications?" (key informant)*
    - Length of PCP/ specialist appointment- not enough time to do thorough assessment particularly with translator (assessment, education, confirming understanding). This can reduce compliance. (key informant)
    - Medicaid no longer pays for transplants for undocumented (key informant)
  - **Medications**
    - Patients are put on medications that their insurance doesn't cover
      - No one thought to check to see if medications are covered
      - Refugees on MA then won't take the medications. Ex: blood thinners not taken by patient after stroke
- **Chronic Diseases**
  - With health conditions being taboo, there is a lack of knowledge of one's own health condition(s)
  - Lack knowledge about how to live a healthier life (can't read English). That's why a lot of them are sick.
  - *"What doctor should I go to for what condition"*
  - Decreased physical activity compared to in Nepal due to their agricultural existence (worked in the fields)

- *"Highly value physical activity, but in Nepal they worked in fields as part of everyday life. Here they have to do exercise on hard, cement, not in green spaces."* (key informant)
- **Hepatitis B** (key informant)
  - Lack of screening for hepatitis B among high risk communities. Wants to see screening at primary care level to increase screening rates
  - Screening is reimbursable but is not being done at primary care level
  - Non-refugee immigrants aren't being tested
    - *"Follow-up care is difficult, requiring follow up twice annually for enzyme testing and ultrasound to screen for cancer. All pregnant women in U.S. are tested for Hep B but follow-up for infected women breaks down. Focus is on baby not mom."* (key informant)
  - Need to collect country of birth and parent country of birth to determine risk
  - Hep B Foundation does most work in South Philadelphia; works with churches and community based organizations to do education and screening
  - Gilead is going into hospital and offering to help pay for adding country of birth to EPIC. Philadelphia is the first to be approached by Gilead
  - Therapy
    - only 25% need treatment
    - about 70% of people don't know they have Hep B
  - Education needed when a patient tests positive for Hep B
    - No drinking. Careful use of herbal supplements, as some can cause liver damage
    - Transmission to others- how not to pass on to others
    - Vaccination and screening for family members
- **Mental Health** (key informants)
  - **Stigma**
    - *"Refugees need mental health services but don't 'want' a referral. Language access is not available. Need more 'art' music, movement therapy rather than basic counseling. Mental health is not discussed in refugee communities."* (key informant)
    - *"Sense of inferiority- just asking for help is hard."* (key informant)
    - *"Mental health has a big stigma in Asian community. Talking about it is taboo; they do not believe in counseling."* (key informant)
    - *"People in the [Cambodian] community are afraid to speak their mind. This is a big barrier, due to Khmer Rouge. They need a trusted person to help them. After building trust, the NSC case manager gets the refugee client to try behavior health services. The counseling can still go badly. Client was asked 'why are you here?' at each visit. She stopped going because she felt they were not 'hearing' her."* (key informant)
    - Speech delays and autism spectrum disorder common in Chinese community (key informant)
    - Suicide is an issue among the Bhutanese, but it is not talked about (key informant)
  - **Services**
    - Educate community about mental health- what to do and where to go

- Mental health- would like substantial mental health services in the community. Providers need to understand the culture and need to be creative in approach
- What's needed? *Mental health services for immigrants and refugees - a westernized approach is not always effective*
- Pediatric developmental services are woefully lacking and inadequate
- Chinese speaking psychologists needed
- Jefferson OT doing stress management in Farsi and Arabic will continue in spring
  - *Need to bring services in through back door such as parenting* (key informant)
  - *Can't get into behavioral health treatment due to language barriers* (key informant)
  - *Interest in learning (being trained) in how to access behavioral health services* (key informant)
- Resettlement Health Screener (RHS-15) coordination efforts: starting to expand testing the use of RHS-15 at past resettlement sites and pediatric care centers, gathering data, looking at referral process, utility, success, barriers, etc.
- **Substance abuse** (key informants)
  - Alcohol is the main substance abused. Alcohol use is common (anecdotally and from physicians) among the (Bhutanese, Burmese, etc.
  - Would like to screen for substance abuse and would like providers to screen
  - Need a tool to use that is linguistically and culturally appropriate
  - Drug- marijuana – handful of youth use
  - Don't acknowledge they need treatment due to cultural beliefs
  - *Need to bring it in through back door such as parenting* (how to keep your kids from using drugs, what do children need to be healthy, what are barriers to this, family management issues) (key informant)
  - “Betel Nut” is used mixed with tobacco in Southeast Asia
  - Immigrant refugee kids being more influenced by gangs and therefore drugs
- **Aging** (key informant)
  - Senior population is growing
    - Older adults concerned about citizenship requirements
    - Need to pass test or will lose benefits
    - Seniors are upset by this and need citizenship classes
  - Older people getting dementia (dementia) - seen as a natural part of aging; but some are re-living their days in the refugee camps
  - Jeff OT is providing home/environmental modifications for elderly, disabled; household management (telling time, how to access emergency services dial 911)
- **Interpersonal Violence (key informants)**
  - Ventivillas de Salud Behavioral Health- Casa del Solis (South Philadelphia) – (founded by the Philadelphia Mental Health Collaborative) has identified sexual abuse of undocumented males in restaurant kitchens
  - Albanians are bullied due to how they look, dress, speak
  - Not much is being done to address bullying of refugees/immigrants

- SEAMAAC has started *Safe Families Program*; getting community leaders involved; starting with Bhutanese and Burmese communities
- Domestic violence: *"If you have sex then you are considered to be married to that person. So if teen has sex with boyfriend then they are considered married. A female may even need to marry rapist. Need to promote that it's not legal here. Family loyalty prevents reporting. Don't want to betray family; getting help is betrayal. Woman's job is to keep family together."*(key informant)
- **Social Determinants (key informants)**
  - Parks are not meeting needs of the South Philadelphia community.
  - Park users include those doing criminal activities
  - Recreation Department doesn't support sports that immigrants are interested in
  - Lack of interpreters in schools. New immigrants can't communicate immediately and may need to wait to start school – frustrating
  - There is limited access to quality affordable early childhood education (Head Start). Not available in immigrant communities
  - Poor housing quality
  - South Philadelphia- access to low income housing particularly close to employment is a problem. Vans take refugees/immigrants to suburbs for work (1½ hours one-way)
- **Maternal Child Health (key informants)**
  - Need to provide wellness activities and promotions
  - Many pregnant women are involved in Maternity Care Coalition services
  - Need additional orientation with pregnant women, labor and delivery tours, and centering pregnancy programs in different languages
  - Need breast-feeding support in other languages
  - Consider developing breast feeding app in other languages
  - Need trained CHWs for Women's health and chronic diseases
- **Women's health –(key informants)**
  - Taboos about sex. STIs are not talked about or dealt with clinically; need education about sexual health issues including STIs.
- **Resources for Refugees and Immigrants**
  - Hall Mercer has language line
  - Jefferson's Refugee Health Partners runs a student clinic
  - Cambodian Association
    - Provide services to Cambodian, Lao, Chinese, Vietnamese
    - Staff is multilingual
    - Afterschool year round program
    - Intake care
    - Case management for social services, legal services, health, legal, housing
    - Provide language assistance
    - Take people to doctor/specialist appointments
    - Assist with prepping instructors, transportation
    - Work with HIAS and NSC on legal issues
  - Congreso domestic violence program
  - South Philadelphia, through St. Thomas Aquinas at 17<sup>th</sup> and Morris
    - Parenting education

- South Philadelphia - Southeast Health Center -8<sup>th</sup> and Washington
  - FQHC takes everyone
  - Connect with hospitals through referrals from ED
  - Predominantly Mexican Burmese
- Chinatown Pediatric and Internal Medicine
  - 9370 Chinese patients (97% Chinese practice)
  - GI, Hepatitis B center
- Gilead
  - Going into hospital and offering to help pay for adding country of birth to EPIC. Philadelphia is first to be approached by Gilead to add this information
- Hepatitis B foundation
  - Does most of its work in South Philadelphia
  - Work with churches and CBOs to do education and screening
  - Work with Jeff, Drexel, Penn, and PCOM Pan Asian medical student groups
  - Drexel has student MPH group and pharmacy students working on Hepatitis B
  - Have worked with RHP at Jefferson
- Lutheran and Children's Services
  - Have "case aid training" group class run by therapists, which brings refugee leaders together to help with compassion, fatigue, citizenship training, boundary setting (individual boundaries vs. community boundaries)
- Casa del Solis
  - South Philadelphia
  - Founded by the Philadelphia Mental Health Collaborative
  - Resilience + empowerment model
- Garces Foundation
  - Beatrice Garces provides dental care for Puentes de Salud
  - Literacy classes for ESL
- Mayor's Office of Multiculturalism does certified training in cultural competence; contracts with 7 vendors
- SEAMAAC
  - Organizational support for enrollment in insurance exchange
  - New Routes for Community Health videos in 2008
  - Comprehensive needs assessment—Southeast Asian
  - HCIF may be willing to help fund but need more funding
  - NSC, AFAHO, Boat People SOS, PICC, PCDC also interested
  - Need funding to support staff
  - Previous Asian survey needed \$120,000 for comprehensive assessment but was not feasible to attain. Therefore a convenience sample used. Need university partner to help conduct a survey in the Asian community including assistance with data entry and analysis
- DIMES
  - OT, PT, and college of population health students
  - Jeff OT students ran playgroups for refugee children while parents went to ESL classes at NSC on Saturdays
  - Students want community mental health positions

- Housing, job preparedness, work skills
- Work with refugees on all daily living skills and work skills
  - NSC trying to develop class/program for 2<sup>nd</sup> level OT (full time internship program) and needs to have an OT on site to supervise students
  - Students work with individuals/families to help them to adjust to lives in US
  - Start at skill level of refugee and build their skills to take on more, do more
- Can work across life span
- OT can bill for services
- Need 8 hours minimum of OT supervision
- OT makes \$72,000 annually
- Cost would be \$14,000 to implement internship program
- Welcoming Center

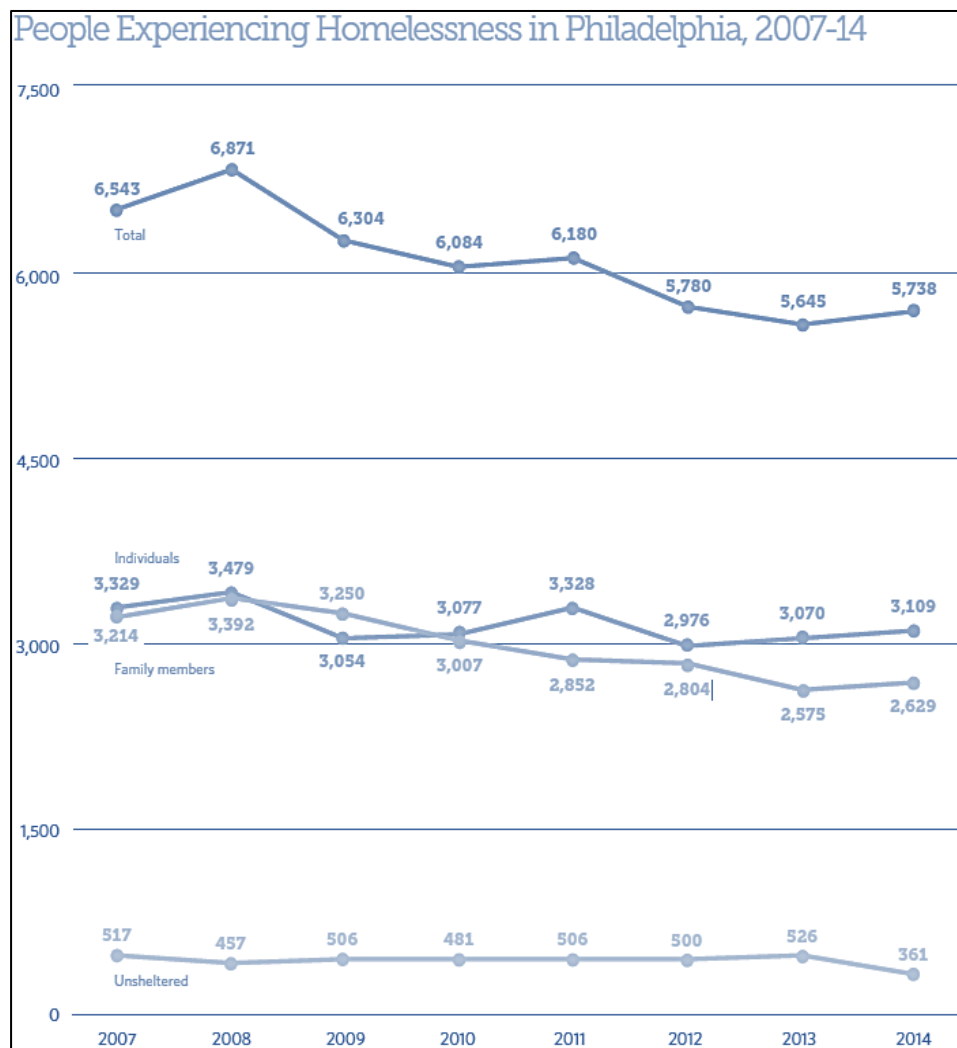
**Based on internal and external key informants, focus groups, existing relationships and programs, and secondary data, actions addressing refugees and immigrants may include:**

- **Partner with the Cambodian Association, SEAMAAC and others to continue to explore feasibility of initiating a Wellness Center in South Philadelphia for the Asian Community**
- **Collaborate with the Unity Clinic**
- **Continue to support and train bilingual immigrants/refugees as community health workers/patient navigators**
- **Partner with AHEC, NSC RAMP program, Jefferson Human Resources, and Jefferson Office of Diversity and Inclusion to develop a health professions pipeline for youth and adults**
- **Support Jefferson's Refugee Health Center and the student run Refugee Health Partners**
- **Create bilingual forms and health education materials**
- **Connect TJUH Psychiatry Department to South Philadelphia immigrant/refugee community**
- **Collaborate with the Mayor's Office of Immigrant and Multi-Cultural Affairs**
- **Assess refugee health needs and health care utilization after initial 8 months of medical assistance has ended**
- **Assist in enrolling refugees/immigrant into health insurance (Enroll America)**
- **Partner with community organizations to raise awareness about community resources for chronic disease and mental illness**
- **Address alcohol and substance abuse**
- **Improve coordination and timely care reports between hospital, specialists, and primary care**
- **Need chronic disease prevention and management for diabetes, hypertension, osteoporosis, Hepatitis B, and cervical cancer**
- **Assist in conducting a community needs assessment of Asian community**
- **Explore behavioral health services for the Chinese community**
- **Continue to study/utilize the Refugee Depression Screening tool (RHS-15)**



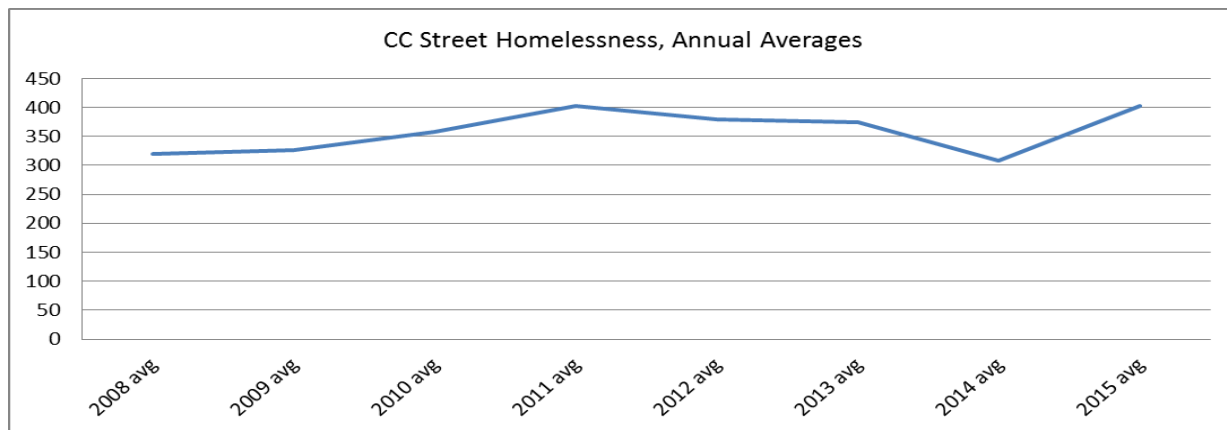
## Homeless

Each year homeless outreach organizations engage over 5,500 individuals living on the street, in cars, abandoned buildings, train/bus stations, and other places not meant for human habitation. About 12,000 people (includes families) access City shelters each year. In addition, numerous individuals are turned away from shelters for various reasons. At a given point in time, Philadelphia estimates an average of 650 people living on the streets, including 300 in Center City. However, it is difficult to calculate the exact number of homeless people living on the street, considering the number of individuals that live in obscure park areas, vehicles, or abandoned houses. The graph below depicts a one-night, city-run count of people staying in emergency shelters, transitional housing, temporary drop-in centers, or on the street between 2007 and 2014 in Philadelphia.



*Pew Philadelphia State of the City 2015*

The number of homeless people living on the street fluctuates seasonally and tends to rise in the summer months. The average number of homeless in Center City has ranged from 300 to 400 over the past seven years.



*Ending and Preventing Homelessness, Project HOME, 2016*

### **There are multiple causes of homelessness:**

- Poverty from a lack of jobs at competitive living wages: Philadelphia has a 26.3 % poverty rate,<sup>32</sup> one of the highest in the nation
- Lack of adequate public supports and/or earned benefits
- Lack of affordable transportation
  - Housing and transportation are the top two largest expenses for the typical American family<sup>179</sup>
  - In Philadelphia moderate income households people spend 53% of their income on housing and transportation (28% on housing; 25% on transportation)
- Lack of affordable housing and inadequate housing assistance
  - The impact of high housing costs falls disproportionately on extremely low-, very low-income and low- households, especially renters<sup>180</sup>
  - 42% of Philadelphia households are paying more than 30% of their income toward housing<sup>181</sup>
  - 57% of all renter households spend more than 30% on rent and utilities<sup>182</sup>
  - 84% of Philadelphians making less than \$20,000 in 2013 paid 30% or more of their household income on housing costs
    - Of poor households who pay more than 30% of income on housing, 70% of those spend more than 50% on housing<sup>183</sup>
    - Severe overpaying occurs when households pay 50% or more of their gross income for housing
    - Lack of affordable health care
    - Domestic violence
    - Inadequate support for mental health and substance use challenges: 94 % of people living on the street have behavioral health challenges: 12% mental health, 12% substance use, and 70% dual diagnosis

Key strategies to end and prevent homelessness include:

- Developing effective solutions for those on the street, including targeted outreach and appropriate facilities and services, particularly for persons with substance-abuse and mental-health problems
- Strengthening the system of shelter and services that enable homeless persons to make the transition to stability and job readiness
- Providing permanent jobs and housing solutions so that people can break the cycle of homelessness and become stable and productive citizens
- Strengthening homelessness prevention programs so that no one ends up in shelters or on the streets; this includes reinvesting in economically vulnerable neighborhoods, improving the school system, ensuring people have access to health care, and providing jobs at a living wage

The City of Philadelphia's current homeless system is based on the concept of creating a "Continuum of Care," which seeks to help homeless people by moving them through a sequence of housing and service models in which consumers are gradually moved from shelter through transitional housing and, eventually, into permanent housing. Continuum of Care has been the "predominant service delivery model designed to address the needs of this chronically homeless population." Moving through this continuum and into permanent housing requires consumers to meet the goals of each program in order to demonstrate that they are "ready" to progress to the next level. Independent, permanent housing is offered as a "reward" for more acceptable behavior. This Continuum of Care approach has been successful in helping a significant portion of homeless households, generally single-parent families who need a safe, affordable place to live while they resettle their lives and gain additional skills and abilities that will allow them to support themselves.

Among those individuals that this system has been unable to help are service-resistant chronically homeless people with serious mental illness. While these people make up a relatively small proportion of the homeless population, they are the most frequent and expensive users of the system. Characterized by serious mental illness, substance abuse, and personality disorder, this subset of the homeless population is adverse to being around and living with other people. For people suffering from personality disorder as part of their mental illness, living alone on the streets is preferable to being around other people, much less abiding by a strict set of externally imposed rules. Understanding this aversion to be around other people provides an opportunity to help them. Nationally, there is a move away from the Continuum of Care approach to dealing with the service-resistant, seriously mentally ill homeless. This emphasis has led to interest among practitioners in the "Housing First" approach to serving this population. The City of Philadelphia has also moved in this policy direction by supporting initiatives to move individuals into permanent housing.

Families are another group among the homeless. The prevalence of traumatic stress in the lives of families experiencing homelessness is extraordinarily high. Often these families have experienced on-going trauma throughout their lives in the form of childhood abuse and neglect, domestic violence, community violence, and the trauma associated with poverty and the loss of home, safety, and sense of security. These experiences have a significant impact on how people

think, feel, behave, relate to others, and cope with future experiences. Families have learned to adapt to these traumatic circumstances in order to survive, but their ways of coping may seem confusing and out-of-place in their current circumstances.

Given the high rates of traumatic exposure among families who are homeless, it has become clear that understanding trauma and its impact is essential to providing quality care in shelters and housing programs. This realization has led to the suggestion that programs serving trauma survivors adapt their services to account for their clients' traumatic experiences, that is, they become "trauma-informed." In order to respond empathically to the needs of trauma survivors, ensure their physical and emotional safety, develop realistic treatment goals, and avoid re-traumatization, all practices and programming must be provided through the lens of trauma.

The National Center on Family Homelessness (NCFH) has created the *Trauma-Informed Organizational Toolkit* to provide programs with a roadmap for becoming trauma-informed. The *Toolkit* offers homeless service providers with concrete guidelines for how to modify their practices and policies to ensure that they are responding appropriately to the needs of families who have experienced traumatic stress. The *Trauma-Informed Organizational Toolkit* includes:

- *Trauma-Informed Organizational Self-Assessment*. The *Self-Assessment* is designed to help programs evaluate their practices and based on their findings, adapt their programming to support recovery and healing among their clients
- *User's Guide*. The *User's Guide* is designed to assist programs implement the *Self-Assessment* and contains additional information about this assessment tool and what it means to provide trauma-informed care
- *How-To Manual for Creating Organizational Change*. The *Manual* identifies concrete steps that organizations can take to become trauma-informed<sup>184</sup>

Despite efforts to improve the lives of the homeless, homeless people die on the streets. For the past 6 years Philadelphia's Homeless Death Review Team (HDRT) has met regularly to review the circumstances surrounding the death of a homeless individual. The team will release an updated report shortly. Its initial report in 2010 identified 90 persons who met homeless criteria at the time of death from the beginning of 2009 to the end of 2010. The average age of death was 53 years. Of the 90 persons reviewed, 83% were male; 63% were African American; and 39% were considered chronically homeless. Twenty-three percent of the decedents were unknown to city homeless service systems, including emergency shelter and street outreach services, while 9% had some street outreach contact but no history with shelter. Despite winters with severe temperatures and record snowfalls in both 2009 and 2010, surprisingly few homeless deaths were weather-related: only 5 cases of hypothermia as a primary cause of death during the two-year span are covered in this report.

As a result of data collected and analyzed during the review of 2009-2010 deaths, the HDRT found that:

- 74% of decedents had at least one known chronic (physical) medical condition at time of death
- 52% of decedents had documentation of psychiatric illnesses.

- 63% of decedents had a history of substance use/abuse, with 44% of decedents having drug or alcohol intoxication as a primary or contributing cause of death
- 61% of decedents had no health care coverage at the time of death

Ninety-four percent of the homeless decedents encountered one or more homelessness-related service systems during their lifetime, with more than one-half interacting with three or more. Just over one-third came into contact with at least one system in the last 30 days of their lives. Based on the data, the HDRT concluded that:

- Gaps in health care and/or coverage may contribute to inadequate access to appropriate care
- For individuals with multiple physical and behavioral health conditions, lack of coordination among systems may contribute to unmet needs and housing instability
- The scarcity of housing subsidies and restrictions on and reductions in service funding limit the number of people who can be assisted

The HDRT recommended the following actions be taken as part of Philadelphia's goal to end homelessness:

- Continue to seek resources to increase permanent supportive housing and appropriate services
- Continue to identify and explore best practices to address addiction and those with dual diagnoses
- Formalize partnerships and data sharing between the homeless service system, managed care organizations, and hospitals to improve coordination and discharge planning processes
- Consider a medical respite program for Philadelphia that is connected to long-term housing

Jefferson has a long history of engagement with the homeless and is working closely with four programs: Project HOME, Jeff HOPE, Pathways to Housing, and Depaul House, as well as the Eliza Shirley House Shelter for Women.

## **Project HOME**

The mission of the Project HOME<sup>185</sup> community is to empower adults, children, and families to break the cycle of homelessness and poverty, to alleviate the underlying causes of poverty, and to enable all to attain their fullest potential as individuals and as members of the broader society. Project HOME achieves its mission through a continuum of care comprised of street outreach, a range of supportive housing, and comprehensive services. Project HOME addresses the root causes of homelessness through neighborhood-based affordable housing, economic development, and environmental enhancement programs, as well as by providing access to employment opportunities, adult and youth education, and health care.

The Steven Klein Wellness Center of Project HOME is staffed by faculty and residents from TJUH and is committed to addressing the health and wellness needs of people living in the community, including residents of Project HOME sponsored housing, people living in North Philadelphia, and people who are currently homeless.

Services are offered regardless of health insurance status, and include:

- Primary medical care for adults
- Behavioral health services for children and adults, including individual, couple, and family therapy, adult support groups, play therapy groups known as the House of Hope and Peace, peer support for people struggling with addiction, and linkage to psychiatry
- Care coordination services including assistance applying for medical assistance, obtaining transportation to medical appointments, applying for free or low-cost medications, and scheduling appointments with specialists
- Support services for a healthy lifestyle, including one-on-one nutrition teaching, diabetes self-management classes through Jefferson's Center for Urban Health, and therapeutic healing touch for stress reduction

For the past 4 years, Project HOME has directed the Hub of Hope, a walk-in engagement center located in the concourses under Two Penn Center in Philadelphia. It provides social and health services from January through April from 7-9AM and 7-10PM five days a week to individuals experiencing chronic homelessness who live in Center City. Jefferson staff and residents assist at the Hub.

The goals of the Hub of Hope are to:

- Transition people experiencing homelessness into permanent housing
- Provide low-barrier access to centralized co-located physical and behavioral healthcare and connect people to ongoing primary care
- Deepen understanding of strategic and effective tools and methods to end homelessness

Hub of Hope accomplishments in 2015 include:

- 6,643 visits from 1,261 unique individuals; 1,005 people were new to the program
- 10,000+ cups of coffee, tea, water, or hot chocolate served by 35+ volunteers

- 445 people sat down with a case manager, 236 of whom had histories of long-term homelessness or other vulnerability indicators
- 144 clinic visits with 98 unique individuals
- 119 clinical assessments and forms completed for housing, services, and benefits
- 176 people placed into shelter, treatment, and other housing options around the City (101 of these individuals were deemed long-term homeless/fragile)
- 248 total placements made – 176 initial placements and 72 follow-up placements (including 148 total placements of long-term homeless/fragile individuals – 101 initial and 47 follow up placements)
- Invited an evolving population of participants, many of whom are in recovery, actively addicted, mentally ill, or vulnerable
- Engaged individuals on the margins of care during a “treatable moment.” Provided possibility for consistent follow up
- Connected and reconnected difficult-to-locate individuals with supports around the City
- Engaged multiple professionals, volunteers, and partners
- Nurtured a sense of community and hope among participants, volunteers, staff, and neighbors by creating a local coffee shop with “regulars.” People were able to be human across many lines of difference, and to joke, relax, work, inspire, check-in with and track one another.

Hub of HOPE lessons learned include:

- A central location promoted initial access and the ability to strengthen existing support systems
- The storefront model allowed participants to build a relationship with a place and talk to a provider when they were ready for services, maximizing efficiency and successful service connections
- A warm, hopeful atmosphere inspired and uplifted everyone involved
- Integrated housing and healthcare services were essential partners in preventing, responding to, and ending homelessness
- The partnership with Arch Street United Methodist Church and Student-Run Emergency Housing Unit of Philadelphia (SREHUP) was key to providing short-term respite options for vulnerable men
- Large crowds gathered in the concourse in the morning hours when individuals who utilized temporary winter beds with early dismissals had nowhere to go, especially in inclement weather
- Strength of collaboration with Philadelphia Outreach teams, SEPTA police, City departments, and providers to collaborate, assess, engage, plan, and follow-up with individuals living in and around the concourse made for a strong project

Based on the experience with the Hub of HOPE, Project HOME recommends the following action steps:

- Strategically target efforts of Philadelphia Outreach teams to collaborate and assess, engage, plan, and follow-up with individuals living in and around the concourse

- Enhance on-site drug and alcohol recovery counseling and linkages to treatment at future Hub of Hope projects
- Explore creative ways to provide consolidated social and health services to people experiencing homelessness in centralized locations
- Advocate for increased psychiatric resources and ability for multiple medical professionals to sign off on housing and services assessments
- Increase emergency options for women

## **Jeff HOPE**

JeffHOPE is a student-run organization of Sidney Kimmel Medical College that aims to improve access to health care for the homeless and underserved population of Philadelphia, as well as to educate students, residents, and faculty members about medical issues, homelessness, and poverty. It was formed in 1991 by a group of medical students who saw a need in the homeless community for proper medical care and the potential opportunities for health professionals to reach out to this population. JeffHOPE is one of the largest and most active student organizations of Thomas Jefferson University, involving more than 700 medical and nursing students and over 50 faculty members. The program is supported by Thomas Jefferson University and Hospital, especially the departments of Family Medicine and Internal Medicine. JeffHOPE is led by student steering committees and nine student directors; Dr. James Plumb, MD, MPH is the faculty advisor.

JeffHOPE's focus has been the provision of medical care through free clinics. JeffHOPE currently operates five clinics at homeless shelters and one clinic in conjunction with Prevention Point Philadelphia, a non-profit syringe exchange program, completing 5,000 patient visits per year. At each clinic, teams of students across health professions work together to provide quality care for patients.

## **Pathways to Housing (PTH)<sup>186</sup>**

PTH was invited to Philadelphia by City of Philadelphia officials in the summer of 2008 to implement its Housing First, scattered-site housing model. By the end of that summer, Pathways had a program and staff in place and began serving chronically homeless Philadelphians with severe and persistent mental illness and co-occurring disorders, following a Housing First approach. The cornerstone of this model is the emphasis on consumer choice. Consumers choose the neighborhoods they want to live in, how their apartments are furnished, and all other decisions regarding the use of their homes. The housing is permanent and is held for the individual during relapse, psychiatric crisis, or short incarcerations. Consumers also determine the frequency, duration, and intensity of the support and treatment services they receive.

Dr. Lara Weinstein, a Department of Family and Community Medicine faculty member, who provides integrated primary care to PTH clients, reported on the chronic physical disease burden of people entering the program. Her evaluation confirmed significantly higher rates of chronic disease (60%) and fair/poor self-reported health status (47%) than the general urban Philadelphia population. The majority of clients reported they wanted to address both medical (67%) and



mental health (68%) problems, but a much lower percentage reported wanting to reduce substance use (23%) or take psychiatric medications (25%). Formerly homeless entrants to Housing First programs have a high burden of chronic disease with complex health-related needs.

### **Depaul House Medical Respite Center**

There is a growing consensus among stakeholders in the community that there is a need to improve the transition of homeless people from hospitals back into their community. Homeless adults are hospitalized more frequently than those in the general population and often require longer inpatient stays; however, their lack of a stable home environment diminishes the long-term effectiveness of their hospital care. Philadelphia's most vulnerable homeless have an increased risk of death despite the availability of high-cost health services in the region. Most homeless individuals are discharged from the hospital to a shelter or the street, frequently without medications, treatment, medical follow-up, or recovery support. This often results in hospital readmissions and the progression of chronic physical and behavioural health problems. Medical respite, a nationally-recognized best practice to address this need, is short-term residential care that allows homeless individuals to rest in a safe environment while accessing medical care and other supportive services which result in improved long term outcomes.

The eight-bed respite, housed within Depaul House located in Northwest Philadelphia, is a short-term, specialized program focused on homeless individuals with acute medical conditions and who may also have a co-occurring mental illness or chemical dependence. The respite serves homeless men who need a place to recuperate following discharge from an acute care medical facility. It is the first program of its kind in Philadelphia. To support disease self-management and recovery, the respite provides rest, recuperation, medication management and case management. Depaul USA also provides comprehensive residential services including 24-hour supervision, meals, and basic shelter services. Dr. Bon Ku from Jefferson's Emergency Department is the medical director. PHMC provides a registered nurse and licensed practical nurse at non-traditional hours to manage health services and provide case management to help respite clients establish medical homes and follow treatment regimens.<sup>187</sup>

Starting with the Center's opening in 2014, the respite house is tracking short-term outcomes. One goal of the respite is to demonstrate cost savings, in addition to improved health outcomes. Other areas for tracking include discharge to stable housing, improved access to a medical home, and improved experience of care.

### **Eliza Shirley House Shelter for Women**

Prenatal care for the underserved is a national concern, with pregnancy rates as high as 22% in homeless women and 75% of these women reporting barriers to care during pregnancy. Inadequate prenatal care confers increased risk for gestational complications and unfavorable postnatal outcomes, including prematurity and low birth weight. Yet while many studies delineate the prevalence and health consequences of inconsistent prenatal care in the homeless population, few address healthcare barriers. To both fill this gap in the literature and design effective interventions increasing consistency of care, Jefferson staff and students explored prenatal care experiences of pregnant homeless women at Philadelphia's primary intake shelter

for women and children. Study participants were recruited from the Eliza Shirley House Shelter for Women for individual interviews, which were subsequently reviewed for thematic elements by all researchers on the study.

Self-identified barriers to consistent prenatal care included limited financial and transportation resources. While women who had received prenatal care reported rewarding relationships with their prenatal care providers, many expressed unmet needs for education on healthy exercise and dietary habits for expecting and breastfeeding mothers. Women also demonstrated interest in support groups, parenting classes, and stress-management sessions as venues to share their stories with, and learn from, others.<sup>188</sup>

### **Issues, challenges, unmet needs and priorities identified by key informants and focus group participants related to the homeless:**

- **Demographics**
  - Homelessness remains an issue in Philadelphia
  - The homeless population is often found near route I95, Front and Washington, and 4<sup>th</sup> and Callowhill, and it is worsening along Columbus Avenue
  - *When I first moved in (Lower North), I've noticed homeless people during the day hunting trash and some of them look like they're on drugs, and drug addiction is huge around the Temple area. Another is neglect of people who are schizophrenic, bipolar, lost their job, and lost everything, so these people have nowhere to go. So when I take the train, the Market Frankford Line, in the early morning I see a lot of homeless people just riding the train.* (focus group)
  - *"These people have nowhere else to go. In my community, it's definitely getting nicer, but on the other hand they're making housing less affordable for people who don't have as much and forcing people out further. I feel like these homeless people they're dispersed, but in the nighttime they tend to congregate in certain areas, and sometimes I don't feel safe going out at night, because sometimes you don't know who's going to pop up behind you."* (focus group)
- **Interaction with Law Enforcement**
  - *"The police have homeless move every day, however they feel they need access to a book of resources where they can refer people regarding housing, food, parenting to address truancy."* (key informant)
  - *"The police are taught 'how to deal with homeless, prostitution, mentally ill, drugs, etc.,' but they feel they need more support regarding mental health."* (key informant)
  - *"There must be a behavioral health person for every division of city jails. They need not be a doctor; the homeless population may feel more comfortable speaking with a civilian than a police officer. They also would like a policy where police officers can contact a mental health professional."* (key informant)
  - *"Police officers would like to be able to help drug abusers and one officer puts info into mailboxes about Broad Street Ministries regarding drug abuse and notes that people are able to receive help if they are arrested."* (key informant)

- **Drug and alcohol abuse**
  - Broad Street Ministries continues to see addiction issues, including crack and alcohol abuse and their clients go to 8<sup>th</sup> and Girard for detox but still see high relapse rates (key informant)
  - Broad Street Ministries has also made a request for Narcan training as they are concerned about high rates of drug abuse among their clients (key informant)
  - The immigrant homeless community is particularly susceptible to high rates of alcohol abuse due to their long work-days (key informant)
  - There is a gap in drug and alcohol rehab with the issue of triaging patients in a time-sensitive manner (key informant)
- **Healthcare Navigation and Education.**
  - There needs to be counseling regarding use of insurance as people don't know how it works (key informant)
  - There needs to be better health care navigation especially for guests at Broad Street Ministries who are discharged from the hospital, either ED or inpatient
    - They are providing tokens for these guests to have follow up care appointments, but they feel there is a communication gap about follow up appointments that are missed
    - When guests are admitted to Jeff ED, they use Broad Street Ministries' address (315 South Broad Street). An assessment of the Jefferson ED data using this address would inform the extent of Broad Street Ministry clients' use of the ED and would lay the foundation for improved communication between the ED and Broad Street Ministry in terms of case management opportunities.
    - The Ministries would like to partner more with Jefferson to incorporate health needs into their services. They feel nursing students triaging guests would be beneficial, they also need medication reviews and would like help from pharmacy school. Providing patients with information regarding PTSD and hypertension are needed and they would like nursing help with this as well. Podiatry services are also desperately needed. The Council for Relationship Family Counseling student placement site treats much of their PTSD and U. Penn manages their dental care. (key informant)
- **Cultural Competence**
  - *"Social service/homeless organizations/agencies should provide training for healthcare providers around culturally competent care for homeless individuals who also have mental health issues (dual diagnosis). Need to decrease the stigma and stereotyping of homeless mentally ill among health care staff."* (key informant)
- **Care Coordination**
  - Need for improved communication and care coordination between the hospital, homeless/social service agencies, behavioral health, and primary/specialized medical care. (key informant)
  - Lack of coordination results in duplication of services (tests, screening, labs, etc.). Care transitions after discharge from hospital are critical. Need to improve communication at discharge between hospital and social service agencies.

- Need more formal psychiatry services offered on-site at a central location that meets the holistic needs of homeless. Substance abuse support should also be provided at a centralized service site. Currently Belmont is providing these services at another site. (key informant)
- *"I think a lot of the homeless people have mental health problems, and I think there are too many outpatient care places for them. I think some would benefit from some hospital stays, because for some reason I don't think the outpatient is helping them, they just get thrown out into communities, they have no place to go, there's no one helping them, they don't have anyone helping them with the medicine, when to take the medicine. A lot of them are not really stable, out on the street addressing crimes, because they're not really getting the attention that they need for the mental health issues that they have."* (focus group)
- *"The inpatient seems in and out, they get the medicine, then they're back out. No groups at outpatient centers are they making them commit to staying, instead they give them the prescription for whatever you like and send them out the door. And some of them to me, they're not even stable, and you can tell a lot of them aren't even on the medications they're supposed to be taking."* (focus group)
- *"I've found most of them are noncompliant because they don't like the side effects, and from the mental health they like being high, they like the mental state, they don't like the effect of medication making them feel more depressed, and they don't have support, they don't have family members. It's hard to tell where they're coming from, so they're just on the streets."* (focus group)
- **Homeless Veterans** (key informant – Veteran's Multi Service Center)
  - There are services which serves meals, and offer showers and haircuts
  - Discuss alcoholism, military sexual trauma, legal assistance
  - The Veteran's Multi Service Center offers a thrift store for veterans but need donations like "furniture, clothing, household items, linens, vehicles." The thrift store provides assistance as well as workforce development-training opportunities. Impact Services, HUD, VA, City of Philadelphia, Project HOME are partners in the Coalition to End Veteran Homelessness – over 1,300 individuals and their families got housing.
  - Multi-session chronic disease management programs are offered, once a year. Since many come and do a single program and then don't return, the center would like programs offered multiple times throughout the year (on-going programs). Provide chronic disease self-management program for our workforce
  - The Veteran's Multi Service Center would like to develop further health integration into workforce development program for veterans
  - Veterans' biggest health problems include PTSD/head trauma, obesity, back pain, diabetes, Agent Orange exposure, hypertension management, and medication management. Assess veteran use of Jefferson's emergency department.
  - Veterans are concerned about barriers to timely care such as time to get appointments, rescheduling when appointments cancelled, and stigma and reluctance to go to VA for mental health concerns due to fear it will limit future employment
- **Housing**
  - The city needs more transitional and supportive housing. (key informant)

- They have male head of households with kids and need sex education as many people living in shelters become pregnant (key informant)
- There is a need for foster child and adoption advocacy work as well to manage this need (key informant)

**Based on internal and external key informants, focus groups, existing relationships and programs, and secondary data, actions addressing homelessness may include:**

- 1. Partner with community based organizations serving the homeless such as PCA, PDPH, Women Against Abuse, the Veterans Multi Services Center, Depaul House, and Broad Street Ministry**
- 2. Support advocacy issues such as affordable housing, workforce development, and economic development**
- 3. Support health education efforts for clients at the Veterans Multi Services Center, Pathways to Home and Project HOME's Wellness Center. Coordinate with TJUHs departments already doing screening such as JHN stroke screening, TJU nursing, breast screening program, Nurse Magnet, and the pharmacy.**
- 4. Train community health workers to enhance care coordination and transition**
- 5. Provide culturally relevant health education for homeless and formerly homeless**
- 6. Provide training to TJUH faculty and staff to improve cultural competence in treating homeless/sheltered individuals**
- 7. Work with TJUH ED to coordinate care across Jeff HOPE, Project HOME's Wellness Center, Broad Street Ministry, and the Veteran's Multi-services Center.**
- 8. Provide case management services for patients at Project HOME's Wellness Center**
- 9. Improve access to behavioral health services through centralization of services and care coordination with primary care**

## ***Lesbian, Gay, Bisexual, and Transgender (LGBT)***

Mazzoni Center<sup>189</sup> is the only health care provider in the Philadelphia region specifically targeting the unique health care needs of the lesbian, gay, bisexual, and transgender communities. Founded in 1979, it is the oldest AIDS service organization in the Commonwealth of Pennsylvania, and the fourth oldest in the nation. As the organization grew and evolved to meet the needs of its constituents, Mazzoni Center has combined HIV/AIDS-related services and health services. With over 30,000 individuals benefiting annually, Mazzoni has developed a reputation for excellence and innovation in service delivery. The Center offers a full array of primary health care services, mental and behavioral health services, and LGBT legal services, as well as HIV and STD testing, food bank and housing subsidies for families and individuals affected by HIV, support groups, outreach and education programs. Three faculty from the Jefferson Department of Family and Community Medicine staff the Mazzoni Center.

According to a 2010 report by Lambda Legal<sup>190</sup>, 70% of transgender respondents experienced serious discrimination in health care. In a 2011 study<sup>191</sup> of more than 6,000 transgender people by the National Center for Transgender Equality and the National LGBTQ Task Force, 19% said they had been denied health care because of their transgender or gender nonconforming status. Many of them avoided doctors' offices altogether: 28% postponed getting health care when they were ill or injured and 33% delayed or did not seek preventive care because of their past experiences with doctors.

### **Issues, challenges unmet needs and priorities identified by key informants and focus group participants related to the LGBT community included:**

- **Access to Care and Care Coordination**
  - *Interacting with the healthcare system is difficult for transgender people. The first disconcerting question is “What sex are you?” and it goes from there. Issues include what exams are appropriate (e.g. mammography and prostate screenings) and when should they be done? For example, transgender people may be taking hormones and in the midst of change, may still have breast tissue, and hormones to contend with those preventive screening recommendations need to consider. Exams can be done in way that makes person feel comfortable.* (key informant)
- **Cultural Competency**
  - *Hospital staff need to learn how to be sensitive to patients and their same sex partners* (key informant)
  - *With marriage equality across states this is less of an issue now. However, patients in same sex marriages are concerned about “proving their marital status”* (key informant)
  - *Sensitivity training is needed in the ER and among specialists. Mazzoni has new staff who can train healthcare providers – Jefferson staff haven’t been trained recently.* (key informant)
  - *Health care professionals should try to refer to doctors who are known to be sensitive to trans sexual issues; there is room for improvement*

- *Health care professionals need to be more sensitive when asking about gender and should use appropriate pronouns and address people using preferred names and pronouns* (key informant)
- *Issue- how can a transgender person be placed in a semi-private room?* (key informant)
- Insurance may list the biological sex because the sexual identity listed hasn't legally been changed yet
- Radiology (trans women need mammograms) Staff and radiologists are pretty sensitive, but they need to be given training
- *Staff turnover can be quick in healthcare and need on-going training* (key informant)
- Cultural competency training is needed for issues related to aging LGBT people
- LGBT individuals may be afraid of being judged in healthcare settings, senior housing, etc. *"Some are re-closeting because they are not sure how they will be accepted (afraid to share and are going back into the closet)."* (key informant)
- **Social Issues**
  - LGBT are becoming parents; issues related to their children may arise
  - *Older LGBT may have estranged families due to sexuality issues and are often lonely, depressed, or isolated* (key informant)
  - Williams Way social groups try to have groups for older LGBT
  - In retirement homes – need to be checked to ensure LGBT couple is comfortable due to cultural issues of older people towards LGBT
  - *Older people are getting HIV in 60s and since they are likely to have other chronic diseases, they often do worse* (key informant)
- **PREP**
  - PREP, a pill, Trevada, is pre-exposure prophylaxis for gay/bi men. No one using PREP has gotten HIV yet. Although PREP is good prevention for men who are very sexually active, there are still side effects like kidney problems. There are some that believe PREP this gives permission to have sex. Approved 1 ½ years ago, there are currently about 500 using PREP
  - A Wash West storefront offers testing (STD & HIV) and is open to talking about PREP and offering PREP
  - PREP outreach is important particularly for black men, who may have high viral loads and not know it

**Based on internal and external key informants, focus groups, existing relationships and programs, and secondary data, actions addressing the LGBT community may include:**

- 1. Cultural competence training in treating LGBT in TJUHs**
- 2. Need for assistance in making appointments and going to specialty appointments**
- 3. Provide wellness programs in partnership with the Mazzoni Center**
- 4. Educate TJUH physicians and staff on the challenges and issues faced by the transgender population**
- 5. Provide PREP in community based sites to increase access for those wishing to use it.**

## *Returning Citizens*

For the past three years, staff from Jefferson's Center for Urban Health have been working with the Federation of Neighborhood Centers, the Pennsylvania Horticultural Society, and the Philadelphia Prison System. The project, the Career Support Network (CSN) and Roots to Reentry, provides chronic disease prevention and self-management and occupational therapy assessments for men in a work release program at the prison. A component of the project is linking men to care following release from prison. The goals of the CSN are to:

- Increase the number of vulnerable adults who will be employed in jobs with sustainable wages for a minimum of one year
- Increase the number of vulnerable adults with physical health conditions such as diabetes, hypertension, and obesity who demonstrate improved disease management and self-efficacy
- Increase the number of vulnerable adults with mental and behavioral health conditions such as depression, anxiety, and addiction who demonstrate improved coping skills and understanding of their conditions
- Reduce the recidivism rate

Incarceration rates in the United States are remarkably high and the number of jailed Philadelphians is sizable. As of June 2015, there were approximately 24,000 Philadelphians incarcerated in county jail or state or federal prison. An additional 60,000 Philadelphians were actively supervised on probation or parole. Those incarcerated present an array of poor health conditions, including mental illness, addiction, and chronic disease. While incarcerated, they can face additional health challenges.

Some correctional facilities are important public health collaborators in the screening and diagnosis of infectious and other diseases, and many correctional healthcare providers across the country are highly trained and deeply committed to their patients' wellbeing. Some correctional facilities have sought partnerships with community-based medical and public health practitioners to ensure that care begun during incarceration is continued following release. Overall, a disconnect exists between correctional healthcare and state or local public health departments in planning and delivering care to inmates while incarcerated and upon release the period immediately following release from prison or jail is especially risky. While mortality rates within prisons and jails are comparable to those of the general population for white males and lower than their non-incarcerated peers for black males, former prisoners are nearly 13 times more likely to die in the two weeks following release than the general population. In particular, former prisoners are 129 times more likely than the general population to die of an overdose during that period. This reflects both the challenges faced upon return to communities and the insufficient nature of substance abuse treatment during incarceration, during which prisoners may not realize their tolerance to opiates has declined. Despite efforts to improve the outcomes of prisoner re-entry through assistance with employment, housing, and other transitional needs that ultimately affect health, only about 10% of prisoners from state prisons in need of discharge planning actually receive it. In general, mentally ill prisoners and those with HIV are more likely than others to receive discharge planning. Nonetheless, they are also more likely to be homeless and rely on extensive emergency department healthcare post-release. Although inmates with mental



illnesses are generally given a supply of medications upon release, medication adherence falls off rapidly upon release.<sup>192</sup>

The vast majority of individuals who are in U.S. jails and prisons will eventually return to the community. Criminal justice policymakers and practitioners everywhere have made it a priority to ensure these individuals, returning in large numbers each year, do not commit new crimes following their release. As part of these efforts, state and local government officials have focused on the need for people released from prison and jail to have jobs, seeing employment as critical to successful reentry. Indeed, incarcerated individuals that have been asked about their post-release plans typically say that getting a job is crucial to their ability to stay crime free.<sup>193</sup>

Staff from Jefferson have been involved in the Philadelphia Reentry Coalition, which was formed after the Philadelphia County Criminal Justice Advisory Board (CJAB) voted to convene a subcommittee that would focus on countywide reentry efforts. In February 2012, the U.S. Attorney's Office for the Eastern District of Pennsylvania hosted leadership from the federal, state, and local levels representing the judiciary, corrections, probation, defense, prosecution, and other key public stakeholders. The initial group was charged with addressing the growing concern that reentry efforts in Philadelphia needed to be better coordinated. In March of 2015, the Coalition merged efforts with Philly PRISM, a collective impact initiative formed in 2014 with similar goals of improving Philadelphia's reentry systems through stakeholder collaboration. The Coalition now includes over 20 county, 3 state, and 6 federal agencies, 6 universities, including Thomas Jefferson University, and two dozen non-profit organizations.

The Coalition's mission is that *every person released from jail or prison to Philadelphia succeeds and is a productive member of the community.*

Engaging the community is integral to reducing recidivism. Recidivism rates are high: 58% of people released from county jail are re-incarcerated in county jail within 3 years, 43% of Philadelphians released from state prison are re-incarcerated in state prison within 3 years, and 60% of people released from state prison to Philadelphia County are re-arrested within 3 years. The broader community contains many important stakeholder groups, such as currently and formerly incarcerated people and their families and networks, employers, service providers, and the general public. Each has a unique perspective and contribution as part of the Coalition's work. In order to ensure the effectiveness of its programs, practices, and policies, it is important that the Coalition actively engage the community in its work

A transitions team seeks opportunities to improve how people transition through the reentry system, from pre-incarceration (arrest prior to incarceration), to behind-the-walls, to immediate post-release, to long-term reintegration into the community. The team will have work groups that focus on issue areas such as housing, employment, education, and health. One workgroup is the Behavioral/Physical Health & Substance Abuse Work Group, with a charge to:<sup>194</sup>

- Quantify the behavioral/physical health and substance abuse needs of Philadelphia's returning citizens
- Collect information on behavioral/physical health and substance abuse programs and services available to returning citizens

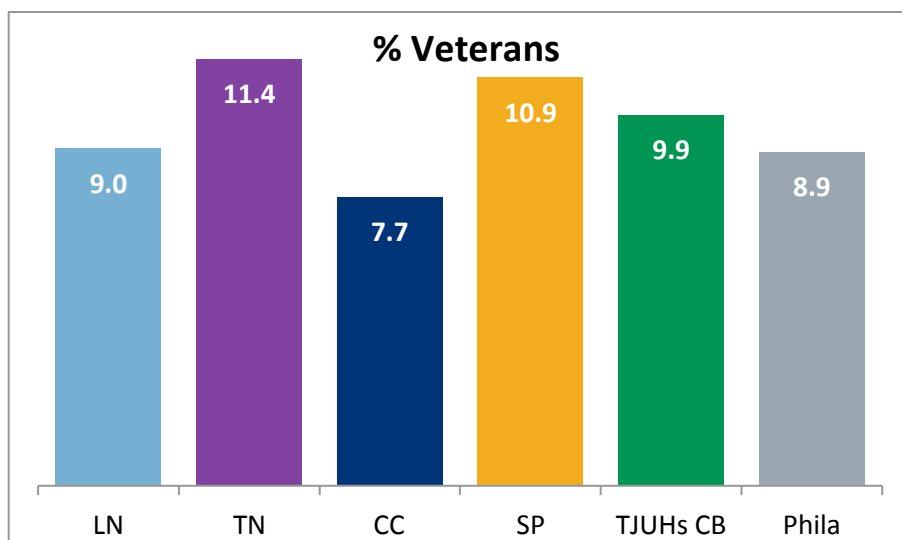
- Determine the number of returning citizens successfully obtaining treatment for behavioral/physical health and substance abuse during incarceration and upon release from jail or prison
- Evaluate the transitional planning of these services

**Based on internal and external key informants, focus groups, existing relationships and programs, and secondary data, actions addressing returning citizens may include:**

- 1. Continue to collaborate with the Behavioral/Physical Health & Substance Abuse Work Group of the Philadelphia Re-entry Coalition**
- 2. Continue to support the Roots to Reentry Program at the Philadelphia Prison**

## ***Veterans***

There are currently 140,264 Veterans in Philadelphia—8.9% of the Philadelphia population, and nearly 42,000 veterans residing in TJUHs Community Benefit area neighborhoods.



*PHMC Household Health Survey 2015*

*Veterans Multi-Service Center (VMC) of Philadelphia:*<sup>195</sup> exists solely to “serve those who served”. They are the only non-profit agency in the Philadelphia and surrounding areas that provides a comprehensive resource center available to all veterans in need. VMC was founded in 1980 to address the multiple needs of Vietnam Veterans. Since that time programs and assistance have grown and diversified to encompass the needs of veterans of all wars and conflicts, up to and including Operation Iraqi Freedom, Operation Enduring Freedom, and Operation New Dawn Veterans.

Services include:

- 1) **Veteran Benefit / Entitlement Assistance** - VMC employs two full time accredited Veteran Service Officers certified by the Vietnam Veterans of America and The Associates of Vietnam Veterans of America. They possess experience and in-depth knowledge of the VA system and are available to assist in developing and filing claims along with addressing questions that veterans may have concerning their entitlements to include the new GI Bill.
- 2) **Employment and Training Services** - The training programs are designed with the current job market in mind to allow Veterans the ability to acquire the necessary skills to compete for demanding positions and to earn a liveable wage.

3) Homeless Veteran Services - Since 1980, VMC has provided assistance to homeless Veterans and Veterans in danger of this life situation. Providing a full continuum of care for homeless Veterans VMC operates:

- *The Perimeter* - Homeless day service center providing immediate needs;
- *Operating Base Cecilia* - Offering SSVF program services to Montgomery, Chester and Delaware counties
- *LZ II* – 95 bed male transitional housing residence\_
- *The Mary E. Walker House* – 30 bed female transitional housing residence\_
- *Freedom's Gate* – 30 unit Shelter Plus Care (SPC) housing program
- *Veterans Home Project* – 10 units of subsidized housing for Veterans with special needs

4) Supportive Services for Veterans and Families (SSVF) provides comprehensive supportive services to very low income veterans and their families who are currently experiencing homelessness or are at risk of losing their homes. Eligible Veterans may receive time-limited financial assistance for rent, utilities, and security deposits. SSVF also offers short term case management services linking Veterans within the Veterans Administration and other community resources.

5) On-Site Resources -Over the past 32 years, VMC has established a wide range of community partnerships and increased efforts to provide the most current and sought after resources for veterans.

**Issues, challenges, unmet needs and priorities identified by key informants and focus group participants related to the Veterans:**

- **Access**
  - Barriers to timely care (administrative issues – time to get appointment; rescheduling when appointment cancelled)
- **Mental Health**
  - Stigma/reluctance to go to VA for mental health concerns due to fear it will limit future employment
  - Additional VMC staff training to deal with mental health issues among clientele
  - Group sessions for stress management (especially for Veterans returning to the workforce)
- **Chronic Disease**
  - Broad education opportunities on health topics and coping with ongoing issues/symptoms/balancing meds
  - Smoking cessation support
  - Study to evaluate the evolving health needs across the Veteran population

- Need programs that are offered on an on-going basis – possibly provide chronic disease self-management program or the workforce development health program (key informant)
- Major health issues - PTSD/head trauma, obesity, back issues, Diabetes; Agent orange, Improve blood pressure awareness and management, Managing medications (key informant)
- HIV/AIDS - *Groups come in regularly to offer on the spot AIDS/HIV testing. However, and have not had luck in scheduling any to return* (key informant)
- Assess emergency department use by VMC clients

**Based on internal and external key informants, focus groups, existing relationships and programs, and secondary data, actions addressing Veterans may include:**

- 1. Explore collaboration with Veteran's Multiservice Center in areas of health education, smoking cessation, chronic disease self-management, and HIV screening and follow-up.**

## Identification and Prioritization of Community Health Needs

### Phase I

To address the community health needs identified in the CHNA, recommendations for initiatives were initially prioritized based on secondary data findings, primary data gathered through internal and external key informant interviews, and focus groups with community residents. Participants in key informant interviews and focus groups were asked to identify the health needs of the community and were then asked to identify those they felt were most important to address. They were also asked to recommend potential initiatives to address these needs.

The identified priority health needs and recommended initiatives were then grouped into the following domains:

- Access to care
- Chronic disease management,
- Health screening and early detection
- Healthy lifestyle behaviors
- Social and built environment

To further prioritize these initiatives, the Community Health Needs Assessment Survey Team from the Center for Urban Health reviewed the prioritization criteria and weights used in the 2013 Health Needs Assessment. An additional three criteria were added for a total of thirteen. Weighted values were assigned and used to assess each health need/issue based on secondary data and input from key informants and focus groups. Scoring ranged from 0-3 depending on the assigned weighted value. A maximum score of 30 was possible for each health need/issue. These criteria and weighted values are provided in the Table below:

### Prioritization Criteria

Criteria	Maximum Weighted Value
Does not meet HP 2020	2
Regional priority (SHIP and CHIP priority)	3
Disparity exists compared to Philadelphia	3
Focus groups and key informants perceive problem to be important	3
Sub-population is special risk	3
Problem not being addressed by other agencies	1
Has great potential to improve health status	3
Positive visibility for TJUH	1
# people affected	3
Feasibility/resources available/existing relationships in place	2
Links to TJUH strategic plan and/or service line plan	2
Sustainability	2
Collaboration opportunities	2

Scores for each health issue were summed across the raters. The mean value was then calculated and used to rank health issues/concerns overall.

## **Community Health Needs Assessment Survey Team Prioritization**

### **Phase II**

In Phase II, the Community Benefit Steering Committee (CBSC), composed of TJUHs Senior Leadership, prioritized the health needs and issues identified by the Center of Urban Health using criteria linked to TJUHs strategic planning process. These criteria included Impact, Importance and Investment and used a scale of 1 to 5. A maximum score of 15 was possible. Scores for each health issue were summed across the raters. The overall mean value was then calculated and used to determine and prioritize CHNA health issues/concerns in relationship to TJUHs strategic plan.

**The following are the health issues/needs that will be addressed in the CHNA Implementation Plan:**

HEALTH ISSUES / NEEDS
Workforce Development
Health Insurance
Language Access
Colon Cancer
Social and Health Care Needs of Older Adults
Obesity
Regular source of care
Women's Cancer
Diabetes, heart disease, hypertension, stroke
Hospital and ED Utilization

The following are the health issues/needs that will not be addressed specifically in the CHNA Implementation Plan, but does not mean that programs in place will not continue, These additional domains will be considered based on existing, or new relationships/collaborations; funding opportunities; regional or local public health priorities; and identified innovative projects/programs. Many of the health related concerns below are underlying root causes or behaviors that impact the prioritized domains above:

HEALTH ISSUE /NEED NOT ADDRESSED BY CHNA IMPLEMENTATION PLAN
Housing
Community Safety
Alcohol and Substance Abuse
Behavioral Health
Maternal & Child Health
Access to Safe Places for Physical Activity
Transportation
Youth Health Behaviors (Obesity will be addressed)
HIV
Access to Healthy Foods
Smoking

The prioritization and rankings inform the Implementation Plan and the timeline for phasing in these interventions. The following recommendations should be considered in the development of the CHNA Implementation Plan:

- The Community Health Needs Assessment Survey Team recommended that an external Community Advisory Group be created and coordinated by TJUHs. This group, consisting of collaborating partners and key community stakeholders and residents, would meet quarterly, or as needed, to share information, help to coordinate efforts, and provide insight into the development, implementation and evaluation of proposed interventions. It will also help to promote partners programs throughout the community and better engage the community in health promotion efforts.
- The Community Benefits Steering Committee (Senior Administration) that spans TJUHs and TJU will coordinate efforts across the university and hospitals. Community Benefit activities should integrate and coordinate service, educational, clinical and research community-based opportunities to support Health Professional education between community, hospital and University.
- The CBSC recommended integrating the CHNA priorities and recommendations for implementation into THUHs Strategic Planning Work Groups where appropriate and relevant.

The CHNA Implementation Plan will be developed by Senior Administration / CHNA Oversight Committee, the Center for Urban Health and Community Advisory Group and key partners.

The link to a description of the resources available to address significant health needs identified through the CHNA is available through a link on Jefferson's website.



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