NOVEMBER 2019

Jefferson Health

Community Health Needs Assessment Implementation Plan

Thomas Jefferson University Hospital
Jefferson Methodist Hospital
Jefferson Hospital for Neuroscience

HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

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Jefferson Health Community Health Implementation Plan

Overview of Jefferson Health

Overview of "Jefferson Health"

Jefferson Health Hospitals and Thomas Jefferson University are partners in providing excellent clinical and compassionate care for our patients in the Philadelphia region, educating the health professionals of tomorrow in a variety of disciplines and discovering new knowledge that will define the future of clinical care.

Jefferson Health (JH), the clinical arm of Thomas Jefferson University, has grown from a three-hospital academic health center in 2015 to a 14-hospital health system through mergers and combinations that include former hospitals at Abington Health, Aria Health, Kennedy Health and Magee Rehabilitation. Jefferson Health has seven Magnet®-designated hospitals (recognized by the ANCC for nursing excellence); one of the largest faculty-based telehealth networks in the country; the NCI-designated Sidney Kimmel Cancer Center (one of only 70 in the country); and more than 40 outpatient and urgent care locations. Thomas Jefferson University Hospital (TJUH), 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. It also continues its national record of excellence with recognition from *U.S. News & World Report.* In 2019-20, TJUH ranked among the nation's best in 8 specialty areas, with two in the top 10 — Ophthalmology (Wills Eye Hospital #2) and Orthopedics (Rothman Institute at Jefferson and the Philadelphia Hand to Shoulder Center #10). Magee Rehabilitation Hospital – Jefferson Health ranked the 13th best hospital in the nation for Physical Rehabilitation.

In 2019, Jefferson Health included 2,867 licensed beds; 7,400 nurses, 6,100 physicians and practitioners; 4,600 faculty and more than 2,100 volunteers. Clinically, in 2019 Jefferson Health provided care for 127,000 inpatients, 517,000 emergency visits, and more than 3.8 million outpatient visits.

We are 30,000+ people reimagining health care, education and discovery. We are many things, but every day all of us are dedicated to one thing: Improving lives.

Mission: We Improve Lives.

Vision: Reimagining health, education and discovery to create unparalleled value.

Values: Jefferson's values define who we are as an organization, what we stand for, and how we continue the work of helping others that began here nearly two centuries ago. These values are:

- *Put People First*: Service-Minded, Respectful & Embraces Diversity
- *Be Bold & Think Differently*: Innovative, Courageous & Solution-Oriented
- *Do the Right Thing*: Safety-Focused, Integrity & Accountability

Jefferson Health recognizes that by providing quality health care to our patients, and education and outreach to our neighbors, we are also enriching the lives and future of our surrounding communities. The work extends beyond the bedside. By partnering with the community, Jefferson Health seeks to improve the health and well-being of young and older Philadelphia and suburban residents through a variety of interventions including prevention and wellness programs, health education seminars, and screenings, as well as efforts that identify and address barriers to health, including the upstream factors (social determinants of health) that impact the health of everyone in the community.

Geographic regions and zip codes served by Jefferson Health

Jefferson Health	County and ZIP Codes
Abington Jefferson Health	**Bucks County:** 18914, 18929, 18932, 18966, 18974 ,18976 **Montgomery County:** 18915, 18936, 19001, 19002, 19009, 19012, 19025, 19027, 19031, 19034, 19038, 19040, 19044, 19046, 19075, 19090, 19095, 19422, 19436, 19437, 19438, 19446, 19454, 19477, 18964, 18969, 19006, 19440
Jefferson Health -Northeast	**Bucks County:** 18940, 18954, 18966, 18974, 19007, 19020, 19021, 19030, 19047, 19053, 19054, 19055, 19056, 19057, 19067 **Philadelphia County:** 19111, 19114, 19115, 19116, 19120, 19124, 19125, 19134, 19135, 19136, 19137, 19140, 19149, 19152, 19154
Jefferson Health- New Jersey	**Burlington, Camden, Gloucester, and Ocean Counties**
Magee Rehabilitation	**Region**
Jefferson Health - Center City	**Philadelphia County:** 19102, 19103, 19106, 19107, 19121, 19122, 19123, 19124, 19125, 19130, 19132, 19133, 19134, 19140, 19145, 19146, 19147, 19148

Overview of the Community Health Needs Assessment and Prioritization Process

The Affordable Care Act (ACA) mandates that, every three years, tax-exempt hospitals conduct a Community Health Needs Assessment (CHNA). By determining and examining the health needs and gaps in communities, these assessments drive hospitals' planning and implementation of initiatives to improve community health.

Recognizing that hospitals and health systems often mutually serve the same communities, during 2018 and 2019, a group of local hospitals and health systems convened to develop this first-ever Southeastern PA (SEPA) Regional CHNA, with specific focus on Bucks, Chester, Montgomery, and Philadelphia counties. This initiative expanded the focus of COACH (Collaborative Opportunities to Advance Community Health), a coalition formed by many of the region's hospitals and Health systems to address the health and social needs in Southeastern Pennsylvania.

Secondary health data findings and primary data gathered through community meetings, focus groups, and key informant interviews, were synthesized by Philadelphia Department of Public Health (PDPH) staff. A list of 16 community health priorities (listed below) was presented to the COACH Steering Committee that included representation from all of the hospitals participating in the Community Health Needs Assessment. Using a modified Hanlon ranking method, the PDPH ranked the size of the problem and the Importance to the community based on secondary data and input from the community collected during the assessment process. Each participating hospital and health system rated each of the priorities based on the following criteria:

- Size of health problem
- Importance to the community
- Capacity of hospitals/health systems to address
- Alignment with mission and strategic direction
- Availability of existing collaborative efforts

Using these five criteria, an average rating was calculated for each priority area. The community health priorities for the region are presented below in ranked order.

PRIORITY HEALTH ISSUES/NEEDS
1. Substance/ Opioid Use and Abuse
2. Behavioral Health Diagnosis and Treatment
3. Access to affordable primary/ preventive care
4. Healthcare and Health resources navigation
5. Access to affordable specialty care
6. Chronic disease prevention
7. Food access and affordability
8. Affordable and Healthy housing

9. Sexual and Reproductive Health
10. Linguistically and culturally appropriate healthcare
11. Maternal Morbidity and mortality
12. Socioeconomic disadvantage (Income, Education, and Employment)
13. Community Violence
14. Racism and Discrimination in Healthcare setting
15. Neighborhood conditions (E.G. Blight, Greenspace, Parks/Recreation, etc.)
16. Homelessness

Jefferson Enterprise Hospitals are working collaboratively to address Substance Use Disorder and Behavioral Health diagnosis and treatment.

Jefferson Health – Center City

Community Health Implementation Plan

Jefferson Health –Center City

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 Health locations in Center City have major programs in a wide range of clinical specialties. Services are provided at five primary locations. Three are highlighted here: Thomas Jefferson University Hospital (TJUH), the main hospital facility, established in 1825 and located in Center City Philadelphia; Jefferson Hospital for Neuroscience (JHN), also located in Center City; and Jefferson Methodist Hospital (JMH), in South Philadelphia. Services are also provided at Jefferson at the Navy Yard, in South Philadelphia.

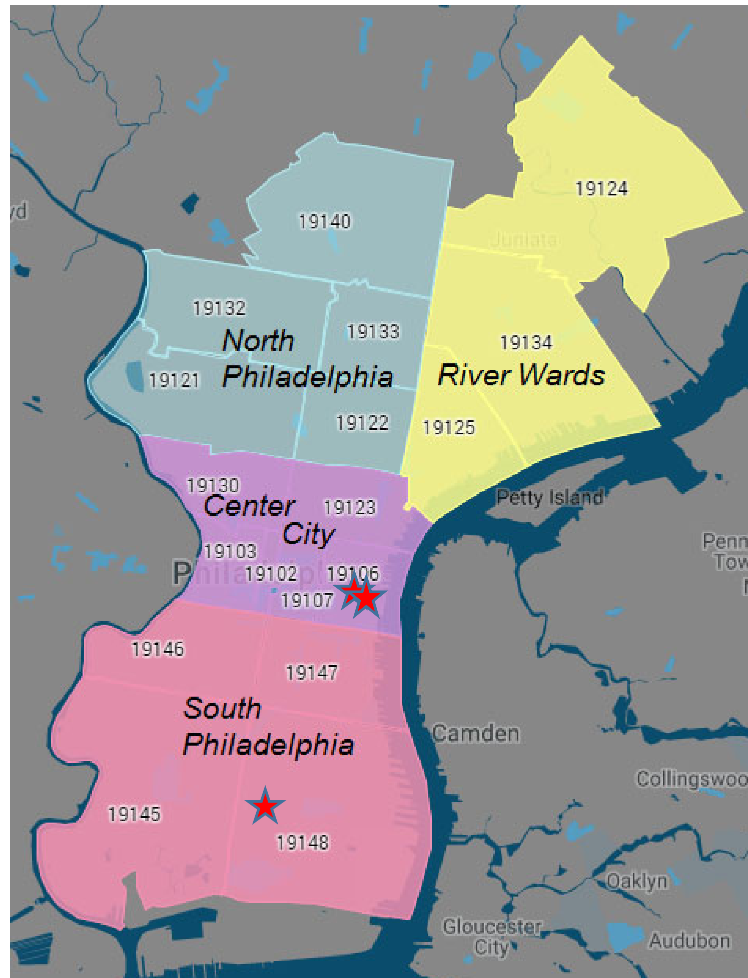
Targeted Service Area for Community Health Improvement

Jefferson Health – Center City defines its community benefit area as the geographic area encompassing 18 zip codes in North Philadelphia-East, North Philadelphia-West, River Wards, Center City, South Philadelphia-East, and South Philadelphia-West. These ZIP codes are the most geographically proximate to TJUH, JHN and JMH campuses. The focus within these zip codes is on communities with a poverty rate >20% and where health disparities are more prevalent. These areas represent a total population of 592,693; more than one-third of all Philadelphia residents.

Jefferson Health – Center City'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. Racial/ethnic and income disparities exist, and for most indicators, people of color and/or Hispanic origin fare far worse than their Caucasian neighbors.

Philadelphia County: 19102, 19103, 19106, 19107, 19121, 19122, 19123, 19124, 19125, 19130, 19132, 19133, 19134, 19140, 19145, 19146, 19147, 19148



Priority Health Issues and Needs to be Addressed

The Table below compares the rankings of the priority health issues of the region to how these were ranked by senior leaders at Jefferson Health –Center City.

Priority	Region Ranking	TJUH Ranking
Substance/opioid use and abuse	**1**	**1**
Healthcare and health resources navigation	**4**	**2**

Priority	Region Ranking	TJUH Ranking
Behavioral health diagnosis and treatment (e.g. depression, anxiety, trauma-related conditions, etc.)	**2**	**3**
Access to affordable specialty care	**5**	**4**
Access to affordable primary and preventive care	**3**	**5**
Chronic disease prevention (e.g. obesity, hypertension, diabetes, and CVD)	**6**	**6**
Maternal morbidity and mortality	**11**	**7**
Sexual and reproductive health	**9**	**8**
Linguistically- and culturally-appropriate healthcare	**10**	**9**
Racism and discrimination in healthcare settings	**14**	**10**
Affordable and healthy housing	**8**	**11**
Socioeconomic disadvantage (income, education, and employment)	**12**	**12**
Food access and affordability	**7**	**13**
Neighborhood conditions (e.g. blight, greenspace, parks/recreation, etc.)	**15**	**14**
Community violence	**13**	**15**
Homelessness	**16**	**16**

Based on the prioritization process for the region and prioritization results specific to Jefferson Health- Center City, the following health issues/needs will be addressed to varying degrees in the 2019-2022 Community Health Implementation Plan:

1. Substance/ Opioid Use and Abuse
2. Behavioral Health Diagnosis and Treatment
3. Access to affordable primary/ preventive care
4. Healthcare and Health resources navigation
5. Access to affordable specialty care
6. Chronic disease prevention
7. Food access and affordability
8. Affordable and Healthy housing
9. Sexual and Reproductive Health
10. Linguistically and culturally appropriate healthcare
11. Maternal Morbidity and mortality
12. Socioeconomic disadvantage (Income, Education, and Employment)
13. Community Violence
14. Racism and Discrimination in Healthcare setting
15. Neighborhood conditions (E.G. Blight, Greenspace, Parks/Recreation, etc.)

16. Homelessness

The Community Health Needs Assessment was approved by the Jefferson Board in June 2019.

Overview of the Implementation Plan

The CHIP was developed by Senior Administration/CHNA Oversight Committee, the Center for Urban Health, key leaders from Thomas Jefferson University and Jefferson Health-Center City and recommendations from key community partners. The plan will be reviewed annually and revised based on changing community needs, best practices and short-term/intermediate outcomes.

The CHIP is organized into the following four Domains and related Priority Issues:

Domain	Health Related Issue
Substance Use and Abuse	• Tobacco, marijuana and Vaping • Alcohol • Opiates • Access to Structured Activities for youth
Behavioral Health	• Training for health care providers, health professional students, community based organizations, youth, schools • Access to timely culturally and linguistically appropriate care • Prevention and Early detection
Access to affordable, culturally appropriate primary and specialty care	• Workforce Diversity and Development • Insurance access and support • Healthcare navigation • Culturally and linguistically appropriate care
Chronic Disease Prevention and Management	• Hypertension • Cardiovascular Disease • Diabetes • Cancer • Obesity • Injury Prevention
Social Determinants of Health	• Food Access and Affordability • Linguistically and culturally appropriate health care • Socio-economic disadvantage • Neighborhood Conditions • Access to Community Health and Social Resources Information • Affordable and Healthy Housing/ Homelessness

The **Implementation Plan** includes an overview of each of the domains, and related priority health needs/issues. A logic model for each priority health need provides an overview of the objectives, proposed strategies/activities, outcomes and impact measures, and potential partners.
The strategies/activities related to Special Populations (refugees/immigrants, the homeless, returning citizens, veterans, and Lesbian Gay Bi-sexual Transsexual and Queer) are integrated throughout the Implementation Plan as are underlying root causes that impact the priority health need such as access to healthy food and safe places for physical activity, health literacy, behavioral health issues including substance abuse, smoking, transportation and housing. Proposed strategies/activities were considered based on their alignment with national, Pennsylvania, and Philadelphia health improvement plans, and national best practices cited by organizations such as the US Department of Health and Human Services, Agency for Health Research and Quality, Healthy People 2020, the American Medical Association, National Council on Aging, the National Prevention Strategy, the Guide to Community Preventive Services, and the Guide to Clinical Preventive Services.

Strategies and activities were also included that can impact health issues at multiple levels of the Social Ecological Model. The model integrates: 1) Individual factors, sometimes called intrapersonal factors, like genetics and individual behaviors; 2) Interpersonal factors, like social support and family characteristics; 3) Institutional and community environments, which might include work sites, schools, service systems and transportation; and 4) Broader social, economic, and political influences, which could encompass a range of factors from laws and regulations to racism and discrimination.

Domain: Substance Use and Abuse

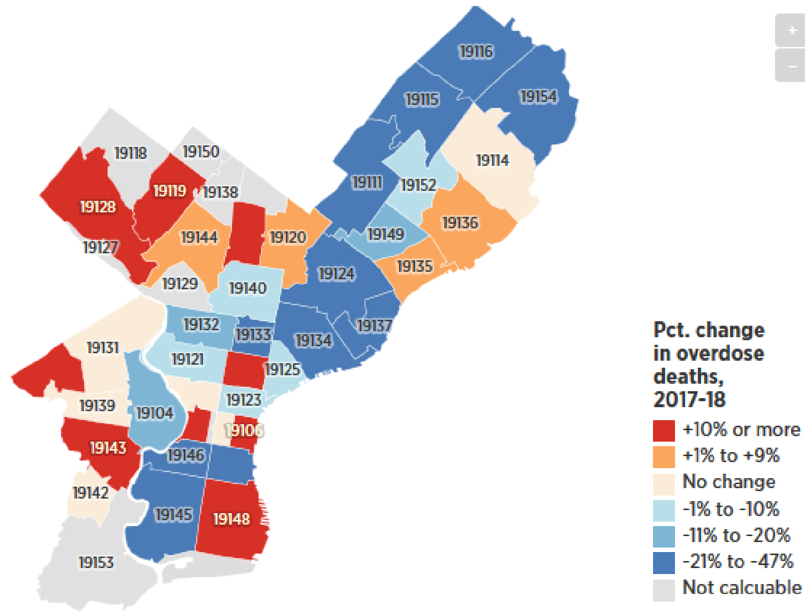
Drug overdose deaths have tripled and are the leading cause of death among young adults (ages 18 – 34) in the region. With the exception of Center City, the rate of drug overdose deaths in Jefferson Health's Community Benefit area is similar to or exceeds the rate in Philadelphia overall. In 2018 there were 1,116 overdose deaths in Philadelphia representing an 8% drop compared to 2017. However, overdoses in Philadelphia remain among the highest for urban communities in the United States. While some neighborhoods in Philadelphia, such as zip code 19133 (Fairhill), 19134 (Kensington, Harrowgate and Port Richmond) and 19124 (Frankford) have experienced a 23% or greater decrease in overdoses between 2017 and 2018, others have experienced an increase in overdoses such as 19148 in South Philadelphia where deaths rose from 44 to 54 (20% increase) between 2017 and 2018. Other neighborhoods saw little change. Hunting Park (19140), which went from 32 overdoses in 2016 to 52 in 2017 (a 62.5% spike), had two fewer overdoses in 2018. Zip codes 19124, 19140, 19134 and 19148 have the highest number of overdoses in the city,

Philadelphia Health Department officials attribute the decline in overdose rates to increased treatment capacity, distribution of naloxone and training the public how to use it.

Adult binge drinking rates are higher in Center City (28.3%), North Philadelphia East (21.7%), North Philadelphia West (20.8%) and south Philadelphia West (28.5%) than in the City of Philadelphia overall (18.9%)

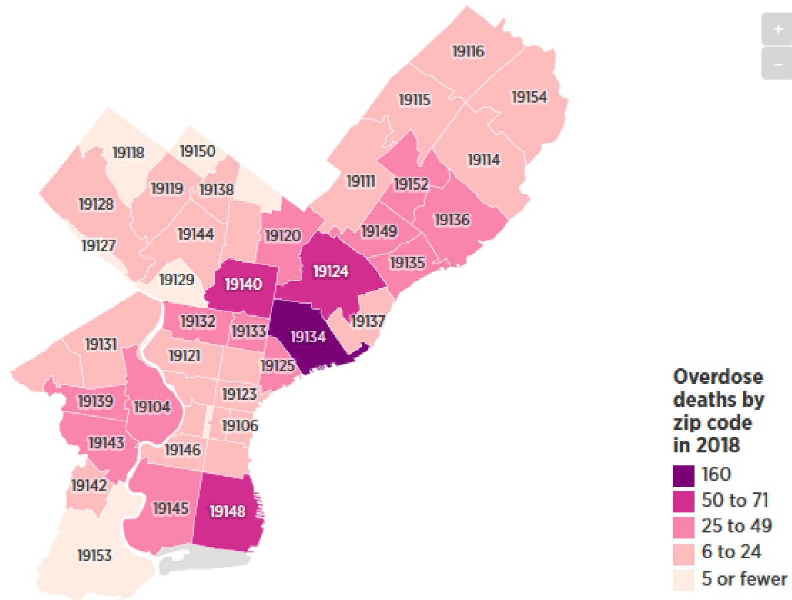
Tobacco is an underlying cause of chronic disease including cancer, heart disease and stroke. Adult smoking rates range from a low of 11% in Center City to 28.8% North Philadelphia East and North Philadelphia West. Four neighborhoods in Jefferson's community benefit area (North Philadelphia East, North Philadelphia West, Riverwards, and South Philadelphia West) have smoking rates that exceed the adult smoking rate in Philadelphia (19.5%). Finally vaping marijuana and tobacco is a growing concern and the Philadelphia Department of Health is promoting educational programs in schools and limiting access to flavored tobacco products to address this issue.

Change in Overdose Deaths, 2017 to 2018



Map: JOHN DUCHNESKIE / Staff Artist • Source: Philadelphia Department of Public Health

Number of Overdose Deaths by Zip Code



Map: JOHN DUCHNESKIE / Staff Artist • Source: Philadelphia Department of Public Health

Substance Use and Abuse	
Goal: Prevent and reduce the consequences of substance use and abuse through education, policy and system changes	
Objective: Reduce the number of people who become addicted to opioids	
Strategy/Action	• Reduce access to opiates and other addictive pain medications by educating healthcare providers and patients/caregivers prescribed pain medications about drug take-back programs through social media, email updates to employees, flyers and the "Opioid Matters" newsletter. • Distribute "Opioid Matters" newsletter throughout the Jefferson Enterprise • Increase awareness among patients taking prescribed pain killers about youth and others who may take pain medication that is not prescribed for them but accessible in the home. • Reduce prescribed painkillers through provider education and adherence to prescribing guidelines/ regulations • Provide X-Waiver training to increase the number of prescribers that can prescribe MAT particularly in primary care • Provide Chronic Pain Self-Management Programs • Implement Jefferson and City opiate taskforces/work groups plans/strategies
Target Population	Patients who are prescribed painkillers and their caregivers; Providers who prescribe pain medication; Hospital ED/inpatient departments; Individuals suffering from Opioid Use Disorder (OUD) or Substance Use Disorder (SUD); Youth Zip codes and specific groups with higher SUD rates particularly in North and South Philadelphia
Outcomes	• Educational/ promotional materials about drug take-back programs developed and disseminated to health care providers, patients prescribed pain killers, youth and the general public. • Increased utilization of drug take-back programs in community benefit area • Reduced youth access to prescription drugs that impact SUD and OUD rates • Reduced # of prescribed narcotic painkillers • Increased access to MAT • Improved chronic pain management • Reduced overdoses
Potential Partners	Internal Partners: Center for Urban Health, primary care, surgery, emergency department, hospital discharge, pharmacy, psychiatry, primary care, NARP, MATER, Myrna Brind Center, OB/GYN, college of pharmacy External Partners: Police Department, lock box programs, Philadelphia Department of Health; Department of Behavioral Health and Intellectual disAbility (DBHIDS); COACH, Prison system/Reentry Coalition, community pharmacies

Objective: Reduce negative health outcomes due to substance use and abuse	
Strategy/Action	• Increase warm-hand-off referrals to NARP and other Medication Assistance Programs (MAT) • Increase MAT in primary care sites • Increase access to NARCAN training and distribution • Refer individuals with OUD to community-based support groups (NA; AA) and Friends and Family of Loved Ones with SUD (Methodist Hospital) • Support pregnant women with substance use disorder through MATER program (education, therapy, housing assistance; centering pregnancy). Expand capacity of MATER to reach more women
Target Population	Individuals with substance use disorder or opiate use disorder; health professional students and providers; community based-organizations; youth
Outcomes	• Increased referrals to and utilization of MAT • Reduced opioid overdose • Improved maternal and infant birth outcomes
Potential Partners	Internal Partners: Center for Urban Health, primary care, surgery, emergency department, hospital discharge, pharmacy, College of Pharmacy, NARP, MATER, Thomas Jefferson University External Partners: Police Department, Philadelphia Department of Health; DBHIDS; COACH, community and faith-based organizations, business community,
Objective: Reduce youth access to and utilization of alcohol, tobacco, marijuana and vaping products	
Strategy/action	• Continue to participate in the South Philadelphia Prevention Coalition and other Drug Free Communities Coalition activities. • Educate youth about the dangers of vaping tobacco and marijuana • Support policy changes that reduce youth access to alcohol, tobacco (flavored) and vaping products
Target Population	North and South Philadelphia youth and community members
Outcomes	• # community members reached through programs • # youth reached • Increase percentage of youth who believe substance use is a problem • Reduce percentage of youth who report using tobacco, alcohol, marijuana, vaping and other drugs.
Potential Partners	Internal Partners: TJUH Center for Urban Health External Partners: SAMSHA CADCA Grant (Youth Serving Organizations, Town Watch, Police, SEPC staff, School Partners: students at Universal Audenried, South Philadelphia High School, Furness High School, Sharswood School, and McDaniel School, Prevention Partners, United Communities; Trinity United Methodist Church; Philly Rising, Friends of Mifflin Square Park, Mural Arts Program, Business Partners, Parents; Philadelphia Department of Public Health – SMOKFREE Philly; DBHIDS; COACH
Objective: Increase substance use screening, brief intervention and referral to treatment (SBIRT) by health care providers	
Strategy/action	Provide SBIRT training (screening, brief intervention, referral to treatment) to health professional students and health care providers

Target Population	Sidney Kimmel Medical College, Pharmacy, Physician Assistant students, Health care providers
Outcomes	• 90% of first, second and third year Jefferson Medical, Physician Assistants and Pharmacy students trained • # healthcare providers trained • # patients screened and referred
Potential Partners	Internal Partners: Primary Care provider, ED, Nursing, College of Pharmacy, Physician Assistants, Sidney Kimmel Medical College, TJUH Center for Urban Health External Partners: SAMSHA SBIRT, DBHIDS

Domain: Behavioral Health

Behavioral health needs emerged as one of the top priorities in the community health needs assessment for Philadelphia and the surrounding counties. One in five adults in the region report diagnosed depression and more than one in 10 adults report experiencing frequent mental distress. Undiagnosed and untreated conditions like depression, anxiety and trauma-related conditions result in higher emergency department utilization particularly among youth, persisting suicide rates, and substance use and abuse. Particularly vulnerable populations include individuals experiencing poverty, homelessness/housing insecurity, racial and ethnic minorities, immigrants and refugees and those who identify as LQBTQ.

Nearly two-thirds of all gun related deaths are due to suicide. Suicide is the second leading cause of death among adolescents aged 10–19 in the U.S. In 2017, approximately 1 in 5 deaths in youth were attributed to suicide. Risk factors for youth suicide include a previous suicide attempt, psychiatric disorders (such as major depression, bipolar disorder, generalized anxiety and personality disorder traits), substance use, lack of social support, and availability of lethal means. Adverse childhood events, family discord, fights with friends, poverty, and legal trouble risk factors related to suicide ideation and attempts. In 2017, 13.8% of Youth in Philadelphia reported suicide ideation and 9.3% reported having attempted suicide.

According to key informants and focus group participants, behavioral health priorities include addressing depression, anxiety and chronic stress in the community related to exposure to trauma (violence, suicide, poverty and substance use). Key informants and focus group participants also described knowledge about and access to behavioral health care resources and services as limited, and community awareness about how to assist individuals with mental health problems as an area for improvement.

Behavioral Health	
Goal : Increase access to culturally and linguistically appropriate patient-centered behavioral health services for adults and children	
Objective: Increase access to mental health services	
Strategy/Action	• Collaborate with the State Health Improvement Plan, Philadelphia Department of Health, Department of Behavioral Health and Intellectual disAbility (DBHIDS) and COACH partners to increase access to a mental health services by raising awareness of providers and the community about available mental health resources and services. • Improve communication between Behavioral Health providers and primary care providers • Increase screening for depression, anxiety, suicide in primary care, OB post-partum patients and emergency department • Co-locate behavioral health services in primary care practices, emergency department, and other venues such as supportive housing sites • Explore telehealth as a means to increase access to behavioral health services • Provide school-based counseling support • Train CHWs as peer specialists/recovery specialists
Target Population	Health care providers; Insurance companies; Philadelphia and Pennsylvania Department of Health; DBHIDS; COACH; youth; adults; Prison system/Reentry
Outcomes	• Develop centralized repository of behavioral health resources and services • Improved communication between behavioral health and health care providers. • Increased referrals to and utilization of behavioral health services
Potential Partners	Internal Partners: Center for Urban Health, Psychiatry Dept., Counseling and Behavioral Health Department, JTEN, Couples and Family Therapy, Population Health, Social Work, Center for Integrative Medicine, Jefferson primary care providers, Emergency Department, OB/GYN External Partners: Philadelphia Department of Health, DBHIDS, PA Department of Health; Healthcare Improvement Foundation, COACH, ALLCOVE, schools, community development corporations, Re-entry Coalition
Objective: Increase awareness about mental health issues, management and treatment	
Strategy/Action	• Provide Mental Health First Aid training in partnership with DBHIDS • Provide trauma informed care training and coaching in schools and after-school programs for staff and parents • Increase awareness of the impact of Adverse Childhood Events on health • Provide trauma informed care training for health care professionals • Provide mindfulness and stress management training for youth and adults • Promote DBHIDS Network of Neighbors program among Jefferson employees and the community (adults and youth) • Support the Pennsylvania Department of Human Services Suicide Prevention Task Force efforts to raise awareness about and utilization of screening in the ED, Lifeline, QPR training (training for health care providers), survivor support groups, and use of guns in suicide attempts and deaths. Document suicide attempt data.

	• Increase understanding of dementia among health professionals, family members and the community
Target Population	Health professionals, health professional students, community and faith-based organizations, schools, after-school programs, senior centers
Outcomes	• Provide 10 Mental Health First Aid trainings to TJUH/Methodist staff reaching at least 15 people per session ; Implement training for all nursing students; expand training to include other Jefferson University students • Provide 10 Mental Health First Aid trainings for school partners and other community and faith- based organizations reaching at least 15 people per training • Improve ability of school staff, health care professionals, parents and individuals working with youth to address trauma among youth and other vulnerable populations • Improve ability of youth and adults participating in mindfulness/stress programs to manage stress • Decreased suicide attempts and deaths • Improve ability of health professionals and the community to assist those with cognitive impairment/ dementia
Potential Partners	Internal Partners: TJUH Center for Urban Health, TJUH and Methodist Hospital ED, HR, College of Nursing, Pharmacy, College of Health Professions, Institute for Emerging Health Professions, Sidney Kimmel Medical College, Psychiatry Department, Counseling and Behavioral Health Department, JTEN, Population Health, Social Work, Center for Integrative Medicine, Trauma Center at Jefferson, Jefferson primary care providers External Partners: DBHIDS, school partners, community partners (Nationalities Services Center, United Communities, Federation of Neighborhood Centers, ACES Taskforce, Steven Klein Wellness Center, faith-based organizations), ALLCOVE, COACH, Concilio, senior centers
Objective: Increase access to mental health coverage	
Strategy/Action	Advocate for a more coordinated system of mental health coverage Continue to work with COACH and the Philadelphia Department of Public Health's Community Health Improvement Plan
Target Population	Health care providers; Insurance companies; Philadelphia and Pennsylvania Department of Health
Outcomes	To be determined by COACH
Potential Partners	Internal Partners: Government Relations, Center for Urban Health, Finance Department, Psychiatry Dept. External Partners: Philadelphia Department of Health, DBHIDS, PA Department of Health; Healthcare Improvement Foundation, COACH, Insurance Payors

Domain: Access to Affordable, Culturally Appropriate Primary and Specialty Care

According to Healthy People 2020**,** access to health services encompasses four components: coverage, services, timeliness, and workforce. Access to affordable, culturally appropriate primary and specialty care is impacted by a workforce that reflects the community it serves, the availability of services in languages most spoken by immigrants and refugees, and financial/logistical barriers including availability and utilization of insurance, high co-pays and deductibles, and lack of timely, convenient appointments to see primary care and specialty physicians. In addition, navigating healthcare services can be challenging due to lack of awareness and fragmented systems.

Workforce Development

Like hospitals in other major urban metropolitan areas, Philadelphia hospitals are often located near communities that have experienced long-term disinvestment and disadvantages. Entry-level and allied health-care jobs can provide local residents from low-income communities entry into ladder employment positions that are stable, provide a living wage, and allow a path for career advancement, especially young men and men of color who have faced compounded educational, economic, and life challenges. At the same time, diversifying these institutions can lead to improved client services and more culturally appropriate delivery of care. (Policy Link - http://www.policylink.org/sites/default/files/pl_brief_nola_healthcare_FINAL_0_0.pdf)

A health care workforce that reflects the demographic diversity of Philadelphia and the region 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 health professions depends on increasing minority youth interest in and capacity to enter health professions through programs such as Precollege education (K-12) focused on STEM education, increased awareness about careers in healthcare, a pipeline program that includes employment/shadowing opportunities for high school/college students to build their employment and experiential skills in health care, and support for high school/college students including career counseling, mentoring and application assistance.

Jefferson, through its Office of Enterprise Diversity, Inclusion and Community Engagement (OEDICE) and Thomas Jefferson University are focusing on developing a diverse workforce that reflects the communities served by Jefferson.

These objectives and strategies align with Healthy People 2020, the Pennsylvania Health Innovation Plan (June 2016) and are supported as best practices by Policy Link Strategies for Health-Care Workforce 2015.
(http://www.policylink.org/sites/default/files/pl_brief_nola_healthcare_FINAL_0_0.pdf)

Workforce Development	
Goal : Increase healthcare workforce diversity to reflect the communities that Jefferson serves	
Objective: Develop workforce pipelines with community partners to increase availability of qualified minority candidates for positions throughout Jefferson and Philadelphia	
Strategy/Action	Work with local, state and national organizations serving under-represented minorities (URM) to identify candidates for positions at Jefferson. (specific focus on community & local based organizations)
Target Population	Post high school graduates from URM communities seeking careers in healthcare related professions (clinical and non-clinical).
Outcomes	Establish or expand relationships between Jefferson and 5 partner organizations; 25% of those interviewed for positions will be from under-represented minorities.
Potential Partners	Internal Partners: Institute for Emerging Health Professions, Center for Urban Health, Human Resources, Office of Enterprise Diversity, Inclusion and Community Engagement (OEDICE), Thomas Jefferson University External Partners: Nationalities Services Center, the Welcoming Center, Health Federation, SEAMAAC, Cambodian Association, Steven Klein Wellness Center, BAOP, Congresso, Puentes de Salud, Philadelphia Public/Charter and private schools , Community Colleges, Cheyney University, Workforce development Programs
Strategy/Action	In coordination with Thomas Jefferson University's Health Professions Pipeline Programs and schools in Jefferson's community benefit area, increase awareness about health careers through participation in Career Days, and provide employment and shadowing opportunities at Jefferson for underrepresented minority (URM) high school students and College Students
Target Population	Under-represented minorities in middle and high schools
Outcomes	• Participate in career days reaching 500 middle or high school youth annually; • Increase number URM High School and college students participating in Jefferson pipeline programs, and internship/shadowing experiences • Increase the number of students applying to Jefferson and other health professions programs • Support efforts to increase URM candidates hired at Jefferson
Potential Partners	Internal Partners: Thomas Jefferson University's Health Professions Pipeline Programs, Thomas Jefferson University, Center for Urban Health External Partners: Independence Charter School, Southwark Elementary School, South Philadelphia High School, Kensington Health Sciences Academy, Esperanza Academy Charter School and College, Vare-Washington, Cristo Rey, Area Health Education Center, Boys Latin, Thomas Mifflin, Liquori Academy
Objective: Provide career counseling support and events in conjunction with community partners	

Strategy/Action	Work with community partners to support and attend local job fairs and other career events. Invite Jefferson subject matter experts and career representatives to participate
Target Population	Post high school graduates from URM in healthcare related professions (clinical and non-clinical).
Outcomes	Number of students counseled; Number of URM applicants interviewed for positions increased by 25%.
Potential Partners	Internal Partners: Human Resources; Nurse Recruitment; OEDICE; PR & Marketing, External Partners: Project HOME; Congreso; 1199C; Welcoming Center; JEVS; OTI; Career Links; EARN Center; Philadelphia Works; Veterans Multi Services Center; Southeastern Pennsylvania Area Black Nurses Association (SEPA BNA); National Association of Hispanic Nurses (NAHN); National Coalition of Ethnic Minority Nurse Association (NCEMNA); National Black MBA Association; National Hispanic MBA Association; National Association of Black Accountants; National Medical Association (NMA); Student National Medical Association (SNMA); Phila OIC; Urban Affairs Coalition; National Urban League and other professional organizations serving URMs
Objective: Increase successful application to Thomas Jefferson University or other health professional schools/ colleges	
Strategy/Action	Continue to support the TJU Health Professions Pipeline Program for high school students and the Saturday Academy for middle school students Provide tutoring/ mentoring/shadowing and guidance regarding the various aspects of health professions school admissions and processes to high school and college students as part of pipeline into health professions
Target Population	Cristo Rey High School, South Philadelphia High School, Esperanza Academy Charter School and College, Southwark School, Independence Charter School (ICS), Vare-Washington School, Julio de Burgos, Furness, Big Brothers Big Sisters SEPA (Beyond School Walls Program), Historically Black Colleges and Universities
Outcomes	• Provide STEM education and workforce development programs reaching 500 students • # students enrolled in TJU pipeline programs and successfully completing programs • Increase number of URM students training for or considering health professions programs/careers • Support URM students applying to Thomas Jefferson University and other health professions program
Potential Partners	Internal Partners: Thomas Jefferson University's Health Professions Pipeline Programs, Thomas Jefferson University, Center for Urban Health External Partners: Independence Charter School, Southwark School, South Philadelphia High School, Esperanza Academy Charter School and College, Vare Washington, Cristo Rey, Julio de Burgos, Furness, Area Health Education Center, Work Ready (PYN), UNCF Colleges & Universities, Philadelphia OIC, Urban Affairs Coalition, National Urban League

Health Insurance

Health insurance coverage helps patients utilize the health care system and avoid overutilization of the Emergency Department. Uninsured people are less likely to receive medical care; more likely to die early, and more likely to have poor health status.

Among adults aged 18-64 in Philadelphia, 14.9% lack health insurance. The percent of adults aged 18-64 without insurance ranges from 5.1% in Center City to 18% in North Philadelphia East, Riverwards, and South Philadelphia East. In addition, lack of understanding about how to best use health insurance plans can result in financial debt. Increasing access to healthcare navigators can help to improve understanding about healthcare benefits such as copays, deductibles, navigating the referral process, and cost of prescriptions.

The strategies/activities below will assist individuals and families to better access prescription drugs, understand the insurance exchange market place, and improve their use health insurance to reduce/eliminate financial burden.

Health Insurance	
Goal : Increase the percentage of Adults who are insured and able to effectively use their health insurance	
Objective: Increase access to medications that may not be affordable for patients due to insurance status/requirements of insurers and copays.	
Strategy/Action	• Identify medication assistance programs • Raise awareness of health care providers, patients, and the community about available medication assistance resources/programs
Target Population	Patients, health care providers, and the public
Outcomes	Strategies designed and implemented to raise awareness of health care providers, patients, and the community about medication assistance programs (for example Resource Guide, app, integration into EHR)
Potential Partners	Internal Partners: Business Office, TJUH Patient Access; clinical departments, Center for Urban Health, Social Work, Marketing External Partners: Pharmaceutical companies; US DHHS, FDA and Center for Drug Evaluation and Research (Donations of prescriptions to free clinics), discount programs (Walmart, Target, NeedyMeds and others)
Objective: Increase the percentage of Adults who are insured and able to effectively use their health insurance	
Strategy/Action	• Provide health insurance education and counseling • Train community based organization's staff who assist community members in navigating health care • Provide community based programs on how to properly use health insurance

Target Population	• Zip codes and specific groups with higher uninsured rates • Newly insured, individuals who speak another language, and community based organizations
Outcomes	• # contacted/counseled/ insured • At least two trainings for community based partners and organizations conducted
Potential Partners	Internal Partners: Government Relations, Center for Urban Health, Finance Department, TJU students, Social Workers, Community Health Workers, Care Management External Partners: Enroll America, Cambodian Association, SEAMAAC, PHAN, Nationalities Services Center, PCA and Senior Centers, PACDC, United Communities, faith-based institutions, other CBOs
Objective: Increase access to mental health coverage	
Strategy/Action	• Advocate for a more coordinated system of mental health coverage • Continue to work with COACH and the Philadelphia Department of Public Health's Community Health Improvement Plan – Access to Care committee
Target Population	Health care providers; Insurance companies; Philadelphia and Pennsylvania Department of Health; DBHIDS
Outcomes	To be determined by COACH
Potential Partners	Internal Partners: Government Relations, Center for Urban Health, Finance Department, Psychiatry Dept. External Partners: Philadelphia Department of Health, DBHIDS, PA Department of Health; Healthcare Improvement Foundation, COACH

Culturally Competent Care and Language Access

As Philadelphia becomes a more racially and ethnically diverse city, health care systems and providers need to respond to patients' varied perspectives, values, and behaviors about health and well-being. Failure to understand and manage social and cultural differences may have significant health consequences for minority groups in particular. Barriers to culturally competent care include: 1) lack of diversity in health care's leadership and workforce; 2) systems of care poorly designed to meet the needs of diverse patient populations, and 3) poor communication between providers and patients of different racial, ethnic, or cultural backgrounds. Assuring cultural competency is a key factor in closing the disparities gap in health care. To ensure highest quality of care, language line and interpreter services need to be used consistently across all points of care and these services must be provided by qualified medical interpreters.
(http://www.commonwealthfund.org/usr_doc/betancourt_culturalcompetence_576.pdf

In Philadelphia, approximately two out of three people read below a 9th grade level and one in five read below a 5th grade level, leading to poor outcomes, mistakes, lack of adherence to treatment, excess hospitalizations and Emergency Department (ED) visits. In addition, about twenty percent of people in Jefferson's community benefit area speak a language other than English at home. Among those who speak another language, 10.6% citywide speak English "less than very well"

with higher rates North Philadelphia East (17.5%), Riverwards (16.1%), and South Philadelphia East (17.3%). Regulations stipulate that translation of healthcare documents is necessary if 5% or 1,000 individuals speak a given language. In Philadelphia about 30 languages meet these specifications.

The strategies below align with CLAS standards, Joint Commission, and Pennsylvania Health Innovation Plan (2016), Department of Health and Human Services, NIH, CDC, the Institute of Medicine, the American Medical Society and Healthy People 2020. The Agency Health Care Research for Quality, found that "asking patients to recall and restate what they have been told" (Teach-Back) is one of 11 top patient safety practices based on strength of scientific evidence.

Culturally Competent Care and Language Access	
Goal: Advance health equity, improve quality, and help eliminate health care disparities through the provision of effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (CLAS Standards' Principal Standard)	
Objective: Provide easy-to -understand, culturally appropriate verbal communication, print material, and multimedia materials in English and the languages commonly used by the populations in the service area	
Activity/strategy	• Adopt health literacy universal precautions and teach-back methods throughout Jefferson. • Review and revise patient education materials, discharge instructions, informed consent, and web-site for readability ease and usability. • Translate written materials/forms into foreign languages where 5% or 1,000 individuals have limited English proficiency. • Provide health literacy training, including language access regulations (language line use and use of interpreters), for Jefferson health care providers, staff and students.
Target Population	Patients and families, Hospital employees, Health care providers and staff, TJU health professional students
Outcomes	• Patient education materials/discharge instructions and website usability reviewed and recommendations made for improvement (# documents revised; web revisions) • Healthstream module developed and implemented to address language access regulations related to translation and interpretation. All new employees completed Healthstream module • A tool to measure satisfaction with communication and adherence to regulations regarding interpretation/translation requirements developed and implemented with patients with Limited English Proficiency and/ or those serving these patients.

Potential Partners	Internal Partners: Patient Education, Marketing, Hospital employees, Health care providers and staff, TJU students, Patient Services, Office of Diversity and Inclusion, EPIC, IS+T, Patient & Family Advisory Council; Center for Urban Health, TJU Colleges, Neu Center External Partners: Patients and Family Members, Community based organizations serving non-English speaking/immigrant populations, Language interpretation vendors/companies – Elsevier, Apple, EPIC, Medical Interpreter certification programs**,** Healthcare Improvement Foundation (SEPA READS)
Objective: Enhance language assistance to individuals who have limited English proficiency and/or other communication needs to facilitate oral communication and ensure communication needs are met	
Strategy/Action	Expand use of video services, to enhance verbal communication (through enhancement of non-verbal cues) when using mobile technology and translation lines.
Target Population	All patients and families
Outcomes	• Availability of Video Language Interpretation tool in highest usage areas (hospital inpatient floors and outpatient practices) • A tool to measure satisfaction with communication and adherence to regulations regarding interpretation/translation requirements developed and used with patients with Limited English Proficiency.
Potential Partners	Internal Partners: Patient Education, Marketing, Hospital Employees , Health care providers and staff, TJU students, Patient Services, Office of Diversity and Inclusion, EPIC, IS+T, Center for Urban Health, College of Population Health External Partners: Language interpretation vendors/companies - Elsevier CyraCom, Apple, EPIC, Community based organizations serving non-English speaking community
Strategy/action	• Continue to provide in-person medical interpretation for the Chinese patients and their families. • Expand in-person interpretation available in other languages. Train staff providing interpretation as medically certified interpreters • In partnership with existing programs (Health Federation, Nationalities Services Center) support medical interpreter training of community health workers and community based organization's staff who provide navigation services to clients
Target Population	• Chinese Health Information Center, Methodist Hospital, Organizations serving immigrant/refugee communities • Community based organizations serving non-English speaking individuals • CHWs
Outcomes	• All patients receive care in needed language at all points of service • 100% staff providing interpretation trained as medical interpreters • Increased number of languages available in in-person interpretation
Potential Partners	Internal Partners: Chinese Health Information Center staff, Methodist Hospital staff; Center for Urban Health; Patient Services External Partners: Nationalities Services Center; Health Federation

Objective: Educate and train healthcare workforce in culturally and linguistically appropriate policies and practices on an ongoing basis	
Strategy/Action	• In partnership with Health Care Improvement Foundation, continue to provide health literacy training, including TeachBack and Motivational Interviewing, in Southeastern Pennsylvania and across the Commonwealth • Continue to advocate for and support policies/system changes that mandate health literacy competence in all written and oral communication through participation in the Pennsylvania Health Literacy Coalition
Target Population	Hospitals, Home Health Agencies, Insurers, Library staff, Primary care providers
Outcomes	• # trained/# trainings • On-line training modules developed, System changes implemented, Patient education materials/documents revised • Continued participation in SEPA READS and the Pennsylvania Health Literacy Coalition
Potential Partners	Internal Partners: Center for Urban Health; College of Population Health, Jefferson Library External Partners: Health Care Improvement Foundation, PA Health Literacy Coalition
Objective: Explore opportunities to improve patient-provider communication through expansion of cultural competence training for healthcare providers related to special populations such as immigrants/refugees, LGBT, older adults, individuals with mental illness, returning citizens, people with mild cognitive impairment, individuals with substance abuse, people experiencing trauma and the homeless.	
Strategy/Action	Partner with community based organizations for support in training health care providers, staff and health professional students
Target Population	Hospital employees, Health care providers and staff, TJU health professional students
Outcomes	• # Trainings developed and implemented • # Trained • Improved CAPHS and HCAPHS scores for respect and other related categories
Potential Partners	Internal Partners: Diversity and Inclusion steering committee ; LGBT and Allies Committee External Partners: - Nationalities Services Center, the Welcoming Center and other CBOs serving non-English speaking refugees and immigrants, Mazzoni Health Center (LGBT), LGBT-Elder Initiative; Philadelphia Corporation on Aging (older adults), Department of Behavioral Health and Intellectual disAbility Services - DBHIDS (Mental Health First Aid; substance abuse), Project HOME, Women Against Abuse (Trauma Informed Care)
Objective: Increase access to care for vulnerable populations including immigrants, refugees, homeless, individuals in Reentry, and individuals with disabilities	

Strategy/Action	- Partner with SEAMAAC, Nationalities Services Center and other community organizations to provide primary care and other co-located health and social services for the immigrant and refugee community in Jefferson's community benefit area. Explore sustainability including FQHC status - Continue to support health care services provided at the Chinese Health free clinic - Continue to provide affordable prenatal care for Latina uninsured immigrants and refugees - Continue to support and provide care for homeless/ housing insecure individuals - Assess access to primary care for individuals with disabilities. Develop and initiate a plan to address identified barriers to care for individuals with disabilities. - Continue to address health and social needs of individuals in reentry through cross-sector collaboration with the City, Philadelphia Reentry Coalition and other community based organizations
Target Population	Immigrants, refugees, homeless, individuals with disabilities, incarcerated and individuals in reentry, low income
Outcomes	- Improved access to affordable, culturally appropriate care # served - Decreased emergency department use for primary care and ambulatory care sensitive conditions among target populations - Increased access to screening and primary care services and behavioral health services
Potential Partners	Internal Partners: Health care providers; health professional students; University health professional faculty; Jeff HOPE; Refugee Health Partners, Magee Rehab Hospital, Center for Urban Health, primary care providers, Emergency Department External Partners: SEAMAAC; DBHIDS; Nationalities Services Center, Philadelphia Refugee Health Collaborative, Mural Arts Storefront; Cambodian Association; BAOP; Vietnamese community based organizations; Project HOME, Broad Street Ministry; Pathways to Housing, Reentry Coalition

Domain: Chronic Disease Prevention and Management

One in four Americans has multiple chronic conditions, and that number rises to three in four Americans aged 65 and older. Approximately 71% of the total health care spending in the United States is associated with care for the Americans with more than one chronic condition. http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/prevention-chronic-care/decision/mcc/mccchartbook.pdf

The high prevalence of chronic disease is a result of the rapidly growing older adult population, increased life expectancy resulting from advances in public health and clinical medicine, and is attributable to six key risk factors: high blood pressure; tobacco use and exposure to second hand smoke; obesity; physical inactivity; excessive alcohol use; diets low in fruits and vegetables; and diets high in sodium and saturated fats.

Risk factors for chronic disease should be addressed at the individual level (including health care interventions) and the population level (including policies and environments that promote health). http://www.cdc.gov/chronicdisease/pdf/four-domains-factsheet-2015.pdf

The Centers for Disease Control and Prevention (CDC) recommends coordinating chronic disease prevention efforts on strategies that:

- Promote and support healthy behaviors through changes to social and physical environments that make healthy choices easier, safer, cheaper, and more convenient
- Collectively address the behaviors and other risk factors that can cause chronic diseases.
- Improve delivery and use of quality clinical services to prevent disease, detect diseases early, and manage risk factors
- Work to simultaneously prevent and control multiple diseases and conditions.
- Reach more people by strengthening systems and environments to support health and linking community programs to clinical services to prevent and control disease. Strategies that link community and clinical services help to reduce barriers to care and ensure that people with or at high risk of chronic diseases have access to the resources they need to prevent or manage these diseases. Improved links between the community and clinical settings allows community delivery of proven programs, to which patients may be referred by a clinician, with third-party payments to community organizations and lay providers.

The proposed strategies/activities integrate individual, institutional, community and system/policy levels of intervention, and follow the recommendations of the Health Innovation in Pennsylvania Plan (2016), the Philadelphia Department of Health's Community Health Improvement Plan, Healthy People 2020, the Community Guide and the Clinical Guide for Preventive Services. They also support AHRQ's *Clinical-Community Linkages* that connect health care providers, community organizations, and public health agencies to improve patients' access to preventive and chronic care services. AHRQ recommends: (http://www.ahrq.gov/professionals/prevention-chronic-care/improve/community/index.html)

- Increasing the use of effective community interventions—such as chronic disease self-management programs, the National Diabetes Prevention Program, and smoking cessation services—by making them widely available, ensuring that doctors refer their patients to them, and helping to ensure that they are covered by health insurance.
- Linking existing public health services, such as tobacco quit-lines, to health care systems.
- Establishing partnerships with hospitals and health care providers to improve community and population health through use of community benefit investments and advocacy.
- Encouraging a broader spectrum of health care workers—including pharmacists, patient navigators, and community health workers—to help people manage their own health.
- Using education and outreach to more fully engage the public in its own health care.

Multiple strategies have been shown to be effective in increasing use of breast and cervical cancer screening. The Community Preventive Services Task Force recommends using clinician and patient

reminder systems, using small media (such as videos, letters, and brochures), and providing clinician assessment and feedback about screening rates. Group education that conveys information on indications for, benefits of, and ways to overcome barriers to screening with the goal of informing, encouraging, and motivating participants to seek recommended screening has been found to be effective for breast cancer screening. One-on-one education, provided by multiple types of providers and volunteers, has been found to overcome colon, breast and cervical cancer screening barriers by providing information, encouragement, and motivation. Interventions to limit or remove economic and other structural barriers that make it difficult for clients to access cancer screening services are essential to increase cancer screening. www.thecommunityguide.org/cancer. The proposed implementation plan to increase cancer screening rates addresses individual, interpersonal and system level strategies/activities and incorporates best practices.

The data below summarizes the extent of chronic disease in Philadelphia and Jefferson Health-Center City's community benefit area:

- Almost 30% of adults in Philadelphia are obese. Adults living in North Philadelphia East (39.3%), North Philadelphia West (31.9%), the Riverwards (38.5%) and South Philadelphia West (29.9%) have similar or higher rates of obesity to Philadelphia overall (29.8%).
- Premature CVD deaths are 2-3 times higher in Philadelphia compared to the surrounding counties. This is due primarily to higher rates of smoking, obesity, and hypertension related to higher rates of poverty. South Philadelphia West (99.9), North Philadelphia East (152.2), North Philadelphia West (165.2) and Riverwards(128.6) have similar or higher rates of premature death due to cardiovascular disease compared to Philadelphia (Philadelphia rate: 104.78).
- 11% of adults in Philadelphia report having diabetes and those living in South Philadelphia West (402.1), North Philadelphia East (529.2), and North Philadelphia West (776.4) experience higher hospitalization rates due to diabetes than other neighborhoods in Jefferson Health – Center City's community benefit area (Philadelphia rate: 371.86).
- 30% of adults in Philadelphia report having high blood pressure. Rates of hospitalization due to high blood pressure are similar to or higher in North Philadelphia West (1278.6), North Philadelphia East (956.9) and South Philadelphia West (651) compared to Philadelphia (Philadelphia rate: 649.19)
- Cancer mortality rates in North Philadelphia East (106.1), North Philadelphia West (148.3), Riverwards (115.8), South Philadelphia East (96.7) and South Philadelphia West (102.2) are similar to and in most cases exceed the mortality rate from cancer in Philadelphia overall (97.62 per 100,000). While women in Philadelphia have achieved the Healthy People 2020 goal for breast cancer screening (81.1%), women in the Riverwards (77.65%) and South Philadelphia East (72.95%) are less likely to get mammograms compared to women in Philadelphia overall (82.94%). Screening for colorectal cancer compares less favorably to Philadelphia (70.75%; Healthy People 2020 goal 70.5%) in North Philadelphia West (56%), North Philadelphia East (69.6%) and the Riverwards (59.35%). Lung cancer is the leading cause of cancer death for both men and women in the United States. More people die from lung cancer each year compared to breast, colon and prostate cancer deaths combined. Cigarette smoking is the primary risk factor for lung cancer, with 80 to 90% of lung cancer deaths attributed to smoking. The USPSTF recommends annual screening with low-dose computed tomography (LDCT) in

individuals who are aged 55-80, have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years.

- Despite steady declines in smoking, the rate of smoking among adults in Philadelphia (19.5%) far exceeds the national average. Smoking rates among adults In North Philadelphia East (28.8%), North Philadelphia West (28.8%), the Riverwards (26%) and South Philadelphia West (22.5%) exceed the Philadelphia rate. Almost one in four adults in Philadelphia reported having no leisure time physical activity in the past month.
- Hospitalization of children ages 2 to14 for asthma are 727.2 per 100,000 in Philadelphia. Children living in North Philadelphia East (1424.2), North Philadelphia West (1484) and the Riverwards (986.9) experience the highest rates of hospitalization due to asthma in Jefferson Health – Center City's community benefit area. Environmental exposures related to housing, such as mold and cockroaches, impact asthma rates.

The Chronic Disease Prevention and Management domain includes a section on Obesity as an underlying cause of chronic disease, and a section that focuses specifically on four chronic diseases/conditions – heart disease, hypertension, stroke and diabetes. The CDCs recommended strategies were considered in the development of the implementation plan.

Access to health education prevention and disease management programs is lacking.

Chronic Disease Prevention and Management: **Heart Disease, Hypertension, Stroke and Diabetes**	
Goal: Decrease the prevalence of chronic disease and improve disease self-management through primary and secondary prevention efforts	
Objective: Improve ability of EMS personnel to rapidly identify signs and symptoms of stroke and treatment for Emergent Large Vessel Occlusion (ELVO Stroke)	
Strategy/Action	Conduct EMS education/training programs in the communities serviced through Jefferson Neuroscience Network and provide large Regional Neuroscience program at Jefferson campus
Target Population	Pre-Hospital Team: EMT's, Paramedic's, Prehospital Nurses
Outcomes	6 EMS community programs, 2 Regional programs provided reaching 600
Potential Partners	Internal Partners: Jefferson Neurosciences Network External Partners: Medtronic and Neurovascular Stryker
Objective: Increase awareness of programs and services that support healthy eating, physical activity and chronic disease management	

Strategy/Action	• Implement a centralized system/database (Aunt Bertha) that links to patient electronic health records to promote awareness about and access to nutrition, physical activity, weight management, and other wellness programs • Engage the Jefferson Physician Relations Managers to provide information to community physicians about community based healthy lifestyle programs. Encourage Jefferson physicians to “prescribe” and refer to healthy lifestyle programs.
Target Population	Community residents; Health care providers; Community based organizations
Outcomes	Database implemented and promoted to targeted audiences; # physicians who "prescribe" and refer patients to healthy lifestyle and chronic disease management programs; Increased number of referrals to resources and program participants
Potential Partners	Internal Partners: Center for Urban Health, Primary Care, Jefferson Neurosciences and Endocrinology, IS&T, Jefferson Physician Relations Managers, Care Managers External Partners: Aunt Bertha, COACH, United Way 211, Philadelphia Department of Public Health, BenePhilly, community based organizations that address food security, housing, and other SDOH
Strategy/Action	• Raise Awareness of "*Food as Medicine*" among health care providers. Integrate routine food security screening into primary care practices, during determination of Medicaid eligibility, and hospital discharge (ED and inpatient) • Refer to and promote food cupboards and other food assistance programs such as MANNA, SHARE, Meals on Wheels, Philabundance and the Coalition Against Hunger
Target Population	All patients
Outcomes	Food Screening tool integrated into EPIC; # screened; # referred; # referred who received assistance; # readmissions for patients with food insecurity
Potential Partners	Internal Partners: Center for Urban Health, Primary Care, ED, Nursing, Social Work, Discharge Planners, Admissions, Care Managers External Partners: COACH, MANNA, SHARE, Philabundance and the Coalition Against Hunger
Strategy/Action	Based on individualized risk factors, refer primary/specialty care patients and hospitalized cardiac, diabetes and stroke patients to community health promotion and disease management programs.
Target Population	Hospitalized cardiac, diabetes and stroke patients; primary and specialty care patients
Outcomes	Number of people referred; Number who attend programs
Potential Partners	Internal Partners: Primary Care, Jefferson Neurosciences Cardiology and Endocrinology
Strategy/Action	Based on individualized risk factors, refer primary/specialty care patients and hospitalized cardiac, diabetes and stroke patients to community health promotion and disease management programs.
Objective: Raise awareness and understanding about chronic disease risk factors, healthy lifestyles and chronic disease prevention	
Strategy/Action	Provide in-person and telehealth Diabetes Prevention Program in partnership with the Philadelphia Department of Public Health, AMA, ADA, CDC and Cities Changing Diabetes; Develop and implement strategies to enhance communication between Jefferson's DPP program and primary care providers (referral to program and follow-up)

Target Population	Adults in North and South Philadelphia with BMI >24 (Asian BMI >22) who have A1c between 5.7 and 6.4 or fasting plasma glucose of 110-125 or a positive screen for prediabetes based on the CDC prediabetes screening test.
Outcomes	50% of the participants who attend a minimum of 4 of 16 core sessions, will have an average weight loss of 5% of starting body weight; 90% of participants will attend at least 4 of 16 core sessions, 70% will attend at least 9 core sessions (months 1-6); 70% of participants will attend at least 3 maintenance sessions (months 6-12); 60% of participants who have attended a minimum of 4 sessions, will report at least 150 minutes of physical activity per week Weight loss maintained by 70% of participants
Potential Partners	Internal Partners: Primary Care, Methodist and Jefferson ED, care managers, Center for Urban Health, Jefferson endocrinology External Partners: PA State DPP Taskforce, Philadelphia Dept. of Public Health; Healthcare Improvement Foundation; Philadelphia Library; senior centers; Steven Klein Wellness Center; YMCA; Cities Changing Diabetes (NovoNordisk); CDC, AMA, ADA, and other community based organizations including community development corporations.
Strategy/Action	• Provide screening for hypertension and associated risk factors to detect and manage high blood pressure. Support the Philadelphia Department of Public Health's Get Healthy Philly and Philly Difference Initiatives by continuing to provide Heart Smarts/Blood Pressure Plus programs • Develop and implement strategies to enhance communication between Jefferson's community based hypertension screening program and primary care providers (referral to program and follow-up) • Provide regular screening at 10 community based site. Screen and counsel adults concerning access to care, healthy lifestyle, blood pressure, smoking status, and BMI. Follow-up individuals with elevated blood pressure readings. • Monitor blood pressure of third trimester and post-partum women with elevated blood pressure through care management that includes blood pressure–monitoring at home and text messaging.
Target Population	Adults in Jefferson Community Benefit area
Outcomes	• # screened; % return screening rate; # who got health insurance;# who got a primary care provider; # appointments scheduled ; # saw primary care provider • # medication changes;# newly diagnosed with hypertension; # referred by primary care doctor;# screened for food insecurity and referred; # Improved healthy lifestyle behaviors; # referred to QUIT Line; # quit smoking • Improved communication with primary care doctors; Improved blood pressure control • Reduced maternal morbidity and mortality due to hypertension
Potential Partners	Internal Partners: Primary Care, Center for Urban Health, Jefferson students, College of Pharmacy External Partners: Philadelphia Dept. of Public Health; Pennsylvania Dept. of Health QUIT Line; Healthcare Improvement Foundation; The Food Trust, Libraries, corner stores, Veterans Multi-Services Center, senior centers
Strategy/Action	Provide chronic disease/obesity management and nutrition education programs in community sites

Target Population	Low income neighborhoods with high rates of overweight and obesity; Preschool children and their families including pregnant women; Jefferson employees; Parents; Veterans
Outcomes	• At least one monthly program reaching at least 20 people per program provided • 80% of program participants indicate they intend to increase their daily fruit and vegetable intake
Potential Partners	Internal Partners: Dietitians, ARAMARK, Center for Urban Health, Endocrinology, College of Pharmacy, Jefferson students External Partners: Food Trust, Steven Klein Wellness Center, faith-based institutions, public library, head start/ preschool, schools, community gardens, Philadelphia Housing Authority, PACDC, Veterans Multi-Services Center, senior centers, New Kensington CDC
Strategy/Action	Screen all patients and refer all smokers to the Pennsylvania Quit Line (FAX to QUIT)
Target Population	Smokers
Outcomes	# identified and referred
Potential Partners	Internal Partners: Jefferson primary care providers, Nursing, ED External Partners: Philadelphia Dept. of Public Health; Pennsylvania Dept. of Health QUIT Line
Strategy/Action	Conduct trainings for bilingual Community Health Workers (CHWs) to provide health education in immigrant communities on variety of topics such as healthy eating, physical activity, and signs and symptoms of stroke, heart attack, diabetes prevention program, FAX to QUIT smoking cessation and how to use 911
Target Population	Non-English Speaking community
Outcomes	# CHWs trained; # of people educated by CHWs
Potential Partners	Internal Partners: Center for Urban Health; Refugee Health Partners, Jefferson Family Medicine Associate's Refugee Health Center, Jefferson students in Refugee Health Partners External Partners: Nationalities Services Center, JEVS, SEAMAAC, BAOP, Cambodian Association, Philadelphia Refugee Health Collaborative, and other community organizations serving the immigrant communities
Strategy/Action	Explore potential for partnering with community pharmacies and payors to provide enhanced services including vaccinations, medication synchronization and reconciliation, and warm hand-offs to care managers as appropriate. Explore the potential for training pharmacy staff and drivers who deliver medications to homes as community health workers.
Target Population	Community pharmacies and community residents utilizing these pharmacies
Outcomes	Improved health outcomes for those receiving services Bi-directional communication between community pharmacies and health care providers Increased access to health and social services related to social determinants of health

Potential Partners	Internal: College of Pharmacy, Center for Urban Health, Care managers, External: Community pharmacies, payors, Pennsylvania Pharmacists Care Network, PA Medicaid MCO
Strategy/Action	Support the Athlete Health Organization's cardiovascular health screening for student athletes in Philadelphia
Target Population	Student athletes in Philadelphia
Outcomes	# physicals provided
Potential Partners	Internal Partners: Athlete Health Organization, Center for Urban Health, College of Nursing External Partners: Schools
Objective: Improve ability of individuals to manage chronic disease	
Strategy/Action	Provide a monthly chronic disease self-management support groups
Target Population	Individuals with diabetes
Outcomes	Monthly support group sessions conducted reaching at least 30 individuals per month; Improved ability to manage chronic disease
Potential Partners	Internal Partners: Center for Urban Health, Jefferson Endocrinology, Primary Care External Partners: American Diabetes Association, American Association of Diabetes Education, American Heart Association, Philadelphia Corporation for Aging
Strategy/Action	Provide in-person and telehealth chronic disease self-management programs
Target Population	Individuals with hypertension and diabetes and other chronic disease
Outcomes	Conduct 3 programs annually reaching 15 or more participants per program Improved ability to manage disease
Potential Partners	Internal Partners: Center for Urban Health; Jefferson Endocrinology, Primary Care External Partners: Philadelphia Corporation on Aging, Steven Klein Wellness Center, faith-based institutions, public library, community schools, Philadelphia Housing Authority, PACDC, Veterans Multi-services Center, community organizations serving the immigrant communities
Strategy/Action	Expand and promote in-person and telehealth community-based DSME programs –
Target Population	Individuals with diabetes
Outcomes	4 programs conducted annually reaching 15 or more participants per program Improved ability to manage disease
Potential Partners	Internal Partners: Center for Urban Health; Jefferson Endocrinology, Primary Care External Partners: Cities Changing Diabetes, ADA, AADE, CDC, Philadelphia Dept. Public Health, Philadelphia Corporation on Aging, Steven Klein Wellness Center, faith-based institutions, public library, community schools, Philadelphia Housing Authority, PACDC, Multi-services Center for Veterans, community organizations serving the immigrant communities
Objective: Reduce the prevalence of obesity through improved access to healthy affordable food, safe opportunities for physical activity and nutrition education	

Strategy/Action	• Partner with 5 schools, Get Hype and Get Healthy Philly to create School Health Improvement Plans • Create healthy cultures and environments in schools and Head Starts that promote healthy eating and physical activity • Partner with three K-8 schools to develop and implement monthly programs/ themes that address healthy lifestyle • Provide nutrition education for 2 Early Head Start and Head Start children, staff and parents.
Target Population	Schools in TJUH community benefit area Low income Preschool aged children in TJUH community benefit area
Outcomes	• Program implemented at 3 K-8 schools reaching 1,500 students • Program implemented at 2 Head Start reaching 300 families 75% of participants report healthier diets and increased physical activity
Potential Partners	Internal Partners: Center for Urban Health, TJU students and faculty External Partners: Southwark School, Independence Charter School, Vare-Washington, Maternity Care Coalition, Get HYPE Philly, Food Trust, Get Healthy Philly, Mercy Neighborhood Ministries of Philadelphia, Norris Square Community Alliance, Esperanza
Strategy/action	In partnership with Head Start and PreK programs develop food buying clubs and nutrition education programs to support access to and consumption of healthy affordable food
Target Population	Low income preschoolers and their families; Head Start Staff
Outcomes	• Continue food Buying club at Mercy Neighborhood Ministries of Philadelphia (North Philadelphia) and expand to at least one additional preschool program. • 30 families recruited to participate at each site • 6 nutrition education related programs provided annually for staff and Head Start families (20 families participate per program) • 6 nutrition education programs provided for 3 to 5 year olds attending the Head Start reaching 100 children annually • Improved dietary habits among 80% of participants
Potential Partners	Internal Partners: Center for Urban Health External Partners: Mercy Neighborhood Ministries of Philadelphia, Norris Square Community Alliance, PreK programs, Common Market, APM, SHARE, Philabundance, and other food distributors, Food Trust
Activity/Strategy	Continue to participate in Philadelphia Department of Public Health's *Get Healthy Philly* and *HYPE* initiatives and Food Policy Advisory Council
Target Population	Philadelphia youth and adults

Outcomes	• Increase # of businesses and academic institutions that implement healthy food policies and programs • Increase # of child care and out of school time programs that adopt best practices in nutrition and eating and physical activity • Increased breast feeding among infants 0-3 months by maintaining Baby Friendly Hospital status, business policy and accommodations • Information sharing protocols between existing on-line physical activity and nutrition information portals developed • Increased use of writing healthy food prescriptions and food security screening into primary care settings • By 2018 reduce the % of obese adults to 28% • By 2018 reduce the % of obese children under age 18 to 17%
Potential Partners	Internal Partners: Center for Urban Health, TJU Colleges, JIMA, JHAP, JFMA (Primary Care); ARAMARK External Partners: Phila Dept. of Public Health- Get Healthy Philly (coalition partners), Get HYPE, FQHCs, Food Trust, FPAC, insurers, American Heart Association, Keystone STARS, PHMC, Health Promotion Council, hospitals
Strategy/action	• Continue Farmers Market at Jefferson and Healthy Food Drives in partnership with the Coalition Against Hunger (fresh produce collected at farmers market at Jefferson and disbursed to local food cupboard.) • Continue to support and expand healthy vending machine options • Continue to support efforts to make eating healthier the default choice in the cafeteria.
Target Population	Jefferson employees, students and visitors to campus; Area food cupboards
Outcomes	• Weekly Farmer's Market at Jefferson provided from May through October • Monthly campaign at Farmers Market conducted to collect and disburse produce to local Food Cupboards. 750 pounds of produce collected and disbursed annually. • Continue participation in Healthy Hospital Initiative, strategies implemented, as appropriate, in the cafeteria and hospitals
Potential Partners	Internal Partners: Volunteers, ARAMARK, Center for Urban Health, Marketing; students; Human Resources External Partners: Coalition Against Hunger, Food cupboards, Farm to City, Philadelphia Dept. of Public Health (Get Healthy Philly)
Objective: Improve asthma management	
Strategy/Action	• Train community health workers to conduct home environmental assessments to identify and address asthma triggers • Train community health workers to demonstrate proper inhaler use
Target Population	Youth and adults with asthma
Outcomes	Improved asthma management
Potential Partners	Internal Partners: Center for Urban Health, emergency department, primary care, pulmonology, College of Health Professions External Partners: Community development corporations, Philadelphia Housing Authority, community based organizations, schools

Objective: Advocate for system and policy changes that support chronic disease prevention	
Strategy/Action	Collaborate with the State Health Improvement Plan and Philadelphia Department of Public Health's Community Health Improvement Plan (Get Healthy Philly) around tobacco, diabetes and blood pressure control policy and system change initiatives; Continue to participate in Philadelphia's Food Policy Advisory Council

Chronic Disease Prevention and Management:

Cancer Early Detection and Treatment

Goal: Reduce morbidity and mortality related to colon cancer

Objective: Increase public awareness about colorectal cancer prevention and the importance of early detection	
Strategy/Action	Provide colorectal cancer education programs in community venues to increase knowledge about the risk factors for colon cancer and the importance of early detection through screening
Target Population	South Philadelphia, Center City and Lower North Philadelphia
Outcomes	2-3 educational programs conducted annually reaching 25 individuals per program
Potential Partners	Internal Partners: GI Physicians and staff, Center for Urban Health, Institute for Healthy Aging and Self care, Sidney Kimmel Cancer Center External Partners: Resources from 80 by 2018 campaign, and the American Cancer Society, Senior Centers, Faith-based organizations, community based organizations serving older adults, Philadelphia Corporation on Aging, Philadelphia Dept. of Public Health, Steven Klein Wellness Center, library
Strategy/Action	Train bilingual CHWs to provide education in immigrant communities concerning risk factors and preventive guidelines pertaining to colorectal cancer
Target Population	Bilingual community health workers Immigrant and refugee communities
Outcomes	# CHWs trained; # educated by CHWs
Potential Partners	Internal Partners: Center for Urban Health Jefferson Family Medicine Associates, Refugee Health Partners, Gastro-Intestinal Dept., Cancer Center, Institute for Healthy Aging and Self Care, Sidney Kimmel Cancer Center External Partners: Nationalities Services Center, JEVS, SEAMAAC, BAOP, Cambodian Association, Philadelphia Refugee Health Collaborative, and other community organizations serving the immigrant communities
Objective: Increase colon cancer screening rates	
Strategy/Action	Provide colorectal cancer screening counseling at Jefferson and community sites as appropriate

Target Population	Uninsured/underinsured Never been screened or not screened in more than 10 years, and populations with low screening rates in Jefferson community benefit area
Outcomes	2-3 screening counseling programs annually; # educated/counseled;# screened
Potential Partners	Internal Partners: Center for Urban Health, Gastro-Intestinal Dept., Cancer Center, Institute for Healthy Aging and Self Care, Sidney Kimmel Cancer Center External Partners: Resources from 80 by 2018 campaign, and the American Cancer Society, Senior Centers, Faith-based, community based organizations serving older adults, Philadelphia Corporation on Aging, Philadelphia Dept. of Public Health, Steven Klein Wellness Center, libraries
Objective: Increase colonoscopies in the targeted areas	
Strategy/Action	Identify Jefferson Internal Medicine Associates and Jefferson Family Medicine Associates patients in South Philadelphia, Center City and Lower North Philadelphia who have not had a screening or follow-up colonoscopy based on the recommended guidelines.
Target Population	Jefferson Internal Medicine Associates and Jefferson Family Medicine Associates' patients in South Philadelphia, Lower North Philadelphia and Center City
Outcomes	20% of patients from Center City, Lower North and South Philadelphia identified as needing a colonoscopy receive a screening or follow-up colonoscopy.
Potential Partners	Internal Partners: Community Internal Medicine physicians, Jefferson Internal Medicine Associates, Jefferson Family Medicine Associates, Sidney Kimmel Cancer Center External Partners: Resources from 80 by 2018 campaign, and the American Cancer Society
Goal : Reduce morbidity and mortality related to breast and cervical cancer	
Objective: Increase public awareness about breast and cervical cancer prevention and the importance of early detection	
Strategy/Action	• Raise community and TJUH health care provider awareness about the Pennsylvania Breast and Cervical Cancer Prevention and Treatment program by publicizing the Pennsylvania Breast and Cervical Cancer Early Detection Program (PA-BCCEDP) and Susan G. Komen screening services on Jefferson Breast Care Web Page, promote breast and cervical cancer programs at the SKCC Welcome Center and across the Jefferson Health enterprise. • Provide community-based breast and cervical cancer education programs (Methodist community day taking place during breast cancer awareness month. (Employee screening day in Center city location). • Continue to provide breast and cervical screening to uninsured/underinsured women through partnerships/resources such as NBCFF, Komen, and the Pennsylvania Healthy Women 40+ program for breast and cervical cancer screening
Target Population	Uninsured, underinsured and underserved women in Jefferson's community benefit area and the greater Philadelphia area

Outcomes	• Pennsylvania's Healthy Women program and Susan G. Komen screening services promoted on Jefferson Breast Care Web Page • # programs provided/ # participants; # physician referrals to breast and cervical cancer programs/screenings; # screened for cervical cancer; # receiving mammography
Potential Partners	Internal Partners: Radiology, Surgery, Ob-Gyn, Sidney Kimmel Cancer Center, Patient Support Services, Breast Cancer Center, Jefferson Family Medicine Associates External Partners: Susan G. Komen, NBCF, Linda Creed, PA-BCCEDP, Partnered Community Based Organization (SEAMACC, Bebashi, Mazzoni, Steven Klein Wellness Center, etc.)
Strategy/Action	Train bilingual CHWs to provide education in immigrant communities concerning risk factors and preventive guidelines pertaining to breast and cervical cancer
Target Population	Bilingual community health workers Immigrant and refugee communities
Outcomes	# CHWs trained; # educated by CHWs; # programs provided/ # participants # screened PAP; # mammography
Potential Partners	Internal Partners: Center for Urban Health, Radiology, Surgery, Ob-Gyn, Sidney Kimmel Cancer Center, Patient Support Services, Breast Cancer Center, Jefferson Family Medicine Associates, Refugee Health Partners, Breast Cancer Center, Institute for Healthy Aging and Self Care External Partners: Nationalities Services Center, JEVS, SEAMAAC, BAOP, Cambodian Association, Philadelphia Refugee Health Collaborative, and other community organizations serving the immigrant communities
Strategy/Action	Promote the human papillomavirus (HPV) vaccine as a cancer prevention method for HPV-related cancers, including cervical cancer
Target Population	Parents of children ages 9-17 who are recommended to be vaccinated; providers who care for children ages 9-17
Outcomes	Percentage of males and females ages 13-17 who are vaccinated against HPV—within Jefferson (health system), Philadelphia County, PA and NJ (state-wide rates).
Potential Partners	Internal: Sidney Kimmel Cancer Center, Jefferson Family Medicine Associates, Nemours Pediatric Practices, Jefferson Internal Medicine External: American Cancer Society, PA Statewide HPV Leadership Committee, Philadelphia Department of Public Health, Philadelphia Immunization Coalition, FQHC's

Goal : Reduce morbidity and mortality related to lung cancer

Objective: Increase public awareness about lung cancer prevention and the importance of early detection

Strategy/Action	Provide lung cancer screening education programs in community venues to increase knowledge about the risk factors for lung cancer and the importance of early detection through screening
Target Population	Asian, African American, LGBT, Veteran, Refugee/immigrant communities
Outcomes	3-4 educational programs conducted annually reaching 25 individuals per program

Potential Partners	Internal Partners: Jefferson Internal Medicine Associates, Jefferson Family Medicine Associates, Pulmonology, Center for Urban Health, Sidney Kimmel Cancer Center External Partners: SEAMAAC, BAOP, Philadelphia FIGHT, Mazzoni Center, Veterans Multi-Service Center, Impact Services, Steven Klein Wellness Center, Philadelphia Dept. of Public Health, senior centers, faith-based, community-based organizations serving older adults, and other organizations serving older adults/and or refugee/immigrant communities
Strategy/Action	Train community leaders to provide education in their respective communities concerning risk factors, preventive guidelines and treatment for lung cancer
Target Population	Bilingual, Asian immigrant/refugee, LGBT, Veteran and African American leaders and communities
Outcomes	# leaders trained; # educated by leaders
Potential Partners	Internal Partners: Jefferson Internal Medicine Associates, Jefferson Family Medicine Associates, Pulmonology, Center for Urban Health External Partners: SEAMAAC, BAOP, Philadelphia FIGHT, Mazzoni Center, Veterans Multi-Service Center, Impact Services, Steven Klein Wellness Center, Philadelphia Dept. of Public Health, senior centers, faith-based, community-based organizations serving older adults, and other organizations serving older adults/and or refugee/immigrant communities
Objective: Increase lung cancer screening rates	
Strategy/Action	• Provide education on shared decision-making and motivational interviewing to Jefferson and community providers to increase screening conversations with patients • Increase awareness about lung cancer eligibility criteria, process for ordering a screening test and making referrals to the lung cancer screening program.
Target Population	Jefferson Internal Medicine Associates, Jefferson Family Medicine Associates, community providers in South Philadelphia, Center City and North Philadelphia
Outcomes	# providers trained and educated # referrals to Lung Cancer Screening Program # screened increased
Potential Partners	Internal Partners: Jefferson Internal Medicine Associates, Jefferson Family Medicine Associates, Pulmonology, Center for Urban Health External Partners: Philadelphia FIGHT, Mazzoni Center, Steven Klein Wellness Center, FQHCs/city health centers
Goal: Reduce morbidity and mortality related to prostate cancer	
Objective: Increase public awareness about prostate cancer prevention and the importance of early detection	
Strategy/Action	Provide prostate cancer screening education programs in community venues to increase knowledge about the risk factors for prostate cancer and the importance of early detection through screening
Target Population	African American, LGBTQ, Veteran communities
Outcomes	3-4 educational programs conducted annually reaching 25 individuals per program

Potential Partners	Internal Partners: Sidney Kimmel Cancer Center, Jefferson Department of Urology, Internal Medicine Associates, Jefferson Family Medicine Associates External Partners: American Cancer Society, Prostate Cancer Foundation, Veterans Affairs, LGBTQ community advocacy organizations, faith-based programs serving African Americans, Philadelphia Health Department, PHMC.
Goal: Provide supportive care services and cancer related information for cancer patients, their families and caregivers	
Strategy/Action	Provide supportive care services and cancer-related information/education at the Welcoming Center including: • Nutritional counseling and seminars • Workshops for patients and families • Exercise classes • Clinical trial and research information • Appointment assistance • Buddy Support Program resources and support group information
Target Population	Cancer patients, families and caregivers
Outcomes	Increased access to information Improved ability to understand and manage disease Increased support through group and individual counseling/assistance
Potential Partners	Internal Partners: Sidney Kimmel Cancer Center, Welcoming Center External Partners: American Cancer Society, Philadelphia Health Department, community based organizations.

Domain: Social Determinants of Health

According to the Robert Wood Johnson Foundation: "*Health equity means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments and health care*." Health disparities arise when individuals do not have the same opportunity to attain their highest level of health because of the social and environmental conditions in which they live, work and play. These social determinants of health include socioeconomic status, education, racism and discrimination, food security and nutrition, housing, built environment, access to health care, environmental hazards and safety.

Philadelphia continues to have the highest poverty rate among the ten largest cities in the United States and while some cities are experiencing reductions in poverty, the rate in Philadelphia remains persistently high with 25.8% experiencing poverty. The rates of poverty within Jefferson Health – Center City's community benefit area vary with only 15% of Center city residents

experiencing poverty to more than one-third of Riverward residents (34%) and almost one-half of those living in North Philadelphia West (45.5%) and North Philadelphia East (47.1%). Almost 40% of Philadelphia residents experience excessive housing costs (38.9%) and residents of North Philadelphia East, North Philadelphia West and the Riverwards experience even higher rates of 41.8%, 41.3% and 42.7% respectively. These households may face housing instability and increased risk of eviction and homelessness. People experiencing chronic homelessness are more likely to have poorer mental and physical health and premature death. In Philadelphia approximately 1,140 individuals were unsheltered in the past year. In addition, poor housing conditions such as lead, mold and pest infestations impact lead poisoning and asthma. Rates of asthma hospitalizations among youth ages 2 to 14 are twice as high in North Philadelphia East and North Philadelphia West neighborhoods compared to Philadelphia (727.3 per 100,000). Poor housing conditions and hazardous built environmental conditions also negatively impact falls among older adults, the highest cause of injury trauma in Jefferson's emergency department. Neighborhood appearance was identified by community residents specifically regarding the amount of litter and trash along streets and vacant lots, lack of green space, and unsafe pedestrian conditions and play environments for children.

As noted in the 2019 Regional Community Health Needs Assessment, "Access to and affordability of healthy foods is a driver of poor health in many communities." In Philadelphia 19% of residents report being food insecure and almost one in four residents receives food assistance. Limited access to healthy affordable food is a result of poverty and poor food environments including lack of grocery stores and supermarkets, overabundance of corner stores with limited fresh produce, oversaturation of fast food outlets, and availability and cost of transportation to healthier food outlets. Food insecurity among children impacts educational achievement and behavioral health. Among older adults malnutrition may result in poorer health and injury due to falls.

A recent PEW report that compared transportation costs in Philadelphia to the 10 largest cities, found that the areas in Philadelphia where transportation costs were most cumbersome were those with lower median incomes and where using SEPTA to get to work required one or more transfers. Neighborhoods in West and North Philadelphia and along the Kensington Avenue corridor were most impacted by higher transportation costs due to the need for transfers. Older adults also shared concerns of becoming injured on public transportation particularly during high volume times when seats may not be available. These transportation issues can cause social isolation for older adults and limit access to healthy affordable food and healthcare.

Healthcare and health resources navigation is challenging due to low health literacy, lack of awareness of resources among health care and social service providers, fragmented systems and resource constraints. Navigation challenges include lack of centralized community health resource directories, transportation costs and limitations to health care and social services, availability of information in languages other than English, and cost.

Linguistically and culturally appropriate access to care, access to health insurance and workforce development were addressed previously in this plan and will not be included here (see: Access to Affordable, Culturally Appropriate Primary and Specialty Care domain).

Social Determinants of Health	
Goal : Improve health equity by addressing social determinants of health that impact health and well-being	
Objective: Increase access to and utilization of health and social services	
Strategy/Action	• In partnership with COACH and the Philadelphia Department of Public Health, implement a centralized system/database (Aunt Bertha) that links to patient electronic health records to promote awareness about and referral to health and social services that address social determinants of health • Engage the Jefferson Physician Relations Managers to provide information to community physicians about community based healthy lifestyle programs. • Screen all patients for socio-economic disadvantage and link to community resources to address needs
Target Population	Community residents; Health care providers; Community based organizations
Outcomes	• Database implemented and promoted to targeted audiences • # physicians who "prescribe" and refer patients to healthy lifestyle and chronic disease management programs • Increased number of referrals to health and social service resources • Increased utilization of health and social service resources/programs
Potential Partners	Internal Partners: Center for Urban Health, Primary Care, Jefferson Neurosciences and Endocrinology, IS&T, Jefferson Physician Relations Managers, Care Managers, Population Health, Sidney Kimmel Medical College clinical experience, Emergency Department External Partners: Aunt Bertha, COACH, United Way 211, Philadelphia Department of Public Health, BenePhilly, community based organizations that address food security, housing, and other SDOH
Objective: Increase access to health and social services through a resource center that provides co-located health and social service navigation assistance.	
Strategy/Action	• Explore potential for a Health and Social Service Resource Center where social services, health education/coaching and navigation services, medical legal partnership and mental health services are co-located to provide patient-centered holistic care and care coordinated with health care providers. • Train and deploy CHWs and Jefferson health professional students to address social determinants of health of patients through resources such as BenePhilly, United Way 211 and Aunt Bertha program. • Train and deploy CHWs to provide healthcare navigation and patient advocacy
Target Population	Lower income people; older adults; ED patients; patients at risk of readmission; immigrant/refugees; homeless; uninsured; individuals in reentry
Outcomes	• Central database and system implemented • SKMC 1st year medical students trained and providing services to patients referred from primary care and ED (# screened, referred, and services received) • # CHWs trained and deployed in Health and Social Service Center, ED, hospital and other sites

	• Feasibility of a Medical Legal Partnership program explored and planning initiated as appropriate
Potential Partners	Internal Partners: Center for Urban Health, SKMC, JFMA, JHAP, JIMA, Care Coordination, Social work, TJUH and Methodist ED, Pastoral Care, Discharge Planners External Partners: COACH, Philadelphia Department of Public Health, Aunt Bertha, BenePhilly, United Way 211, Steven Klein Wellness Center, Legal Services for the Disabled
Strategy/Action	• Assess need for Medical Legal Partnership (MLP) to address legal barriers to accessing needed social services including housing, utilities, food, education, guardianship, etc. • Increase primary and specialty care providers awareness of MLP services • Develop business plan and implement MLP as appropriate
Target Population	Patients; primary and specialty care providers
Outcomes	• Reduced legal barriers to needed social services
Potential Partners	Internal Partners: Center for Urban Health, SKMC, JFMA, JHAP, JIMA, Care Coordination, Social work, TJUH and Methodist ED, Pastoral Care, Discharge Planners External Partners: Legal Services for the Disabled; Community Legal Services
Objective: Increase awareness of *Food as Medicine* among health care providers	
Strategy/Action	Screen all primary care patients, Emergency Department patients and patients admitted to the hospital for food security and refer as appropriate to food assistance and medical nutrition therapy (MNT) programs
Target Population	ED and Inpatients at Methodist and TJUH; Primary care providers
Outcomes	Screening questions added to EPIC for ED and hospital admissions 100% screened and referred Increased referral to and utilization of MNT and food assistance programs Improved patient health outcomes Reduced readmissions
Potential Partners	Internal Partners: Center for Urban Health, TJUH and Methodist ED providers, EPIC, JFMA, JHAP, JIMA, Discharge Planners, Pastoral Care, Care Coordinators, Volunteer department, Sidney Kimmel Medical College clinical experience External Partners: COACH, Food Policy Advisory Council Hunger Subcommittee, Coalition against Hunger, MANNA, SHARE, Philabundance
Objective: Reduce access barriers to healthy, affordable food	
Strategy/action	In partnership with Head Start and PreK programs develop food buying clubs and nutrition education programs to support access to and consumption of healthy affordable food
Target Population	Low income preschoolers and their families; Head Start Staff
Outcomes	• Continue food Buying club at Mercy Neighborhood Ministries of Philadelphia (North Philadelphia) and expand to at least one additional preschool program. • 30 families recruited to participate at each site • 6 nutrition education related programs provided annually for staff and Head Start families (20 families participate per program) • 6 nutrition education programs provided for 3 to 5 year olds attending the Head Start reaching 100 children annually • Improved dietary habits among 80% of participants

Potential Partners	Internal Partners: Center for Urban Health External Partners: Mercy Neighborhood Ministries of Philadelphia, Norris Square Community Alliance, PreK programs, Common Market, APM, SHARE, Philabundance, and other food distributors, Food Trust
Strategy/action	• Continue Farmers Market at Jefferson and Healthy Food Drives in partnership with the Coalition Against Hunger (fresh produce collected at farmers market at Jefferson and disbursed to local food cupboard.) • Explore potential of Food RX program with primary care and Emergency Department • In partnership with Food Policy Advisory Council and Food Insecurity workgroup, explore potential solutions to increase food access for youth when school is not in session (vacations; summer feeding programs)
Target Population	Jefferson employees, patients, students and visitors to campus; Local food cupboards, youth
Outcomes	• Weekly Farmer's Market at Jefferson provided from May through October • Monthly campaign at Farmers Market conducted to collect and disburse produce to local Food Cupboards. 750 pounds of produce collected and disbursed annually. • Improved access to healthy, affordable food for adults and youth
Potential Partners	Internal Partners: Volunteers, ARAMARK, Center for Urban Health, Marketing; students; Human Resources, primary care physicians External Partners: Coalition Against Hunger, Food cupboards, Farm to City, Philadelphia Dept. of Public Health (Get Healthy Philly)
Objective: Reduce injuries related to the Built Environment	
Activity/Strategy	In partnership with Vision Zero and the City of Philadelphia, continue to support a comprehensive plan designed to reduce traffic related injury and deaths in Philadelphia.
Target Population	Bikers, Pedestrians, Motorists
Outcomes	Reduced injuries and fatalities
Potential Partners	Internal Partners: Jefferson Hospitals ED Center for Injury Prevention; Trauma Center External Partners: Vision Zero Alliance partners (Bicycle Coalition of Greater Philadelphia, AAA-Mid Atlantic, the African-American Chamber of Commerce, 5th Square, the Clean Air Council, Run 215, Public Health Management Corporation, and Parsons Brinckerhoff)
Activity/Strategy	Train Community Health Workers and Jefferson students to conduct Home Environmental Assessments to reduce falls among older adults
Target Population	Older adults; Community Health Workers; students
Outcomes	Reduced falls among older adults Reduced ED visits due to falls in homes
Potential Partners	Internal Partners: Center for Urban Health, College of Health Professions (OT/PT) External Partners: Community Development Corporations; Health Federation; CHW programs
Activity/Strategy	Reduce the rate of Emergency Department visits and hospitalizations at Jefferson among older adults due to fall related injuries • Educate the public and older adults about fall prevention, provide fall prevention/home safety screening and fall prevention/mobility programs (Matter of

	Balance, Tai Chi, and Healthy Steps programs) through coordinated approach across Jefferson and the community • Explore potential campaign that encourages the public to "Give Up Their Seats" to older adults taking public transportation. • Explore potential for scheduling older adult patient visits between 10 and 2 when public transportation is less crowded and safer for older adults. • Explore partnering with Uber-like services and/or providing remote parking for older adults with van services to various hospital services and discounted • Address pedestrian safety and walkability in South Philadelphia in partnership with the South Philadelphia Aging Collective, PCA and the Mayors Planning Office
Target Population	Older adults in Lower North, Center City and South Philadelphia
Outcomes	# of programs provided ; # of participants; reduced rate of ED trauma visits and hospitalizations among older adults due to falls; 2 strategies initiated to improve transportation and pedestrian safety
Potential Partners	Internal Partners: Center for Injury Prevention Research, the Institute for Healthy Aging and Supportive Care, TJU Nursing, college of Health Professions (OT/PT) External Partners: Philadelphia Corporation on Aging, Senior Centers, Philadelphia Department of Parks and Recreation, South Philadelphia Aging Collective, SEPTA
Objective: Increase access to affordable and healthy housing	
Activity/strategy	• Identify patients in need of affordable home repairs and remediation and refer to available resources for housing repair assistance • Screen for housing insecurity • Refer to medical legal partnership to address potential evictions or other housing issues such as utility shut offs. • Explore options for addressing affordable housing and respite housing needs of patients and the community
Target Population	Low income patients; homeless individuals; primary care providers; emergency departments; community health workers; Jefferson students
Outcomes	• Increased ability to remain in home and to age in place • Decreased housing insecurity due to inappropriate eviction processes • Improved health outcomes for homeless; reduced ED use
Potential Partners	Internal Partners: Center for Urban Health, Emergency Department, primary care providers; care managers External Partners: Legal Clinic for the Disabled, Healthy Rowhouse Initiative (Clarifi; PHMC); Philadelphia Corporation for the Aging, TAC
Objective: Improve Neighborhood Conditions	
Strategy/action	• Continue to support efforts to change vacant lots into productive land use such as community gardens and spaces for socialization and physical activity • Support neighborhood remediation and clean-up activities
Target Population	Schools, Head Start/PreK programs, refugees/immigrants, community sites (parks and playgrounds)
Outcomes	3 gardens in place; 45 families participating 2 vacant lots improved based on community preferences for lot use Cleaner streets and parks

Potential Partners	Internal Partners: Center for Urban Health, Philadelphia University landscape design (Park in a Truck); coLab External Partners: Food Policy Advisory Council, PACDC, Head Start, Pennsylvania Horticulture Society; department of recreation; real estate developers
Activity/Strategy	Work with Philadelphia Association of Community Development Corporations and member CDCs, and Drug Free Community Coalitions in South Philadelphia to increase perception of community safety related to the built and social environment (reduce alcohol and drug related activity through community clean-ups and other initiatives)
Target Population	South Philadelphia zip codes 19145, 19146, 19147 and 19148
Outcomes	Changes in youth perceptions and behaviors related to drug use in their community; Improved perception of community safety and trust; increased physical activity
Potential Partners	Internal Partners: Center for Urban Health; TJU students and faculty; TJUH employees External Partners: South Philadelphia Prevention Coalition members; YMCA, Philadelphia Dept. of Recreation, Police Department, SEAMAAC
Objective: Address barriers related to access to transportation	
Activity/Strategy	Explore implementing transportation services such as AMBULANZ, UBER and LYFT to reduce transportation barriers to accessing health care
Target Population	Older adults; lower income patients and their families; individuals with disabilities
Outcomes	Increased access to health care services
Potential Partners	Internal Partners: Center for Urban Health; Care managers; discharge planners; Emergency Department; healthcare providers External Partners: AMBULANZ, UBER and LYFT etc.

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