



2013

Thomas Jefferson University Hospitals Community Health Needs Assessment Report

Thomas Jefferson University Hospitals, Inc.

Community Health Needs Assessment

Thomas Jefferson University Hospital – Center for Urban Health
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Introduction

Over the past century the major causes of morbidity and mortality in the United States have shifted from those related to communicable diseases to those due to chronic diseases. Just as the major causes of morbidity and mortality have changed, so too has understanding of health and what makes people healthy or ill. Research has documented the importance of the social determinants of health (for example, socioeconomic status and education), which affect health directly as well as through their impact on other health determinants such as risk factors. Targeting interventions toward the conditions associated with today's challenges to living a healthy life requires an increased emphasis on the factors that affect the current causes of morbidity and mortality, factors such as the social determinants of health. Many community-based prevention interventions target such conditions. Community-based prevention interventions offer three distinct strengths. First, because the intervention is implemented population-wide it is inclusive and not dependent on access to the health care system. Second, by directing strategies at an entire population an intervention can reach individuals at all levels of risk. And finally, some lifestyle and behavioral risk factors are shaped by conditions not under an individual's control. For example, encouraging an individual to eat healthy food when none is accessible undermines the potential for successful behavioral change. Community-based prevention interventions can be designed to affect environmental and social conditions that are out of the reach of clinical services. (An Integrated Framework for Assessing the Value of Community- Based Prevention – Institute of Medicine 2012)¹

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

Thomas Jefferson University Hospitals, an academic medical center within the Jefferson Health System, serves patients in Philadelphia and the surrounding communities in the Delaware Valley. Thomas Jefferson University 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.

Thomas Jefferson University Hospitals (TJUHs) - Thomas Jefferson University Hospital, Jefferson Hospital for Neuroscience, and Methodist Hospital Division - trace its origins to 1825, when Jefferson Medical College started an infirmary to provide medical treatment to the indigent. In 1877, Jefferson opened a 125-bed hospital, the first in the nation affiliated with a medical school. Recognized nationally as a center for excellence in medical education, research, and health services, Jefferson is committed to serving the healthcare needs of its community.

Founded in 1892, Jefferson's Methodist Hospital has a long history of providing the highest level of compassionate care to South Philadelphia. Methodist offers the unique warmth and hospitality of a smaller community hospital combined with the leading experts, treatments and technologies you expect from larger teaching institutions. As the leading healthcare provider in the heart of South Philadelphia, Methodist serves the community by offering numerous health education programs,

fitness and nutrition classes and screenings to enhance the well-being of area residents and partners with various civic organizations to address the community's healthcare needs.

Jefferson Hospital for Neuroscience (JHN) is the Philadelphia area's preeminent center for the diagnosis and treatment of stroke and cerebrovascular diseases, brain tumors, epilepsy, movement disorders, neuromuscular diseases, headaches, Alzheimer's disease and spine and spinal cord injuries.

With the growing burden of chronic disease, the medical and public health communities are reexamining their roles and opportunities for more effective prevention and clinical interventions. The potential to significantly improve chronic disease prevention and impact morbidity and mortality from chronic conditions is enhanced by adopting strategies that incorporate a social ecology perspective, realigning the patient-physician relationship, integrating population health perspectives into the chronic care model, and effectively engaging communities.

Jefferson highly values the principles of community engagement articulated by the Centers for Disease Control (Table 1) and has built its community benefit efforts on a community engagement model. Jefferson also recognizes the value of an Expanded Chronic Care Model (Figure 1) as a framework for addressing chronic disease in a comprehensive way that respects clinical care, the health system, community and patients as equal partners in meeting the Triple Aim of improving population health, the patient experience, and reducing per capita costs.

Table 1 - Principles of Community Engagement²

Principle	Key elements
Set Goals	<ul style="list-style-type: none"> • Clarify the purposes/goals of the engagement effort • Specify populations and/or communities
Study Community	<ul style="list-style-type: none"> • Economic conditions • Political structures • Norms and values • Demographic trends • History • Experience with engagement efforts • Perceptions of those initiating the engagement activities
Build Trust	<ul style="list-style-type: none"> • Establish relationships • Work with the formal and informal leadership • Seek commitment from community organizations and leaders • Create processes for mobilizing the community
Encourage self-determination	<ul style="list-style-type: none"> • Community self-determination is the responsibility and right of all people • No external entity should assume that it can bestow on a community the power to act in its own self-interest
Establish partnerships	<ul style="list-style-type: none"> • Equitable partnerships are necessary for success
Respect diversity	<ul style="list-style-type: none"> • Utilize multiple engagement strategies • Explicitly recognize cultural influences

Principle	Key elements
Identify community assets and develop capacity	<ul style="list-style-type: none"> • View community structures as resources for change and action • Provide experts and resources to assist with analysis, decision-making, and action • Provide support to develop leadership training, meeting facilitation, skill building
Release control to the community	<ul style="list-style-type: none"> • Include as many elements of a community as possible • Adapt to meet changing needs and growth
Make a long-term commitment	<ul style="list-style-type: none"> • Recognize different stages of development and Provide ongoing technical assistance

Principles of Community Engagement: Edition 2. Clinical and Translational Science Awards Consortium Community Engagement Key Function Committee Task Force on the Principles of Community Engagement. 2011;11-7782.

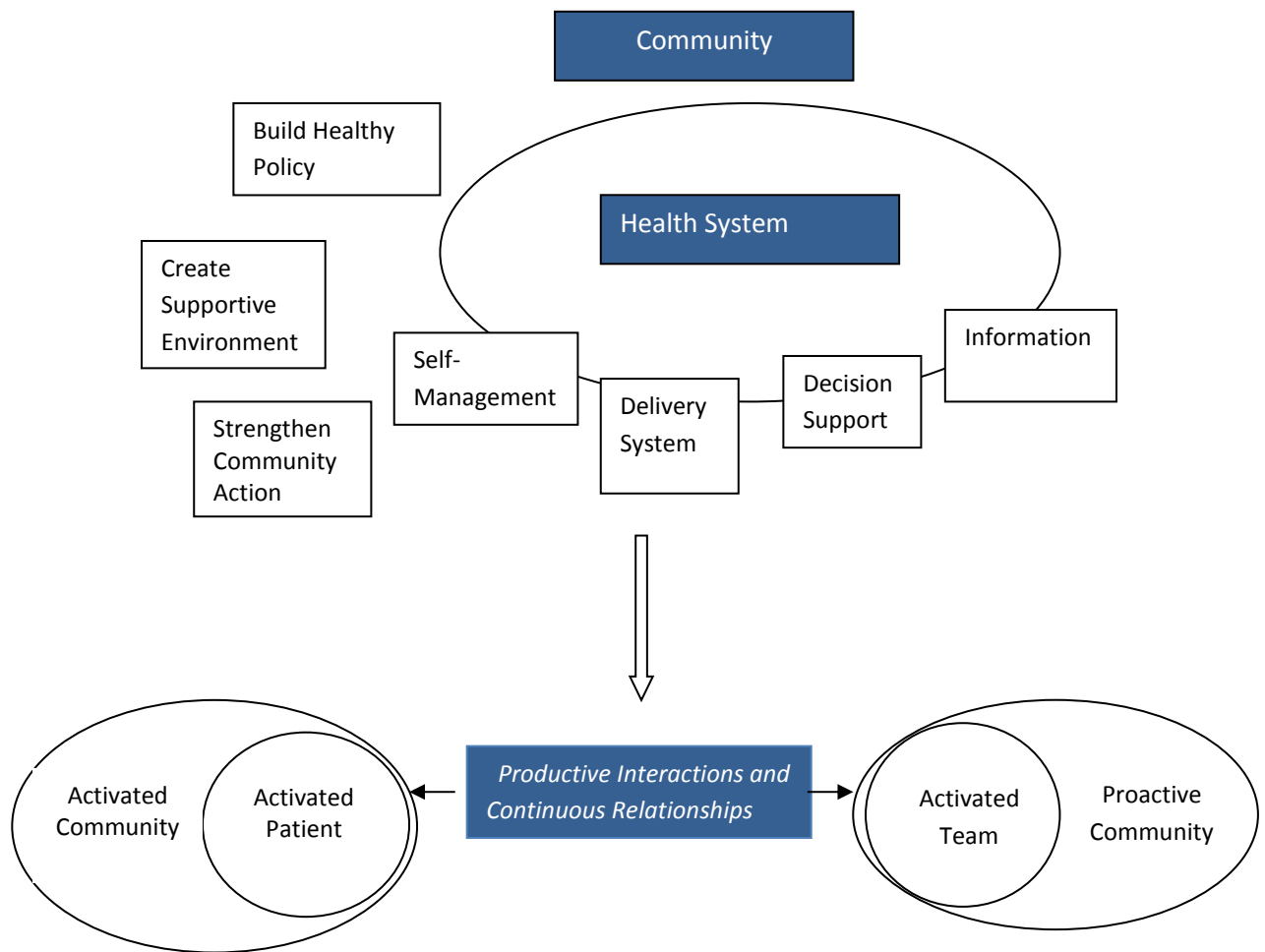
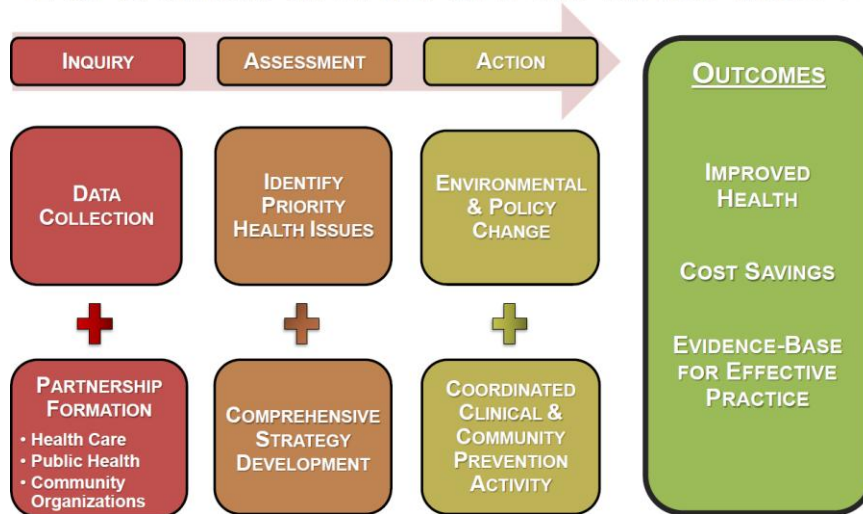


Figure 1 - Adapted From: Barr, V., Robinson, S., Marin-Link, B., Underhill, L., Dotts, A., Ravensdale, D., & Salivaras, S. (2003). The Expanded Chronic Care Model: An Integration of Concepts and Strategies from Population Health Promotion and the Chronic Care Model. Hospital Quarterly, 7(1), 73-82.³

The Community Benefit Committee recommends using the following model to guide planning and programmatic efforts, and to explain to internal and external stakeholders the rationale for the Community Health implementation plan⁴.

CLINICAL/COMMUNITY POPULATION HEALTH INTERVENTION MODEL



Purpose of the Community Health Needs Assessment (CHNA)

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

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

Specifically, the PPACA mandates a new Section in the IRS Code –Section 501(r) for Hospitals to Obtain/Maintain 501(c)(3) Status

- Each hospital facility must conduct a community health needs assessment at least once every three taxable years and adopt an implementation strategy to meet the community health needs identified through the assessment

- The community health needs assessment must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or public health expertise
- Must be made widely available to the public

To undertake this mandate, TJUHs formed a CHNA Advisory Group and an Internal Community Benefit Steering Committee (CBSC). The role of the CHNA Advisory Group was to provide guidance about conducting the health needs assessment, to suggest community experts/organizations who should be included in the process, provide suggestions for additional resources to be included, to review the needs assessment finding and recommendations and provide guidance and insight into priorities and strategies for the implementation plan. The CHNA Advisory group met three times during the past year. The TJUH CBSC met bimonthly over the past year.

Members of these Committees and their departments/organizations are listed in the Tables below:

CHNA Advisory Group

Name	Title/Organization
Marcus Allen	CEO, Achievability
Chris McIsaac	Managing Director, Institutional Investor Group, Vanguard
Jill Michal	President and CEO, United Way of Greater Philadelphia & Southern New Jersey
Peter A. Ryan	Partner, KPMG LLP

Internal Community Benefit Steering Committee

Name	Department/Title
Hugh Lavery	TJUH Administration
Rickie Brawer PhD, MPH	Associate Director – Center for Urban health
James Plumb MD, MPH	Family Medicine; Director – Center for Urban Health
Diane Pirollo	Methodist Hospital Foundation
Lore Szymonowicz	Finance
Jackie Guilfoyle	Finance
Pam Kolb	TJUH-JHN Administration
Stephen Smith	Jefferson Foundation
Ann Clark	Nursing
Rob Simmons DrPH, MPH	Director – MPH Program – Jefferson School of Population Health

Name	Department/Title
Ann Clark	Nursing
Monica Doyle	Marketing
Marietta Jeffers	TJUH – Strategy and Market Development

Specifically, the Committee was charged to:

- **Develop a strategic plan based on a comprehensive needs assessment**
- **Align the plan with TJUHs Strategic Plan**
- **Develop an annual action plan and budget**
- **Monitor plan implementation** and institute corrective measures if needed
- **Conduct ongoing evaluation** of community benefit structure & processes
- **Evaluate the effectiveness** of individual projects and the impact of community benefit initiatives as a whole
- **Communicate** with external and internal audiences

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

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

In addition to these principles, the Steering Committee chose additional factors in determining a **neighborhood focus of its community benefit approach to maximize effectiveness.** These urban neighborhoods:

- **Are geographically proximate to both TJUH and Methodist.** As an Academic medical Center, Jefferson serves a region that spans three states. For purposes of community benefit, the steering committee agreed that the focus for community benefit should be narrowed to include those neighborhoods in Philadelphia that are most proximate to THUHs campuses. These communities include Lower North Philadelphia (zip codes 19121, 19122, 19123, 19125, 19130, 19132, 19133), Center City (zip codes 19102, 19103, 19106, 19107), and South Philadelphia (zip codes 19145, 19146, 19147, 19148).
- **Have a density of high-risk patients who demonstrate poor health indicators** (health disparities)
- **Have a poverty rate >20%**
- **Have assets and resources that are not linked and coordinated to TJUHs outreach**
- **Have individuals and organizations with developed historical relationships with Jefferson staff** or have the potential for partnering to address specific health and social issues

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

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

Community Health Needs Assessment Methods

Literature Review and Secondary Data Sources

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

- Public Health Management Corporation - Household Health Surveys– 2008, 2010,2012
- Youth Risk Behavior Surveillance System (YRBSS) 2010-2012
- Behavior Risk Factor Surveillance System (BRFSS) 2010-2012
- Healthy People 2020
- County Health Rankings and Roadmaps 2012 and 2013
- TJUH and Methodist 2012 Emergency Department and hospital admission/readmission data
- Philadelphia Health Department Data 2010-2012
(<http://www.phila.gov/health/commissioner/DataResearch.html>) Data and Reports from the Health Commissioner
- Philadelphia 2013 - State of the City - Pew Charitable Trusts
- City of Philadelphia data: (Economic data, School data, Transportation, Vacant properties, City zoning/food work initiatives, Homelessness)
- Pennsylvania Department of Health - <http://www.portal.health.state.pa.us/portal/>
- <http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>
- <http://www.portal.state.pa.us/portal/server.pt?open=514&objID=1164302&mode=2> Health equity conference 2012
- Pennsylvania Life Expectancy - <http://www.worldlifeexpectancy.com/top>
- Community Needs Index⁵
- Kaiser Family – State Health Facts⁶ -
- Philadelphia Corporation on Aging⁷
- American Diabetes Association⁸

- Feeding America – Map the Meal Gap⁹
- FRAC – Food Hardship in America 2012¹⁰ - <http://frac.org/>
- Drexel University School of Public Health - Center for Hunger Free Communities¹¹ –
- Findings from the Philadelphia Urban Food and Fitness Alliance (Annual Reports)
- Reports from a variety of community coalitions focused on specific neighborhoods or health issues such as Promise Neighborhoods, Philly Rising Initiatives to reduce crime/violence, and coalitions to improve access to Behavioral Health Services.
- 100, 000 Homes campaign – Data on homelessness in Philadelphia¹²
- Maternity Care Coalition Early Head Start Community Assessment¹³
- American Community Survey¹⁴
- Restaurant Opportunities Centers United¹⁵
- SEAMAAC Asian Health Survey¹⁶
- Walkable Access to Healthy Food in Philadelphia, 2010-2012¹⁷
- 2012 The Nielsen Company, © 2013 Truven Health Analytics Inc

Primary Data Sources:

TJUHs Strategic Plan

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

Interviews

More than 60 interviews were conducted with individuals representing health care and community based organizations that have knowledge of the health and underlying social conditions that affect health of the people in their neighborhood and broader community. These interviews were conducted by a qualitative public health researcher from TJUHs Center for Urban Health to gain insight about health needs and priorities, barriers to improving community health, and the community assets and efforts already in place or being planned to address these issues and concerns. Medical students from Refugee Health Partners, a student run clinic, assisted with interviews with organizations who assist the refugee community as part of the community needs assessment they are doing to inform their student run refugee clinic in South Philadelphia. In addition, interviews were conducted with faculty and health providers from Methodist Hospital, Jefferson Neurosciences and Thomas Jefferson University Hospital to gain their perspective about the health issues of their patients and community and to identify Jefferson’s and other efforts to address these issues. Interviewees were asked to prioritize the needs /recommendations discussed during their interview. The table below lists those interviewed, their affiliation, the sector they represent, and the focus of the interview based on their area(s) of expertise.

Organization	Contact	Community/ Jefferson	Focus
American Heart Association	Charmie Cuthbert; Michele Bowles	community	Heart Disease/stroke
Jefferson Medical College- Department of Family and Community Family Medicine; Former President of the American Cancer Society	Dr. Richard Wender	community	cancer
American Diabetes Association	Michele Foster	community	diabetes
Philadelphia Department of Health	Dr. Girdihar Mallya Claudia Siegel Sara Soloman	community	public health
Philadelphia School District	Glenn Mc Devitt Betty Ann Creighton	community	student health
United Communities Southeastern Philadelphia	Carys Davies Katie Brooks Cory Miller	community	immigrant/refugee; mental health; youth
Federation of Neighborhood Centers	Diane Cornman Levy	community	community needs; youth
Diversified Community Services	Mitch Little Jennifer Swain Jaime Bednarchick	community	community needs
Nationalities Services Center	Julianne Ramic; Gretchen Wendell	community	immigrant/refugee
Pennsylvania Immigrant Care Coalition	Natasha Kelemen	community	immigrant/refugee
Lutheran and Children's Services	Melissa Fogg	community	immigrant/refugee; mental health
YMCA	Aimee Smith	community	physical activity; diabetes; nutrition
Maternity Care Coalition	Margie Mogul Bette Beggleiter	community	maternal child health
Drexel School of Public Health – Center for Hunger Free Communities	Marianna Chilton	community	food security
Area Health Education Center –	Mara Lipshutz	community	health profession workforce development
Philadelphia Business Health/Wellness Collaborative	Neil Goldfarb	community	work place wellness
Philadelphia Housing Authority	Edward Rudow, Mildred Drake Carla Fleming Virginius Bragg	community	housing; community health
Restaurant Opportunities Center	Fabrizio Rodriguez	community	immigrant

Organization	Contact	Community/ Jefferson	Focus
Juntos	Erika Almiron (presentation to SEPC coalition members)	community	immigrant/Latina
Health Promotion Council	Vanessa Briggs	community	community health and wellness
SHARE	Steveanna Wynn	community	food security
Urban Tree Connection	Skip Weiner	community	food security
Council for Relationships	Sara Corse (also on staff in Psych Dept at Jefferson)	Community Jefferson	mental health
Food Trust	Sandy Sherman; Stacy Taylor	community	food security; access to food; nutrition; obesity
Cambodian Association	Sarun Chan Rorng Sorn	community	immigrants
SEAMAAC	Elaine Yuen Amy Jones	community	immigrants
TJUH Emergency Medicine	Dr. Ted Christopher Linda Davis Moon Dr. Paris Lovett	Jefferson	clinical care
Jefferson Hospital of Neurosciences TJUH Stroke Center	Anne Clark Toby Mazer Pam Kolb	Jefferson	Stroke; clinical care
TJU Endocrinology (Diabetes Center)	Cheryl Marko	Jefferson	Diabetes
TJU JOGA clinic	Abigail Wolff	Jefferson	maternal child health
TJU Cardiovascular Disease	Dr. David Shipon (cardiac prevention at Methodist and TJUH)	Jefferson	Heart Disease/stroke
Mazzoni Center	Dr. Nancy Brisbon	Jefferson	LGBT; clinical care
Pathways to Housing	Dr. Lara Weinstein	Jefferson	Homeless and formerly homeless
Project HOME	Monica McCurdy Lisa Greenspan Dr. Kevin Scott Dr. Lara Weinstein Dr. James Plumb	Community Jefferson	Homeless and formerly homeless; clinical care
Jefferson Medical College - Department of Family and Community Medicine- Jefferson Family Medicine Associates - Refugee Health Clinic	Dr. Marc Altshuler Dr. Kevin Scott Dr. Ellen Plumb	Jefferson	refugee; family medicine; clinical care
Jefferson Medical College - Department of Family and Community Medicine- Jefferson Family Medicine Associates - Older adults	Dr. Chris Arenson	Jefferson	family medicine; geriatrics

Organization	Contact	Community/ Jefferson	Focus
Thomas Jefferson University - School of Nursing	Molly Rose Amy Szaji	Jefferson	Nursing; community outreach
Thomas Jefferson University - School of Pharmacy	Rohit Moghe	Jefferson	pharmacy/medication issues
Nemours - Pediatrics	Dr. Esther Chung	Jefferson	Pediatrics; clinical care
TJUHs Human Resources; Workforce Development	Terri Manning	Jefferson	workforce development
TJUHs – Finance Dept. - MA assistance	Lori Szymonowicz	Jefferson	MA assistance
TJUHs – Nursing-Nurse Magnet	Rachel Behrendt	Jefferson	clinical care
Methodist Hospital	Diane Pirolo Stephanie Gaber Nina Boffa	Jefferson	clinical care; community health
Jefferson Family Medicine Associates Department of Family and Community Medicine – Social Work	Maria Hervada- Paige	Jefferson	Community health and social services
Philadelphia Health Initiative	Coalition discussion	community	worksite wellness
Asian Chamber of Commerce of Greater Philadelphia; St Thomas Aquinas Church; Methodist community relations Subcommittee of the foundation	Mary Faustino	community	immigrants; community health
Migrant Education	Lian Niang Naw Doh	community	Refugee Health
Philadelphia Burmese Baptist Church	Saw Min Dr La Seng	community	Refugee Health
Philadelphia Chin Baptist Church	Thomas Bik	community	Refugee Health
HIAS	PK Subedi	community	Refugee Health

Focus Groups

Focus groups were conducted with TJUHs employees who live in the neighborhoods that are part of Jefferson’s CB area. This was done purposefully in order to raise awareness among TJUHs employee community about the health needs assessment and to engage them in future efforts to improve community health. A list of employees who live in zip codes that make up the community benefit area was obtained from Human Resources. Employees were randomly selected from each zip code and contacted about their interest in participating in the focus groups. Four focus groups were held, one with employees from South Philadelphia, one with employees from Lower North Philadelphia east of Broad Street, one with employees from Lower North Philadelphia west of Broad Street and one with employees from Transitional Neighborhoods. Thirty-five employees participated. Focus groups were conducted by qualitative public health researchers from both Thomas Jefferson University’s School of Population Health and TJUHs Center for Urban Health. Employees received lunch and movie tickets for their participation.

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

Community Health Needs Assessment Findings

The results from the Community Health Needs Assessment are organized into the following categories:

- Demographics
- Social Determinants of Health
 - Education
 - Income and poverty
 - Access to healthy and affordable food
 - Employment and job training
 - Community safety
 - Built and natural environment
 - Healthcare access
 - Health insurance
 - Transportation
 - Literacy
 - Culture and language
- Mortality
- Morbidity
- Health Behaviors
- Special Populations
 - Older Adults
 - Immigrants and Refugees
 - Homeless
 - LGBT

Philadelphia and TJUH Community Benefit Area Demographics

According to the Official 2010 census, Philadelphia is the fifth largest city in the country with approximately 1.5 million people. According to the County Health Rankings and Roadmaps 2013, the population of the city of Philadelphia is 37% non-Hispanic white, 42% non-Hispanic African American, 13% Hispanic or Latino, and almost 7% Asian. The demographic profile of Philadelphia is

quite different than the state of Pennsylvania, where African Americans represent only 11% and Caucasians 79%.

For the first time since 1950, Philadelphia's population is growing - 0.6% over the past decade. Also, Philadelphia became more ethnically diverse. The biggest changes were the drop in the number of non-Hispanic whites (13% decrease) and growth in the numbers of Hispanics and Asians, 46% and 42% respectively. The number of foreign-born residents represents about 11% of the city's population. Almost 24% of Philadelphians and residents in Jefferson's community benefit area speak a language other than English in their home (Pew 2013; County Health Rankings 2013).

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

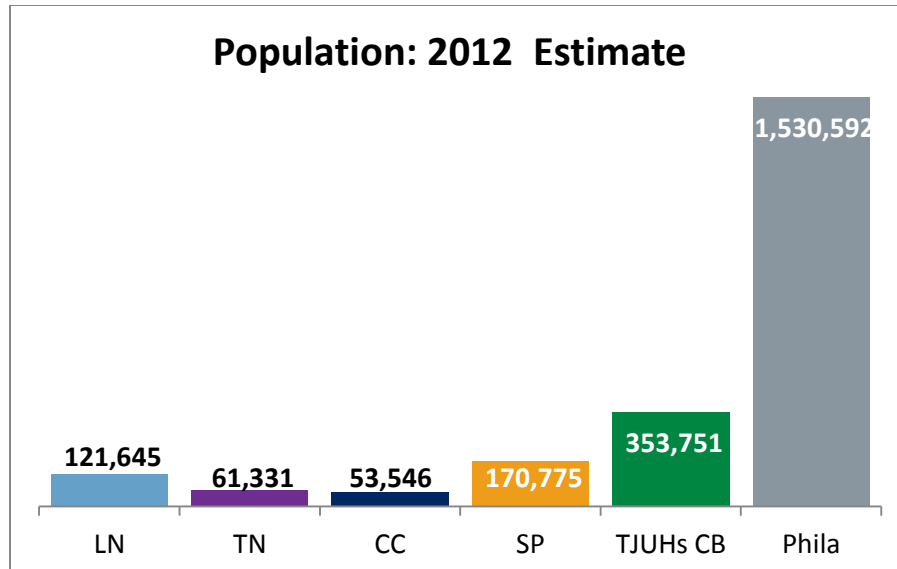
Area	ZIP Codes	Sub Area	ZIP Codes
Lower North Phila. (LN)	19121, 19122, 19132, 19133	Lower North east of Broad Lower North west of Broad	19122, 19133 19121, 19132
Transitional Areas (TN)	19123, 19125, 19130		
Center City (CC)	19102, 19103, 19106, 19107		
South Phila. (SP)	19145, 19146, 19147, 19148	South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

The map below depicts these areas. Each area has been assigned a color which will be used throughout this report in graphs to depict that specific area.

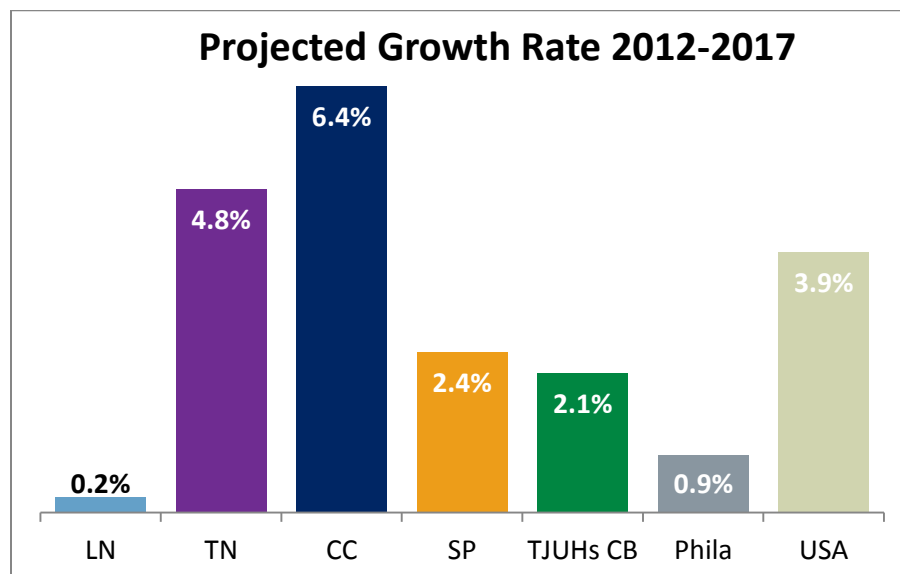


Philadelphia and Jefferson's CB Area Demographics

Almost 354,000 people live in Jefferson's CB area. This represents 23% of all residents of Philadelphia. While Philadelphia only anticipates a 0.9% increase in population between 2012 and 2017, Center City is expected to grow by 6.4% and Transitional Neighborhoods by 4.8% followed by more than a 2% increase in population in South Philadelphia.¹⁸

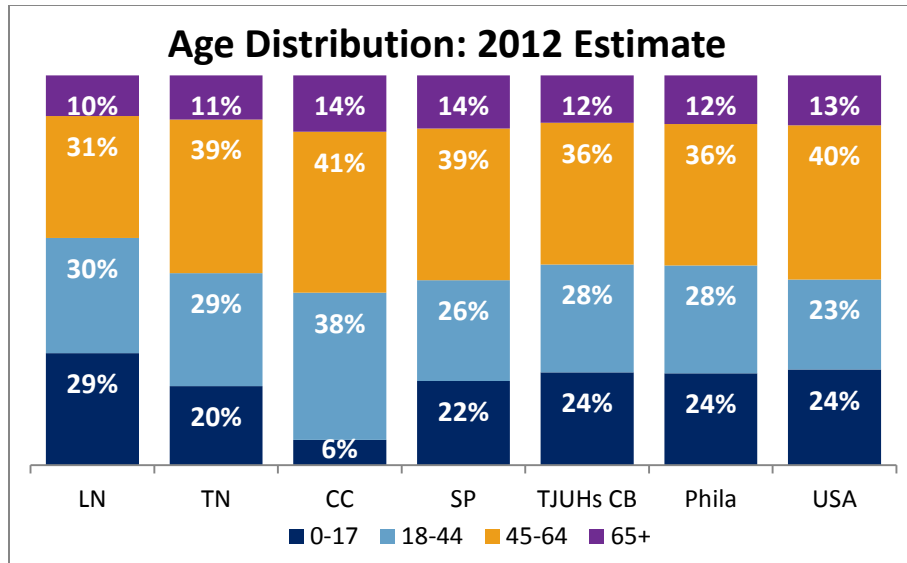


(2012 The Nielsen Company, © 2013 Truven Health Analytics Inc)



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Similar to Philadelphia, Jefferson’s CB area is 53% female and 47% male and varies little across CB areas. Lower North Philadelphia has more youth ages 0-17 than the rest of Philadelphia and Jefferson’s CB area. Center City has a higher percentage of adults aged 18-44 than Philadelphia (38% vs. 28%) and is more likely to have adults over age 44 (55% vs. 48%).



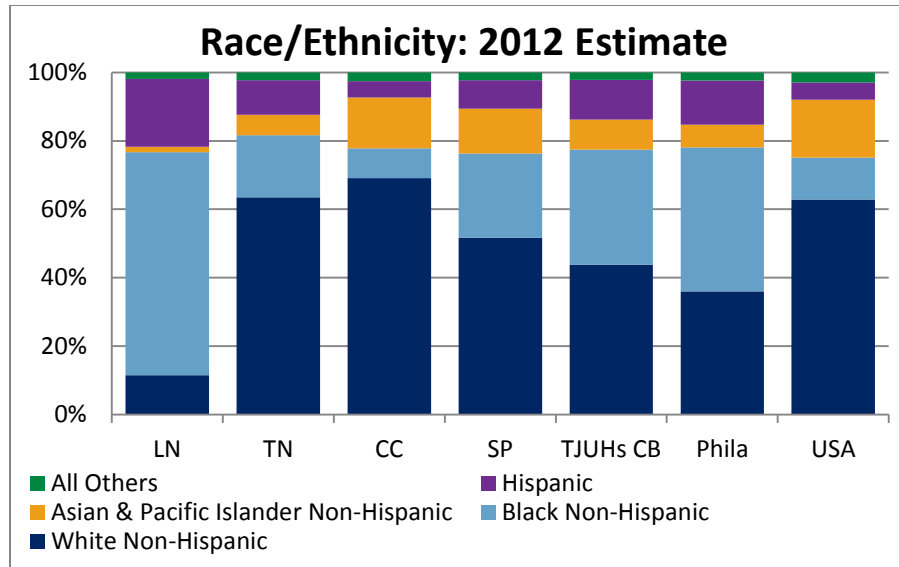
(2012 The Nielsen Company, © 2013 Truven Health Analytics Inc)

Compared to Philadelphia, Jefferson’s CB area (353,751 residents) is slightly more likely to be White non-Hispanic (39.9% vs. 37%) and less likely to be non-Hispanic African American (37.4% vs. 42%). Non-Hispanic Whites are more likely to live in Center City, South Philadelphia and Transitional Neighborhoods; non-Hispanic Blacks are more likely to live in Lower North Philadelphia west of Broad Street and in South Philadelphia west of Broad street.

More than 197,000 residents in Philadelphia identify themselves as Hispanic. The majority of Hispanics in the Philadelphia area are from Puerto Rico (72%) and live predominantly in Eastern North Philadelphia; 17% are Mexican with the remaining Hispanic population from Latin America, the Caribbean, Central America, and Mexico. In Jefferson’s CB area 44,586 (12.6%) of the population is Hispanic. The majority of these residents live in North Philadelphia East of Broad (21,837) and South Philadelphia East of Broad Street (10,266). Southeast Philadelphia is home to a growing immigrant population from Mexico. Although they share a common language, each Hispanic community is culturally unique, and internally diverse by gender, generation, class and race.

The Asian community in Philadelphia represents 6.6% of the total population (100,950 residents). Slightly more than one-third of these residents (35,904) live in Jefferson’s CB area. Southeast Philadelphia has the largest Asian community with 13,633 (15.6%) of residents, followed by 8,647 (10.4%) in South Philadelphia west of Broad street (8,647) and 14.9% in Center City (7,964). The Asian community in Center City is predominantly of Chinese descent, while in South Philadelphia residents include immigrants from Vietnam and refugees from Cambodia (the largest population of Asian residents) as well as newly resettled refugees from Burma, Nepal and Bhutan.

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



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Social Determinants of Health

Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood) have been referred to as “place.” In addition to the more material attributes of “place,” the patterns of social engagement and sense of security and well-being are also affected by where people live. Resources that enhance quality of life can have a significant influence on population health outcomes. Understanding the relationship between how population groups experience “place” and the impact of “place” on health is fundamental to the social determinants of health. (Healthy People 2020)¹⁹.

To address social determinants of health, Healthy People 2020 uses a “*place-based*” approach that consists of five key areas: economic stability (poverty, employment status, access to employment, housing stability/homelessness); education (high school graduation rates, school environments, enrollment in higher education); social and community context (family structure, social cohesion, civic participation, incarceration); health and healthcare (access to health services including clinical and preventive care, access to primary care including wellness and health promotion programs); and neighborhood and built environment (crime and violence, access to healthy foods).

TJUHs community assessment focuses on the following social and determinants of health through a “*community benefit neighborhood-based*” approach:

- Education, Employment and job training
- Income and poverty

- Access to healthy and affordable food
- Community safety
- Family and social support
- Built and natural environment (green space, bike lanes, parks, walkability, etc)
- Health care access (transportation, health insurance, language and literacy and culture)

According to a representative from a community based organization “*We talk about diabetes, heart disease, obesity, but what we need to do is invest in the social determinants of health in order for people to get access and resolve poverty, housing issues, etc.*”

“Philadelphia is the second poorest city in the US. Specific neighborhoods are even worse. Average household income is really low. Knowing where to start to address social determinants is like a ball of string - what thread do you pull to make the most impact? household income?, education? “

“We know that income and education are root causes of poor health outcomes. Right now, access to food and physical activity are the major focus, but these have environmental underpinnings related to low income/poverty, poor access, crime, policy shifts in agriculture, school physical activity, school food etc. We blame the person (lack of personal responsibility) rather than the policy or system or environment.”

The information about social determinants that follows relates to the **general** community benefit population. Social determinant issues that pertain to **special** populations will be provided in the CHNA section for *Special Populations*.

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

- 1) The **2013 County Health Rankings** for Pennsylvania ranked Philadelphia last of all 67 counties in the state for social and economic factors.²⁰
- 2) **Community Need Index** - In 2005 Dignity Health, in partnership with Truven Health, pioneered the nation’s first standardized Community Need Index (CNI). The CNI identifies the severity of health disparity for every zip code in the United States and demonstrates the link between community need, access to care, and preventable hospitalizations. The CNI accounts for the underlying economic and structural barriers that affect overall health. These barriers include those related to income, culture/language, education, insurance, and housing. The CNI gathers data about a community’s socio-economy (percentage of elderly living in poverty; percentage of the uninsured or unemployed, etc). A score is then assigned to each barrier condition (with 1 representing less community need and 5 representing more community need). The scores are then aggregated across the barriers and averaged for a final CNI score (each barrier receives equal weight in the average). A score of 1.0 indicates a zip code with the lowest socio-economic barriers, while a score of 5.0 represents a zip code with the most socio-economic barriers²¹

The CNI score is highly correlated to hospital utilization – high need is associated with high utilization. The CNI considers multiple factors that limit health care access, and therefore may

be more accurate than existing needs assessment methods. In addition, the most highly needy communities experience admission rates almost twice as often as the lowest need communities for conditions where appropriate outpatient care could prevent or reduce the need for hospital admission such as pneumonia, asthma, congestive heart failure, and cellulitis. Of cities in the United States with populations of more than 500,000, Philadelphia (CNI score 4.29) is among the top 10 cities with the highest need. The chart below provides the CNI for zip codes in Jefferson’s CB area (<http://cni.chw-interactive.org/printout.asp>).

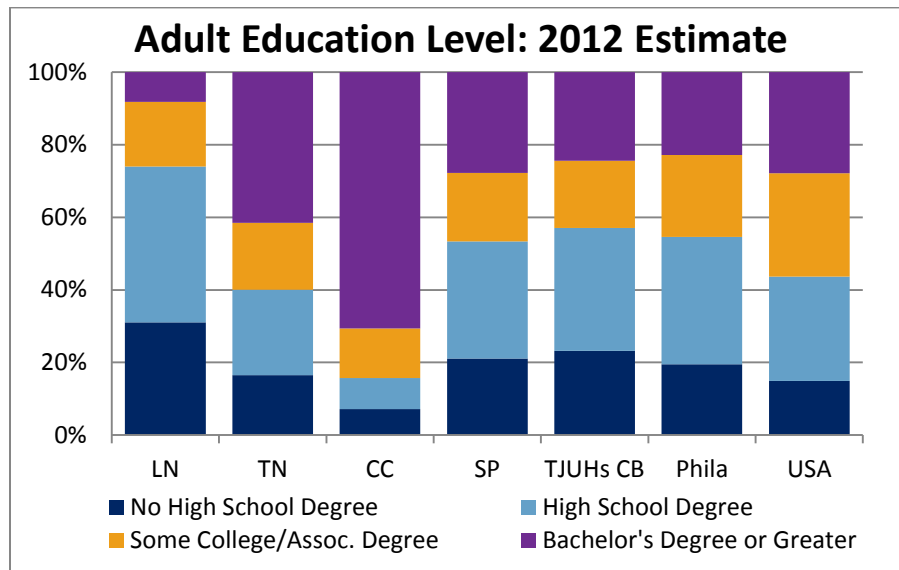
CNI Scores by ZIP Code							
Center City		Lower North		Transitional Neighborhoods		South Philadelphia	
Zip Code	CNI Scores	ZIP Codes	CNI Scores	ZIP Codes	CNI Scores	ZIP Codes	CNI Scores SP
19102	3.4	19121	5	19123	5	19145	5
19103	3.2	19122	5	19125	4.8	19146	4.8
19106	3	19132	5	19130	4.2	19147	4.6
19107	4.6	19133	5			19148	4.6

Education

According to the Census, Philadelphia’s educational attainment level, though rising, is well below the national average and the levels of cities of similar size. Philadelphia ranks 22nd among the 25 largest U.S. cities in terms of educational attainment. In 2012, the Philadelphia School District and the State saw a big drop in the percentage of schools that achieved Adequate Yearly Progress as defined by U.S. Department of Education’s *No Child Left Behind Act*. One reason for this decrease is most likely due to standards that became much tougher²²

While Philadelphia’s overall level of educational attainment remained low compared to other cities and the nation as a whole, the percentage of city residents ages 25 to 34 with bachelor’s degrees was 37.5 percent compared to 26.9% in 2000. This rate is 6 percentage points higher than the national average and suggests a positive trend.²²

The level of education among residents in Jefferson’s CB area varies greatly. Residents living in Transitional Neighborhoods and Center City are more likely to have college degrees or higher (41.5% and 70.6% respectively) compared to Philadelphia (22.8%), while residents in Lower North Philadelphia Neighborhoods are more likely not to have graduated from high school (31%) compared to Philadelphia (19.5%). Overall, 23.2% of adults over age 25 living in Jefferson’s CB area report they did not graduate from high school²³



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Income and Poverty

Philadelphia has the highest rate of deep poverty – people with incomes below half of the poverty line – of any of the nation’s 10 most populous cities. The annual salary for a single person at half the poverty line is around \$5,700; for a family of four, it’s about \$ 11,700. Philadelphia’s deep-poverty rate is 12.9%, or approximately 200,000 people¹⁴ (U.S Census American Community Survey). In Philadelphia, 42.2% of households are below the Self Sufficiency Standard compared to 25.6% of Pennsylvanians. The Self Sufficiency Standard is defined as the income a family must earn to meet their basic needs without public or private assistance²⁴

Poverty can result in an increased risk of mortality, prevalence of medical conditions and disease incidence, depression, intimate partner violence, and poor health behaviors. Among Jefferson’s CB neighborhoods, Lower North Philadelphia residents are almost twice as likely to live below 100% poverty as others in Philadelphia (41.3% vs.21.9%) and more than five times more likely than those living in Center City. In addition, people living in Jefferson’s CB area are more likely than other Philadelphians to live below 50% of the federal poverty level (11.1% vs. 8.3%) and Lower North residents are more than twice as likely to live below 50% of the federal poverty level.

While negative health effects resulting from poverty are present at all ages, children in poverty experience greater morbidity and mortality than adults due to increased risk of accidental injury and lack of health care access. Children’s risk of poor health and premature mortality may also be increased due to the poor educational achievement associated with poverty. According to the County Health Profile for 2013²⁵, 39% of Philadelphia’s children under age 18 live in poverty (below 100% federal poverty level) compared to 19% in Pennsylvania (national benchmark is less than 14% of children living in poverty). In addition, 58% of children in Philadelphia live in single parent households compared to 32% in Philadelphia; the national benchmark is 20% of children living in single parent homes. Adults and children in single-parent households are at risk for adverse health outcomes such as mental health problems (including substance abuse, depression, and suicide) and unhealthy behaviors such as smoking and excessive alcohol use. According to the School District of Philadelphia, 82% of Philadelphia’s 149,500 students are economically disadvantaged²⁶.

TJUH Community Benefit Area Poverty

Poverty Level	LN	TN	CC	SP	TJUHs CB	Phila
Less than 50% Poverty	17.6	11.2	3.4	8.2	11.1	8.3
Less Than 100% Poverty	41.3	22.1	7.9	21.4	26.2	21.9
Less Than 150% Poverty	56.7	27.2	8.3	30.7	35.7	32.6
Less Than 200% Poverty	66.1	36.5	8.6	41.1	44.6	41.5

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The median household income in Philadelphia is \$48,832 and ranks 45th of the 50 largest cities in the US. While Center City and the Transitional Neighborhoods have average household incomes above others in Philadelphia, and Center City’s average household income is above the U.S. level, people living in other community benefit areas are at or below the average household income for Philadelphia. About 60% of people living in Lower North Philadelphia’s have household incomes less than \$25,000.

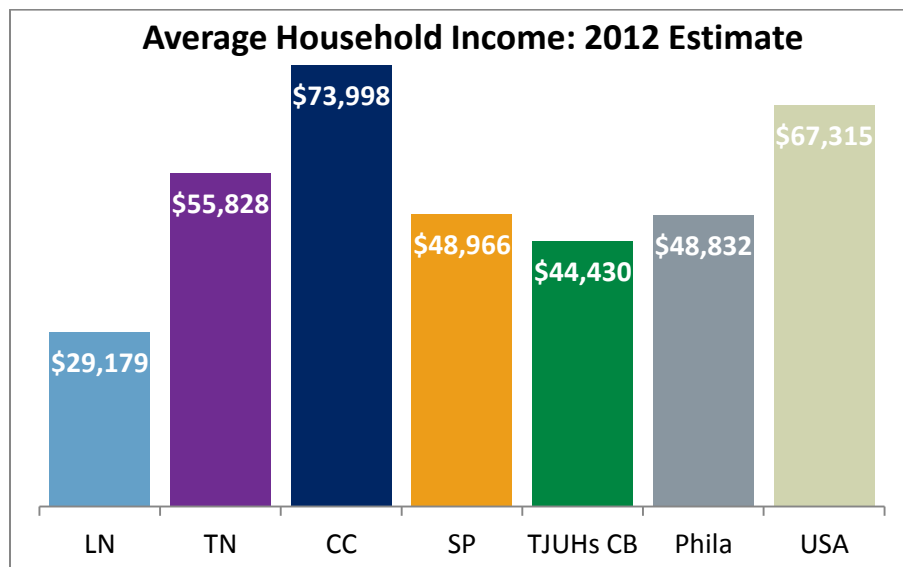
According to PEW’s Philadelphia 2013 – State of the City report, nearly a third of residents live below the poverty line, and slightly more than three out of ten are eligible for food stamps. Of the city’s 46 residential zip codes, 24 had poverty rates over 20 percent. The range of poverty across zip codes was 5.8% in Chestnut Hill to 54% in North Philadelphia (19133). Of the 7 zip codes with the highest rates of poverty, 4 are in TJUHs CB area. Between 2004 and 2012, the number of people in poverty increased by 56,000 and the number of residents eligible for food stamps increased by 172,000 (food stamp requirements qualifications were expanded in 2009). Latinas and African Americans are more likely to be living in poverty than Whites (49.4%, 41% and 15.9% respectively (PHMC, 2013). For a family of four, the federal government defined poverty in 2012 as an annual income below \$23,050²².

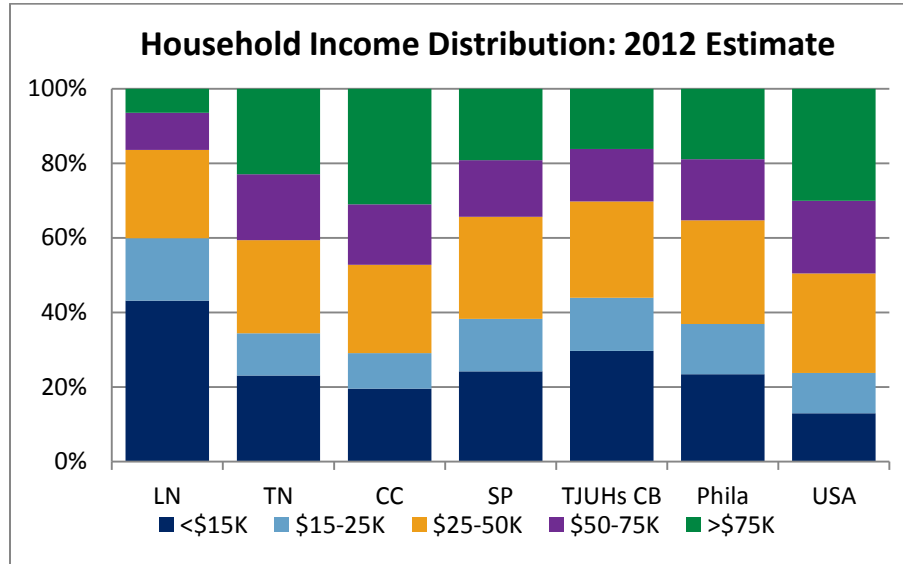
Philadelphia ranks eighth among the comparison cities and 24th out of the 25 largest cities in the country in median household income. This reflects relatively high unemployment in Philadelphia and a relatively low number of high-paying jobs²².

TJUH Community Benefit Area Poverty by ZIP Code

Zip	Neighborhood	% of Residents in Poverty
19133	North Phila. – East of Broad	54.0
19121	Fairmount North/Brewerytown (West of Broad)	53.4
19122	North Phila. – Yorktown (East of Broad)	41.9
19132	North Phila. – West of Broad	41.5
19146	South Phila. – Schuylkill (West of Broad)	29.6
19107	Center City	24.7
19125	Kensington/Fishtown	23.2
19148	South Phila. – East of Broad	21.8
19145	South Phila. – West of Broad	21.5
19123	Northern Liberties/Spring Garden	20.8
19102	Center City West	18.9
19147	South Phila. – Queen Village/Bella Vista	<i>Between 16.2 and 16.6</i>
19103	Center City West	13.5
19106	Center City – Society Hill	7.1

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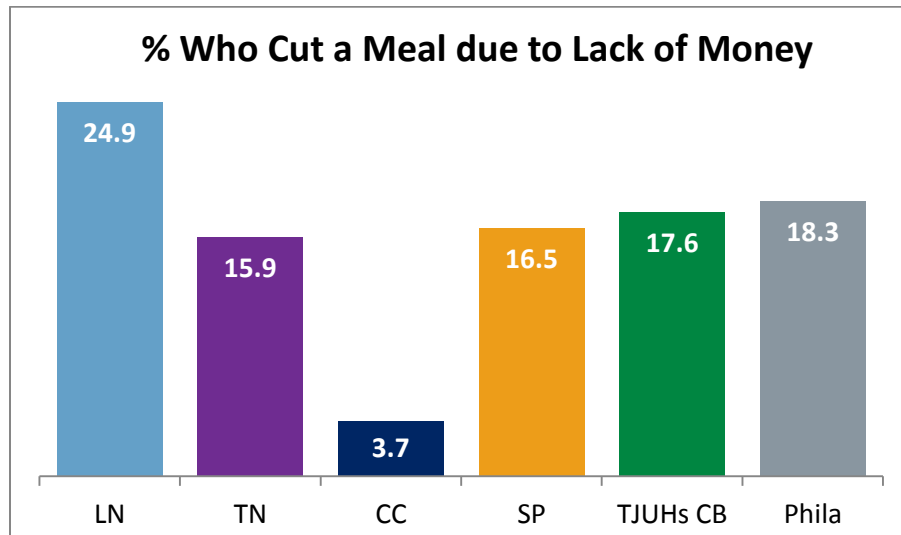
Access to Healthy and Affordable Food

Philadelphia is the only major U.S. city with two of the hungriest Congressional districts. Among households with children in 2010, approximately half in Philadelphia’s 1st Congressional District and nearly a third in the 2nd Congressional District did not have enough money to buy food that their family needed²⁷ According to Feeding America – Map the Meal Gap, Congressional Districts 1 and 2 which include Philadelphia, have the highest food insecurity rates in Pennsylvania and rank 20th and 147th nationally out of the 436 congressional districts²⁸ An estimated 184,100 people in Congressional District 1 (28.3%) and 167,030 people in Congressional District 2 (26.4%) are food insecure. Most of Jefferson’s CB area falls into these two districts. Overall, 22% of children in Philadelphia are food insecure²⁹ Food insecurity, defined as limited access to sufficient nutritious food, impacts a child’s development both in terms of brain development and growth and has been shown to be related to increases in childhood obesity. Children who experience food insecurity and hunger are more likely to require hospitalization, be at risk of chronic health care conditions such as anemia and asthma, at increased risk of oral health problems, and may affect their ability to fully engage in daily activities such as school and socially with peers. They are also likely to be behind academically. Behavior challenges are also evident among children who experience food insecurity. These children are at greater risk for truancy, and behavioral problems such as aggression at school, hyperactivity, anxiety, mood swings and bullying⁹. These health and behavioral risks may contribute to the cycle of poverty and future success as an adult. Food insecure adults are more likely to be at risk for diabetes, hypertension, and high cholesterol,. Pregnant women who are food insecure are more likely to experience major depression, have low weight babies, and experience birth complications compared to women who are food secure. Seniors are also adversely affected by

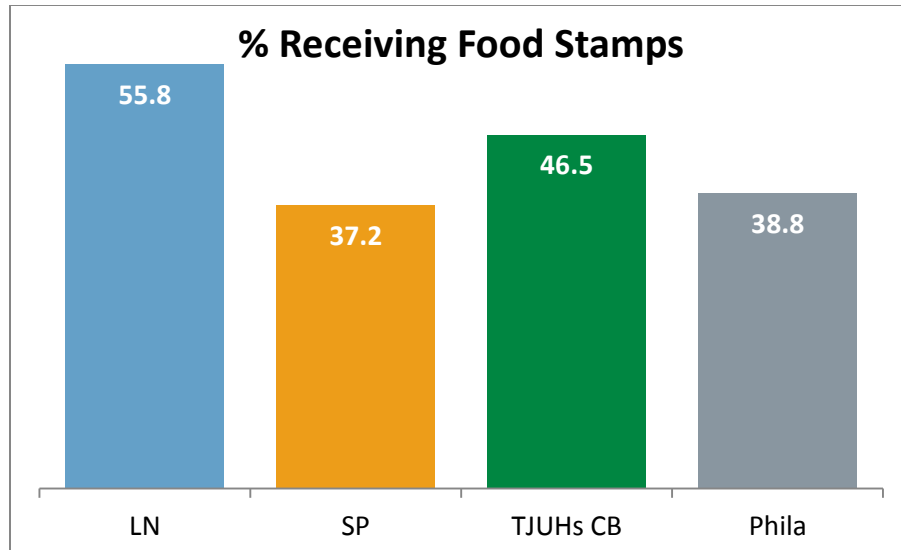
hunger. WIC and Food Stamps, according to Children’s Watch, are the “best medicine” to treat food insecurity. In Philadelphia 470,189 residents receive the Supplemental Nutrition Assistance Program (SNAP (1 in 3 residents) and 61,659 receive WIC. In addition, 75% of children in Philadelphia qualify for the free lunch program.

The percent of adults who reported cutting a meal due to cost is an indicator of food insecurity. While Center City neighborhoods have low food insecurity rates (3.7%), all other community benefit areas exceed the rate in Philadelphia, particularly in Lower North Philadelphia where almost one in four adults are food insecure. In addition, almost half (46.5%) of children in TJUHs CB area live in households receiving food stamps and 28% are receiving WIC. According to SHARE Food Program Philadelphia (sharefoodprogram.org/), an organization addressing food security through Philadelphia food cupboards and backpack programs, between 2002 and 2012 the number of households participating in their program increased from 53,370 to 223,553 and the total number served increased five-fold from 130,631 to 624,720 individuals served. The number of children reached increased from 54,073 to 243,096, adults from 63,174 to 198,359, and the elderly from 13,384 to 52,634. Given the percentage of children eligible for free lunch in Philadelphia, there appears some households may not be taking advantage of Government food assistance programs.

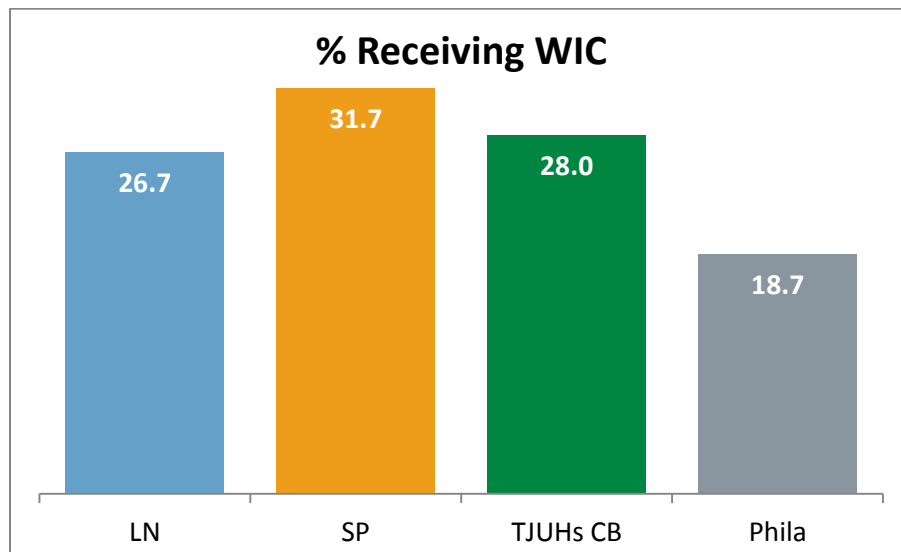
In Pennsylvania there are 470,000 eligible residents who don’t participate in SNAP and only 56% of eligible Pennsylvanians receive WIC benefits.²⁹ Despite increases in utilization of food services in Philadelphia, such as SHARE, there appears some households may not be taking advantage of Government food assistance programs.



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PHMC Household Health Survey 2012



PHMC Household Health Survey 2012

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

- **Food insecurity** is high and has been increasing over the past several years.
 - Food insecurity, food deserts and safety issues are underlying causes of obesity and diabetes.

- One community based organization in South Philadelphia shared they had served 159 families during the first quarter of 2012 and had to turn away 18 families because they ran out of food at the end of the month. (key informant)
- *The local food cupboard handed out bags of tortilla chips and frozen pizzas. This was all that was delivered at the end the month* (key informant)
- **Screening for food insecurity** is not systematically being done.
 - *“Primary care offers an opportunity to screen as does screening inpatients. This could be done at the same time you sign people up for MA - you can screen for SNAP (food stamp eligibility). Consider integrating this into programs you do to enroll people into insurance. Also, consider giving a \$25 food voucher to patients being discharged who may be food insecure ...it’s cheaper than a readmission)”*. (key informant)

Recommendations included:

- 1. Screening SNAP eligibility when determining MA eligibility**
- 2. Screening for food insecurity in TJUHs physician practices**
- 3. Providing food cupboard resources to patients seen in in primary care practices**
- 4. Conducting “healthy food” drives for area food cupboards in partnership with SHARE**

Employment and Job training

Philadelphia’s unemployment rate in January 2013 was 11.4 percent. The rate increased by 0.3 percentage points compared to December 2012 and 0.6 percentage points since January 2012. Since December 2007 (the official start of the Great Recession), the unemployment rate in Philadelphia increased by 5.0 percentage points. Philadelphia’s unemployment rate remains the highest in comparison to all other local workforce investment areas in Pennsylvania.

The number of unemployed individuals in January 2013 was about 75,700; 2,600 more individuals compared to December 2012 and 6,400 more individuals compared to January 2012. Since December 2007 the number of unemployed persons in Philadelphia increased by 35,500.

The number of people employed in Philadelphia during January 2013 was 589,900; 4,700 more individuals compared to December 2012 and 16,500 more individuals compared to January 2012. Philadelphia’s employment was 6,100 jobs above employment in December 2007 before the recession had an impact.²²

When compared to cities of similar size, Philadelphia had the second highest average unemployment rate, just behind the city of Detroit. Philadelphia’s rate is more than double the benchmark for the United States (5% unemployment). Twelve of the largest private employers are health and education focused. Federal and City government is the largest employer.^{22, 25}

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

Compared to the employed, the unemployed in the CB areas are more likely to report their health as fair or poor, a diagnosis of clinical depression, a diagnosed mental health condition and a chronic condition (diabetes, arthritis and high blood pressure). In addition, unemployed adults are more likely to smoke and twice as likely to report extreme stress (a rating of 10 out of 10 with 10 being extreme stress) in the past year compared to employed adults. Unemployed adults are more likely to be obese than those who are employed and overall 53% are either overweight or obese.

The implications of poor health on labor market outcomes are enormous for patients, families, employers and policy makers. Poorly managed health conditions have been associated with increased absenteeism, poor productivity, decreased job retention, and fragmented work histories. In a survey sponsored by Nationwide Better Health³⁰, 85 percent of respondents reported that unplanned absences are normally due to a health condition, either their own or that of a family member. Half of these absences were due to a recurring health condition. Mental and physical health illnesses, personal problems, the need to be with their families or job-related stress also increase lost productivity at work, which is known as presenteeism. According to the Partnership for Prevention³¹, reducing just one health risk can increase productivity by nine percent and reduce absenteeism by two percent. Absence management leads to a healthier workforce and keeps people on the job at full strength to maximize a company's productivity and profit.

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

“High unemployment rates and individuals with poor literacy skills need jobs that pay a living wage. Health is major reason why people lose their job within the first year or return to prison. The Career Support Network, (a partnership between federation of Neighborhood centers and TJUH and TJU), works with low resourced individuals to enhance literacy, provide job training and career development and improve ability to manage health conditions” (CBO representative).

Workforce Diversity - According to Healthy People 2020, public health infrastructure is fundamental to the provision and execution of public health services at all levels. A strong infrastructure provides the capacity to prepare for and respond to both acute (emergency) and chronic (ongoing) threats to the Nation's health. Infrastructure is the foundation for planning, delivering, and

evaluating public health. As minority populations in Philadelphia and the United States increase, a more diverse public health workforce will be needed. In Philadelphia, Hispanics and African Americans are underrepresented in the public health workforce. In addition, while there are Asian providers, language barriers across Philadelphia's diverse Asian communities exist. According to Cohen , Gabriel , and Terrell, increasing the racial and ethnic diversity of the health care workforce is essential for the adequate provision of culturally competent care to our nation's burgeoning minority communities. A diverse health care workforce will help to expand health care access for the underserved, foster research in neglected areas of societal need, and enrich the pool of managers and policymakers to meet the needs of a diverse populace. The long-term solution to achieving adequate diversity in the health professions depends upon fundamental reforms of our country's precollege education system³². (

There exists a growing literature related to the use of community health workers/navigators/coaches (CHWs) to increase the diversity of the workforce and in care management, facilitation of transitions of care, chronic disease management and bridging cultural divides. Interviews with organizations serving immigrants shared the need to train members of limited –English speaking communities in health professions including health care providers and community health workers. Developing a recruitment and training program for CHWs has the potential to provide job opportunities for minority populations and meaningful employment. It has also been shown to improve the quality and outcomes of care.

Interviews with TJUH's Human Resources Department/Nurse recruitment and Jefferson University's Associate Dean for Diversity and Community Engagement found that efforts are on-going to improve the diversity of the health workforce and student body. Plans to initiate a Diversity Council are underway composed of people representing community organizations and residents, the TJUH Board, Jefferson University, and TJUH staff. TJUH also participates in the *Workready* Philadelphia program which provides employment opportunities for high school students that build their employment skills. Interviews also highlighted the need to develop a pipeline to improve the capacity of Philadelphia youth to enter health professions. This was also supported by key informant interviews in the Asian community to increase bilingual providers.

Recommendations included:

- 1. Partner with Refugee Academic Mentoring Program (NSC program) that helps people get the skills needed to get health related employment. (example Burmese nurse).**
- 2. Provide Community Health Worker training and training for medical interpretation for young refugee and immigrant adults who are bilingual**
- 3. Work with NSC RAMP program, AHEC, TJU and TJUHs human resources to build Health Coaches/community health worker program and youth pipeline into health professions.**
- 4. Provide tutoring/mentoring as part of pipeline into health professions.**
- 5. Continue the WorkReady program with Philadelphia Youth Network at TJUHs**
- 6. Continue the Career Support Network program with low resourced workers**

Community Safety

The health impacts of community safety include the impact of violence on the victim, symptoms of post-traumatic stress disorder (PTSD), psychological distress due to chronic exposure to unsafe living conditions and various other health factors and outcomes including birth weight, diet and exercise, and family and social support. Exposure to crime and violence has been shown to increase stress, which may exacerbate hypertension and other stress-related disorders and behaviors such as smoking in an effort to reduce or cope with stress. Exposure to violent neighborhoods has been associated with increased substance abuse and sexual risk-taking behaviors as well as risky driving practices²⁰

Violent crime is represented as an annual rate per 100,000 population. Violent crimes are defined as offenses that involve face-to-face confrontation between the victim and the perpetrator, including homicide, forcible rape, robbery, and aggravated assault. There were 1,296 violent crimes in Philadelphia in 2012 compared to 386 for the state and the national benchmark of 66 (County Health Profiles 2013). While the number of violent crimes, not including homicides, was the lowest in decades, the homicide rate increased 10% since 2009. In 2012 homicides numbered 331 or almost one homicide daily. While Philadelphia has the highest homicide rate of the 10 largest cities, among the County Health Profile comparison cities Philadelphia's rate (21.6) was lower than Detroit (54.6), Baltimore (35) and Cleveland (24.6). The typical homicide victim in Philadelphia is male (88%), African American (80%), is between the ages of 18-34 (62%), has a previous arrest record (81%) and is killed by a gunshot (82%). Gun violence in Philadelphia is not evenly distributed. In 2012, eight of the city's 22 police districts accounted for 60 percent of the violence.²²

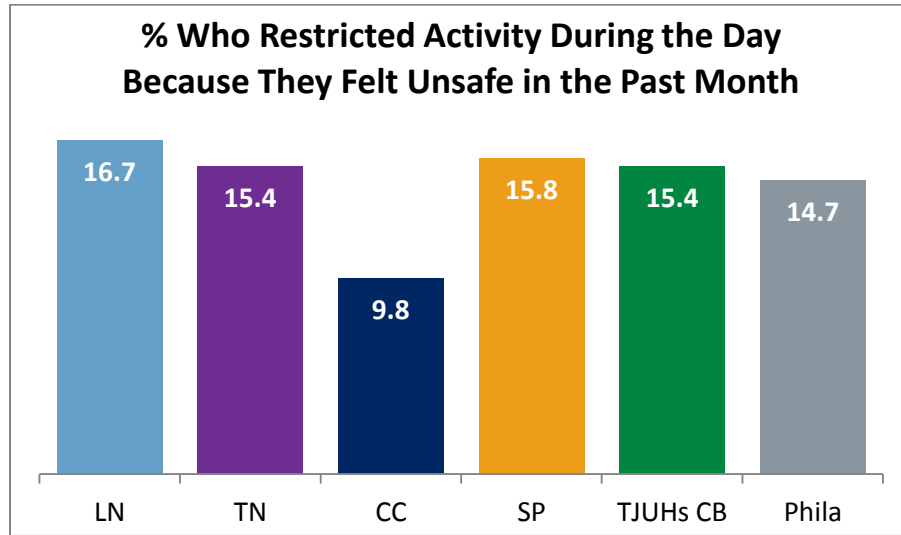
The table below depicts the violent crimes in TJUHs CB area by police district. Violent crime rankings range from the second highest rate of crime in the city (North Philadelphia – west) to one of the lowest ranking in the City (South Philadelphia is ranked 19th out of 22 police districts).

Rank	Police District	Principal Neighborhood	Total
2	22	North Phila./West	1,535
12	3	South Phila./East	1,535
13	26	North Phila./East	658
15	6	Center City/East	517
16	17	Point Breeze	514
17	9	Center City/West	433
19	1	South Phila./West	344

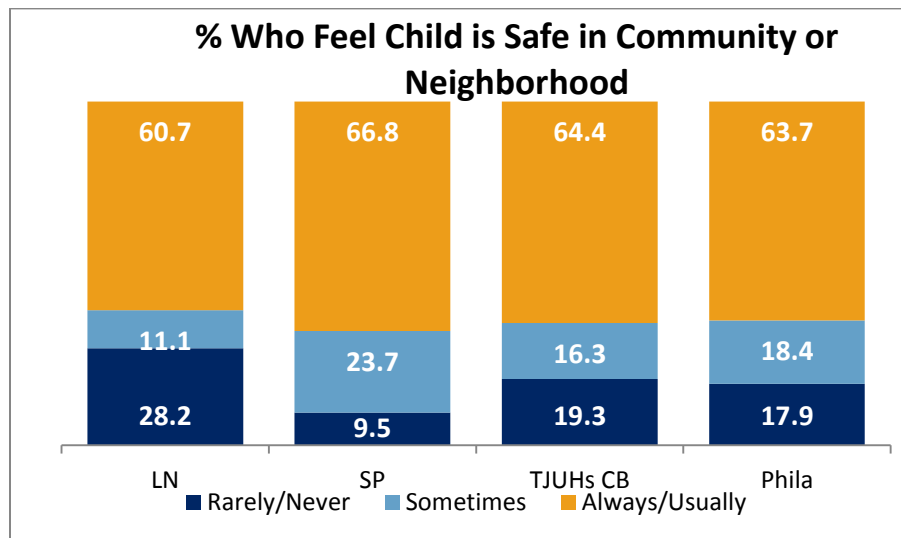
PEW Philadelphia 2013 – State of the City

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

In TJUHs CB area 15.4% of people reported restricting their activity during the day because they felt unsafe. Almost 20% of parents in TJUHs CB area felt their child was safe in the neighborhood. In focus groups held with community residents being physically active, such as walking in the community or going to the park/playground was restricted because of safety concerns for themselves and their children.



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PHMC Household Health Survey 2012

One organization focusing on community violence/safety is **Philly Rising**³³ which targets neighborhoods throughout Philadelphia that are plagued by chronic crime and quality of life

concerns, and establishes partnerships with community members to address these issues. The Philly Rising Team coordinates the actions of City agencies to help neighbors realize their vision for their community through sustainable, responsive, and cost-effective solutions. The basic goal of Philly Rising is to lower crime, in both a real and perceived sense, and to increase residents' self-sufficiency and involvement in their community. The Philly Rising Collaborative does this by significantly altering the way the City delivers services to its residents in areas with chronic crime and disorder problems that require a coordinated multi-agency response. This coordinated approach focuses on building the capacity of local organizations, so that they may institute visible, sustainable changes in their neighborhoods. United Communities and SEPC are helping to coordinate this effort in Southeast Philadelphia's 3rd Police District. The highest crime area in the 3rd District includes the area in which Mifflin Square Park is located, which has been a major focus of current community benefit activities to increase physical activity and promote community safety. In addition, Jefferson is represented on the School Safety Taskforce in South Philadelphia and the Southeast Philadelphia Substance Abuse Task force which are developing interventions to reduce crime by addressing substance use among youth, specifically alcohol and marijuana. Drug addiction, guns and violence were identified as priorities by key informants and focus group participants.

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

- **Interpersonal violence**
 - Prevalence of IPV high in communities – need to raise awareness of IPV and available resources (multiple key informants and focus groups)
 - There is not a domestic violence provider physically located in South Philadelphia (key informant)
 - *There is fear among immigrants about deportation so therefore they may not report IPV. In addition, some cultures do not see IPV as inappropriate behavior culturally. Information about IPV is needed in other languages. In general, the community "takes care of it". Cultural leaders need education about resources etc.*(key informant)
- **Drug use**
 - Rampant substance abuse
 - Prescription drugs sold on the street
 - *Drug infested neighborhoods* (focus group).
 - *Dealers are on the corners, hanging out near public transportation stops; they eliminated police patrolling the neighborhoods – they (police) only come when there are shootings* (focus group)
 - *No longer have the needle exchange drug mobiles in the neighborhoods (e.g. Prevention Point). Some people at the Methadone clinic appear to be high. Sometimes you see evidence of drug use (needles) but not "people".* (focus group)
- **Gun violence**
 - *Gun violence in the community creates chronic stress. People want to move but often can't. That's where I live, It's awful but that's where I am* (focus group)
 - *There is a perceived lack of personal safety, need to guns off the street (gun control). Driving requires you to pass a test - shouldn't you have to pass a test in order to own a gun and use it?* (key informant)

- **Truancy** resulting from youth fear of walking through certain neighborhoods
- **Lack of community cohesion and trust leading to increased violence**
- **Lack of access to constructive activities for youth**
 - *There is a lack of constructive things for youth to do as a result of community centers closing or cost of programs (South Philadelphia). (key informant)*

Recommendations included:

1. **Work with Pennsylvania Immigrant Care Coalition’s Public Safety Committee**
2. **Work with Philly Rising initiative in South Philadelphia which is addressing violence through reducing substance abuse among youth (focus is on reducing use of entry drugs such as alcohol and marijuana)**
3. **Explore “walking bus” intervention**
4. **Domestic violence training for community residents and providers**
5. **Conflict and anger management programs for youth.**
6. **Organized afterschool and summer programming for youth of all ages is needed**
7. **Partner with the YMCA to provide programs in community sites**

Family and Social Support

“A lack of family and social support-- defined as the quality of relationships among family members and with friends, colleagues, and acquaintances, as well as involvement in community life--is associated with increased illness and premature death.

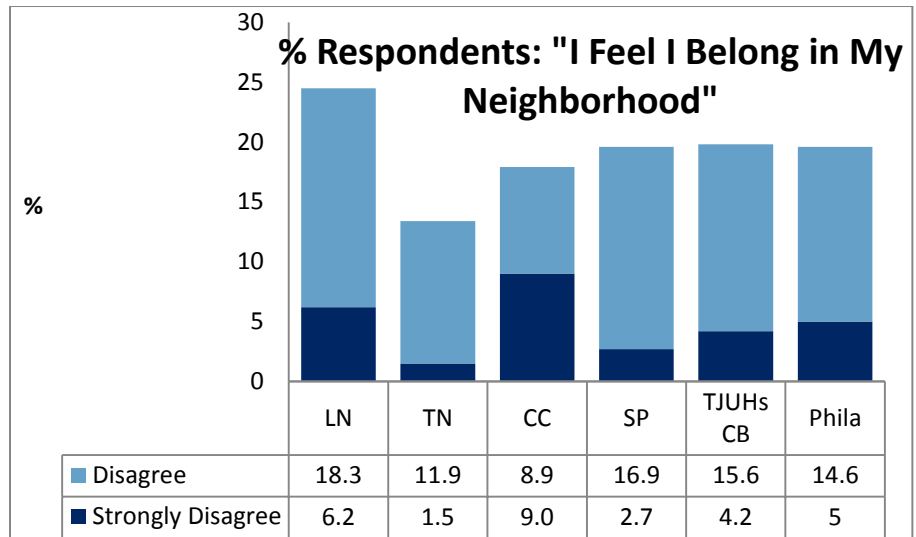
Understanding how many individuals in a community are socially isolated also provides a more complete perspective on a community’s health. This is because socially isolated individuals are more likely to be concentrated in communities with poorer community networks. A study that compared Behavioral Risk Factor Surveillance Survey (BRFSS) data on health status to questions from the General Social Survey found that people living in areas with high levels of social trust were less likely to rate their health status as fair or poor.

Similar to socially isolated individuals, adults and children in single-parent households are both at risk for adverse health outcomes such as mental health problems (including substance abuse, depression, and suicide) and unhealthy behaviors such as smoking and excessive alcohol use. Not only is self-reported health worse among single parents, but mortality risk also is higher.

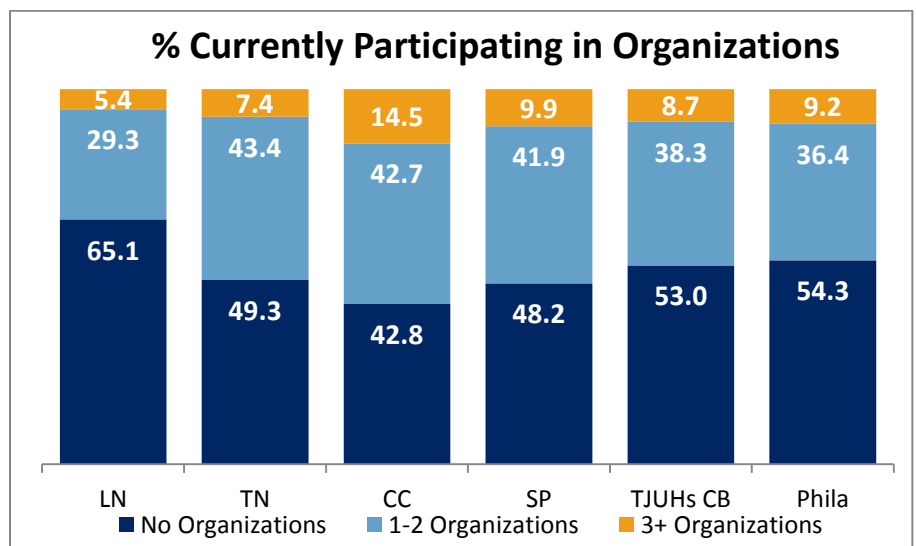
Likewise, children in these households also experience increased risk of severe illness and death”. ²⁵

Social capital refers to the social connectedness of people within a community and has been shown to impact the health status of individuals and populations. Factors such as sense of belonging in a community, participation in community groups, and perception of trust within the community as well as their willingness to help each other are often measured to assess social capital within a community. Compared to Philadelphia, residents in TJUHs’ CB areas are slightly more likely to disagree or

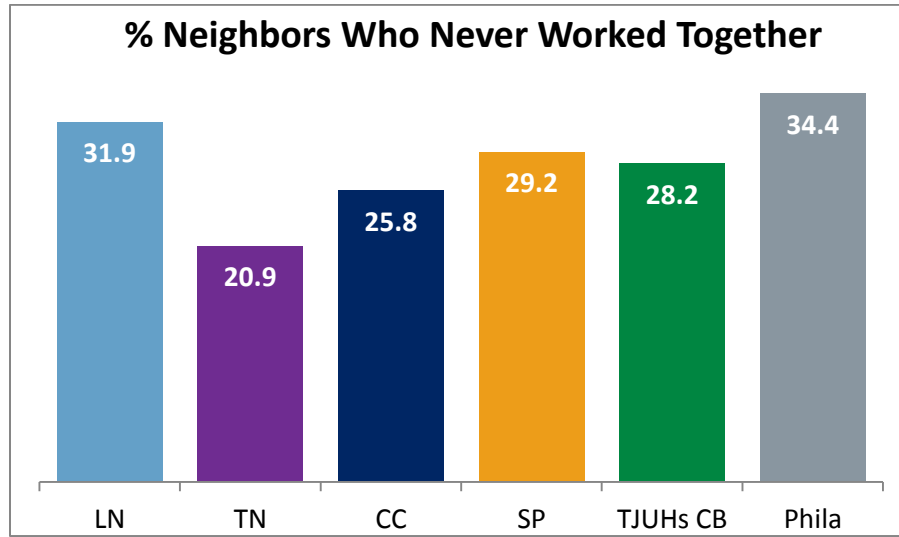
strongly disagree with the statement “ *I feel I belong in my neighborhood.*” This is particularly true for residents of Lower North Philadelphia (24.5%) and those living in zip code 19148 in South Philadelphia (33%). Similarly, residents of Lower North Philadelphia are less likely to participate in organizations; 65.1% of residents in Lower North Philadelphia did not participate in any groups during the past year. On the other hand, compared to Philadelphia, residents in TJUHs CB area are more likely to have worked on a project together (65.6% vs. 71.8% respectively). Importantly, compared to Philadelphia residents as a whole, people living in TJUHs CB areas, with the exception of Lower North Philadelphia, are more likely to feel that people in their neighborhood can be trusted.



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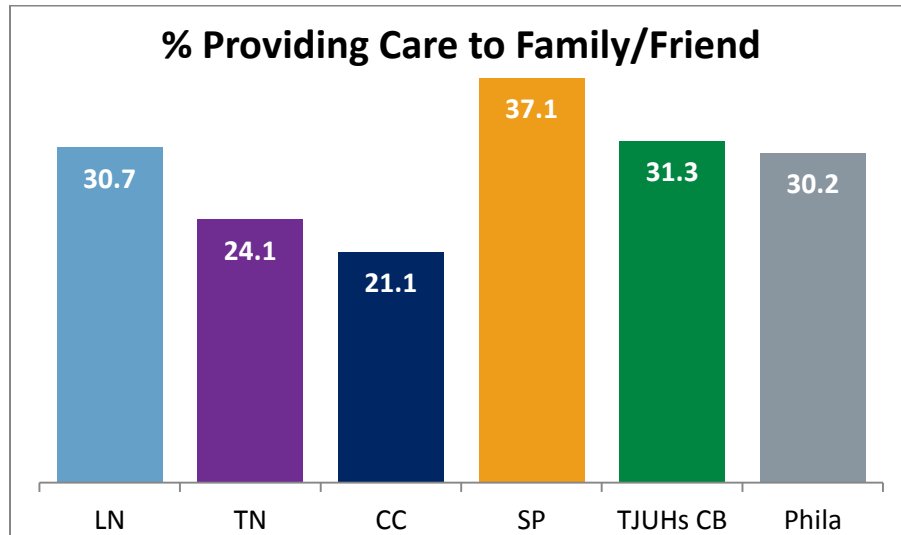


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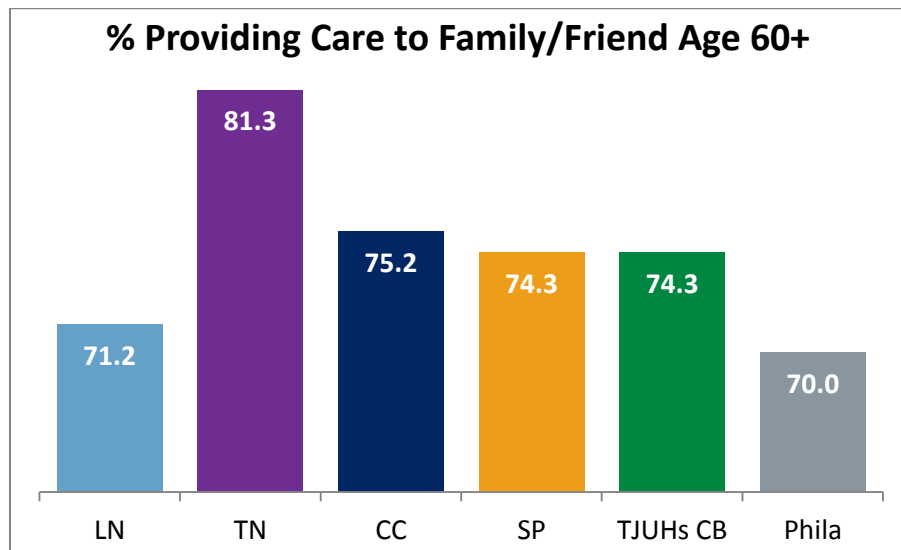
Neighbors are willing to help each other	
Neighborhood	% Rarely or Never
Lower North	18.6
Transitional Neighborhoods	13.6
Center City	19.4
South Philadelphia	14.0
TJUHs CB area	15.8
Philadelphia	17.2

People in my neighborhood can be trusted	
Neighborhood	% Agree/ Strongly Agree
Lower North	50.7
Transitional Neighborhoods	76.0
Center City	70.6
South Philadelphia	72.8
TJUHs CB area	67.4
Philadelphia	66.7

Almost one-third of Philadelphians provide care for family or friends. In South Philadelphia 37.1% of residents reported caring for a family member or friend. People living in TJUHs CB areas are more likely than others in Philadelphia to be providing care to an older adult (age 60+). More than 80% of residents in the Transitional Neighborhoods report caring for a family or friend who is over age sixty.



PHMC Household Health Survey 2012



PHMC Household Health Survey 2012

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

- **Support**
 - Older adults need caregiver support, respite care, end of life discussions.
 - *These are concerns in the near future because of aging populations particularly the Bhutanese. 20% have significant issues needing hospitalization and/or tests. Elderly are cared for by someone in the Bhutanese community who doesn't work - caring for the elderly person is seen as their job. Given that this is seen as their job, they may not receive community support. In addition, the family loses the earning potential of the person who is caring for the elderly person. (key informant)*
 - *Need to link to community centers as entry points to services. Develop warm hand-offs between community centers and hospitals and vice-versa. Community centers could provide follow-up with patients/clients. Neighborhood centers could serve as "triage centers" to help with lack of centralization/coordination of information and services. Competition between providers/resources is a barrier. We need to coordinate not compete and create system changes. We need to change from a culture of self-preservation to one that makes an impact. (key informant)*
- **Single parent households** have limited social and economic opportunities
- **Older adults** need an environment that supports socialization and decreases environmental stressors
 - *There is not a senior center in the community and there is no place for older adults to go to be physically active. They need a senior center that is within walking distance. They would like a place to go where you can learn to exercise safely and that provides opportunities for socializing. A lot of people are older and have lived in the neighborhood all of their lives. They need social outlets. People go to the coffee shops and Reading Market several times a week for socialization.(Transitional Neighborhoods) (focus group)*
- Need to connect to **community supports/resources** for support such as food, caregiving, and transportation
- Need to increase **community cohesion, trust, respect.**
 - *We need to learn how to communicate with each other.*
 - *Southeast Philly is not as organized in terms of Block Captains and town watch (key informant)*

Recommendations included:

- 1. Assist/identify community networks for transportation and socialization.**
- 2. Support formation of a community council consisting of organizations serving older adults to enhance understanding and address needs of seniors aging in place.**

- 3. Consider partnerships with community centers to provide follow-up with patients/clients. Neighborhood centers could serve as "triage centers" to help with lack of centralization/coordination of information and services. They address community needs in a holistic way including workforce development, food access, literacy training, and access to health and social benefits. Build their capacity to promote health in the community.**

Built and Natural Environment

The public health community has become increasingly aware that the design of the built environment can have a major impact on the health of the public. For example, people living in communities with convenient, safe walking paths, bike lanes, bike racks, parks/playgrounds that are in good condition and access to healthy, affordable food sources may be more physically active and have healthier diets. Conversely, poorer health indicators may be expected among residents of communities with high crime rates, few parks or walking paths, numerous alcohol and tobacco outlets, and little access to fresh food. The powerful influence of the built environment on health suggests that public health practitioners should be involved in planning and policy decisions related to land use, zoning and community design. Health practitioners can serve an essential role in collaborating with other professionals and working alongside neighborhood residents to create and promote healthy communities. Health practitioners need to engage in actions that support: (1) assessing the health impact of land use and community design options before decisions are made as well as after improvements are implemented; and (2) policymaking on issues related to the built environment to ensure protection from toxins, access to healthy food outlets, places to walk and recreate, and other health promoting environments³⁴.

European research suggests that people who live proximate to areas of greenery are 3 times more likely to engage in physical activity and 40% less likely to be overweight³⁵. A recent study in Philadelphia conducted by researchers from the University of Pennsylvania³⁶ found that greening vacant lots may affect health and safety. The study focused on 4000 lots that were cleaned and greened from 1999-2008 by the Pennsylvania Horticulture Society as part of their Vacant Land Stabilization Program. Researchers found significantly lower levels of gun assaults, vandalism and stress among residents, as well as significantly higher levels of physical activity among residents. Green space may also, according to the research, build social ties that are important for health. However, in certain barren parts of Philadelphia, guerrilla gardening is common - low-income communities revitalize their neighborhoods by transforming abandoned lots into open green spaces, but have no legal authority to do so. According to a November 18, 2011 editorial in the Philadelphia Inquirer written by Dr. Eugenia Garvin – a physician and RWJ clinical scholar at UPENN, “That it (greening) also appears to improve residents’ health and safety makes greening an even more attractive means of dealing with vacant land. She further states that going forward health and safety should be part of the city’s rationale for managing vacant land.

Philadelphia is committed to productive land use and is making great strides towards this goal through new zoning code regulations that support urban agriculture as a land use category and

systems to make procurement of vacant lots easier. The new code allows residents to have a say in how the city will be expanded as well as protected. The previous code did not adequately protect parks, gardens and playgrounds from being re-developed, creating loss of valued community resources. In addition Philadelphia has multiple greening plans and projects that support greening and vibrant sustainable places. These efforts include the Pennsylvania Horticulture Society, the *Next Great City*, *Green Plan Philadelphia*, *Green2015* (park implementation), and *Philadelphia 2035* (comprehensive plan). These plans include:

- Planting more trees (goal: 30% tree canopy in all neighborhoods)
- Providing new open space
- Providing new community open space
- Improving maintenance of park, recreation and other facilities
- Changing planning policies on new development
- Improving neighborhood communication and coordination
- Improving maintenance of vacant properties
- Improving lighting
- Improving appearance of transit stops and corridors
- Improving access to parks by transit
- Increase access to fresh, local produce through urban agriculture and community gardens
- Increase access to parks, recreation centers, and trails.

The availability of places to recreate and exercise and the availability of fresh produce can make sure Philadelphia has healthy residents. Parks, recreation centers, schoolyards, and community gardens that are in good repair all help foster a sense of community, which leads to strong, safe neighborhoods³⁷.

While Philadelphia boasts 225 miles of bike lanes/trails, 63 neighborhood parks and 52 recreation facilities, 60% say they never or rarely (less than once monthly) use the public recreational facilities. One of Philadelphia's premier natural resources, parks have been neglected and not utilized to their full potential. The parks are used by, cleaned and beautified by the residents of Philadelphia, but almost half of Philadelphians polled had stayed away from a park in the previous year because they feared for their children's safety or their own. Over the past few years existing Friends Groups and newly formed groups have provided the leadership to improve public parks throughout Jefferson's CB area. These groups coordinate park clean-ups and activities that encourage park usage and build community. One park in South Philadelphia, Mifflin Square Park, has engaged its diverse immigrant and refugee community in maintaining the park and has been successful in reducing alcohol use in the park by working with police to increase foot patrols through the park. Children who previously avoided the park because of safety concerns now regularly walk through the park on their way home from school. In South Philadelphia multiple gardens (such as the Teen Orchard Project, Growing Home Refugee Garden and Aida's Garden) have been established through the efforts of many community partners including but limited to the Public Interest Public Law Center of Philadelphia, Federation of Neighborhood Centers, PHS, United Communities, Urban Tree Connection, Southeast Philadelphia Coalition, Mural Arts program, and Nationalities Services Center. The newly elected Councilman for the 1st District (Councilman Squilla) is leading an initiative to Clean and Green his district. During a news conference held in Mifflin Square in South Philadelphia in January 2012, the councilman outlined plans to clean and green the first district. The initiative involves a renewed partnership with city officials and educates citizens about the new laws and whom to call if they have

issues with city services. The Councilman was joined in his announcement by representatives from the Department of Licenses and Inspections, Department of Parks and Recreation, Department of Streets and the Philadelphia Water Department. Decaying neighborhoods have been a longstanding problem in the city, and addressing blight is a priority for the new councilman. According to the councilman:

“Parks and playgrounds that are clean and safe, instead of vacant lots and houses, make people want to move into the neighborhoods. It will help reduce crime, because it is a proven fact that where you see trash and graffiti, you see crime. If people buy into the process of cleaning these communities, then they will buy into the idea of safer neighborhoods...Trash, graffiti and vacant properties add to the blight of these neighborhoods, and that’s no stranger to the people that live there. Now, it’s time to work together to see results... The city doesn’t have the resources to do it themselves, but we do want to work with people committed to having an organized effort to make things happen. Neighborhoods get galvanized by wanting to help — it’s contagious”.

TJUHs Center for Urban Health has been an active partner in built environment efforts that support gardening, urban agriculture and safe places for physical activity including Mifflin Square Park. The Center has helped lead efforts that assessed parks and playgrounds five years ago in parts of South, West and North Philadelphia as part of the initial assessment and planning process of a grant from the WK Kellogg Foundation. The PDPH, with Drexel University, is planning to assess public parks and playgrounds in Philadelphia. Jefferson has been asked to assist with the assessments that are within its community benefit area.

Recommendations included:

- 1. Continue to support efforts to revitalize Mifflin Square Park**
- 2. Support zoning changes that encourage vacant lot repurposing and long term “ownership”**
- 3. Support urban gardening and agriculture efforts**
- 4. Bring health services to Parks and playgrounds**

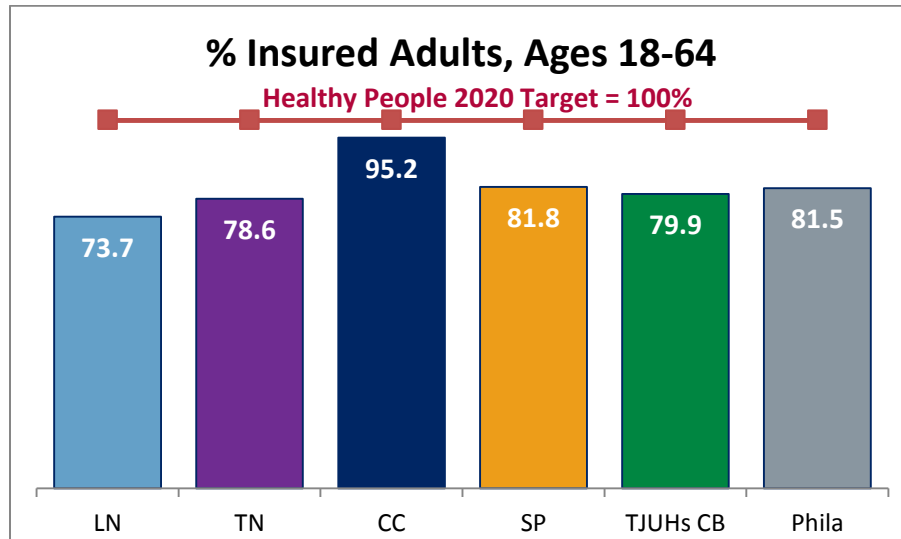
Health Care Access

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

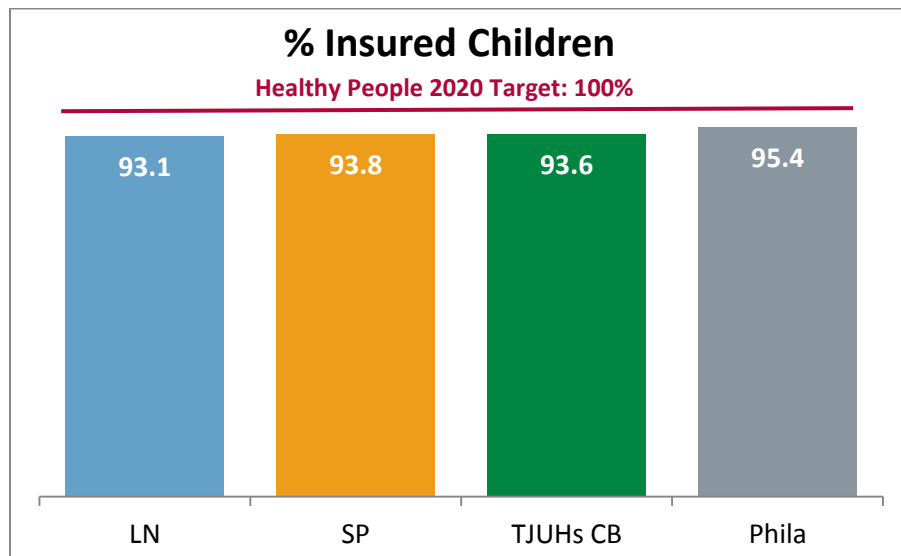
Health Insurance

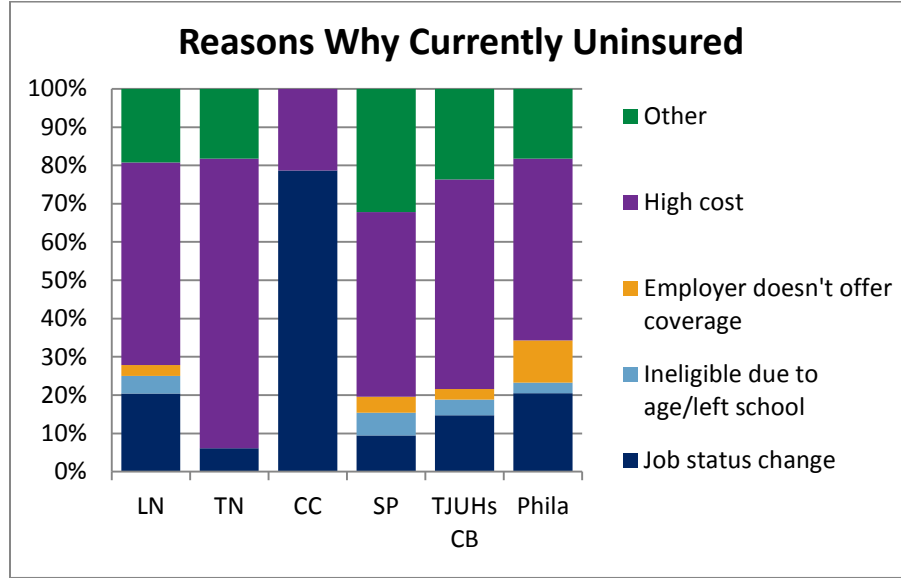
Overall, in Philadelphia 15 percent of all adults are uninsured and approximately 5 percent of children. The Healthy People 2020 goal is insurance for everyone. In Philadelphia, 4.6% of children

lack health insurance. In TJUHs CB area about 7% of children lack health insurance. Among adults aged 18-64, 18.5% of Philadelphians lack health insurance. The percent of adults aged 18-64 without insurance ranges from 4.8% in Center City to 26.3% in Lower North Philadelphia. However, the rates are higher in several zip codes in Lower North Philadelphia - 19123 (28.1%), 19125 (29.9%) and 19133 (37.2%). Cost and loss of employment were the main reasons given for not having insurance. In zip code 19133 immigration status was a factor for access to health insurance. In 2012, more than half of the visits to the eight city-run health centers were made by people who had no health insurance²².



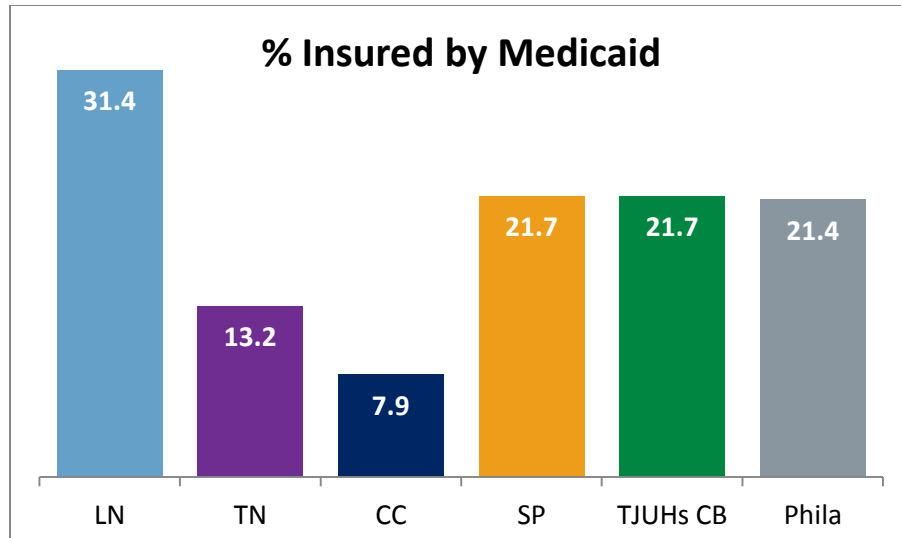
PHMC Household Health Survey 2012





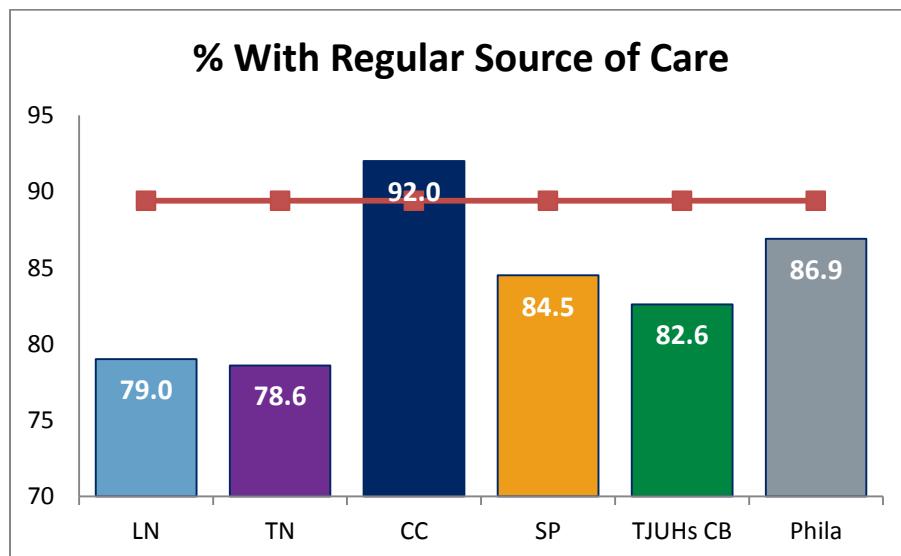
PHMC Household Health Survey 2012

The share of adult Philadelphians with no health insurance declined slightly in 2012, according to the survey done for Public Health Management Corporation’s Community Health Data Base. The percentage of children without health insurance held steady. According to a different set of numbers, those compiled in 2011 by the Census Bureau, a smaller share of Philadelphians lack health insurance than do residents of most of the comparison cities and residents of the nation as a whole. In terms of health care, Philadelphians were heavily dependent on government programs. In the first half of 2012, Medicare and Medicaid paid for 72.8 percent of all city residents treated in Pennsylvania hospitals. According to PHMC Household Health Survey for 2012, 49.4% of adults are insured through employment, 29.7% have Medicare, and 21.4% have Medicaid. Adults in TJUHs CB area are slightly more likely to be insured by Medicaid, particularly those living in Lower North Philadelphia (31.4%).

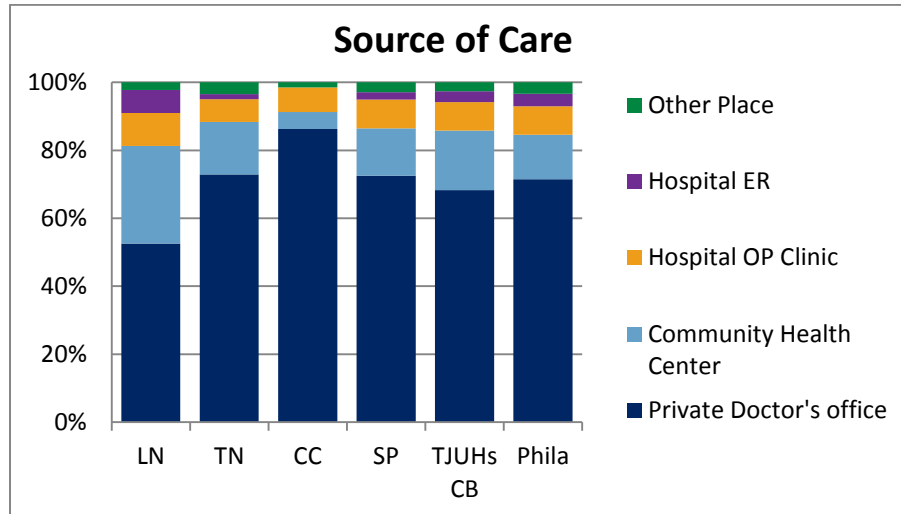


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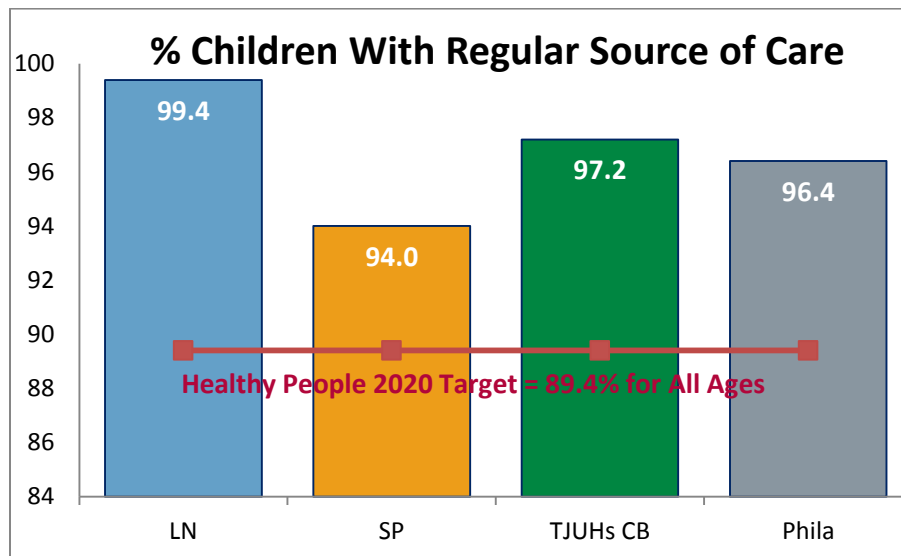
Adults in Philadelphia are more likely than adults in TJUHs CB areas to have a regular source of care with the exception of Center City residents. Adults in Lower North and the Transitional Neighborhoods are least likely to have a regular source of care and more likely to use community health centers for care, particularly adults in Lower North east of Broad street (38.1%). Center City residents are more likely to see a physician in private practice than are others in TJUHs CB area and the City. Almost all children in Philadelphia have a regular source of care and exceed the Healthy People 2020 goal of 89.4%. Children in TJUHs CB areas are more likely to receive care at community health centers and hospital outpatient clinics than are children in Philadelphia.



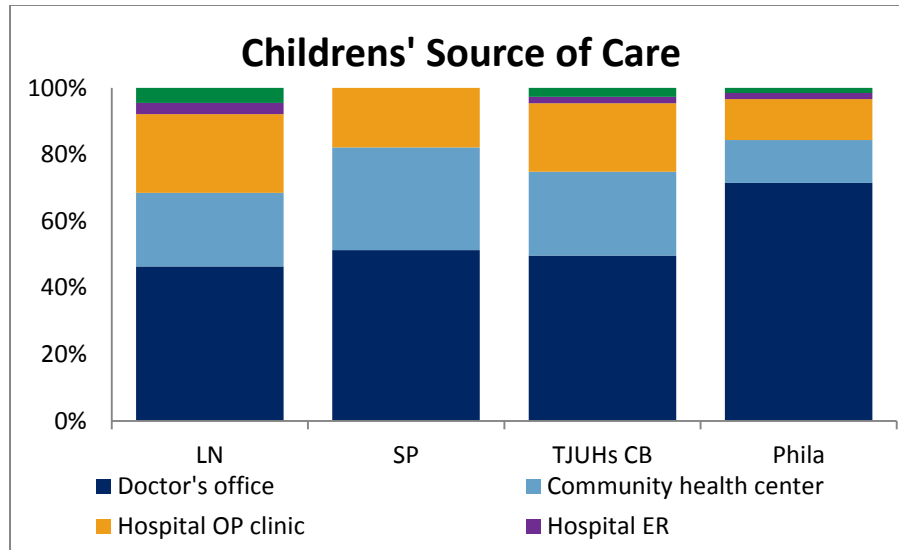
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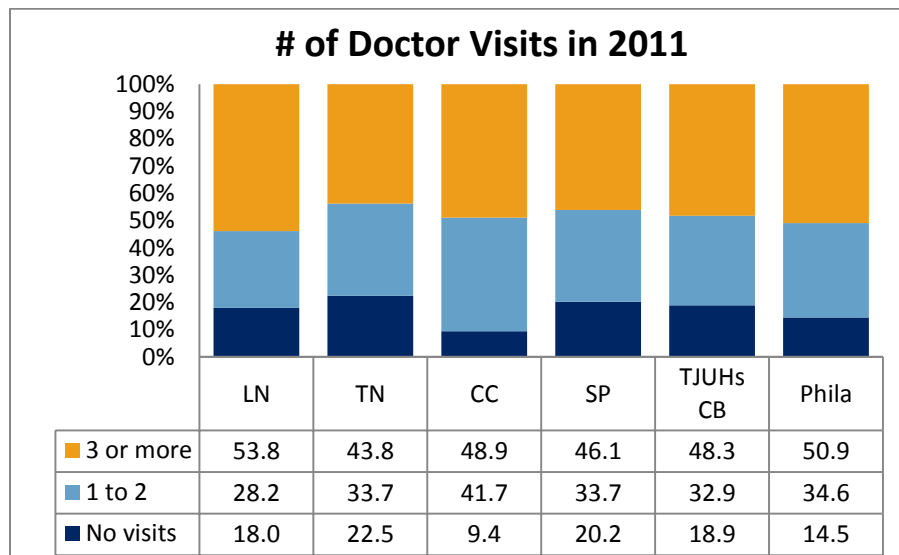
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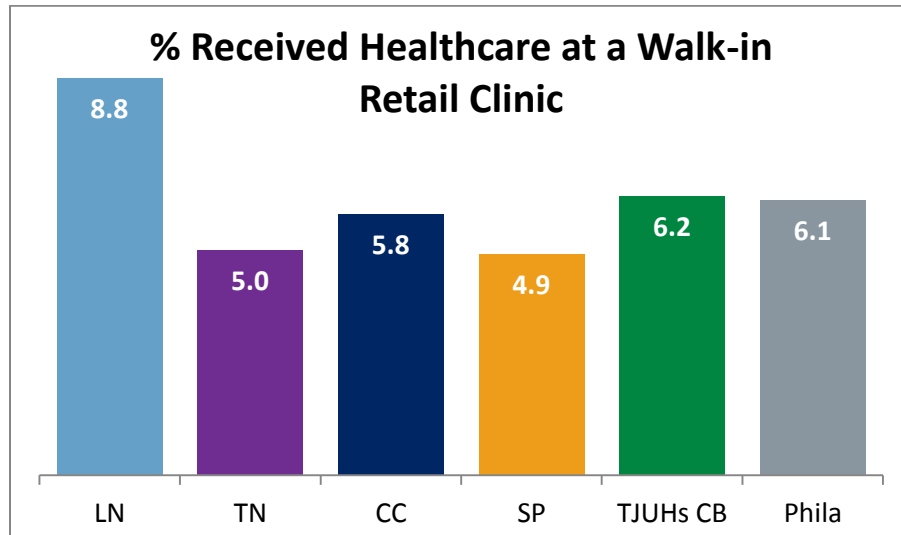


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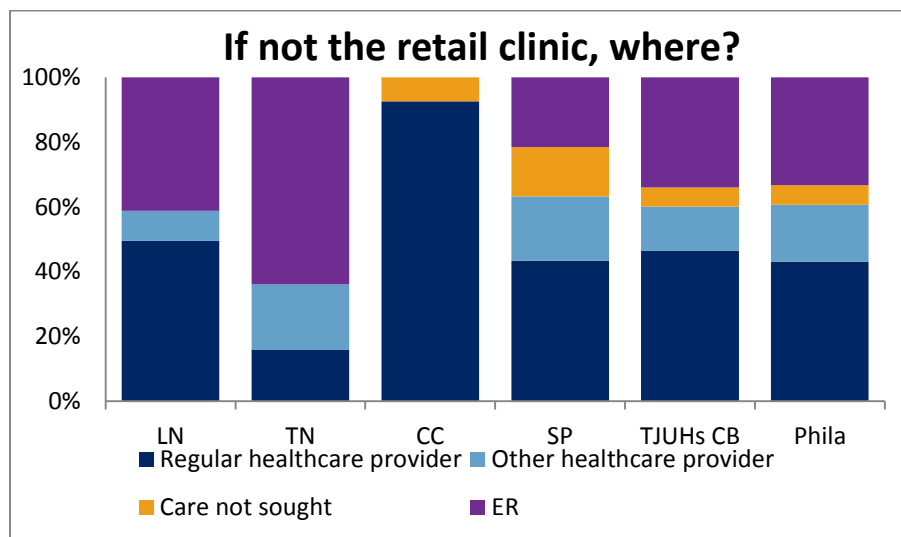
Residents in TJUHs CB area (18.9%) were more likely not to have seen a doctor last year than Philadelphian residents as a whole (14.5%). This is particularly true for people living zip codes 19148 (25.6%) and 19146 (29%) where there is a large community of immigrants, refugees, and lack of primary health care.

Very few residents in TJUHs CB area currently use walk-in retail clinics for health care; however, people living in Lower North Philadelphia (8.8%) are more likely to use retail clinics than

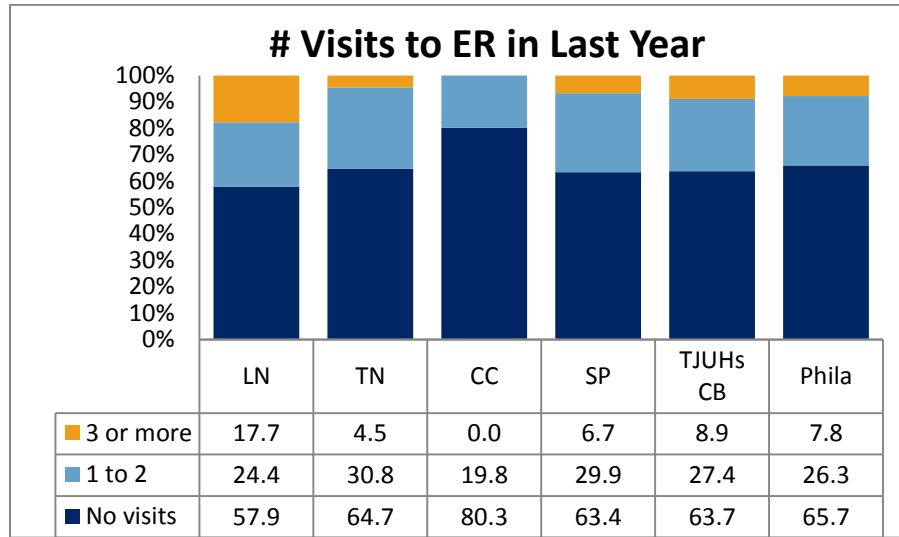
Philadelphians as a whole (6.1%). The two zip codes with the highest use of retail clinics are 19133 (11.9%) and 19147 (13.6%). When asked where they would go for care if the retail clinic was not available, 41.2% of Lower North and more than 63.9% of Transitional Neighborhood residents indicated they would go to the emergency department. More than 17% of Lower North adults had 3 or more visits to the ED in the past year. This is twice the rate of the rest of Philadelphia and TJUHs CB area. This indicates the retail walk-in clinics are providing an important service to reduce unnecessary ED use and improving access to primary care. Adults in Center City are least likely to have used the emergency department in the past year (19.7%) and adults in Lower North were most likely to have used the emergency department (42.1%).



PHMC Household Health Survey 2012



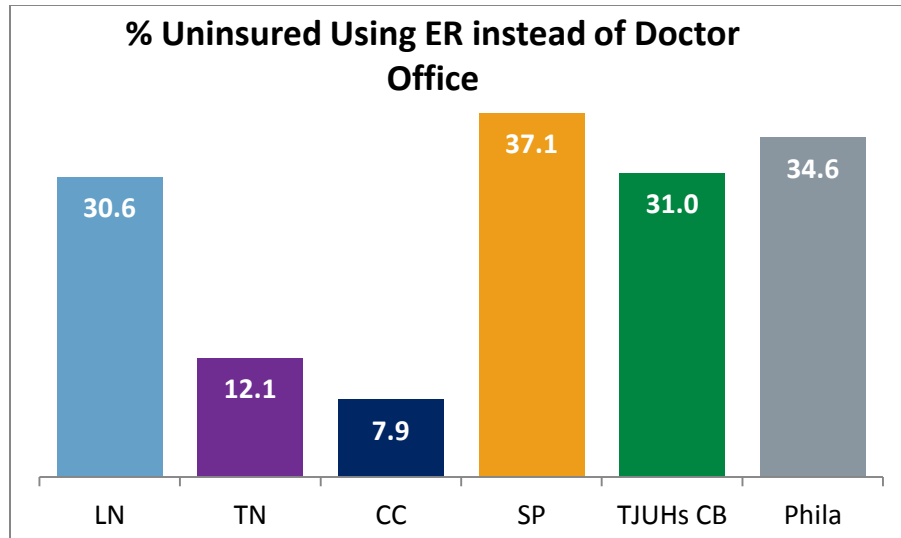
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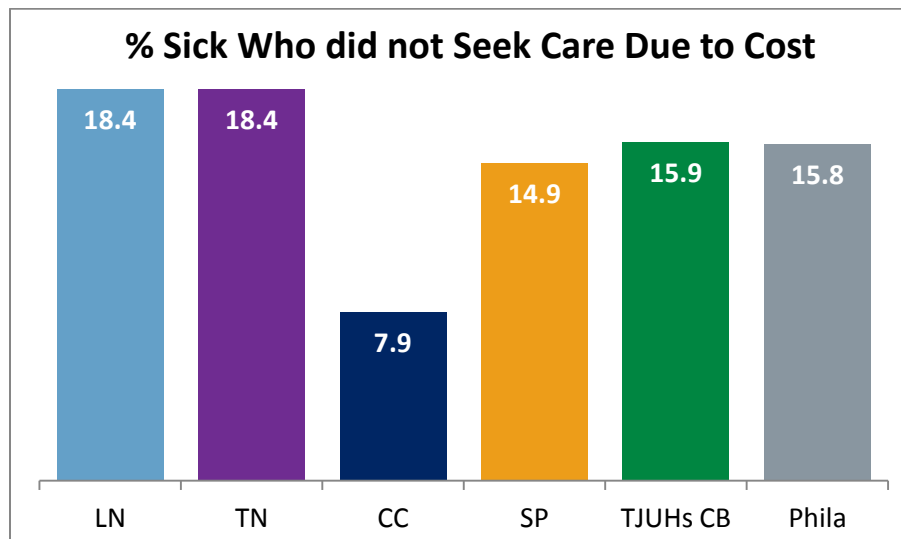
PHMC Household Health Survey 2012

According to 2012 data from Jefferson and Methodist Hospital, there were 72,144 emergency room visits from residents in Jefferson’s CB area. Overall, 42% of these visits were rated a 4 or 5 on the acuity scale that is used in the emergency department. Acuity scores of 4 or 5 are considered non-emergent or ambulatory care sensitive conditions and preventable through primary care. Sixty-five percent of all emergency care visits with an acuity scale of 4 or 5 were from South Philadelphia and 15.6% were from Lower North. The majority of these visits were for complaints related to pain (arm, leg, back, ear, knee, ankle), swelling, sore throats or other cold symptoms, mass or lump, toothache, infections, wound checks and lacerations. These chief complaints account for 68% of all ED visits with acuity scores of 4 or 5. The majority of ED visits for conditions with acuity scores of 4 or 5 were among 18 to 39 year olds (46.2%) and 39-64 year olds (35.1%).

Compared to Philadelphia, uninsured adults living in South Philadelphia were more likely to report using the emergency room instead of a Doctor’s office. Adults living in South Philadelphia, Transitional neighborhoods and Lower North Philadelphia were more likely not to have seen a doctor in the past year and adults from Lower North and Transitional neighborhoods were more likely not to have seen a doctor when sick due to cost than were others in Philadelphia. This indicates that access to care may be problematic for some areas, particularly South Philadelphia, Transitional Neighborhoods and Lower North Philadelphia.

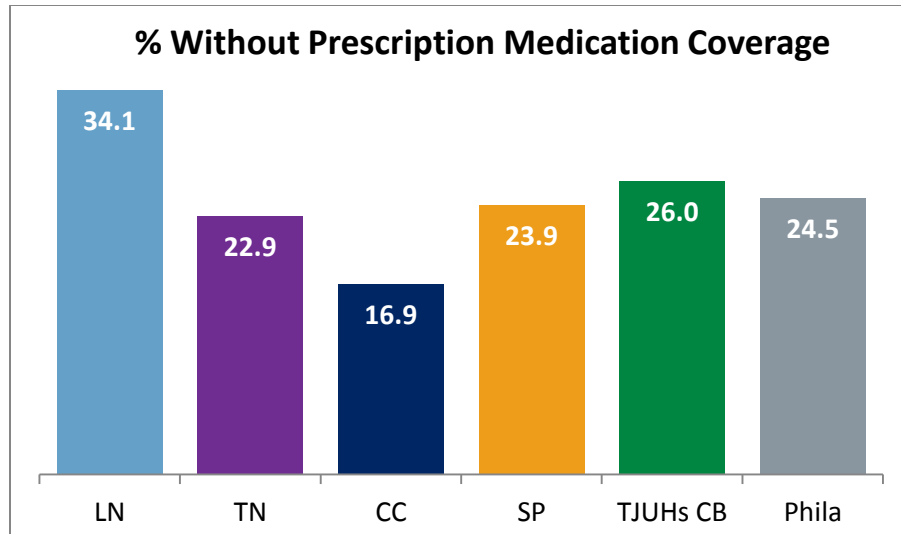


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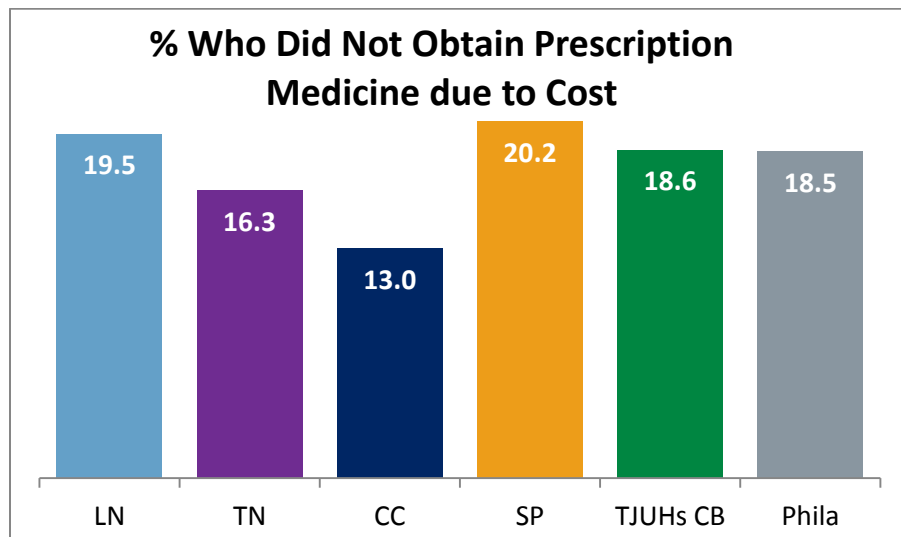


PHMC Household Health Survey 2012

The majority of people in Philadelphia have prescription coverage (75.5%). Overall, residents living in Jefferson’s CB are slightly more likely not to have prescription coverage for medications. More than one third of North Philadelphia residents lack prescription coverage. On average, one in five residents of Lower North Philadelphia and South Philadelphia did not get a prescription due to cost. This is slightly higher than the rate in Philadelphia (18.5%). In addition, focus groups and key informant interviews revealed that there is not a pharmacy convenient to the Point Breeze-Grays Ferry neighborhood in South Philadelphia.



PHMC Household Health Survey 2012



PHMC Household Health Survey 2012

Under the Affordable Care Act, millions of Americans will be eligible for new coverage opportunities in 2014. According to **Enroll America**³⁸, a nonpartisan 501(c)(3) organization whose mission is to ensure that all Americans are enrolled in and retain health coverage, 78% of uninsured Americans don't know the Health reform law will help them. Three out of four newly eligible people want in-person assistance to learn about and enroll in coverage. For those who are not familiar with health insurance, have limited English literacy, or are living with disabilities, navigators will serve an important role in ensuring people understand the health coverage options available to them. Approximately 196,000 people in Philadelphia will be eligible for insurance under the ACA

regulation. Open enrollment in the Marketplace begins Oct. 1, 2013, with coverage to begin Jan. 1, 2014.

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

- **Cost for services** for the uninsured and under-insured is prohibitive for many.
 - *Co-pays can be as much as \$50 per visit depending on insurance type and have been rising. Between transportation, copays and other costs a single visit could be as much as \$100 out of pocket. This is why many of our patients don't come for classes or appointments.* (key informant)
 - *There is a high unemployment rate in South Philadelphia and a high percentage of people lack health insurance. Therefore they delay care and as a result go to the ED sicker.* (key informant)
 - *Many refugees lose health insurance after 8 months. How refugees manage health care after losing their MA is not well understood.* (key informant)
- **Emergency MA** is getting more difficult to obtain due to changes in the form and procedures. There is a Lack of information and confusion about public benefits, qualifications and application process
 - *Some Doctors don't sign MA forms because they think they are signing off that the person is disabled* (key informant)
- **Cost of medications**
 - *People without insurance can't afford medications. My son has asthma and is uninsured. Flovent costs \$140. He can't afford that.* (focus group)
- **Continuity of care**
 - *The Asian community needs improved continuity of care. According to key informant interviews with community organizations serving the Asian community in South Philadelphia the primary care providers who have served the Asian community are retiring or have closed their practices. In addition Health Center #2, according to key informants, is not taking new patients and has a 3 to 6 month wait for appointments. They perceive a need for primary care services for Asian immigrants and refugees that are culturally and linguistically appropriate and want to create an Asian Health Center that would serve all Asian ethnicities and have co-located services that address physical and mental health as well as social needs of their clients.*
 - *Those who are uninsured often use the PDPH Health centers for primary care. Several participants mentioned long waits to get an appointment, long waits on the day of the appointment, disrespectful attitudes towards patients, and the need to coordinate with emergency departments about patients who are sent there for treatment.*
 - *There is a stigma with using the Health Clinic. They have very long waits, judgmental and disrespectful treatment.* (focus group)
 - *They act like they're doing you a favor* (focus group)
 - *If it takes 6-8 months to get an appointment – I could die in that time* (focus group)
 - *Limited health resources for uninsured, poor, disabled or those who need assistance getting to doctor appointments*

- *I go to neighbors houses to do blood pressures because they are not able to go to the doctor's office because they need a family member or friend to accompany them or the cost is prohibitive. People in the neighborhood call me because they know I am a nurse and talk with me about their health issues. They don't have health insurance or a doctor, but they need their glucose checked. (focus group)*
- **Emergency care**
 - Need assistance on how to access 911. Immigrants don't understand how it works

Recommendations included:

- 1. Work with Maternity Care Coalition to raise awareness about CHIP, assist with filling out forms and then follow up to ensure they get insurance**
- 2. Support Enroll America activities at community sites, Pathways to Housing and St Elizabeth's Wellness center**
- 3. Support Project HOME's application for a new Access Point FQHC.**
- 4. Partner with the Cambodian Association and others to explore feasibility of initiating a Wellness Center in South Philadelphia for the Asian Community. The center would include physical and mental health services and social services under one roof.**
- 5. Provide training for United Communities staff and community organizations in applying for/enrolling in medical insurance**
- 6. Support community education around prescription access programs**
- 7. Partner with TJUH Finance to train community leaders and CBOs to assist with enrolling community members into insurance programs such as MA and CHIP as well as new Enroll America insurance programs**
- 8. Educate community around PDPH project to limit co-pays for hypertensive medications**

Transportation

Finally, 35% of Philadelphians do not own a car. Among adults aged 60 and over, 55% do not own a car. For most people in Philadelphia public transportation is the predominant method of travel to work and throughout Philadelphia. In addition, 12.5% of people in TJUHs CB area cancelled a doctor appointment due to a transportation problem compared to 13.7% in Philadelphia. Transportation costs and convenience were identified by key informant interviews and focus groups as barriers to seeking health care. One in five people in Lower North Philadelphia reported that transportation problems resulted in their cancelling a doctor appointment.

In Philadelphia County, the Medical Assistance Transportation Program (MATP) is run by LogistiCare Solutions. LogistiCare manages non-emergency medical transportation benefits for the medically fragile, disabled, under served and elderly enrolled in Medicaid and Medicare portions of managed care organizations. For persons receiving Medical Assistance all medical rides must be arranged through the Department of Public Welfare's Medical Assistance Transportation Program. Rides can be reserved 30 days in advance of ride but must be made at least three days in

advance. Through this program, clients receive tokens for SEPTA in order to go to medical appointments, or if unable to take public transportation, van service is available.

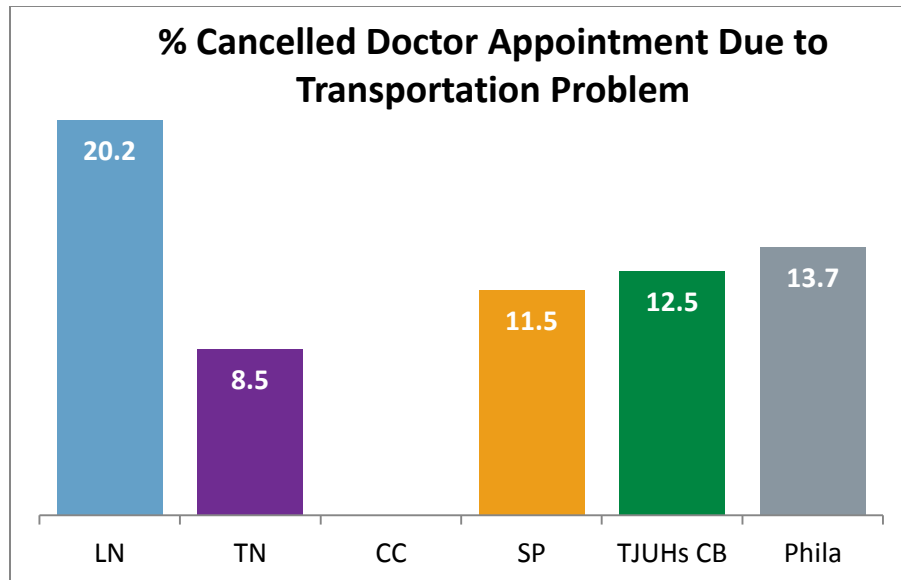
Issues, challenges, unmet needs and priorities identified by key informants and focus group participants related to health care access and transportation include:

- **Cost of transportation** for parking or public transportation
 - *People don't come even if class is free because of transportation costs.*(key informant)
 - *Co-pays can be as much as \$50 per visit depending on insurance type and have been rising. Between transportation, copays and other costs a single visit could be as much as \$100 out of pocket* (key informant)
- **Convenience**
 - Paratransit requires scheduling a week in advance - if an appointment needs to be changed the paratransit cannot be flexible enough to do this (key informant and focus groups).
 - Paratransit can be unreliable. While paratransit will take physically ill to appointments, transportation for those with mental health issues is limited. It is often difficult for those who are mentally ill to take a bus. More home-based and community based services are needed (key informant and focus groups).
 - Para transit is available but you may wait 3 to 5 hours to be picked up (key informant and focus groups).
 - *Jefferson used to have a van to transport elderly to hospital but now there is a 'regulation' that prohibits bringing people to the hospital ("can't pull people into services") although van services back to homes is permitted. People don't see their doctor because of transportation issues* (key informant)..
 - Bus routes to Center City are not convenient and can require multiple transfers and long walks to bus stops which can be problematic for the elderly and ill.
- **Reliance on caregivers for transportation**
 - Elder isolation: difficulty accessing healthcare due to lack of finances, and transportation; *The elderly rely on family (if there is any); friends and neighbors for help*
 - *Many children and parents are working full-time and can't come in themselves or take family members to visits or tests* (focus group).
 - *Elder care and other resources for elderly: many elderly live alone and need help in home and with meeting basic needs e.g., grocery shopping, getting and taking medication, getting to physicians. Family members are busy with their own lives. Caregivers need help and support to deal with stress. Transportation and pharmacy issues are also important*
- **Medication issues** related to transportation
 - Partner with local pharmacies to deliver medications. *There are few pharmacies in the Point Breeze, Gray's Ferry communities; the closest pharmacy is at the corner of Broad and Snyder. There is a CVS, Walgreens, Rite Aid but they don't delivery medications. ShopRite delivers groceries but not sure if they deliver prescriptions.* (key informant)

- I live at 30th and Moore, but goes to Broad Street for prescriptions because the Rite aid is in a 'trouble area' and people don't want to go there (key informant)

Recommendations included:

1. Explore possible TJUH van transportation system
2. Explore prescription and food delivery
3. Community health workers to facilitate arranging transportation
4. Raise awareness about LogistiCare transportation services among providers and the community



PHMC Household Health Survey 2012

Literacy

Health literacy is a stronger predictor of individual health status than age, income, employment status, education level or racial/ethnic group³⁹ Inadequate health literacy, as measured by reading fluency, independently predicts all-cause mortality and cardiovascular death among community dwelling elderly persons,⁴⁰ Health literacy also contributes to disparities associated with race/ethnicity and educational attainment in self-rated health and some preventive measures⁴¹. Race/ethnicity (African American and Latino/Hispanic), age (older than 65), not completing high school, poverty, and not speaking English prior to entering school have also been associated with lower literacy levels⁴² (NAALS, 2003). Older adults are disproportionately more likely to have below basic health literacy than any other age group. Almost two-fifths (39 percent) of people age 75 and over have a health literacy level of below basic compared with 23% of people age 65–74 and 13% of people age 50–64.⁴² (NAALS, 2003).

Low patient literacy is associated with limited disease-related knowledge and self-management, poor adherence to treatment, and a 30-50% increased odds of hospitalization. Preventable hospital admissions are also associated with poor health literacy⁴³. The Joint Commission's National Patient Safety Goals specifically address communication issues related to provider-patient interaction⁴⁴.

The health literacy of patients is often underestimated by health care providers and may not even be considered as a factor in patient care.⁴⁵⁻⁴⁷ The safety of patients cannot be assured without mitigating the negative effects of low health literacy and ineffective communications on patient care. However, there is more to health literacy than understanding health information.⁴³ Health literacy also encompasses the educational, social and cultural factors that influence the expectations and preferences of individual, and the extent to which those providing healthcare services can meet those expectations and preferences⁴³

In addition, the growing prevalence of chronic conditions and an aging population requires even more attention to effective strategies to address health literacy. One in four Americans has multiple chronic conditions, with hypertension being the most common. Individuals with chronic conditions account for 84% of all health care spending. People with chronic conditions are much more likely to be hospitalized. More than 50% of people with serious chronic conditions use 3 or more different physicians. Those with chronic conditions report not receiving adequate information – e.g, 14% report receiving different diagnosis from different providers, only 16% report receiving information about drug interactions, 17% received conflicting information from providers, and 19% report having duplicate tests or procedures. The role health literacy plays in these disconnects between information provided, medication use, and duplicate testing is significant.⁴³ While the above data reflects all adults, older adults, given the higher prevalence of chronic disease, are more at risk for disconnects in communication.

In Pennsylvania, ineffective communication among providers, between providers and patients, and between providers across healthcare settings were among the common themes related to Pennsylvania hospital readmissions reported between January and August 2009.⁴⁸ Using custom individualized discharge instructions that incorporate health literacy principles (plain language strategies, such as using words with fewer than three syllables, short sentences and paragraphs, large font, limited medical jargon, abundant white space, and teach-back) – as well as strategies designed to improve care transitions are suggested for use in inpatient settings to enhance patient learning and improve handover communication into community settings.⁴⁸

There has been little progress nationally and regionally in addressing the impact of limited literacy⁴³ The reasons for this are complex and include the following: 1) Demands for reading, writing and numeric skills are intensified due to health care systems' complexities, advancements in scientific discoveries, and new technologies; 2) Health professionals and staff have limited education, training, continuing education, and practice opportunities to develop skills for improving health literacy; and 3) Studies indicate a desire on the part of adult learners and adult education programs to form partnerships with health communities, but there have been limited opportunities to engage.⁴³

Many experts suggest that low-literate adults should be educated using simple language geared to the layperson, and using teach-back techniques to confirm patient understanding, as well as visual methods including pictures, multimedia, use of pill-boxes, and graphic medication schedules⁴⁹⁻⁵¹

In Philadelphia, 22% of residents read at the Below Basic level⁴² and more than half of all Philadelphians will have difficulties with some aspects of health literacy. A person with below basic literacy can circle the date of a medical appointment and can identify how often a person should have a specified medical test based on information in a clearly written pamphlet, but may have difficulty with tasks such as determining when they should take a prescription medication, based on information of the label that describes when to take the medication based on eating⁵²

Recommendations included:

- 1. Continue to provide health literacy training to TJUHs staff**
- 2. Explore PCORI funding to support enhanced patient communication through Teach-Back training sessions**
- 3. Continue to support health literacy systems changes such as patient education materials, and informed consent and patient-provider education**
- 4. Adopt Health Literacy Universal Precautions**

Cultural Competence and Language

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.⁵³

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

Culture and language may influence: health, healing, and wellness belief systems; how illness, disease, and their causes are perceived; both by the patient/consumer and the behaviors of patients/consumers who are seeking health care and their attitudes toward health care providers; as well as the delivery of services by the provider who looks at the world through his or her own limited set of values, which can compromise access for patients from other cultures.

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

As described above, Jefferson’s community benefit area serves diverse communities, one of the most diverse areas of the City, including large immigrant and refugee populations, a significant homeless/sheltered population with complex mental and physical health issues, a growing elderly population, and the LGBT community. Focus groups and key informants both suggested that TJUHs staff and providers would benefit from learning more about the communities they serve. The Center for Urban Health and the Healthcare Improvement Foundation have been providing health literacy training for 13 hospitals in Southeastern Pennsylvania, including Jefferson staff, using a “train the trainer” model. Jefferson has been systematically training nursing staff and others in communication techniques such as *plain language* and *Teachback* and to date has trained close to 1,000 employees.

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

- **Communication**

- Need to educate ED providers about how to communicate "risk" effectively with lower health literate populations.
- Limited health resources and information for non-English-speaking populations in the 19125 community including markets with healthy food options and food security resources.
- Need for more bilingual information, Information about IPV is needed in other languages.
- Need health literacy training for Residents and physicians including *Teachback*. Integrate training into Intern orientation.

- **Culture**

- Refugees and immigrants may have cultural issues around medication/therapy for mental health issues. They don't link mental and physical health. *For many people, including refugees and immigrants, behavioral health issues are not a priority and may be less valued.*(South Philadelphia key informant)
- Cambodian immigrants live on both sides of Broad Street in South Philadelphia. Cambodians living west of Broad need increased awareness about community resources. The Asian community works long hours and as a result have difficulty learning English. They also don't want to lose their culture concerns about no longer speaking native language.
- Need bilingual, culturally competent providers. While phone translators are better than nothing they are not the solution. Healthcare workers/providers need to be culturally competent (lack of respect in how women are treated)
- Physicians who don't understand the needs of LGBT patients. Cultural competence in treating LGBT in hospital is needed. Perceived or actual "disrespect" based on LGBT experiences. LGBT may have to explain their sexuality issues to others over and over again
- Need to decrease the stigma and stereotyping of homeless mentally ill among health care staff.
- *Varied cultural beliefs about risk factors, signs and symptoms and use of health services*

- Cultural constraints – no outreach to Hispanic community
- **Interpretation.**
 - Interpretation is a major issue. Refugees don't follow through with treatments plans/ medication therapy. Interpreters for mental health issues have been available at TJU/H. However, interpreters can be unreliable; that is, there may not be an interpreter available who knows a needed language or dialect
 - No addiction services available in other languages
 - Language barriers are a barrier to care. Not all dialects are available (Karen, Chin)
 - Need a system to help non-English speaking immigrants that includes front desk people, and providers. The JOGA clinic has Spanish speaking staff and nurses.
 - Community Health Worker training and training for medical interpretation for young adults who speak English would be useful.
 - Need to address the needs of non-English speaking consumers' including transportation to appointments, scheduling appointments, correctly preparing for procedures, increasing awareness of community resources, and communicating health information.
 - *Investigate if there is a function of Language Line or other interpreter services that enables consumers/patients to call into the hospital with questions, to schedule appointments, to receive guidance and support*
 - *Implement health literacy initiatives for hospitals and community health clinics to support care for the diverse community populations.*
 - *Increase on-site language assistance for Hispanic population*
 - *20% of daily volume in radiology and ED is non-English speaking.*
 - *Scheduling does not have translators or access to the interpreter lines*

Recommendations included:

- 1. In partnership with PICC, increase awareness about regulations pertaining to access to interpreters**
- 2. Explore technology of interpreter services to assist non-English speaking people to schedule appointments, call the hospital or health care provider for information, guidance about procedures etc.**
- 3. Implement health literacy initiatives such as way finding and translation of patient education materials to support care for diverse populations**
- 4. Consider partnering with community based organizations for medical interpreter services and community health worker services. Provide training and oversight.**
- 5. Provide training for staff and providers about refugees, homeless, LGBT, geriatric care to improve cultural awareness.**

Health Status

Mortality

Philadelphia ranks 67 of the 67 counties in Philadelphia for mortality.²⁰ According to the 2010 Vital Statistics Report City of Philadelphia Department of Public Health, life expectancy in Philadelphia has increased since 2009; life expectancy among males was 72.5 years and among females 80.2 years. Life expectancy increased between 2000 and 2010 for all groups except Asian males. However, disparities in life expectancy are evident. On average, Non-Hispanic Black men live 68 years, while non-Hispanic Asian women live 87.4 years.

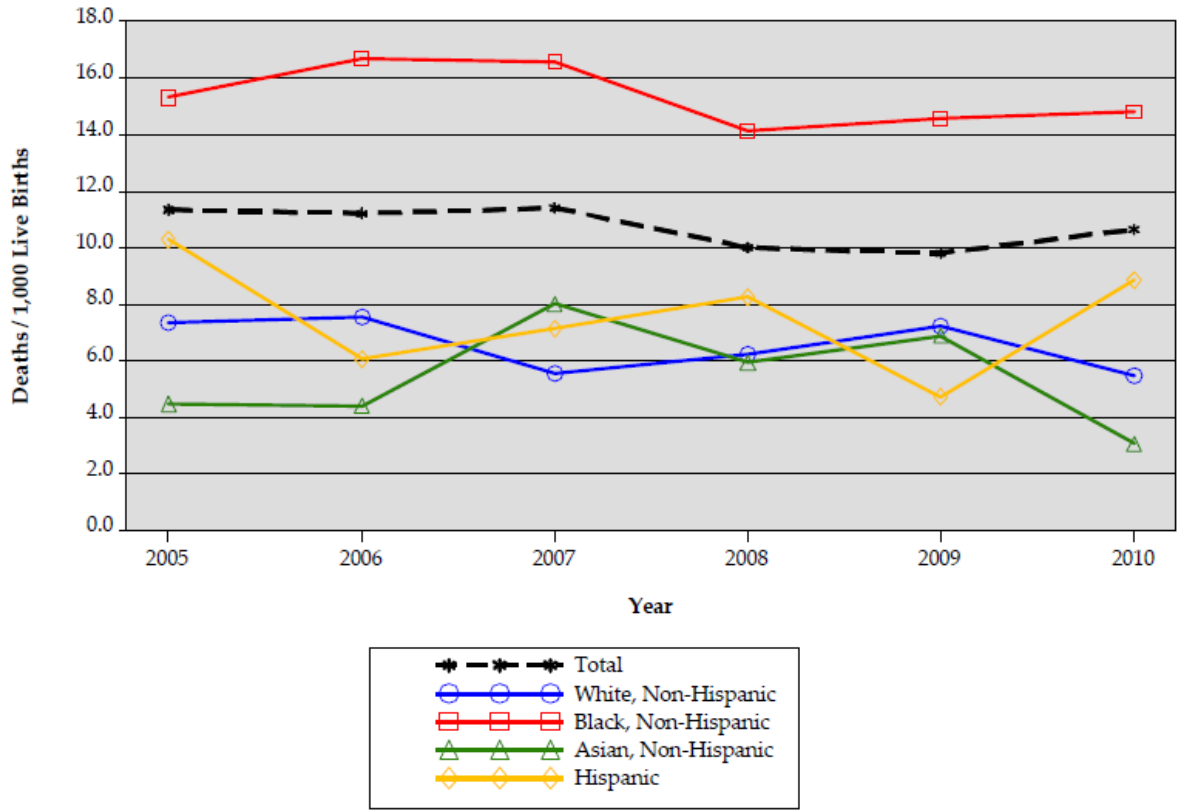
Age adjusted mortality rates per 100,000 population decreased for all causes between 2000 and 2010.

Cause	Rank 2010	Rate 2000	Rate 2010	% Reduction	# Deaths
All		1086.2	840.2	22.6	13,746
Heart Disease	1	295.6	218.0	26.3	3,605
Malignant Neoplasms	2	249.5	196.1	21.4	3,144
Accidents	3	48.5	41.7	14.0	662
Cerebrovascular Disease	4	68.3	41.7	38.9	698
Chronic lower respiratory disease	5	40.8	34.0	16.7	548
Septicemia	6	36.7	22.3	39.2	366
Nephritis	7	27.2	22.1	18.8	366
Diabetes	8	27.2	20.6	25.6	329
Homicide	9	20.6	19.1	7.7	308
Influenza and pneumonia	10	22.4	11.7	47.8	195
Suicide	12	10.6	9.4	11.3	
HIV/AIDS	13	18.6	8.4	54.8	
Colorectal Cancer	-	28.1	20.2	28.1	
Lung Cancer	-	70.3	52.7	25.0	
Breast Cancer	-	19.4	15.6	19.6	
Prostate Cancer	-	15.1	1.2	25.8	

2010 Vital Statistics Report City of Philadelphia Department of Public Health

Non-Hispanic Blacks have the highest mortality rates for heart disease, septicemia, nephritis, diabetes HIV/AIDS, and all cancers. Hispanics and non-Hispanic Blacks have stroke mortality rates that are almost twice that of non-Hispanic Whites. Homicide rates for non-Hispanic Blacks is more than twice that of Hispanics and more than ten times that of non-Hispanic Whites.

Infant Mortality Rate by Mother's Race/Ethnicity: Philadelphia, 2005 - 2010



Infant mortality per 1,000 live births increased from 10.3 in 2000 to 10.7 in 2010. Infant mortality is lowest among Asian women (3.1) and highest among non-Hispanic Blacks (14.8) and Hispanics (8.9). The major reasons for infant deaths were pre-term birth and low birth weight. (2010 Vital Statistics Report City of Philadelphia Department of Public Health)

Cause	White Non-Hispanic	Black Non-Hispanic	Asian	Hispanic	All Races/Ethnicities
Heart Disease	194.6	266.7	105.6	158.8	218.0
Malignant Neoplasms	175.7	242.2	120.3	104.7	196.1
Accidents	48.7	39.3		36.0	41.7
Cerebrovascular Disease	31.2	56.9		59.5	41.7
Chronic lower respiratory disease	37.6	33.7			34.0
Septicemia	16.7	30.7			22.3
Nephritis	15.3	33.7			22.1

Cause	White Non-Hispanic	Black Non-Hispanic	Asian	Hispanic	All Races/Ethnicities
Diabetes	15.5	27.4		31.3	20.6
Homicide	3.2	36.8		14.2	19.1
Influenza and pneumonia	11.0	12.9			11.7
All causes	735.2	1,039	487.8	644.8	840.2
HIV/AIDS		16.1			8.4
Colorectal Cancer	18.8	23.8			20.2
Lung Cancer	50.1	64.3			53.7
Breast Cancer	13.4	20.5			15.6
Prostate Cancer	4.8	22.0			11.2
Suicide	14.3	5.1			9.4
Infant Mortality per 1,000 births	5.5	14.8	3.1	8.9	10.7

2010 Vital Statistics Report City of Philadelphia Department of Public Health

Rates shown are age-adjusted rates per 100,000 population. Values have not been shown when there are fewer than 20 deaths per 100,000.

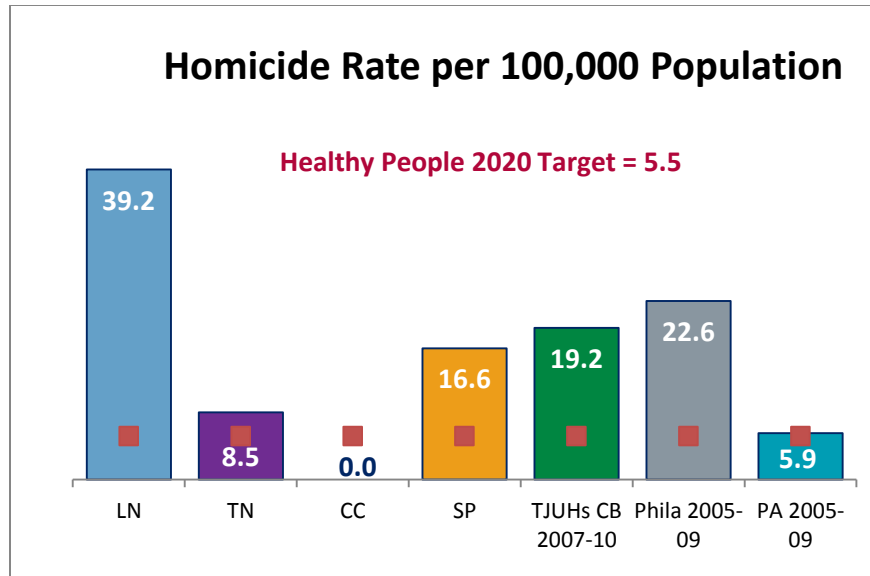
Non-Hispanic black males had the highest rates of death for each cause except accidents and suicide. Compared to non-Hispanic White males their death rate was:

- More than 10 times higher for homicide
- More than 5 times higher for prostate cancer
- 1.6 times higher for diabetes and 1.4 times higher for heart disease
- 1.5 times higher for all-cause mortality

Compared to non-Hispanic White females, non-Hispanic Black females' death rate was:

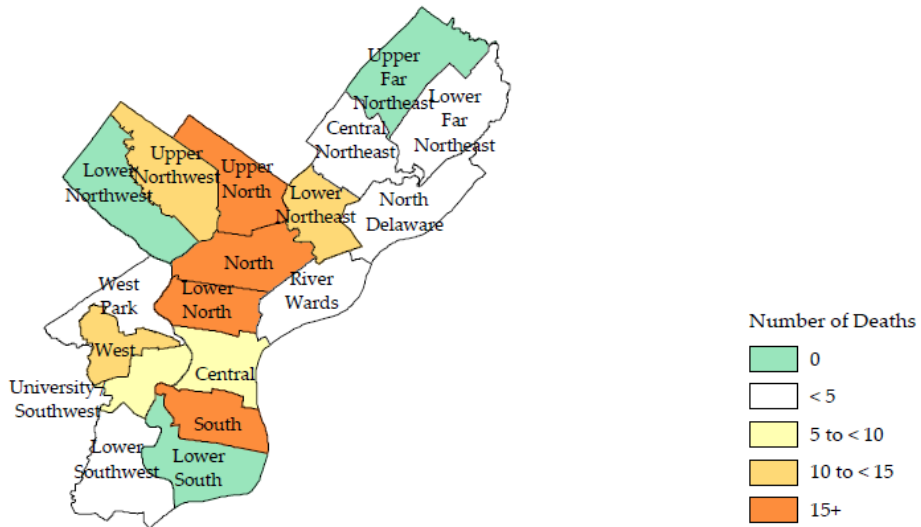
- Almost twice as high for diabetes
- 1.5 times higher for heart disease and colorectal cancer
- 1.4 times higher for breast cancer and all-cause mortality

Homicide is the major cause of death among 14 to 24 year olds. Of the 132 homicides in this age group in 2010, 116 of 132 (87.9%) were among non-Hispanic Blacks. Gun violence was responsible for 125 (94.7%) of these deaths. Homicide rates for Philadelphia are more than 4 times the Healthy People 2020 target (5.5) and are almost four times the rate for Pennsylvania (5.9). Lower North Philadelphia (39.2) has the highest rate of all Jefferson's CB areas. South Philadelphia has the second highest homicide rate in Jefferson's CB area and is three times higher than the Healthy People 2020 benchmark.



PHMC 2010 Vital Statistics Report

Youth and Young Adult Homicides Ages 10-24 by Planning District: Philadelphia: 2010



2010 Vital Statistics Report City of Philadelphia Department of Public Health

Top 10 causes of Death by Age Group

Age Group	Major Causes of Death
15-24	<ul style="list-style-type: none"> Assault (homicide) Unintentional Accidents Intentional self-harm (suicide) Malignant neoplasms Heart disease HIV Chronic lower respiratory diseases Pregnancy, childbirth, puerperium Septicemia Diabetes mellitus Cerebrovascular disease Congenital malformations, deformations and chromosomal abnormalities Legal intervention
25-44	<ul style="list-style-type: none"> Unintentional Accidents Heart disease Assault (homicide) Malignant neoplasms Intentional self-harm (suicide) HIV Diabetes mellitus Cerebrovascular disease Chronic lower respiratory diseases Viral hepatitis
45-64	<ul style="list-style-type: none"> Malignant neoplasms Heart disease Unintentional Accidents Cerebrovascular disease Septicemia Chronic lower respiratory diseases Diabetes mellitus HIV Chronic liver disease and cirrhosis Nephritis Viral hepatitis

Age Group	Major Causes of Death
65+	Heart disease Malignant neoplasms Cerebrovascular disease Chronic lower respiratory diseases Nephritis Septicemia Diabetes mellitus Alzheimer's Disease Unintentional Accidents Influenza and pneumonia

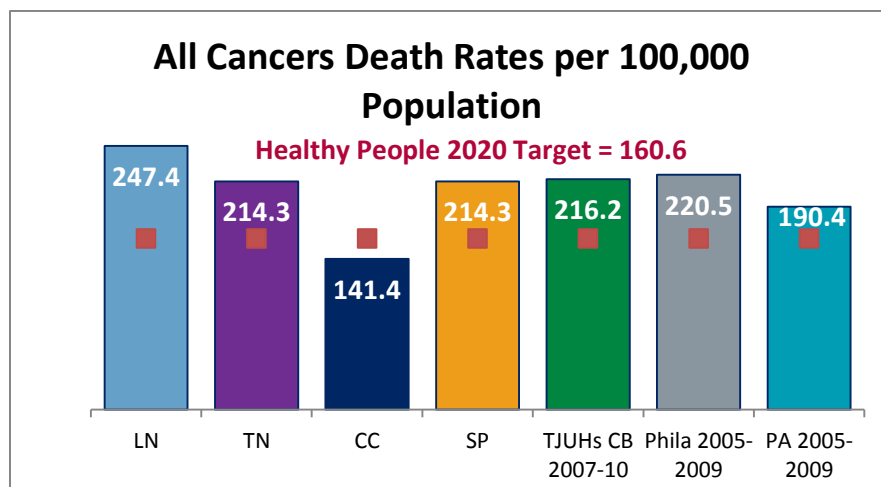
2010 Vital Statistics Report City of Philadelphia Department of Public Health

Within Jefferson's CB area, mortality outcomes also differ by neighborhood. In general, neighborhoods with higher poverty, lower levels of educational attainment and a greater percentage of racial/ethnic minorities had the highest mortality rates.

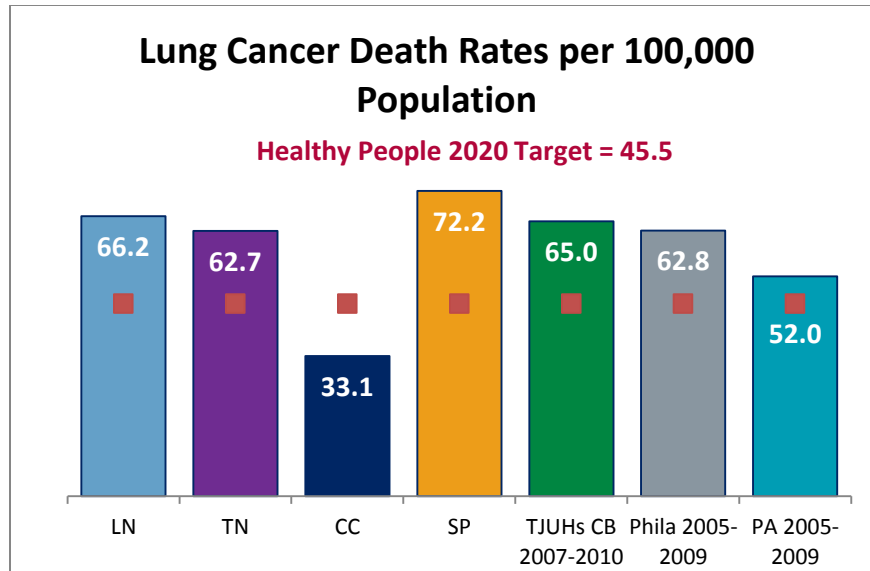
Lower North Philadelphia had the highest mortality rates of all community benefit areas for:

- All cancers, breast, cervical and colorectal cancers
- Heart Disease
- Stroke
- Homicide

South Philadelphia had the highest rate of mortality of all community benefit areas for lung cancer. Mortality rates for Center City compare favorably to the Healthy People 2020 benchmarks.

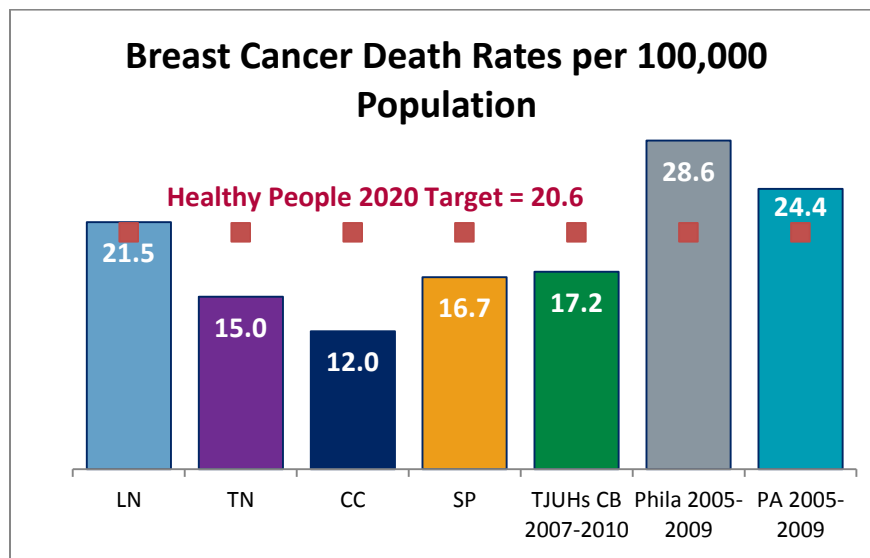


PHMC 2010 Vital Statistics Report



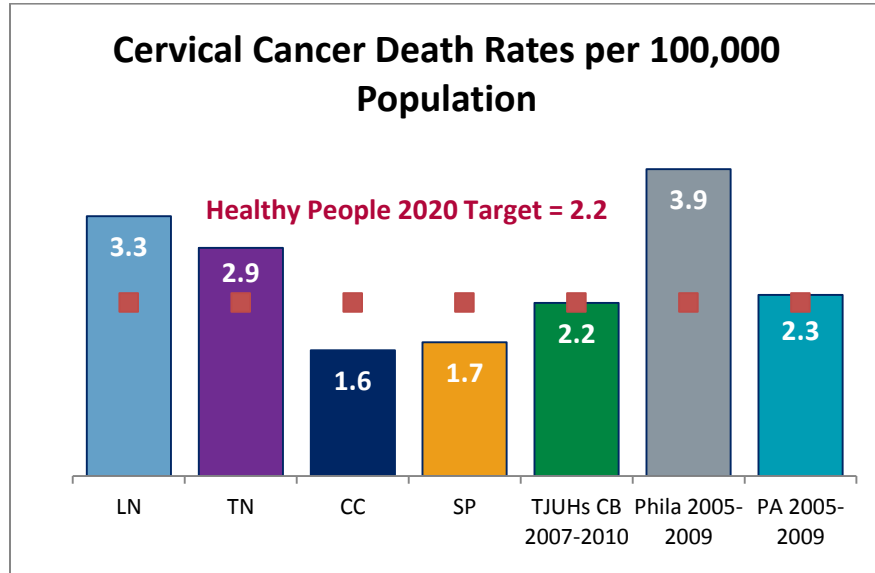
PHMC 2010 Vital Statistics Report

Overall, lung cancer mortality rates are higher in Jefferson’s CB area compared to Philadelphia and Pennsylvania. South Philadelphia and Lower North Philadelphia have the highest rates and all but Center city have rates higher than the Healthy People 2020 benchmark.



PHMC 2010 Vital Statistics Report

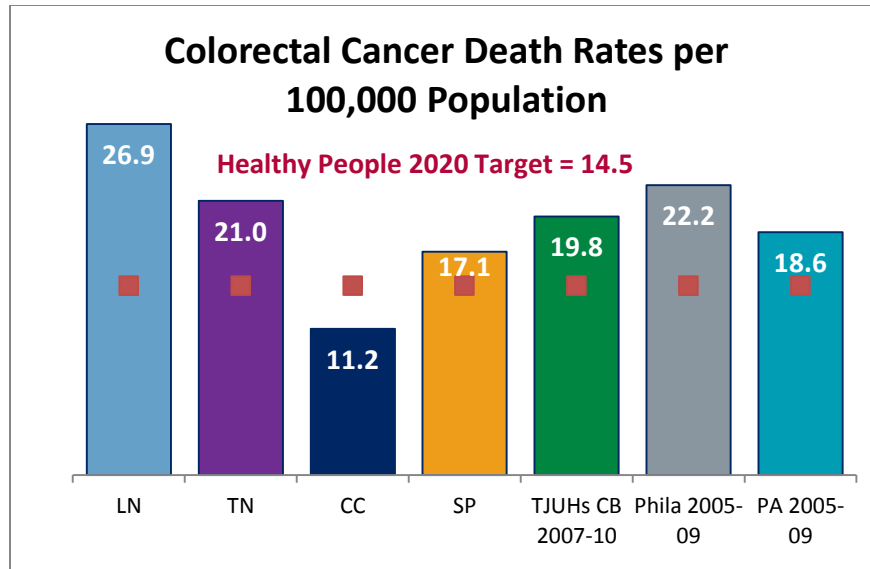
Breast cancer mortality rates compare well to Philadelphia, Pennsylvania and the Healthy People 2020 benchmark. Lower North Philadelphia has the highest breast cancer mortality rate (21.5) which is just above the Healthy People 2020 target of 20.6.



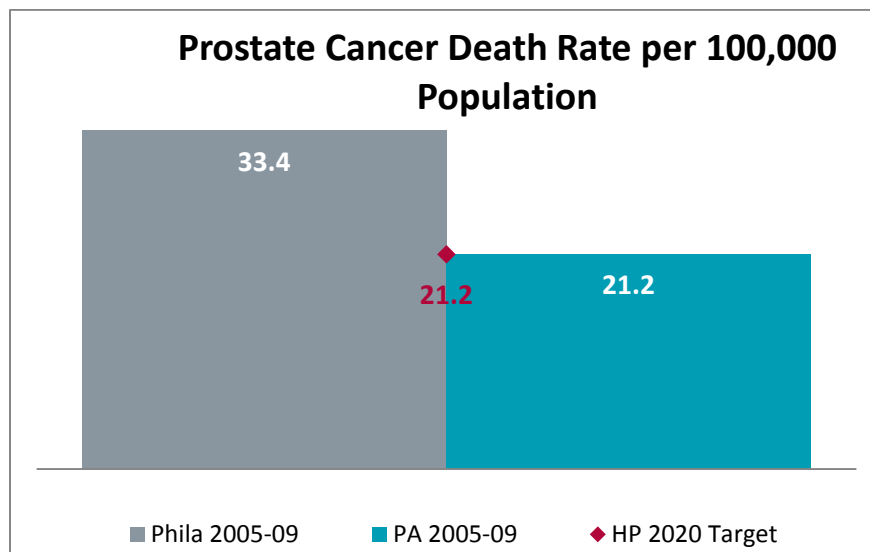
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Overall, Jefferson CB areas compare well to Philadelphia for mortality from cervical cancer. North Philadelphia (3.3) and the Transitional Neighborhoods (2.9) have higher cervical cancer rates than other Jefferson CB areas and both are above the desired Healthy People 2020 target (2.2).

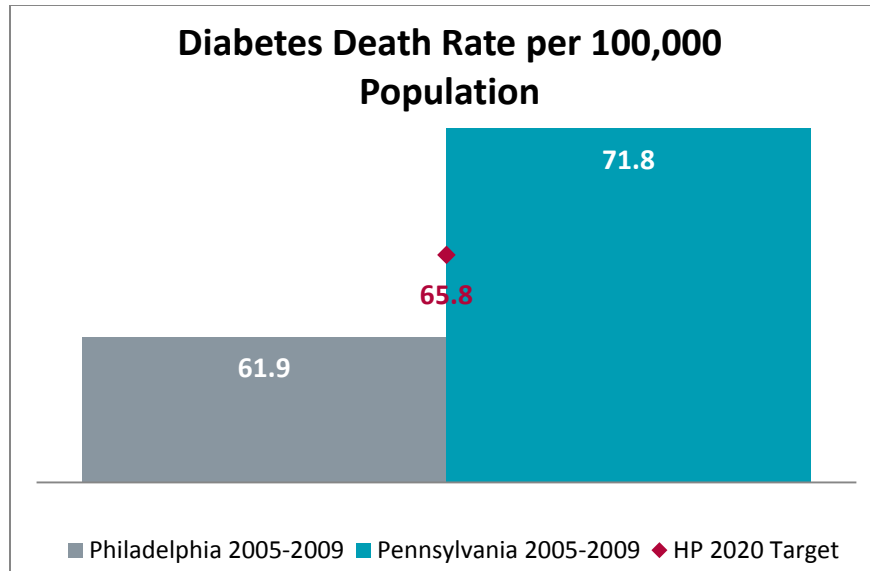
Except for Center City, colorectal cancer death rates in Jefferson’s CB areas are all above the Healthy People 2020 benchmark of 14.5 per 100,000. Lower North Philadelphia and the Transitional Neighborhoods have the highest rates (26.9 and 21.0 respectively).



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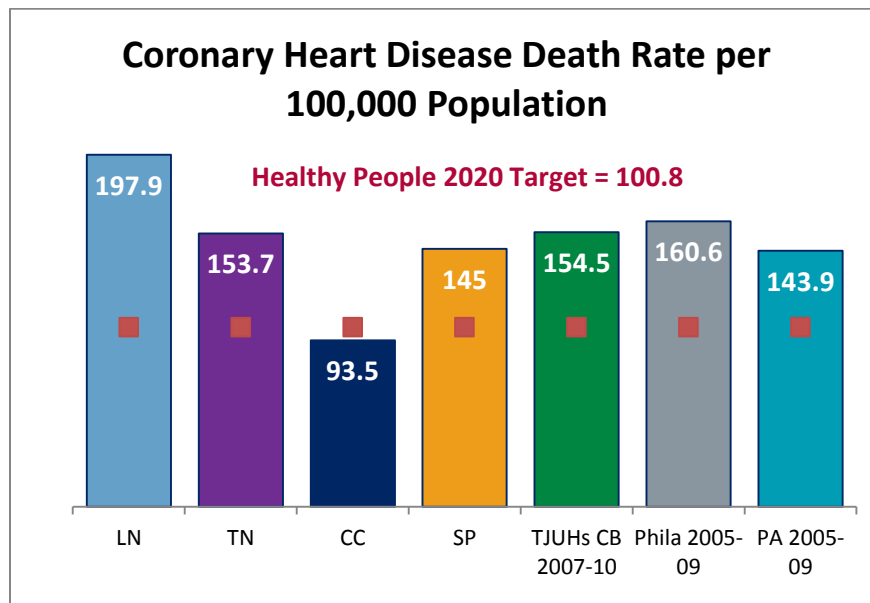


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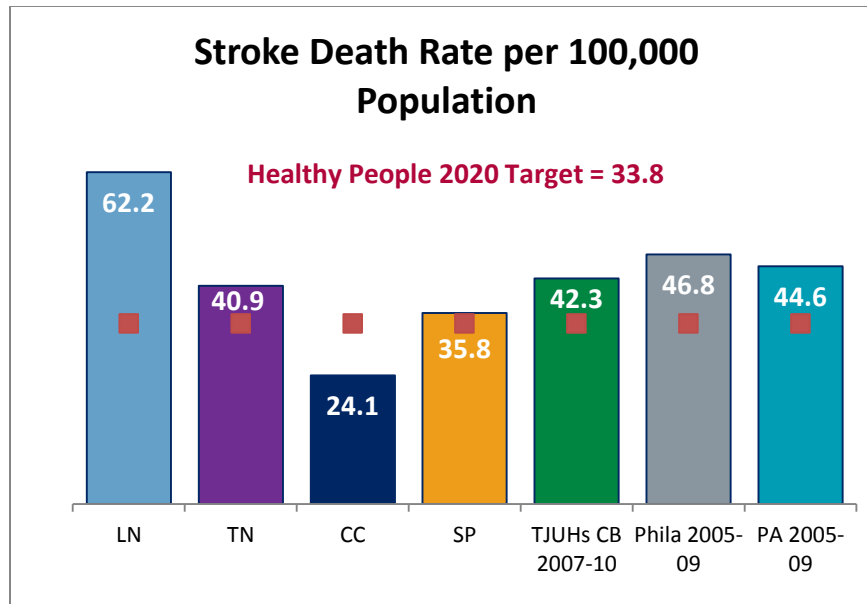


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Deaths related to diabetes mellitus in Philadelphia compare favorably to Pennsylvania and Healthy People 2020 (65.8). However, only Center City has a heart disease mortality rate lower than the Healthy People 2020 target (100.8). Lower North’s coronary heart disease mortality rate (197.9) is above both Philadelphia (160.6) and Pennsylvania rates (143.9). Similarly, Lower North Philadelphia’s stroke mortality rate (62.2) is above the rate for Philadelphia (46.8) and Pennsylvania (44.6) and the highest of all Jefferson’s CB areas. Only Center City has achieved the Healthy People 2020 stroke mortality target (33.8).



PHMC 2010 Vital Statistics Report



PHMC 2010 Vital Statistics Report

Recommendations included:

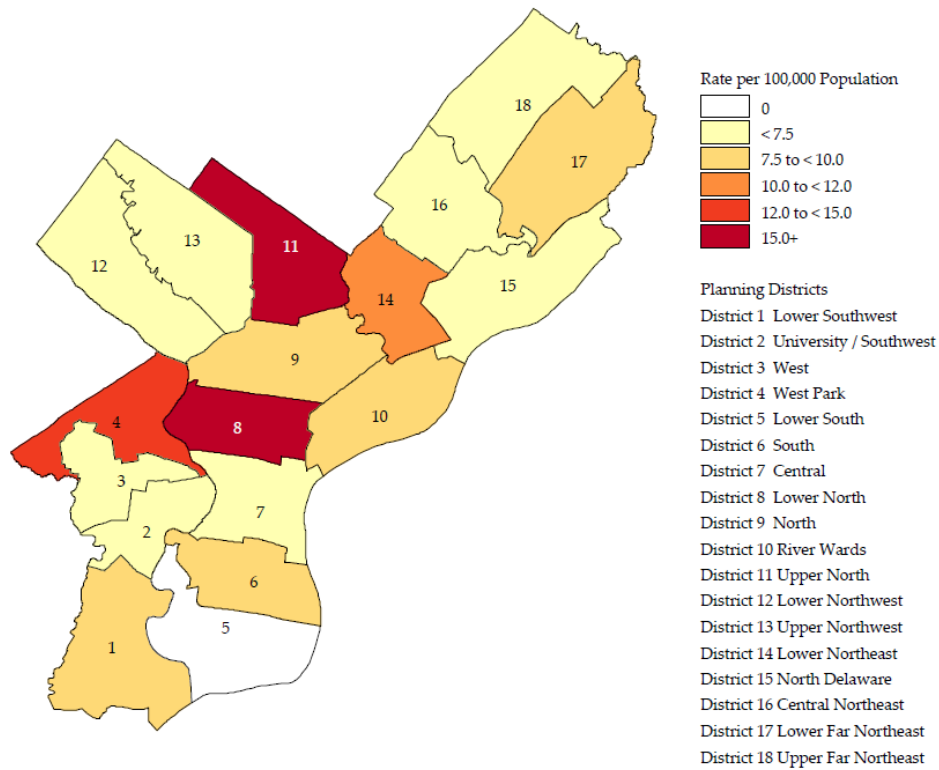
- 1. Raise awareness about signs and symptoms of heart attack and stroke**
- 2. Raise ED doctors and staff awareness about and utilization of about stroke interventions now possible (increase use of TPA). Increase utilization of robot in rural communities to improve stroke care.**
- 3. Increase family awareness about stroke prevention. FAST acronym (face, arms, speech, time) to community.**
- 4. Initiate support groups for conditions such as stroke, brain tumors and aneuisms for patients and caregivers.**
- 5. Promote early detection and screening**
- 6. Promote healthy lifestyles**

Maternal and Child Health

Data for natality is derived from the 2010 Vital Statistics Report City of Philadelphia Department of Public Health and Healthy People 2020.

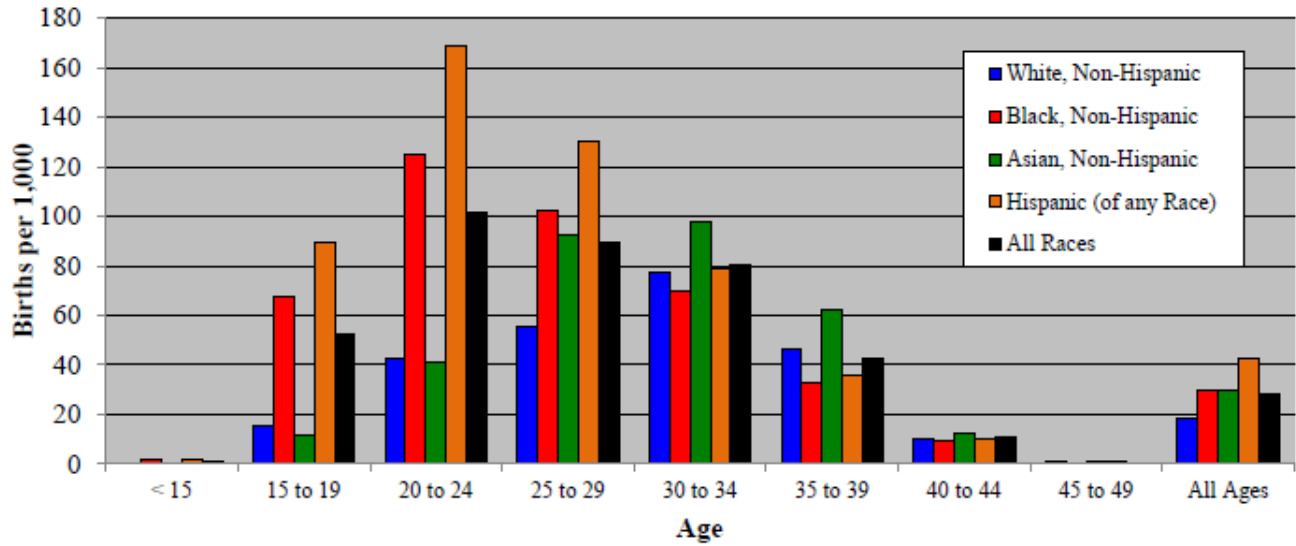
The Healthy People 2020 target rate infant and neonatal mortality is 6.0 and 4.1 respectively. The major reasons for infant deaths in Philadelphia were pre-term birth and low birth weight. (2010 Vital Statistics Report City of Philadelphia Department of Public Health). Lower North Philadelphia has one of the highest infant mortality rates in Philadelphia.

Infant Mortality per 1,000 Live Births by Planning District: Philadelphia, 2010

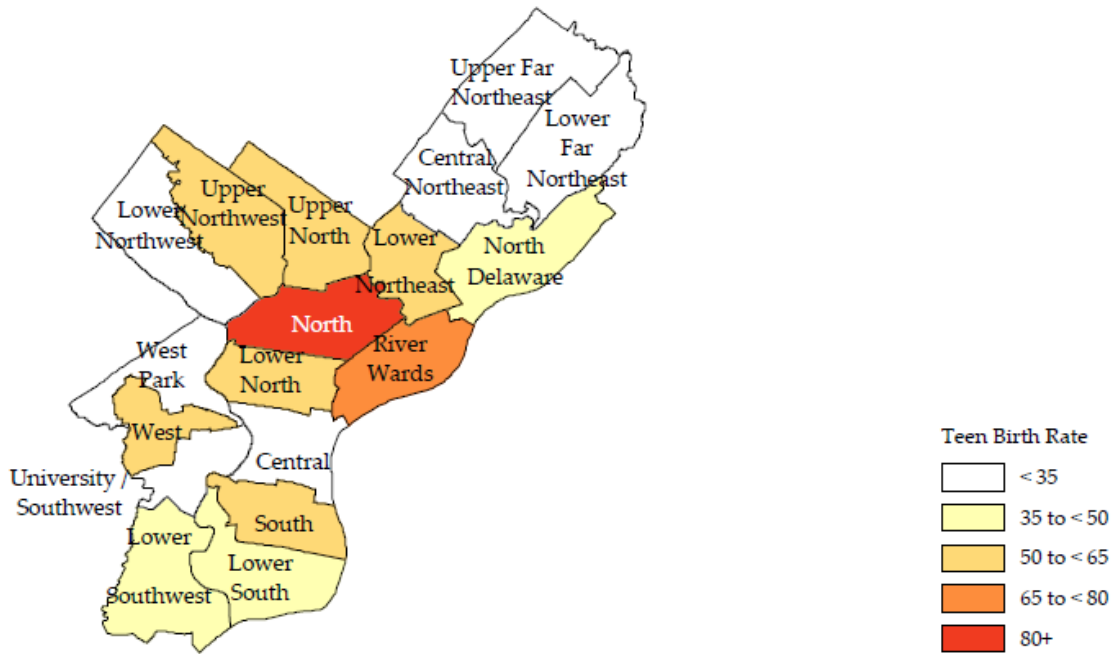


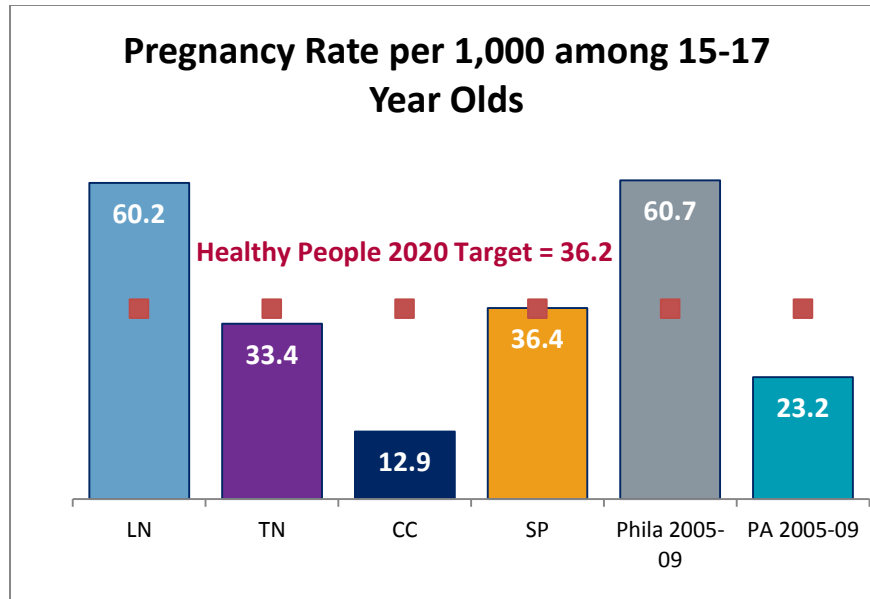
Overall, the birthrate in Philadelphia is 13.1 per 1,000 with the highest rates among Hispanics (15.6) and non-Hispanic Blacks (15.4) followed by 10.1 among the Asian community and 9.0 among non-Hispanic Whites. The rate of births to teens 15-19 years of age increased from 49.6 births per 1,000 in 2003 to 60.6 births per 1,000 in 2006 and then decreased to 52.7 births per 1,000 in 2010. In 2010, the highest rate of births to teens aged 15-19 was among Hispanics (89.8 births per 1,000) followed by non-Hispanic Blacks (67.6 births per 1,000). From 2003 to 2010, the rate of births to teens decreased among non-Hispanic Black women from 74.3 births to 67.6 births per 1,000 and among Hispanics from 110 to 89.8 per 1,000 births. Lower North and South Philadelphia have the highest teen pregnancy rates of Jefferson's CB areas. Public high schools in Philadelphia provide access to condoms and information about adolescent sexuality issues.

Age-Specific Birth Rates by Race/Ethnicity Philadelphia, 2010



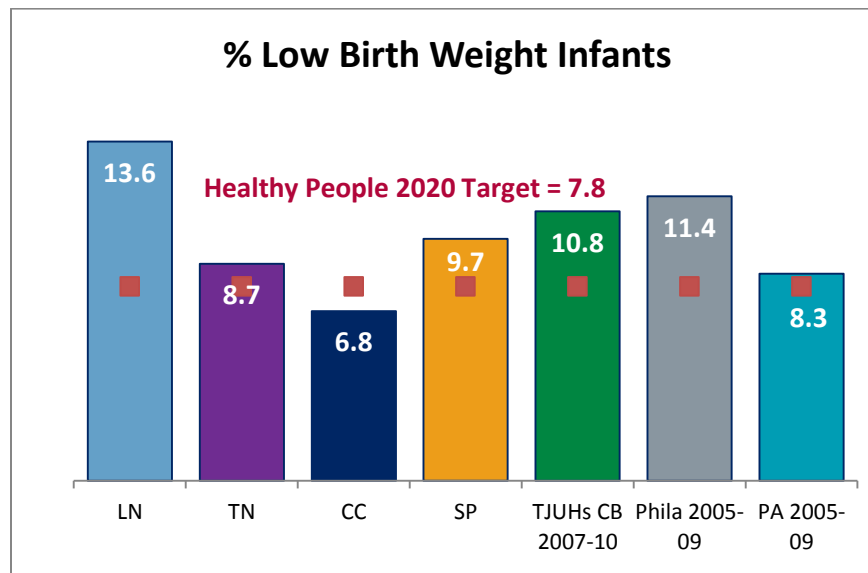
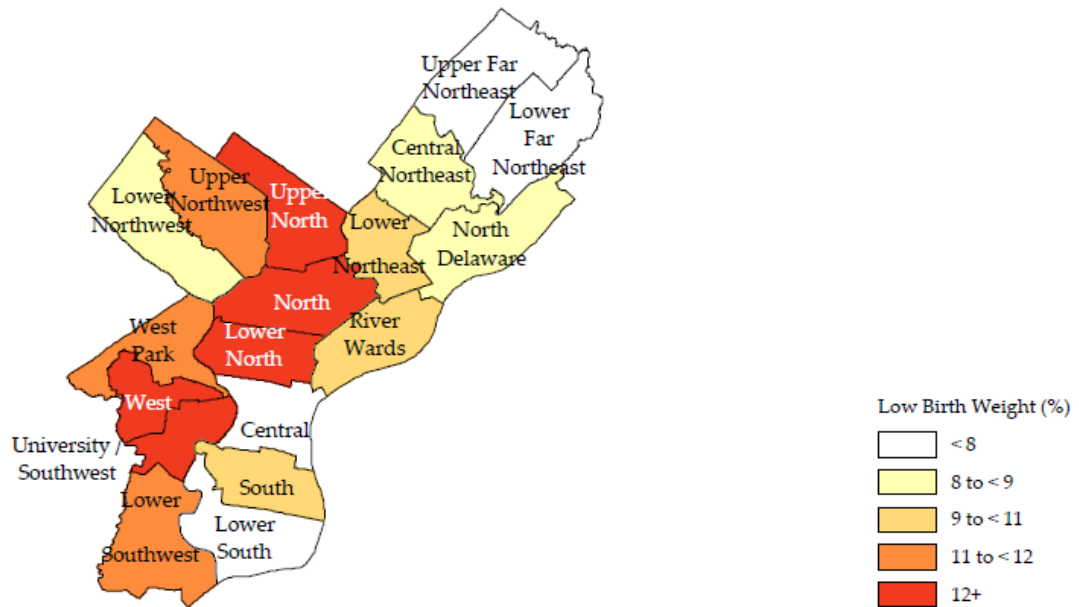
Teen Birth Rate by Planning District: Philadelphia: 2010





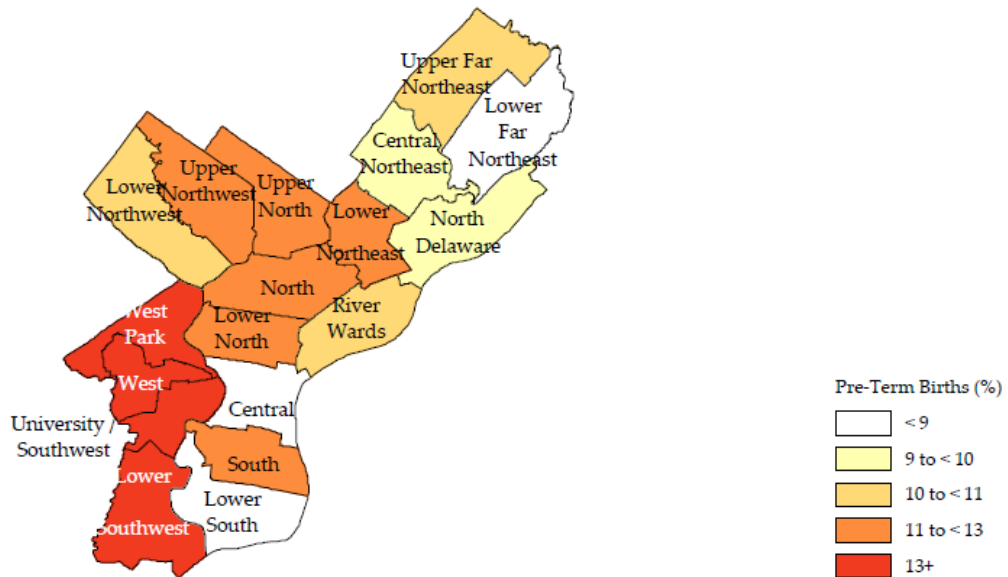
Babies weighing less than 2,500 grams at the time of birth are considered to be of low birth weight. In 2010, 10.9% of all live births in Philadelphia were of low birth weight. The racial/ethnic group with the highest rate of low birth weight in 2010 was non-Hispanic black women; 13.8% of their babies were of low birth weight, followed by 9.6 among Asians and 8.8 among Hispanics. Babies weighing < 1,500 at the time of birth are considered to be of very low birth weight. In 2010, 2.5% of all live births were of very low birth weight. As with low birth weight, the racial/ethnic group with the highest rate of very low birth weight in 2010 was non-Hispanic black women; 3.2% of their babies were of very low birth weight. Lower North Philadelphia's low birth weight rate (13.6%) is one of the highest in Philadelphia. Overall, the percent of very low birth weight births remained stable from 2003 to 2010. The Healthy People benchmark for 2020 is no more than 7.8% of babies will be low birth weight.

Low Birth Weight by Planning District: Philadelphia: 2010



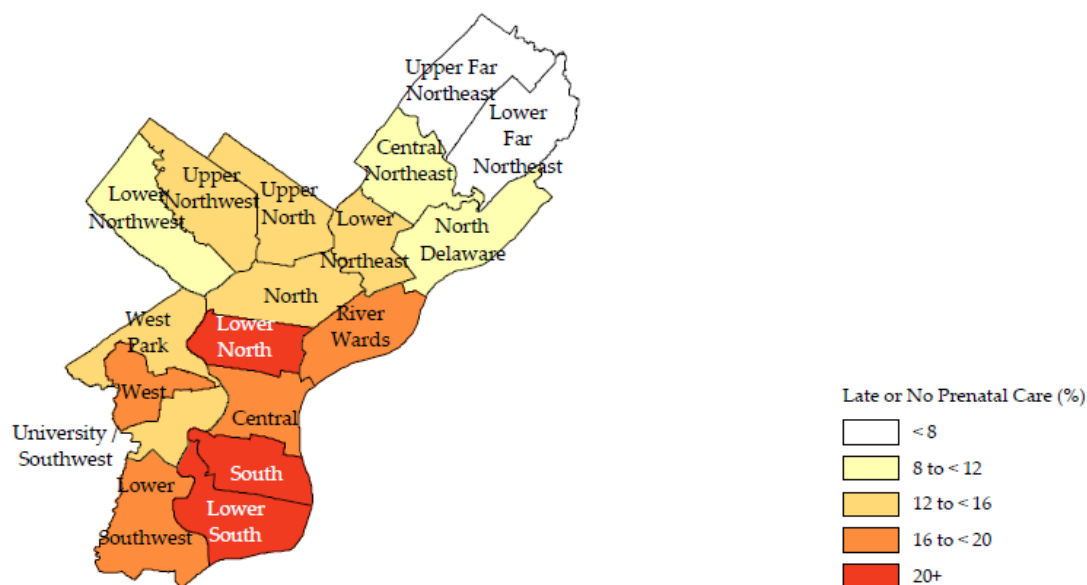
Preterm births are defined as births with less than 37 completed weeks of gestation. In 2010, 11.7% of births in Philadelphia were preterm. The highest rate of pre-term births was among non-Hispanic black women, with 14.1% of their babies being born preterm, followed by Hispanics (10.1) and Asians (8.6). Overall, the percent of preterm births remained stable from 2003 to 2010. Lower North and South Philadelphia have preterm birth rates that range from 11 to 13%. The Healthy People 2020 target for preterm birth is less than 11.4% of births will be preterm.

Pre-Term Births by Planning District: Philadelphia: 2010



The Healthy People 2020 target for initiation of prenatal care in the first trimester is 77.9%. Prenatal care is often not noted on birth certificates; however, since 2003 this omission has been reduced from 40.7% to 26% in 2010. Of birth certificates with prenatal care information, 15.5% of women in Philadelphia had no prenatal care or did not start prenatal care until their third trimester. The highest percentage of late or no prenatal care in 2010 was among non-Hispanic black women at 18.7% followed by Hispanic women (13.6%). Jefferson's CB area has the highest rates of late or no prenatal care within Philadelphia (Lower South 25.6; South Philadelphia 24.1%; Lower North Philadelphia 21.7%; Central 19.7%).

Late or No Prenatal Care by Planning District: Philadelphia: 2010



Nativity by Planning District: Philadelphia, 2010

District	All Births		Teen Births		Low Birth Weight		Pre-Term Births		Late or No Prenatal Care (%)	
	N	Rate	N	Rate	N	%	N	%	N	%
Citywide	23,088	14.8	3,011	52.7	2,510	10.9	2,677	11.7	2,641	15.5
1 Lower Southwest	799	18.2	115	49.1	95	11.9	118	14.8	93	16.2
2 University / Southwest	945	11.7	130	22.8	128	13.6	130	13.8	105	14.6
3 West	1,783	16.4	306	61.6	241	13.6	250	14.1	268	19.7
4 West Park	598	12.4	63	24.6	68	11.4	78	13.2	70	14.5
5 Lower South	56	12.0	3	37.5	4	7.3	5	8.9	11	25.6
6 South	2,054	16.0	249	56.5	205	10.1	227	11.1	325	24.1
7 Central	1,403	13.3	48	22.7	100	7.2	118	8.4	204	19.7
8 Lower North	1,665	19.1	319	55.5	214	13.1	212	12.8	270	21.7
9 North	2,759	19.8	613	97.6	357	13.0	351	12.8	355	16.0
10 River Wards	1,208	18.7	180	77.1	126	10.4	131	10.9	153	16.2
11 Upper North	2,130	14.6	313	51.4	286	13.5	275	13.0	191	13.8
12 Lower Northwest	627	13.3	18	12.3	50	8.0	62	10.0	45	8.8
13 Upper Northwest	1,187	14.3	143	53.3	137	11.6	147	12.5	112	14.3
14 Lower Northeast	1,878	18.9	255	58.4	191	10.2	205	11.0	188	14.6
15 North Delaware	1,362	13.7	138	41.4	111	8.2	130	9.6	100	9.8
16 Central Northeast	1,061	13.7	56	29.2	85	8.0	97	9.2	66	8.5
17 Lower Far Northeast	882	12.3	45	23.4	58	6.6	72	8.2	42	5.8
18 Upper Far Northeast	692	10.5	17	9.6	54	7.8	69	10.0	43	7.7

According to Maternity Care Coalition's Early Head Start Community Assessment 2012¹³, significant issues for the MCC's work in South Philadelphia include:

- High unemployment rate – with 40% of adults not finding work
- Limited educational attainment of many clients
- Difficulties in accessing health care
- Highest levels of uninsured
- Infant mortality rates of 10%
- Lack of access to prenatal care
- Increased prevalence of diabetes, particularly in the Latino population
- Depression among immigrants
- Lack of dental health
- Lack of childcare for working parents
- Obesity and food insecurity
- Violence – with a homicide rate of 104.7 per 100,000 persons in 2009, compared to 77.1 in Philadelphia as a whole.

In addition, Maternity Care Coalition's South Philadelphia Area Early Head Start¹³ program offers both home and center-based services serving Zip Codes 19145, 19146, 19147 and 19148. Over half the clients are now Asian, with 80% of these being Indonesian. The home-based program is also seeing a growing number of Nepalese clients.

MCC recommends, among other things, an increase in mental health providers; health and mental health navigators to assist individuals in moving through the complex array of benefit services and health systems; legal services for the undocumented population; educational outreach and training for low literacy individuals; working with grocery and corner stores to increase the amount of healthy food options.

Maternity Care Coalition has been tracking the number of births at each hospital in Philadelphia since 1996-1997. During this time thirteen of the hospitals in the city closed their OB facilities. Today only 6 hospitals deliver babies in the city of Philadelphia. All of these hospitals have seen an increase in the number of births except for TJUH which saw a decrease of 36.2%. The OB Chairs at all academic medical centers meet regularly to systematize OB practices across the City.

Hospital Births In Philadelphia	2010-2011 Births	1996-1997 Births	% Change
Albert Einstein Medical Center	3073	1441	113.3%
Hahnemann University Hospital	2045	1223	67.2%
Hospital of the University of Pennsylvania	4319	2422	78.3%
Pennsylvania Hospital	4842	3946	22.7%
Temple University Hospital	3473	1651	110.4%
Thomas Jefferson University Hospital	1991	3122	-36.2%
County Total	20,065	23,706	-15.4%

Issues, challenges, unmet needs and priorities identified by key informants and focus group participants related to Maternal Child Health included:

- **Access to OB services**
 - Need for information/training on condom use, safe sex practices, relationship violence pre-conception counseling (smoking, vitamins, emotional readiness, financial readiness, diabetes etc), pregnancy prevention and pregnancy termination information is needed for women.
 - Shortage of OBs in the City.
 - *Need improved access to prenatal care. Improve infant birth outcomes (early prenatal care, birth weight, preterm birth, teen pregnancy, drug use during pregnancy) (key informant)*
 - *Jefferson should consider increasing the number of deliveries annually. Need more OBs and improved retention rate (key informant)*
 - *Jefferson needs a friendlier image in patient areas (key informant)*
 - Waiting times-
 - *On average, pregnant women covered by MA in Philadelphia have to wait 2.5 weeks for an initial appointment (the wait for some was up to 62 days). MA directories for OB services are not correct (incorrect phone numbers, incorrect practitioner information). Waiting time in Center City is 20.3 days, 9 days in South Philadelphia, and 13.2 days in Lower North Philadelphia. In Bridesburg, Kensington- Port Richmond the wait is 27.7 days. There are 97 practitioners in Center City, 12 in South Philadelphia, 12 in Lower North, and 14 in Bridesburg/Kensington (Philadelphia Business Journal).*
 - *It can take a long time to get a new patient visit. This limits what options are available for patient care. Have increase NPs but the wait is still significant. The Southeast Health Center coordinates care with the JOGA clinic already (for inpatient delivery). JOGA clinic could also partner with others so that primary care takes place in the community health centers and JOGA does inpatient. (key informant)*

- *Women with mental health issues and transportation issues are more likely to cancel their appointments. Babysitting/childcare at clinic is needed (key informant)*
- *Care for undocumented pregnant women is "heart breaking". Many get late or no prenatal care. In Philadelphia the Health Centers will provide care for undocumented, but women fear deportation and they do not have insurance to cover hospital charges for birth of the baby (enter through ED). Limited access to food stamps, support for childcare etc. (key informant)*
- Use of ED -
 - *When a woman calls 911 they take her to the nearest ED, not necessarily to the hospital where her records are and she has been receiving care. MCC is working with the PDPH and insurers to develop strategies to improve care. (key informant)*
 - *Need a city-wide data base of pregnant women to reduce unnecessary testing when women in labor are brought to ED by ambulance or they enter the hospital through the ED. Consider a "maternity passport" to document what has been done in terms of prenatal care. (key informant)*
- **Transitional care**
 - *49% of new homeless women in the city are pregnant women. In addition, there is a growing hidden homeless population who "couch surf". (key informant)*
 - *The best care in the world won't trump the social issues. Women are released from the hospital with no place to go, no cribs. Etc. (key informant)*
- **Culture and Language**
 - *Growing Asian community - About 85% of MCC clients (313 families) in South Philadelphia are Asian (Indonesian). (key informant)*
 - *Need bilingual, culturally competent providers. While phone translators are better than nothing they are not the solution. (key informant)*
 - *Need to expand interpreter services to other languages based on Chinese Health Information Services model. Need a system to help non-English speaking immigrants that includes front desk people, and providers. The JOGA clinic has Spanish speaking staff and nurses. Need to raise awareness about this in the community. (key informant)*
 - *Healthcare workers/providers need to be culturally competent (lack of respect in how women are treated) (focus group)*
- **Mental and Physical Health**
 - *People who are becoming pregnant are less healthy (overweight/obese, high blood pressure, diabetes). In addition, many have behavioral/mental health problems. (key informant)*
 - *Depression and bi-polar illness among women are problems. They don't take meds due to cost or cost shifting (need money to pay rent, feed children, etc). It's very difficult for people with behavioral health issues to get regular care. People on SSI (mental health disabled) are less likely to be on treatments or medications. There is no money to get to care/appointments and some have had a negative experience with therapists. Behavior providers say that more clinical behavioral care is needed. (key informant)*
 - *The system is extraordinarily fragmented. People may have 6 to 12 service providers in their lives and none of them meet all their client's needs. There is no coordination.*

They need in home health therapy since they have barriers to getting to services. Medicaid won't cover all costs. MCC is trying to make in home services cost effective but currently is not economically feasible. There is fragmentation, lack of service coordination and all needed services are not available. (key informant)

- **Obesity:**
 - *Need to help women lose weight after birth (Post natal weight loss) and prevent children from becoming overweight. (key informant)*
 - *Obesity and pre-existing diabetes, and undiagnosed diabetes results in complications. Fetal complications (structural abnormalities and increased risk of complications resulting in c-sections). Babies of obese and/or diabetic mothers may need to go to the NICU for blood sugar management. (key informant)*
- **Breastfeeding** – see obesity findings in the morbidity section
 - Lack of lactation consultants in hospitals (key informant)
 - Lack of support for breast feeding in communities (key informant and focus group)
 - Support Baby Friendly Hospital programs (key informant)
 - Continue TEXT for Baby program at Jefferson (also addresses post natal weight loss)
 - *Skype with women who can't make appointments or use skype as a home visit. This is being done for encouraging breastfeeding. We need to use technology better.*
- **Communication**
 - *Need to raise awareness about community resources such as MCC services with medical residents/nurses and create a more formal relationship with MCC (key informant)*
- Need to **reduce child abuse through parenting education**. *Children and young parents don't have hope for a better future. Need parenting education, education about child development. (key informant)*
- **Second hand smoke in homes**

The following quote from a key informant summarizes many of the issues above:

"Less healthy women having babies that are too small, not having services they need, fragmentation of care. They need more intensive services right away - Patient navigation model is needed to coordinate care and services." Patient navigator services needed prior to birth, at birth and frequently after birth. Rather than having 15 inadequate services, why not 1 comprehensive service."

Recommendations included:

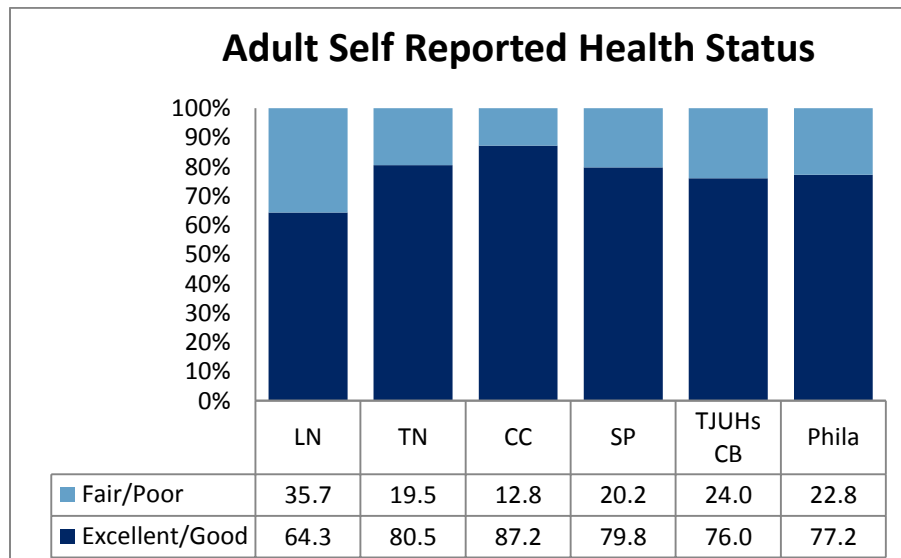
- 1. Implementing Baby Friendly Hospital Initiative at TJUH**
- 2. Culturally competent services at TJUH**
- 3. Improve TJUH OB image in the community through outreach and staff development**
- 4. Through coordination of obstetrical services across the city address access to care issues including need for OBs and long wait times to obtain prenatal care services**
- 5. Parenting education programs**

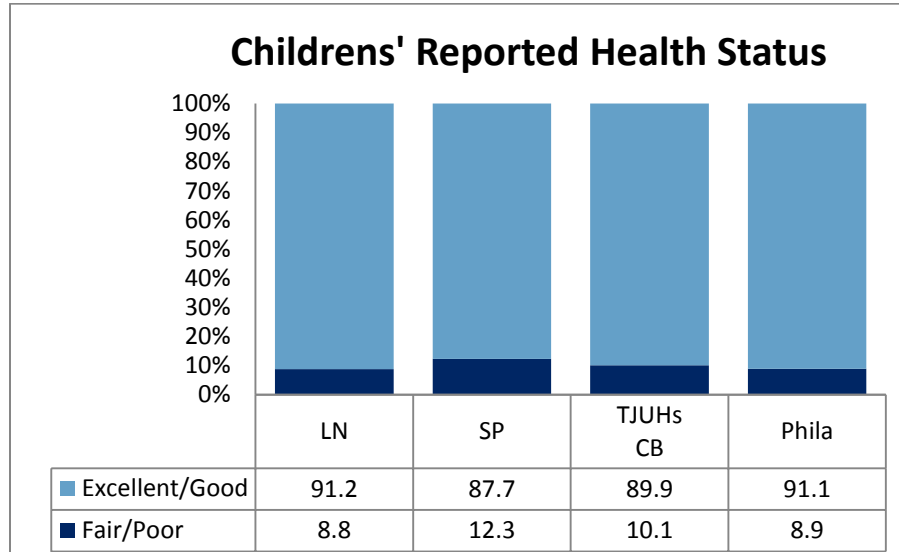
6. Use Community Health Workers for care management. Create a more formal relationship with MCC to improve utilization of prenatal care and transitions home after birth
7. Raise awareness about and refer to existing community resources (behavioral/mental health services, transportation, housing)
8. Improve access to language
9. Explore “maternity care passport” concept
10. Talk to school principals and School Nurse supervisors about health needs in schools. Partner with schools to address the school health improvement plans.
11. Continue TEXT for Baby program at Jefferson

Morbidity

Philadelphia ranks 67th out of the 67 counties in Pennsylvania for morbidity²⁰. Twenty percent of all adults in Philadelphia rate their health as fair or poor compared to 14% in Pennsylvania and the Healthy People 2020 goal of 10%. Adults in Philadelphia were more likely to report poor physical health days (average number of physically unhealthy days reported in past 30 days - age-adjusted) than other Pennsylvania residents (4.3 vs. 3.5 respectively) and more poor mental health days (average number of mentally unhealthy days reported in the past 30 days (4.5 days vs. 3.6 days). The national benchmark for poor physical health days is 2.6 and 2.3 for poor mental health days (County Health Rankings 2013).

Adults in Jefferson’s CB area are more likely than other Philadelphians to report fair or poor health (24% vs.22.8%); 35.7% of adults in Lower North Philadelphia report having fair or poor health. Compared to Philadelphia, parents in Jefferson’s CB areas are more likely to rate their children’s health as fair or poor (10.1% vs. 8.9%), particularly in South Philadelphia (12.3%).





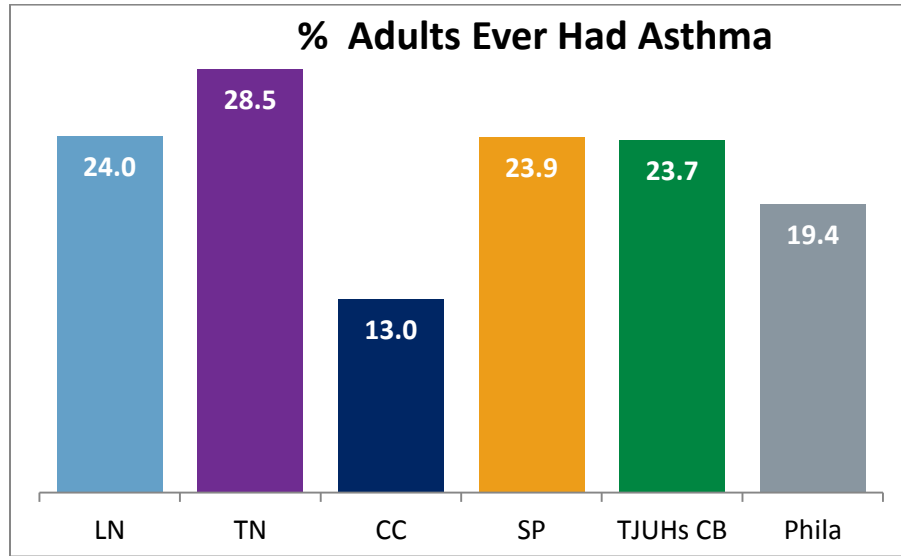
Chronic disease management was identified by focus group participants and key informant interviews as a community benefit priority. Lack of knowledge about disease prevention, early detection and management was highlighted as well as competing priorities such as food security, housing and employment.

- *We talk about diabetes, heart disease, obesity, and diabetes but what we need to do is invest in the social determinants of health in order for people to get access and resolve poverty, housing issues, jobs, etc. (CBO representative)*
- *Health is not a priority for many because other needs trump health (CBO representative)*
- *Many people do not understand the risks, signs and symptoms of illness and how serious it is (focus group)*
- *We need health education and screening in community sites such as churches, farmers markets, recreation centers and schools (focus groups)*
- *People need information about how to access care regardless of their health insurance status. We need information in multiple languages (focus groups).*

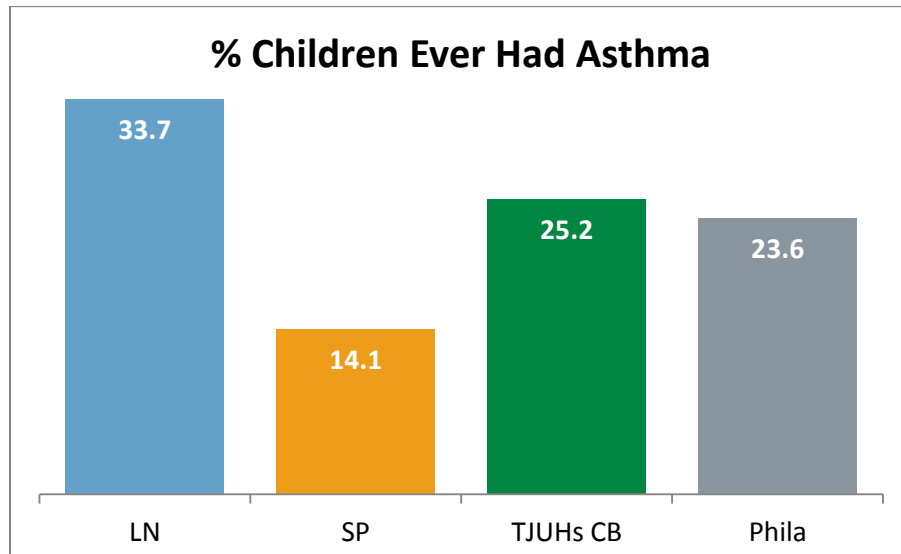
Asthma

Asthma rates for adults exceed the rate for Philadelphia (19.4%) and Pennsylvania (12.9%) in all community benefit areas except Center City. Almost 1 in 4 adults (23.7%) in Jefferson’s CB areas report having asthma (approximately 71,500 adults). Children in Jefferson’s CB areas are also more likely to have asthma compared to Philadelphia (25.2% vs. 23.6%); one-third of children living in Lower North Philadelphia are reported to have asthma according to PHMC Household health survey

respondents. Asthma is a major reason for high absenteeism and truancy among school-aged children. Healthy People 2020 objectives for people with asthma focus on reducing asthma mortality, reducing asthma hospitalizations and increasing the proportion of persons with asthma who receive formal patient education. Focus group participants identified childhood asthma as a priority need.



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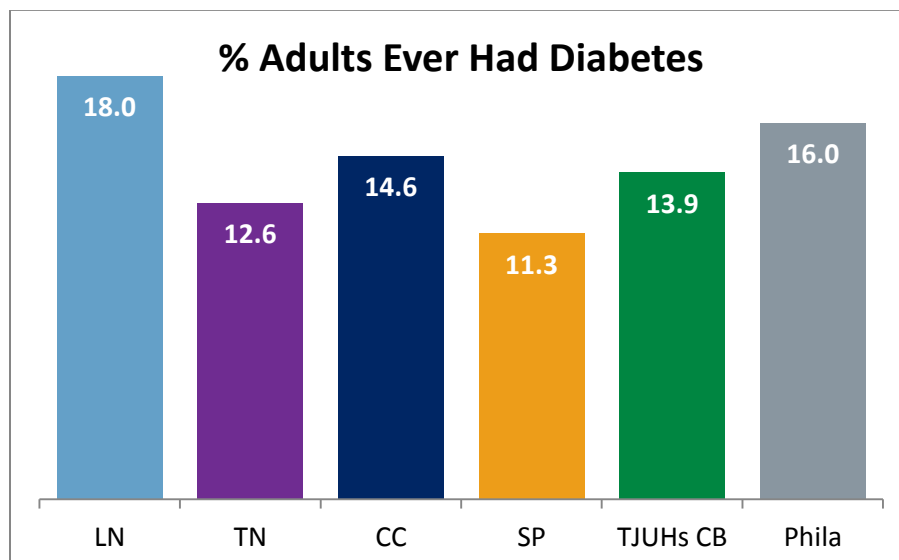
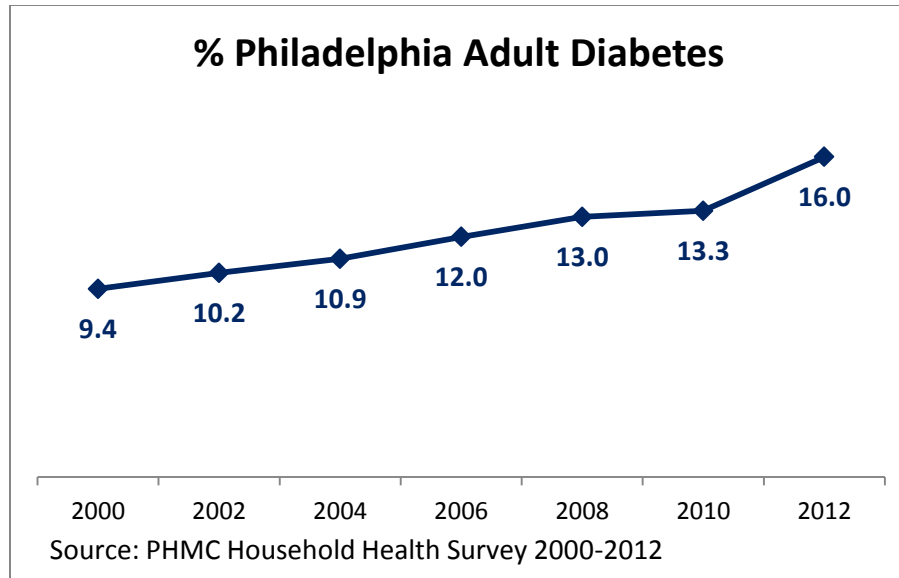
Cardiovascular Disease, Stroke and Diabetes

Heart Disease, Stroke and Diabetes are among the top eight causes of mortality in Pennsylvania. Obesity and hypertension are underlying chronic diseases that increase risk of heart attack, stroke and complications of diabetes. The goal of Healthy People 2020 for Heart Disease and Stroke is to improve cardiovascular health and quality of life through prevention, detection and treatment of risk factors for heart attack and stroke, early identification and treatment of heart attacks and strokes; and prevention of repeat cardiovascular events.

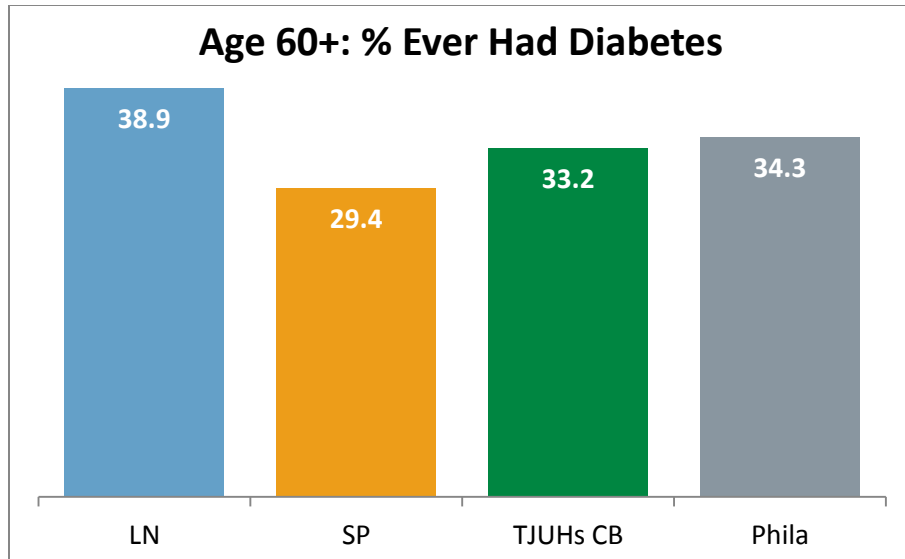
Diabetes

In Pennsylvania, 9.5% of adults have been diagnosed with diabetes. The percentage of adults with diabetes has steadily risen in Philadelphia since 2000 from 9.4% to 16% in 2012. This represents approximately 114,000 adults who have been told they have diabetes. Almost 21% of those living below 200% FPL have diabetes and rates are higher among non-Hispanic Blacks (20.2%) and Hispanics (16.7%). The rise in diabetes among adults is related to rising rates of obesity in the population. In Jefferson's CB areas 13.9% or almost 42,000 adults, have been told they have diabetes. Diabetes rates are highest in Lower North Philadelphia (18%) and lowest in South Philadelphia (11.3%). Among older adults (aged 60+) in Jefferson's CB areas, one-third have diabetes, and those living in Lower North have the highest rates (38.9%). Diabetes education was identified as a priority by multiple key informants including the Philadelphia Department of Public Health and by multiple focus groups. Among adults with diabetes who have attended Jefferson's Center for Urban Health's free community-based diabetes self-management programs, almost 90% have indicated they never attended a formal diabetes education program. Only 49.5% of adults in Jefferson's CB area who have diabetes say they exercise 3 or more times weekly. Healthy People 2020 objectives for people with diabetes include:

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



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

- **Obesity**
 - *The increase in the prevalence of diabetes is a result of the obesity epidemic, the causes of which are complex and include food insecurity, poverty, decreased exercise (key informant).*
 - Lack of affordable weight management programs
 - Lack of access to recreational facilities.
- **Insurance**
 - Un or underinsured are not able to access care in a timely fashion
- **Language** barriers impede effective management in non-English speakers (key informant)
- **Transportation** costs are prohibitive to attending DSME classes at TJUHs – taxi, parking, para-transit (long waiting times)
- **Knowledge**
 - *Chronic disease management – people lack knowledge on how to keep healthy and management of chronic illness...such as diabetes and unhealthy eating. People have difficulty getting medications and glucose strips*
 - *My mother does not understand risk factors. She thinks you get diabetes from drinking too much sugar-sweetened drinks: and high blood pressure if you drink too little water. The doctor does not fully explain what she needs to do*

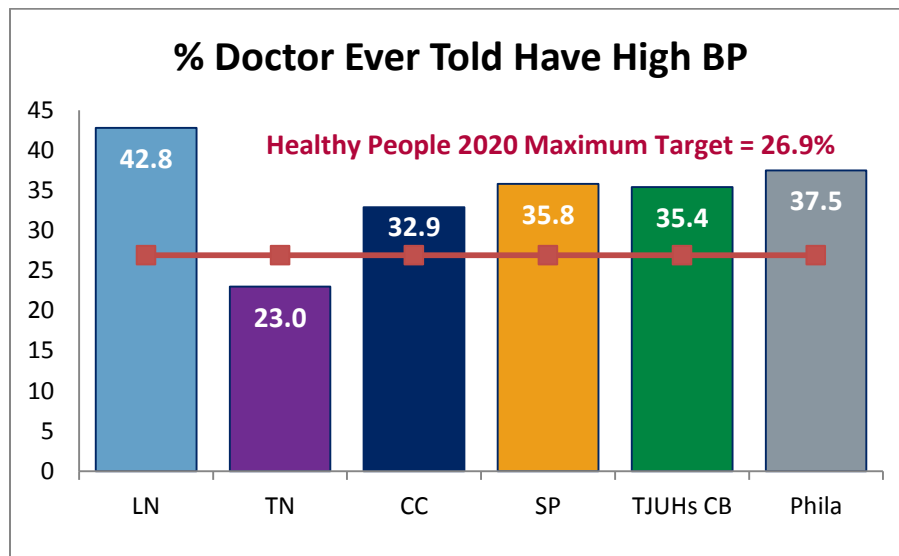
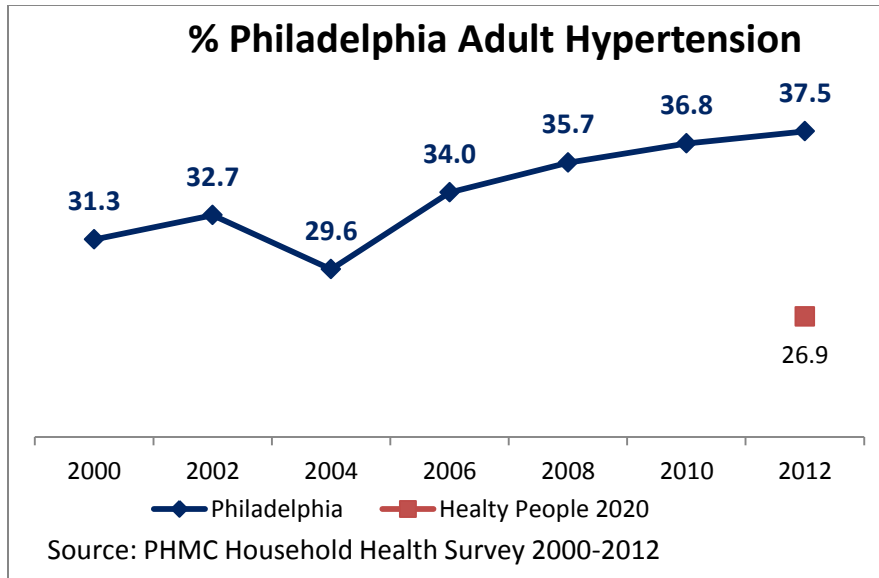
Recommendations included:

- 1. Expand and promote community-based DSME and Diabetes Prevention Programs – CUH should continue to partner with the YMCA and the Philadelphia Department of Public Health.**
- 2. Encourage TJUHs physicians to “prescribe” these programs**
- 3. Work with the Cambodian Association to develop and provide training for chronic disease management programs that will be provided by community residents interested in or employed in health care.**

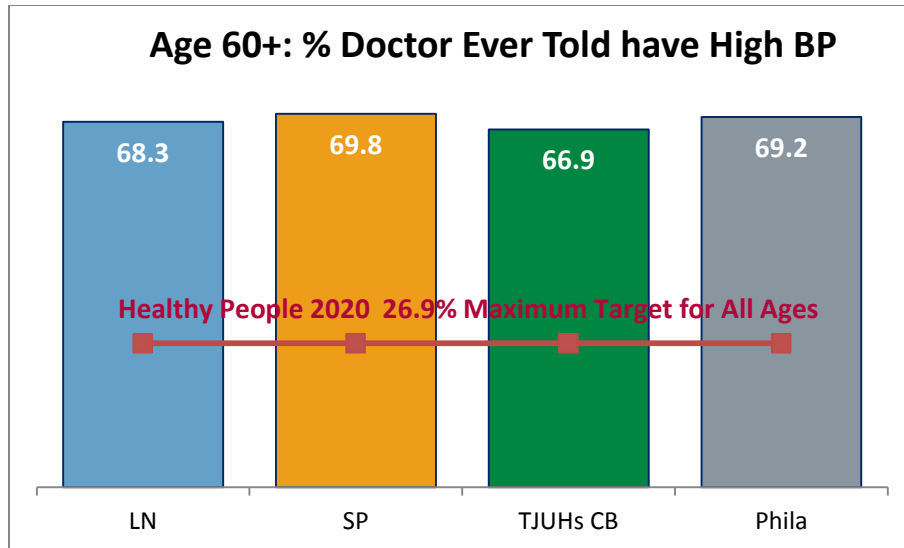
Hypertension

Hypertension rates have increased in Philadelphia between 2000 and 2012 (31.3% and 37.5% respectively). These rates are above the rate for Pennsylvania (31%) and well above the Healthy People 2020 goal of 26.9%. Forty-two percent of those living below 200% FPL have hypertension and rates are higher among non-Hispanic Blacks (47.1%) and non-Hispanic Whites (34.6%). Almost 107,000 adults in Jefferson’s CB areas (35.4%) have been told they have hypertension. Adults in Jefferson’s CB areas have similar rates of hypertension compared to Philadelphia with the exception of Lower North Philadelphia where 42.8% of all adults report having been told they have high blood pressure. Almost 70% of all older adults (aged 60+) in Jefferson’s CB areas and Philadelphia have hypertension. Adults in Jefferson’s CB area are more likely not to have had a blood pressure screening in the past year compared to Philadelphia (12.4% vs. 11.5%). This is particularly true in the Transitional Neighborhoods where almost 1 in 5 adults did not have their blood pressure measured in the past year. Healthy People 2020 objectives related to hypertension include:

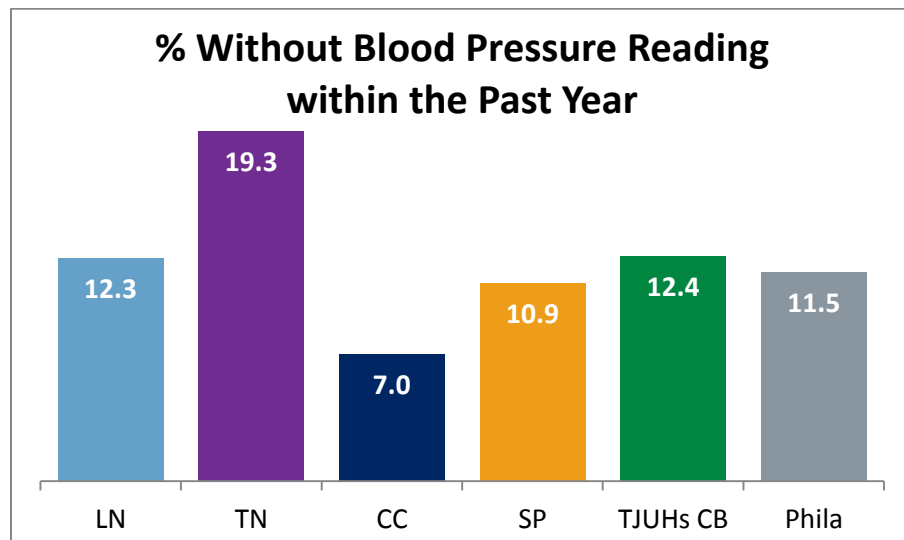
- Reduce the proportion of adults with hypertension to 26.9%
- Increase the proportion of adults aged 20 and older who are aware of the early warning symptoms and signs of a heart attack to 43.6%
- Increase the proportion of adults who have had their blood pressure measured within the past two years and can state whether their blood pressure is high or normal to 92.6%
- Increase the proportion of adults with hypertension who are taking the prescribed medications to lower their blood pressure to 69.5%



PHMC Household Health Survey 2012



PHMC Household Health Survey 2012



PHMC Household Health Survey 2012

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

- **Insurance**
 - Un or underinsured are not able to access care in a timely fashion
- **Awareness**
 - Raising awareness about hypertension, high cholesterol, heart disease, stroke and kidney disease was cited as a priority by focus groups and key informants.

- *Many people are unaware they have hypertension* (key informant)
- Need for community based screening with follow-up and database to track participants and connect participants to primary care
- *Need to increase awareness about the link of smoking, diabetes and hypertension to stroke. We need to activate patients about signs/symptoms of stroke and the need to get to ED within 4 to 12 hours so TPA can be administered in order to reduce stroke morbidity and mortality. We need to educate ED providers about how to communicate "risk" effectively with lower health literate populations* (key informant)
- *Raise awareness of and utilization of ED doctors and staff about stroke interventions now possible (increase their use of TPA). We need to expand utilization of robot in rural communities to improve stroke care.* (key informant)
- **Treatment**
 - Those with hypertension are often undertreated (key informant)
- **Risk Factors**
 - Little understanding of the link between smoking, hypertension and stroke
 - Little understanding of the link between obesity, hypertension and stroke
 - Smoking prevalence is alarmingly high
 - Lack of smoking cessation programs
- **Access to healthy (low sodium) foods in corner stores**
- **Access to low cost or free weight management, physical activity and smoking cessation programs**
 - The need for chronic disease management programs was identified as a priority by focus groups and key informants.
- **Language**
 - Language barriers limit cardiovascular and stroke care
- **Stroke Rehabilitation**
 - *Uninsured and undocumented do not have money for medications (BP, pulmonary). They need assistance with Medicaid applications. They do not have money for canes/walkers. The hospital pays for these things so that patients can leave.* (key informant)
 - Need community resources that help keep patients "in the community". For example, someone who can stay with stroke patients during the day. Need to identify community resources such as churches and volunteers who can assist stroke victims in staying in the community and get to appointments. Need transportation services. Need adult day care. For example, a placement for a stroke patient was not available so the patient remained in the hospital for an additional 2 days during which time the family was trained in care. As a result, the stroke victim went home with family caregivers and not to the nursing home. When Medicaid refused reimbursement an appeal was filed and won since "the insurer saved money by not discharging patient to a nursing home". (key informant)

Recommendations included:

1. Partner with the PDPH in Million Hearts Initiative⁵⁴ and app intervention
2. Partner with AHA 360 campaign⁵⁵, Get to Goal and End Stroke program
3. Link existing stroke screening programs at TJUHs to target neighborhoods
4. Develop database to track blood pressure screening participants and close communication loop with providers
5. Work with the Athlete Health Organization
6. Educate TJUHs physicians about PDPH low sodium initiative in Chinese restaurants
7. Provide free smoking cessation program at TJUH
8. Link JUP activities to Pennsylvania Quit Line (FAX to QUIT)
9. Raise awareness about signs and symptoms of heart attack and stroke
10. Increase access to chronic disease management programs
11. Work with the Cambodian Association to develop and provide training for chronic disease management programs that will be provided by community residents interested in or employed in health care.

Obesity and Nutrition Education

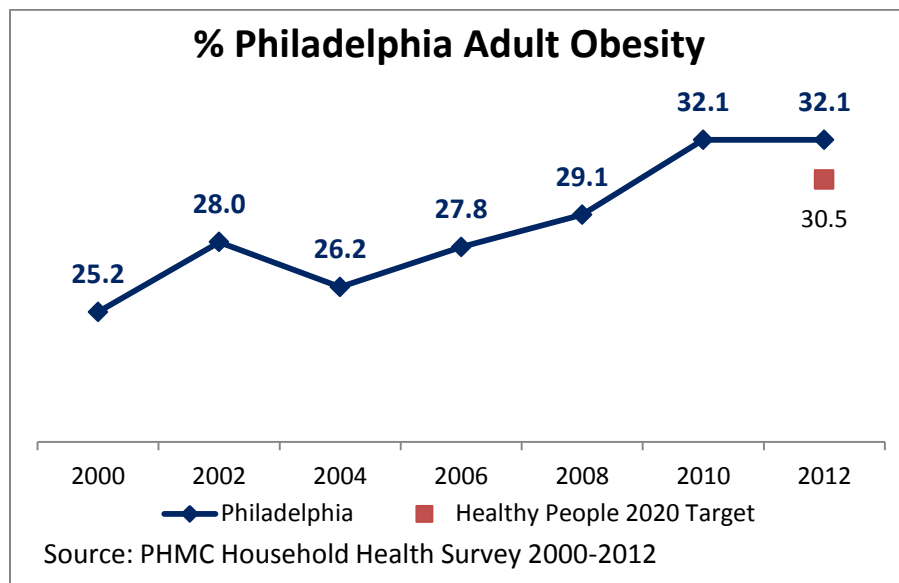
Like obesity rates in the United States, adult obesity rates in Philadelphia have increased between 2000 and 2012 (25.2% to 32.1% respectively). Diet and body weight have been shown to be related to overweight/obesity, malnutrition, iron deficiency anemia, heart disease, high blood pressure, dyslipidemia, Type 2 diabetes, osteoporosis, asthma, and some cancers. Over the years, Philadelphia has been labeled a city where people are fat and out of shape. In fact, at one time Philadelphia had the dubious honor of being the “fattest city in the United States”. Since 2002, Philadelphia has made great strides in addressing obesity through multiple coalitions that have worked to improve access to healthy, affordable food and access to safe places for physical activity. After increasing for 10 years, the obesity rate stabilized between 2010 and 2012 (PHMC Household Health Surveys 2000-2012). The obesity rate in Jefferson’s CB areas (28.9%) is lower than the city and below the Healthy People 2020 goal of 30.5%. However, almost 38% of adults in Lower North Philadelphia are obese; almost 42% of adults in Lower North Philadelphia west of Broad Street are obese. Center City has the lowest obesity rate (16.1%). In addition, 34.2% of adults in Jefferson’s CB areas are overweight. The rate of overweight adults ranges from 28.8% in Lower North Philadelphia to 41.4% in Transitional Neighborhoods. People in Philadelphia with incomes above 200% FPL are less likely to be obese compared to those below this level (29% vs. 39.9%). Disparities in obesity exist with non-Hispanic Blacks most likely to be obese compared to Hispanics and non-Hispanic Whites (41.8%, 32.4% and 24.8% respectively). Overall, 87,300 adults in Jefferson’s CB area are obese and 103,300 are overweight.

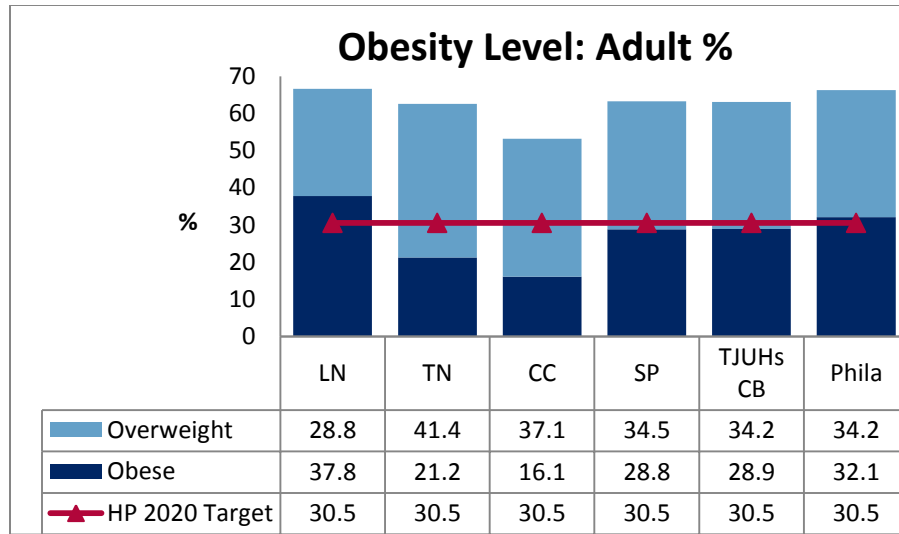
Obesity rates for youth in Philadelphia are well above the Healthy People goal of less than 14.5%. Child obesity rates for Jefferson’s CB areas are slightly higher than those in Philadelphia (26.6% vs. 24.5%). The rate of obesity in Lower North Philadelphia children is 30.5% and in South Philadelphia it is 21.5%. In addition, 6% of children in Jefferson’s CB area are overweight.

Breastfeeding has been shown to be associated with lower obesity rates in children. Between 2005 and 2009, 61.6% of mothers in Philadelphia reported breastfeeding their infants, compared to 69% in Pennsylvania. The Healthy People 2020 breastfeeding objective is 81.9%. Jefferson Hospital is actively pursuing becoming a *Baby Friendly Hospital*⁵⁶ which includes promoting breastfeeding and eliminating formula gift bags to new mothers.

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

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



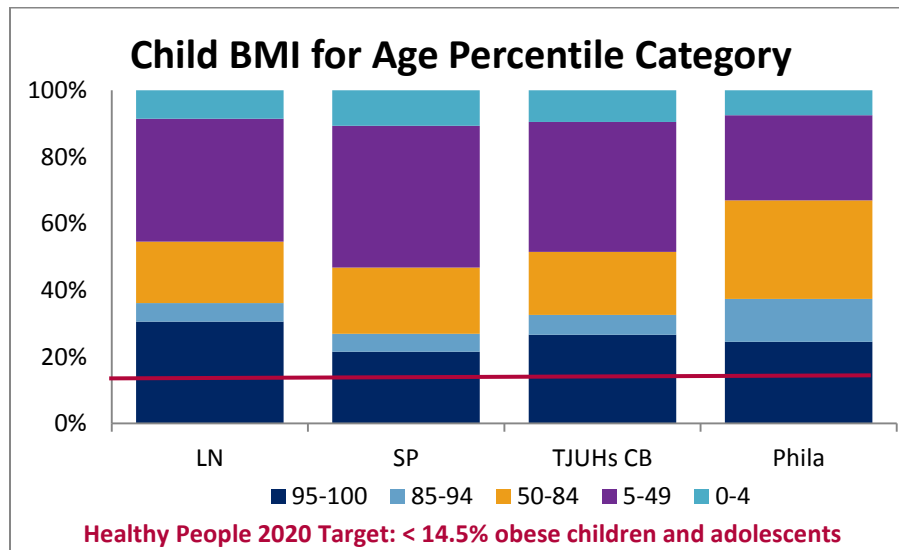


PHMC Household Health Survey 2012

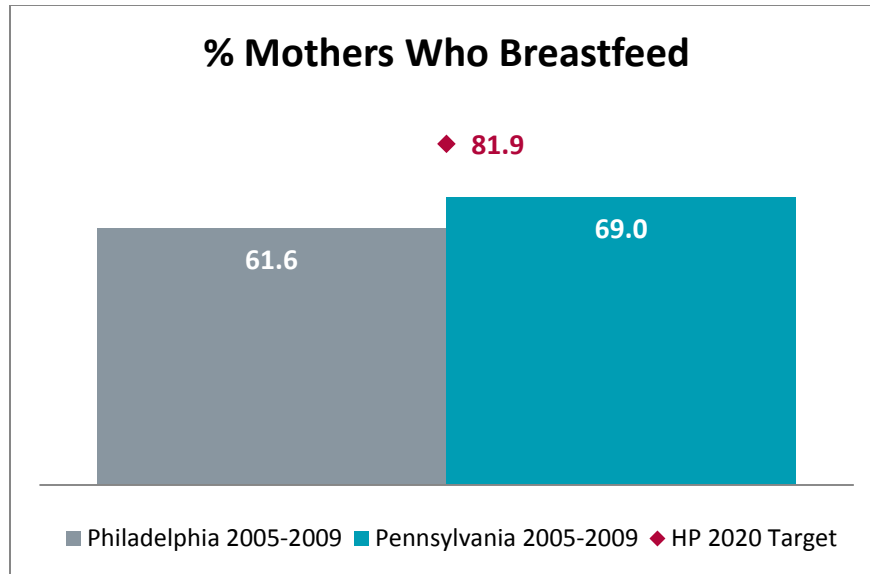
Obesity and Overweight Adults in Philadelphia by Race/Ethnicity

Adults 18+	% Philadelphia	% White non-Hispanic	% Black non-Hispanic	% Hispanic
Obesity	31.8	24.8	41.8	32.4
Overweight	33.4	35.6	32.1	35.2
Overweight or obese	65.2	60.4	73.9	67.6

(PHMC Household Health Survey 2012)



PHMC Household Health Survey 2012



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

- **Increase awareness**
 - The need for health information and screening was identified as a need by focus groups and key informants
 - *We need to communicate that all behaviors related to obesity affect health, diabetes, and cancer. We need a communication strategy with the city. We need to increase awareness about obesity and other behaviors that increase risk for all major disease (key informant).*
 - *Greatest health need is obesity. Nutrition is number one priority, followed by lack of physical activity and the need for support group for adults with chronic disease. We need physical activity programs for adults under age 60 that are affordable. We need chronic disease management education in the community (key informant).*
- **Increase physical activity**
 - *We need to increase physical activity during the school day. We need to work on a policy to require schools to provide a specific, minimum number of minutes of physical activity weekly (key informant).*
 - *The city has done a great job with childhood obesity- need to continue efforts; we need to continue to advocate for a sugar beverage tax and safe green spaces for play. We need more school and community physical activity opportunities for youth (key informant).*
 - Lack of access to affordable recreational facilities particularly for adults.
- **Improve access to healthy, affordable food**
 - The need for affordable healthy grocers/markets was identified as a priority by focus groups and key informants
 - *Lack of access to healthy food options in neighborhoods (focus group)*

- *There are limited health resources and information for non-English speaking populations in the 19125 community including markets with healthy food options (focus group)*
- *Mothers lack access to healthy food, don't know how to cook, physical activity is not part of everyday lives. Don't know what "real food" is. (focus group)*
- **Improve access to weight management programs**
 - Lack of affordable weight management programs
 - Lack of awareness about nutrition programs available in the community
 - Limited recreational facilities in Lower North Philadelphia (focus group)
 - Promote weight loss program the TJU endocrinology offers. They provide 7 group weight loss classes per week. Discounts/free classes are available (3-5 per month out of about 50) (key informant)
- **Continue to promote breastfeeding**
 - *Need huge culture shift to increase breastfeeding particularly among African American women. Poorer women need to see breastfeeding as part of their culture. OB needs to discuss breastfeeding early and often with pregnant women. Lactation support is needed in hospital and in the community. This type of support is spotty for poor women. Philly WIC could do more like in other parts of the country, to promote breastfeeding. Philadelphia had one lactation consultant for 15,000 women. They are now training more. Women at WIC are saying they are using formula just in case breastfeeding problems occur (key informant).*

Recommendations included:

1. **Expand Diabetes Prevention Programs in our CB areas**
2. **Link TJUHs dietitians to community education programs. Promote weight management program offered by TJU endocrinology**
3. **Provide chronic disease management and nutrition programs in community sites**
4. **Continue to support efforts to enhance physical activity opportunities at Mifflin Square Park in South Philadelphia**
5. **Continue to support efforts to change vacant lots into productive land use such as community gardens.**
6. **Promote walking clubs in collaboration with the YMCA**
7. **In collaboration with the Philadelphia Health Initiative (a worksite wellness coalition) promote healthy eating and weight management at worksites. Integrate with *Philly First* (an academic medical center initiative and *Wellness Together*, a family and community health initiative.**
8. **Support PDPH efforts to pass a school policy that requires a specific number of minutes of Physical activity weekly in schools. Work with school Wellness Councils to encourage regular classroom movement breaks and socialized recess.**
9. **In collaboration with PDPH, School Wellness Councils and others, support school food reform through policy and behavioral changes.**
10. **Create a central place to promote nutrition, physical activity, weight management and other wellness programs**
11. **Continue to support the CSA, Winter Harvest and Farmers Market at Jefferson**

12. Collaborate with the Food Trust to promote health screening, education/prevention activities and healthy eating in “Super corner stores”.
13. Continue to pursue *Baby Friendly Hospital* status

Mental Health

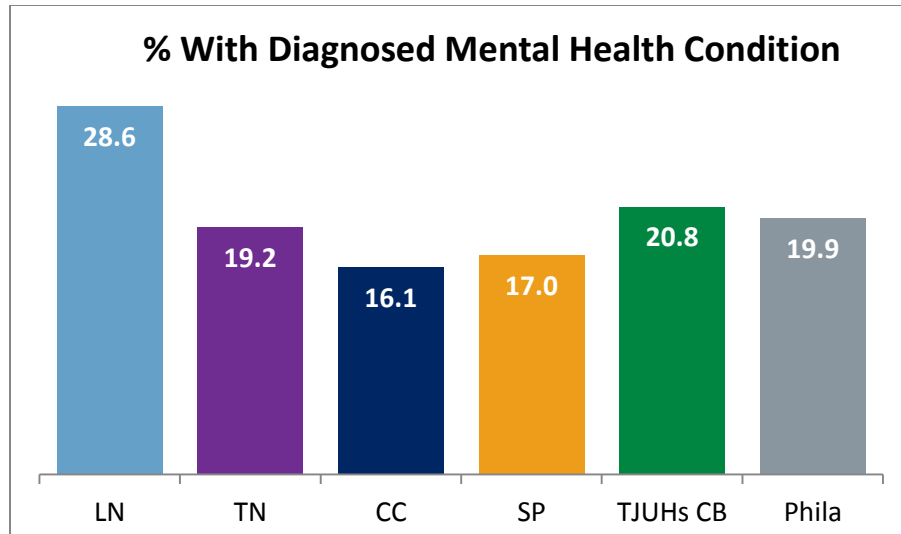
Mental and physical healthcare inter-related. Mental health plays a major role in people’s ability to maintain good physical health. However, mental illness, such as depression and anxiety, can limit the ability to integrate health-promoting behaviors into one’s life. Conversely, physical health issues,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

Just under 20% of all adults in Philadelphia have been diagnosed with a mental health condition. People living below 200% FPL are almost twice as likely to have a mental health condition (27.4%) compared to those who live above 200% of the federal poverty level (14.4%). The rate of people in Jefferson’s CB area that report having been diagnosed with a mental health condition is slightly higher than in Philadelphia. Residents living in Lower North Philadelphia report the highest rates with 28.6% diagnosed with a mental health condition. More than 41.7% of those with a mental health diagnosis in Jefferson’s CB area report they are not receiving treatment for their condition. Compared to Philadelphia, people living in Jefferson’s CB area are slightly more likely to have been told by a doctor or health provider that they have a substance abuse problem (3.5 vs. 3.7%). Adults living in Lower North Philadelphia and Center City report the highest rates of substance abuse (5.2 and 3.8 respectively).

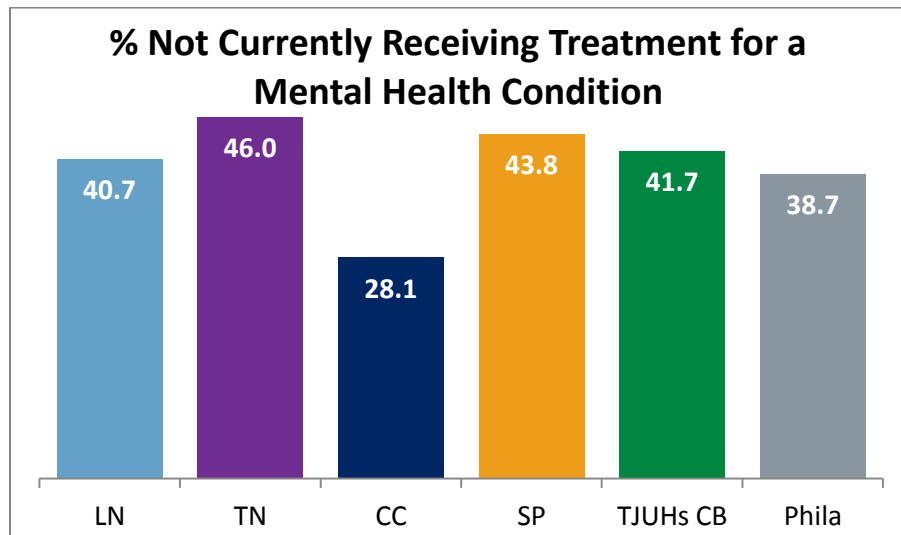
Mental Health issues for Older Adults are discussed in the Special Population section.

Healthy People 2020 objectives related to mental health include:

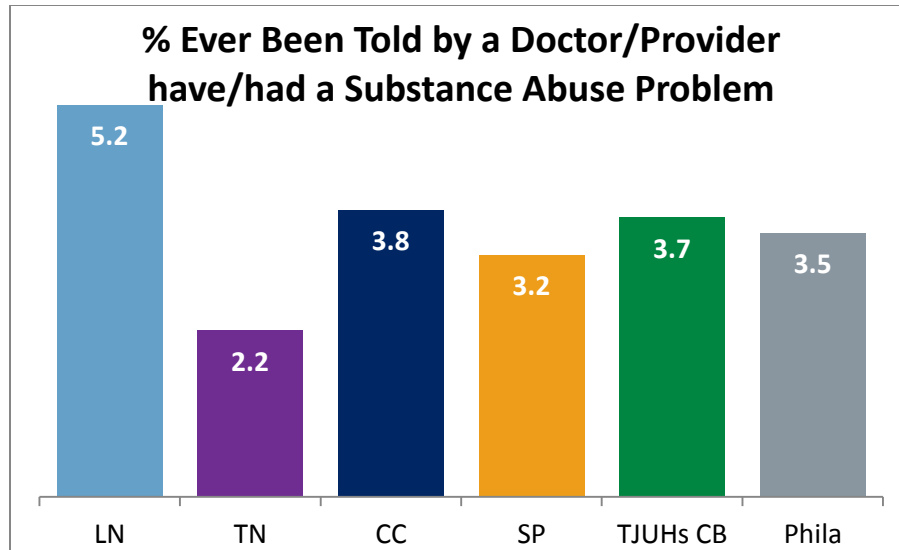
- Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral to 87%.
- Increase the proportion of adults with mental disorders who receive treatment to 64.6 percent.
- Increase the proportion of adults aged 18 years and older with major depressive episodes (MDEs) who receive treatment to 75.1 percent.
- Increase the proportion of primary care physicians who screen adults aged 19 years and older for depression during office visits to 2.4 percent.
- Increase the proportion of homeless adults with mental health problems who receive mental health services to 41 percent.



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

- **Training**
 - Lack of training in Trauma Informed Care. Multiple community based organizations and health care providers feel they would benefit from training in Trauma Informed Care.
 - *There are too many youth of medication for ADHD. We need training on how to deal with children with ADHD. CHOP has been doing some counseling but could do more. Community organizations that serve children (United Communities, Diversified Community Services and SEPC) need training on ADHD and moving off medications, and Oppositional Defiance Disorder (key informant)*
 - *We could benefit from training on how to prevent and diffuse violence among kids in summer camp (key informant)*
 - *Improve parenting skills in dealing with ADHD behaviors. (key informant)*
- **Cultural issues**
 - Multiple cultural issues related to mental health screening, diagnosis and treatment in refugee community
 - *Refugees and immigrants may have cultural issues around medication/therapy for mental health issues. They don't link mental and physical health. For many people, including refugees and immigrants, behavioral health issues are not a priority and may be less valued (key informant)*
- **Insurance**
 - Uninsured face barriers to mental health services. Many do not want to use public services. The Council for Relationships provides mental health care for low income people including the uninsured and underinsured.

- *Many do not have health insurance. The cost for services for those without insurance is prohibitive (key informant)*
- **Transportation**
 - *Cost of transportation and long waits. Paratransit can be unreliable and while it will take physically ill and disabled to appointments, transportation for those with mental health issues is limited. It is often difficult for those who are mentally ill to take a bus. More home-based and community based services are needed (key informant).*
- **Fragmentation**
 - *Fragmentation of care between Mental Health and Medical services*
 - *The system is extraordinarily fragmented. People may have 6 to12 service providers in their lives and none of them meet all their client's needs. There is no coordination (key informant).*
- **Interpretation**
 - *Lack of or unreliability of interpreter services at mental health facilities problematic for refugees*
 - *While clients go to therapy, when interpretation is needed therapy often falls apart*
 - *Interpretation is a major issue. Refugees don't follow through with treatments plans/ medication therapy. Interpreters for mental health issues have been available at TJU/H. However, interpreters can be unreliable; that is, there may not be an interpreter available who knows a needed language or dialect. (key informant)*
- **Community Resources**
 - *Without community and residential resources, people with mental illness are walking around the neighborhoods without anywhere to go for help or services. Mental illness results in homelessness. Since Byberry closed there has been no real place to go for help (focus group)*
 - *Need referral sources for mental health for children and adults*
- **Depression**
 - *Underdiagnoses of depression, particularly in older women, pregnant women and refugees*
 - *Depression among pregnant women is a problem as is bi-polar diagnosis. Access to care for these women is also an issue. It's very difficult for people with behavioral health issues to get regular care. People on SSI (mental health disabled) are less likely to be on treatments or medications. Pregnant women with mental health issues may also have poor housing, children, lack food, etc. No one service provider can care for all their needs. They need in home health therapy since they have barriers to getting to services. Medicaid won't cover all costs. MCC is trying to make in home services cost effective but currently is not economically feasible. There is fragmentation, lack of service coordination and all needed services are not available. (key informant)*
 - *There is no money to get to care/appointments and some (women) have had a negative experience with therapists. The system is extraordinarily fragmented. People may have 6 to12 service providers in their lives and none of them meet all their client's needs. There is no coordination. Everyone recognizes it's a train wreck about to happen and no one can do anything to stop it (key informant).*

Recommendations included:

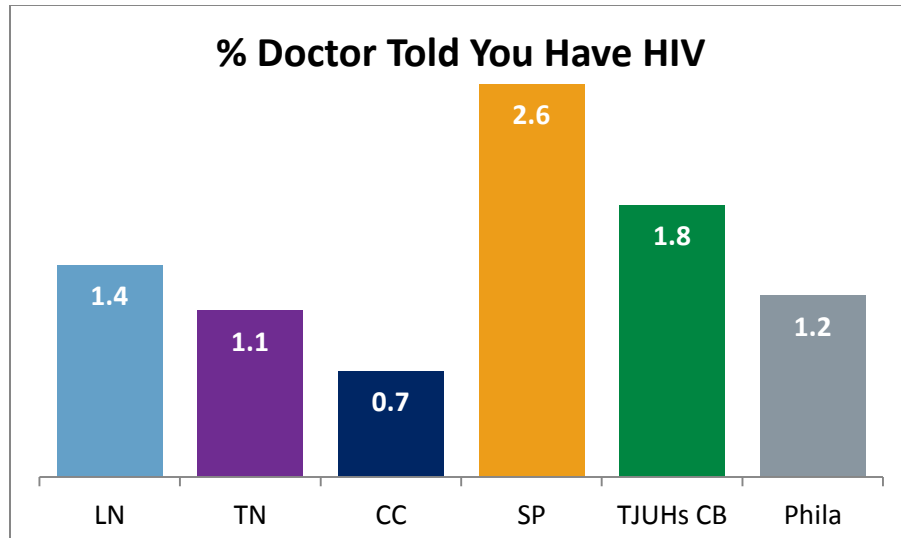
1. **Cultural competence training for mental health and primary care providers**
2. **Increase language access services for non-English speakers**
3. **Mental health services that are community based**
4. **Improve access to transportation**
5. **Coordinate training for community based organizations in *Trauma Informed Care*, working with children with ADHD and managing behavior/anger management of children and adolescents**
6. **Raise awareness of providers about mental health resources**

HIV Status

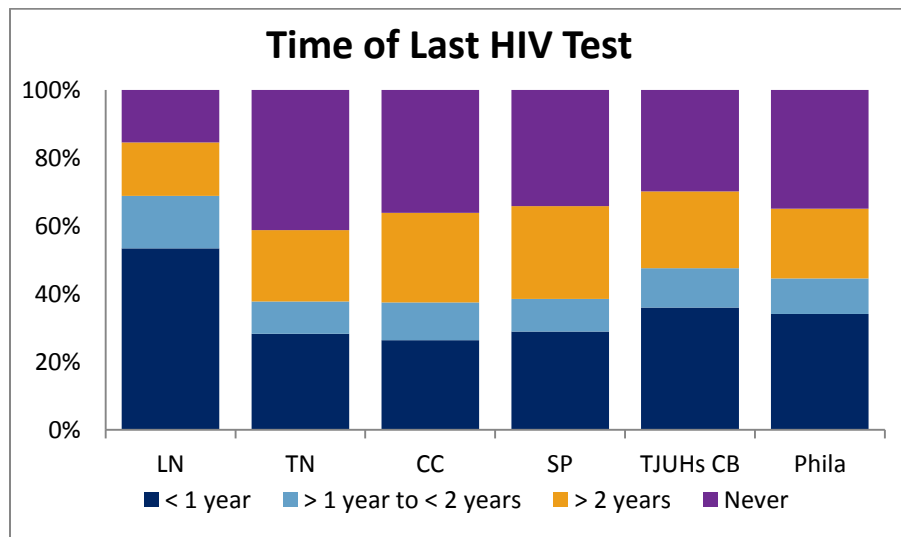
The prevalence rate of HIV in Philadelphia is 45.87 per 100,000 population. There are 16,598 individuals living with HIV in Philadelphia. In Southeastern Pennsylvania people with HIV are more likely to be male (71%) and Black (68%) vs. 23% among Whites and 13% among Hispanics. The most common mode of transmission is 34% heterosexual transmission followed by MSM (33%) and 24% IDU. HIV is twice as likely to be transmitted by MSM among whites compared to Blacks (50% vs. 26%) and among Blacks heterosexual transmission is twice as common compared to Whites (47% vs. 24%)⁵⁷

According to PHMC Household Health Survey 2012 data, residents living in Jefferson's CB areas are more likely to have been tested for HIV (70.2% vs. 65.1%) and slightly more likely to have been diagnosed with HIV than adults in Philadelphia (1.8% vs. 1.2%). Residents in South Philadelphia are twice as likely to have a diagnosis of HIV (2.8%) compared to Philadelphia. Almost 85% of adults in Lower North Philadelphia have been screened for HIV, while just under 59% of adults in Transitional Neighborhoods have been screened. According to data provided by the Office of Addiction Services/Department of Behavioral Health and Intellectual Disability Services (DBHIDS), the planning analysis sections in Philadelphia with the highest rates of people living with HIV are in Center City (19102, 19103, 19106, 19107), Lower North Philadelphia (19121, 19122, 19123, 19130), and Upper North Philadelphia (19132, 19133 and 19140). All but one of these zip codes is in Jefferson's CB area.

TJUH's Emergency Department provides rapid screening tests for HIV.



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Hospital Readmissions

“Teams ... have found that many people with chronic medical conditions struggle with multiple illnesses combined with social complexities — for example, mental health and substance abuse needs, extreme medical frailty, and a host of social needs such as social isolation and homelessness.”
Berwick et al, *Health Affairs* 2008

The Centers for Medicare & Medicaid Services (CMS) defined readmission as an admission to a hospital within 30 days of a discharge from the same or another hospital. Readmissions are prevalent and expensive. Avoidable complications and readmissions due to inadequate care coordination and poor management of care transitions were responsible for \$25 to \$45 billion in wasteful spending in 2011. As of October 2012, the Affordable Care Act requires CMS to decrease payments to hospitals for excess readmissions, providing the policy lever that induces hospitals to act quickly to reduce readmissions. Thousands of hospitals have already faced penalties for high readmissions for pneumonia, heart failure and heart attack, and more of the hospitals that take care of high proportions of poor and underserved patients are being penalized.

Nationally, and in Pennsylvania, the re-hospitalization rate among Medicare beneficiaries within 30 days is 20%, and 50% of the patients readmitted within 30 days were not seen by an outpatient provider prior to readmission⁵⁸ (Jencks et al, *NEJM*, 2009). According to HCIF data for hospitals in SEPA, the region has a higher readmission rate for CHF (29.5%); stroke (20.9 hemorrhagic, 15.7% non-hemorrhagic; chest pain 12.8%) than the Commonwealth of Pennsylvania (27.2; 18.6; 14.7 and 12.1 respectively). These re-hospitalizations are costly and, for the most part, preventable through timely and effective outpatient care and adequate patient disease self-management practices. According to AHRQ’s HCUP project⁵⁹, in 2006 nearly 18% of Medicare admissions were for a condition that could potentially have been prevented. Lastly, the actual average cost for all cardiovascular conditions in SEPA exceeds the state costs (HCIF, 2009). The 30 day readmission rate at Jefferson is 17 percent. As previously stated, health literacy is one factor related to readmission to the hospital within 30 days of discharge.

An important subset of readmissions due to chronic illness affects a particularly vulnerable population struggling with complex medical and psychosocial challenges and may be addressed by improved discharge planning, care coordination, and care management. Care coordination and care management can include components such as patient navigators, care or case managers, community health workers, nurses, social workers, and coaches for target patient groups. Models include design of individualized plans with and for patients in the context of the patients’ assets (social support, existing relationships with providers, etc.). These plans must be dynamic, and the process of care coordination includes feedback loops to respond in an ongoing way to the changing needs of the patient. Coordination can be performed by a person or team with three primary responsibilities: value proposition, service design, and service delivery, requiring skill sets of social workers, nurses, and community health workers, depending on the primary needs of the individual patient.

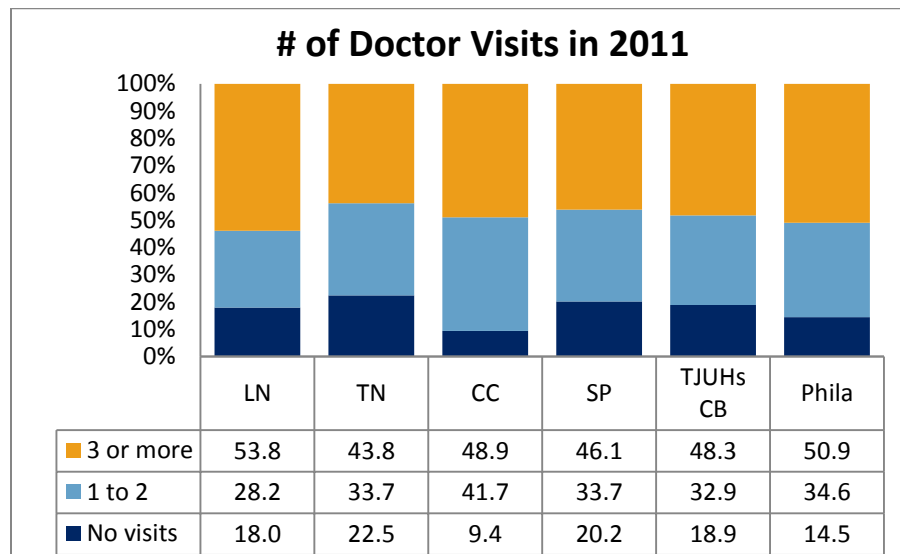
While most patients could benefit from improved discharge planning and care coordination and management, non-English speaking patients, homeless/sheltered patients, the elderly and those with both mental illness and chronic diseases may be most likely to benefit.

Preventive Care and Early Detection of Disease

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

Lack of health insurance and low socio-economic status are factors most related to disparities in cancer incidence and death. The Healthy People 2020 objectives for cancer reflect the importance of promoting evidence-based screening for cervical (PAP), colorectal (fecal occult blood testing, sigmoidoscopy, or colonoscopy) and breast cancer (mammography). These objectives are to:

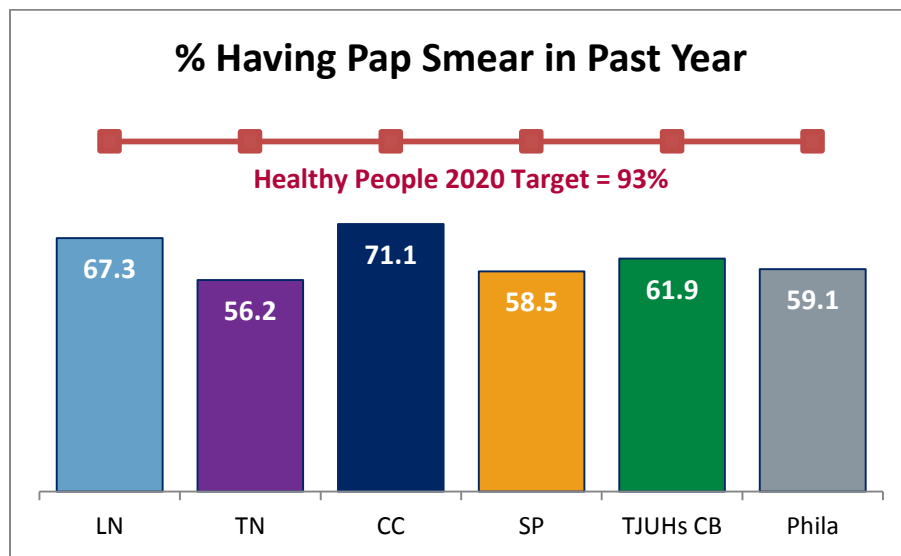
- Increase the proportion of women aged 21-65 who receive a cervical cancer screening based on the most recent most recent guidelines to 93 percent.
- Increase the proportion of adults aged 50-75 who receive a colorectal cancer screening based on the most recent guidelines to 70.5 percent.
- Increase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



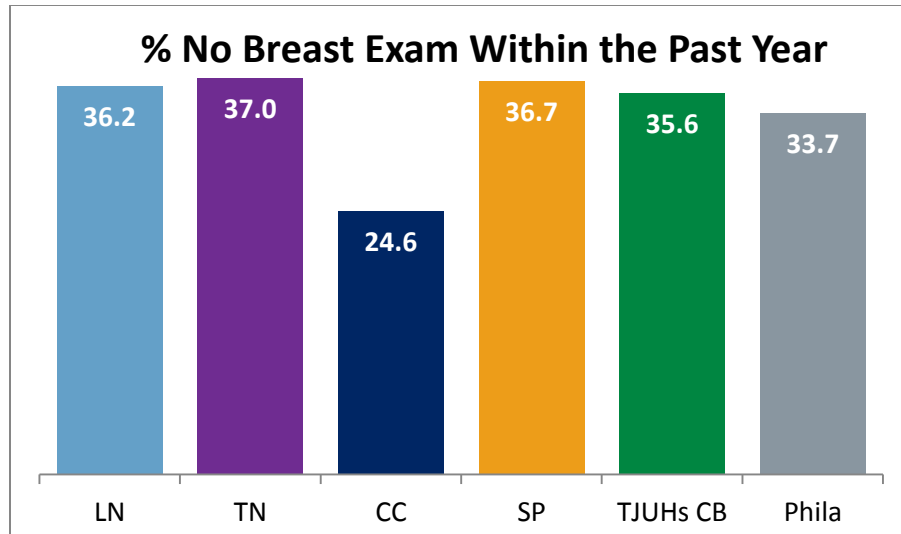
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Compared to Philadelphia, adults in Jefferson’s CB area are less likely to have seen a doctor in the past year (81.1% vs. 85.5%). While residents of Center City were most likely to have seen a doctor in the past year, 20.2% of residents of South Philadelphia and 22.5% of residents in Transitional Neighborhoods did not see their doctor in the past year. Lack of physician counseling and referral is known to negatively impact preventive screen rates.

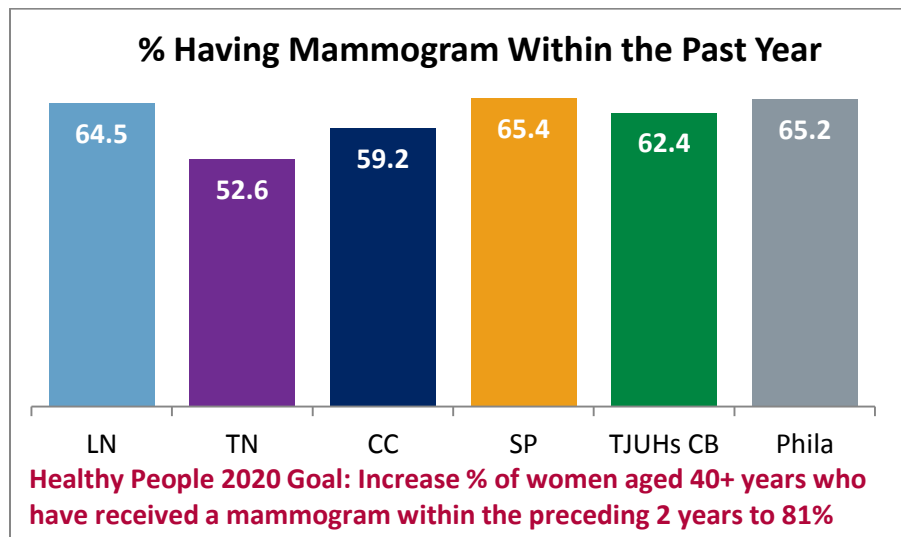
Breast cancer is the second most common type of cancer for women in the United States and accounts for one-third of all cancer deaths in females in Pennsylvania. Jefferson and Methodist Hospitals participate in Pennsylvania’s Healthy Woman Program and Pennsylvania’s Breast Cancer and Cervical Cancer Prevention and Treatment Program. These programs assist un and underinsured women with low incomes to obtain cervical and breast cancer screening and assist women in getting treatment if they are diagnosed with cancer. The percentage of women in Philadelphia and in Jefferson’s CB area who were screened for cervical cancer in the past year was well below the Healthy People 2020 goal of 93%. Women in Jefferson’s CB area are slightly more like to have had a PAP smear in the past year (61.9%) than were women in Philadelphia (59.1%). Women living in Center City were most likely to have been screened for cervical cancer and women in South Philadelphia and Transitional Neighborhoods were least likely to have been screened (58.5% and 56.2% respectively). Compared to women in Philadelphia, women in Jefferson’s CB neighborhoods were less likely to have had a breast exam in the past year, with the exception of Center City. The Healthy People 2020 goal for mammograms in the past 2 years is 81% of women. Both Philadelphia and Jefferson’s community benefit area are close to achieving this goal (80.8% and 79.7% respectively). Women in North Philadelphia exceeded the Healthy People 2020 goal (82.3%) and women in Center City and Transitional neighborhoods had lowest mammography rates (77.6% and 77.4% respectively). Interestingly, White non-Hispanic women were less likely to have had a mammogram in the past two years (77.2%) compared to non-Hispanic Black women (84.5%) and Hispanic women (85.1%). This speaks well for Breast Screening efforts to reach minority women in Philadelphia, but highlights a need to ensure white women also reach the screening goals.



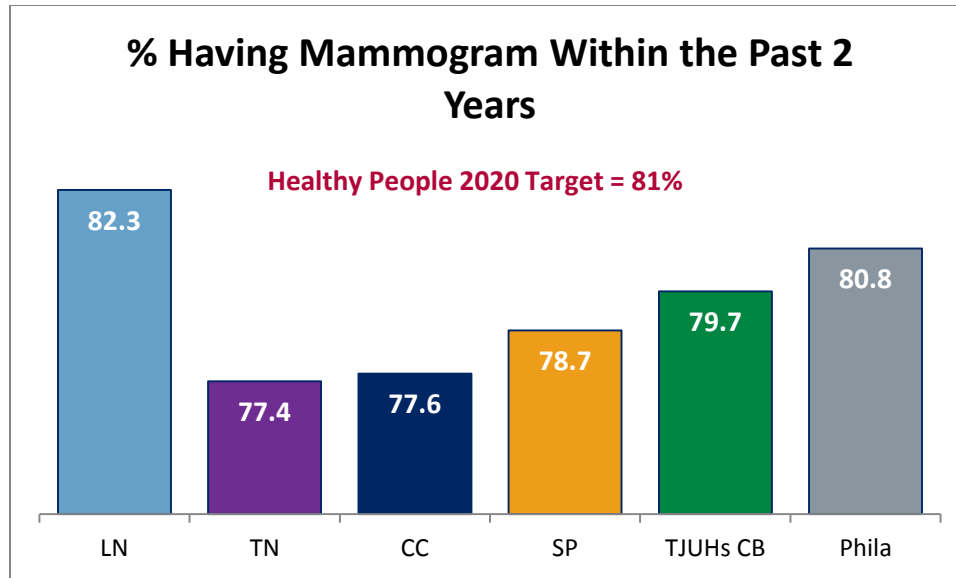
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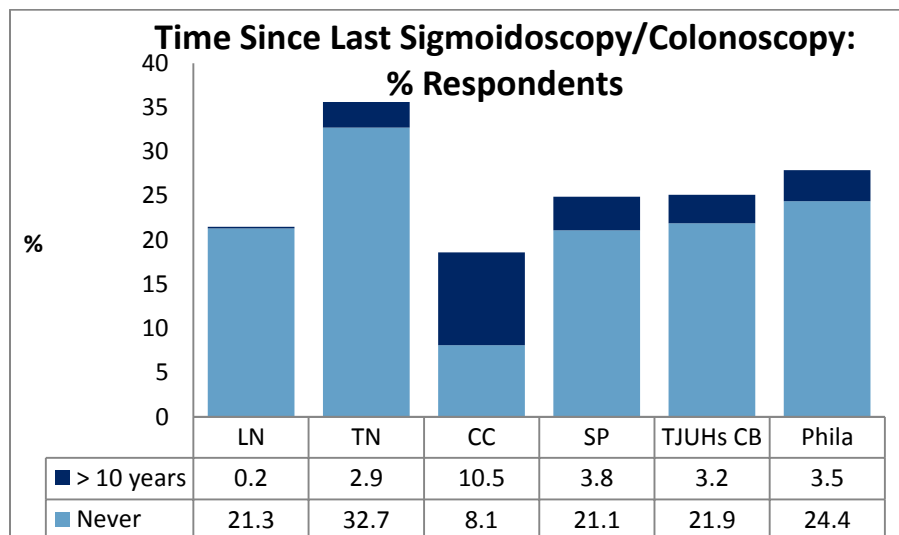


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The Healthy People 2020 target for colon cancer screening is for 70.5% of people aged 50-75 to meet the most recent screening guidelines. Almost 28% of adults aged 50-75 in Philadelphia have never or not had a colonoscopy/sigmoidoscopy in 10 or more years. The rate is similar in Jefferson's CB area (25.2%). Center City residents are most likely to have had colon cancer screening and residents of Transitional Neighborhoods least likely to have had this screening. People living below 200% FPL were more likely not to have had colon cancer screening in 10 or more years compared to those living above this level of poverty (30.9% vs. 25.7%). In addition, non-Hispanic Whites (69.3%) were less likely than non-Hispanic Blacks (75.5%) and Latinos (72.6%) to have had a colonoscopy/sigmoidoscopy in the past 10 years.



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

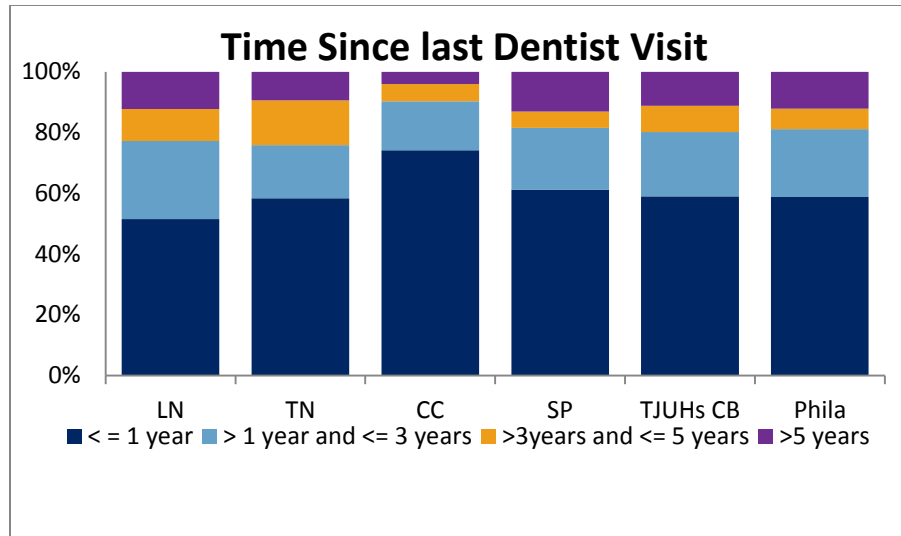
- **Cancer**
 - Need to raise awareness about the link between obesity and cancer (key informant)
 - Need to raise awareness of screening and treatment resources among Jefferson primary care providers and the community (focus group)
 - Need to raise awareness about the cultural barriers to cancer screening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

Recommendations included:

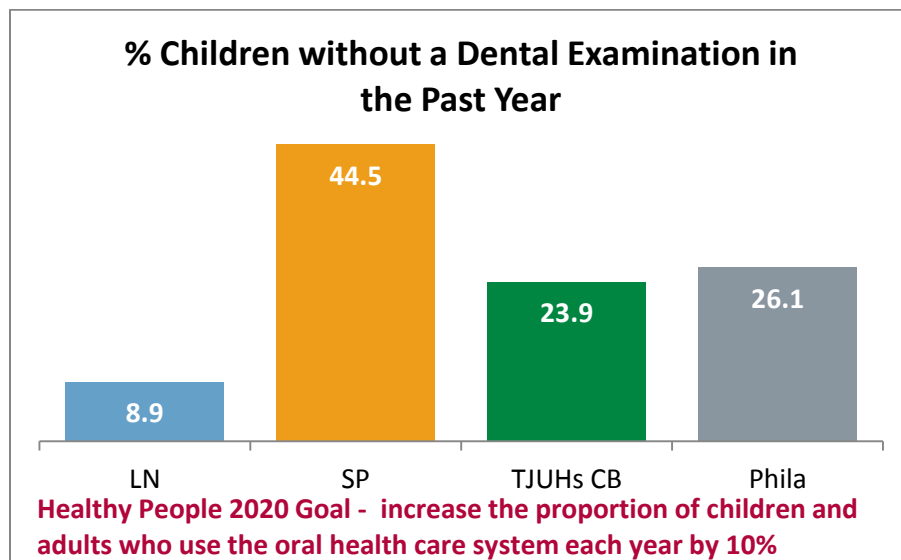
- 1. Encouraging colorectal screening at community venues**
- 2. Utilizing existing screening resources such NBCFF, Komen, Healthy Women 40+ program for breast and cervical cancer screening**
- 3. Raising community and TJUH health care provider awareness about the Pennsylvania Breast and Cervical Cancer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

Dental Care

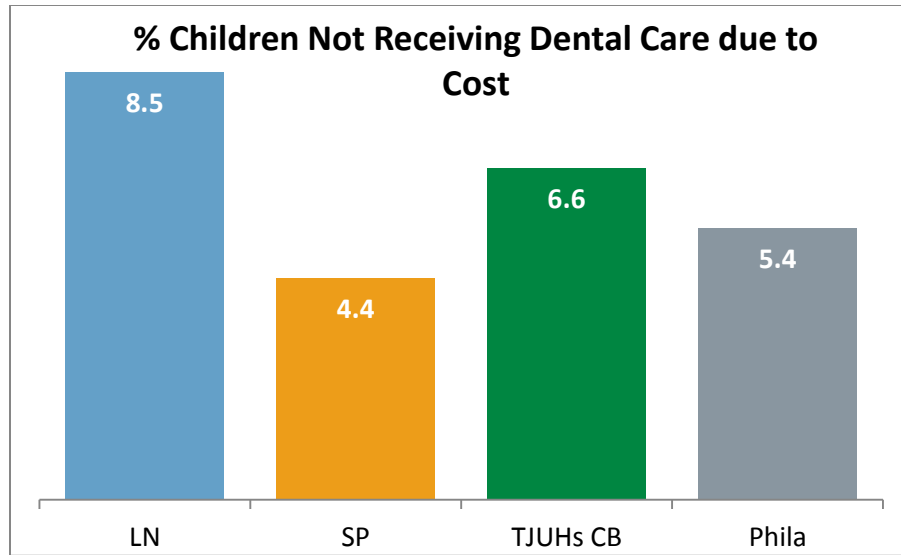
Fifty-eight percent of Philadelphians did not see a dentist in the past year. Almost 1 in 5 adults in Philadelphia (18.8%) and Jefferson's CB area (19.7%) has not seen a dentist in more than 3 years. In 2012, 23.9% of children did not see a dentist in the previous year compared to 26.1% of children in Philadelphia. Children in South Philadelphia were almost twice as likely not to have seen a dentist in the past year as children in Jefferson's CB area. People living below 200% of the poverty level were less likely to have seen a dentist in the past year (49%) compared to those above this poverty level (66.1%) and non-Hispanic Blacks and Hispanics were less likely than non-Hispanic Whites to have seen a dentist (56.3%, 50% and 66.3% respectively).



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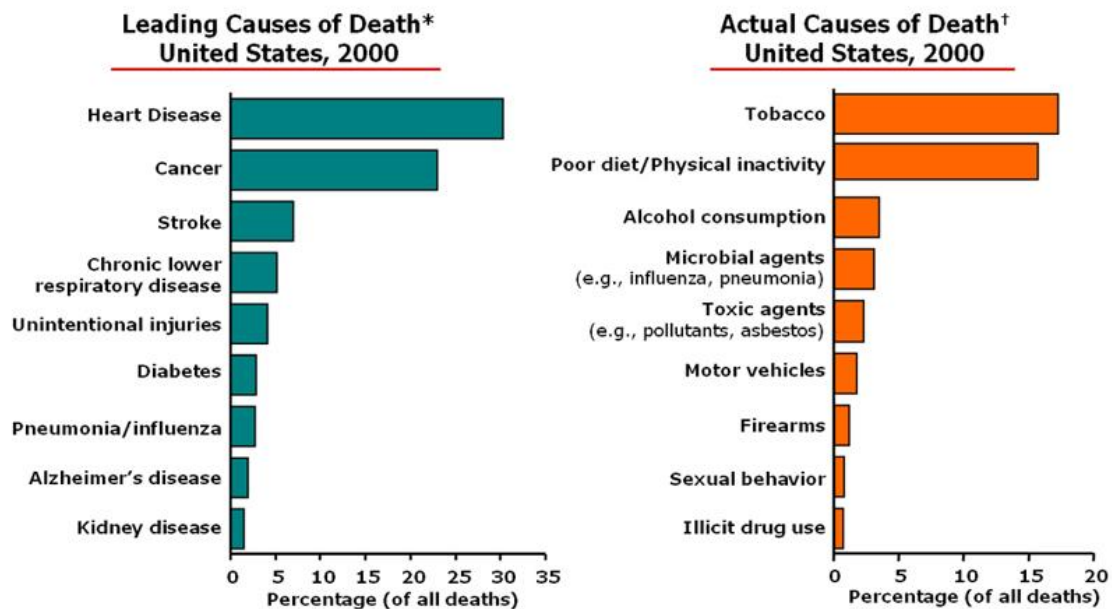
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Health Behaviors

The figure below depicts the leading **reported causes** and **actual causes** of death in the United States at the turn of the century - **tobacco, poor diet, alcohol and lack of physical activity**. Counseling for these health behaviors and policy changes to create a healthier environment and improved access to healthy affordable food are keys to improving health in the United States and Philadelphia.



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

Since 2002, Philadelphia has been steadily working to reduce smoking rates and improve access to healthy affordable foods and safe places for physical activity. The PDPH, Health Promotion Council, Food Trust, School District of Philadelphia and many others have worked to improve school food, create new farmers markets, improve food choices in corner stores and pass legislation, such as the menu labeling act. But much more needs to be done to reduce smoking and obesity rates and their associated diseases in the City. The following describes the current health behaviors of adults and youth in Philadelphia.

Smoking

Tobacco use is the single most preventable cause of death and disease in the United States. Tobacco use costs the U.S. \$193 billion annually in direct medical expenses and lost productivity. More than 23% of Philadelphians smoke – almost twice the Healthy People 2020 target of 12%. However this rate has decreased by 2% since 2002. Nearly 32% of those living below 200% FPL smoke compared to 17% of those living above 200% FPL. Smoking rates are higher among non-Hispanic Blacks (26.7%) and Hispanics (25.1%). Adults living in Jefferson’s CB area are more likely to smoke (27.6%) than Philadelphia with the highest rate of smoking in Lower North Philadelphia (33.4%). Almost 57% of smokers in Philadelphia and Jefferson’s CB area attempted to quit smoking in the past year. Smokers in Transitional Neighborhoods were most likely to try to quit smoking (78.3%) and least likely to attempt quitting in Center City (40.2%). According to one key informant, “*While Medicaid covers smoking cessation classes (no co-pays), this is not true for all private insurers*”. However, there are free smoking cessation resources available at the state (PA QUIT Line and FAX to QUIT programs) and local level (smoking cessation programs are offered by the PDPH). New JCAHO standards require identifying smoking status of patients and helping them develop a plan to quit.

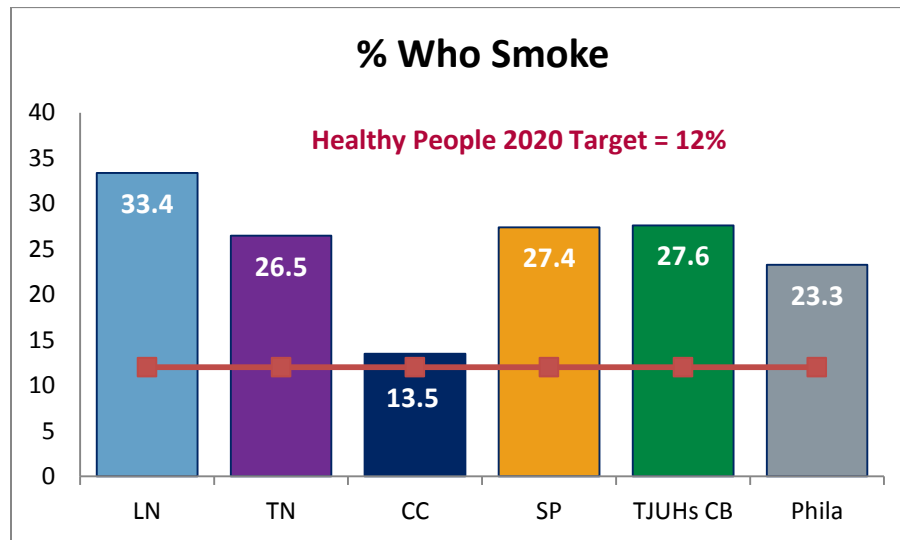
Despite social marketing and legislation attempts to raise awareness about the dangers of second hand smoke, approximately 12% of Philadelphians and those in Jefferson’s CB area do not believe that second hand smoke is harmful. This is particularly true in South Philadelphia where almost 15% of residents believe that second hand smoke is not harmful.

Healthy People 2020 objectives related to smoking cessation include:

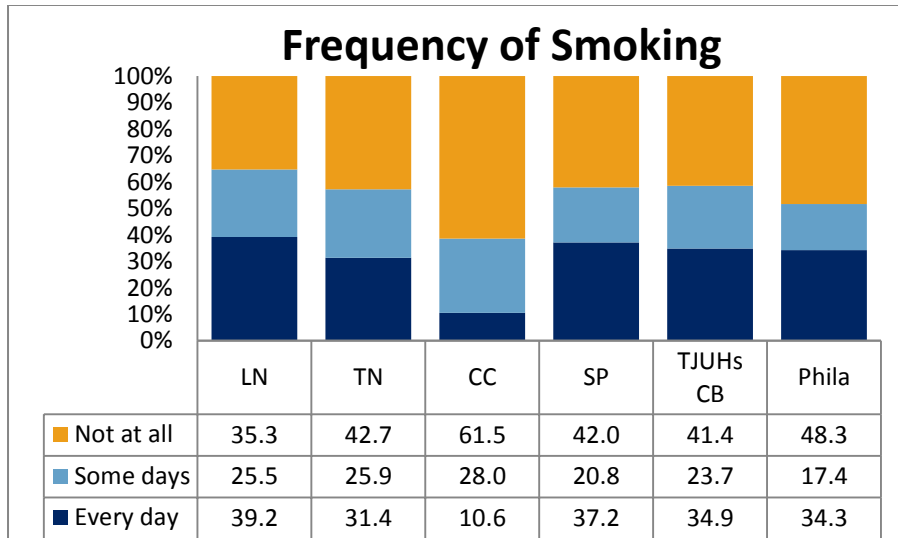
- Reduce cigarette smoking by adults to 12%
- Increase smoking cessation attempts by adults to 80%
- Increase recent smoking cessation success by adult smokers to 6% and adolescent smokers to 64%
- Increase tobacco screening in office-based ambulatory care setting to 68.6%
- Increase tobacco screening in hospital ambulatory care setting to 66.2%
- Increase tobacco cessation counseling in office based ambulatory care settings to 21.1%
- Increase tobacco cessation counseling in hospital ambulatory care settings to 24.9%

*Get Healthy Philly*⁶⁰ is partnering with government agencies, community based organizations, and academic institutions to change policies, systems, and environments that reduce exposure to secondhand smoke, limit access to tobacco products, assist smokers to quit, and change tobacco prices and community norms. Examples of strategies planned by *Get Healthy Philly* to accomplish this include (*Get Healthy Philly Annual Report on Tobacco Policy and Control 2011-2012*)⁶¹:

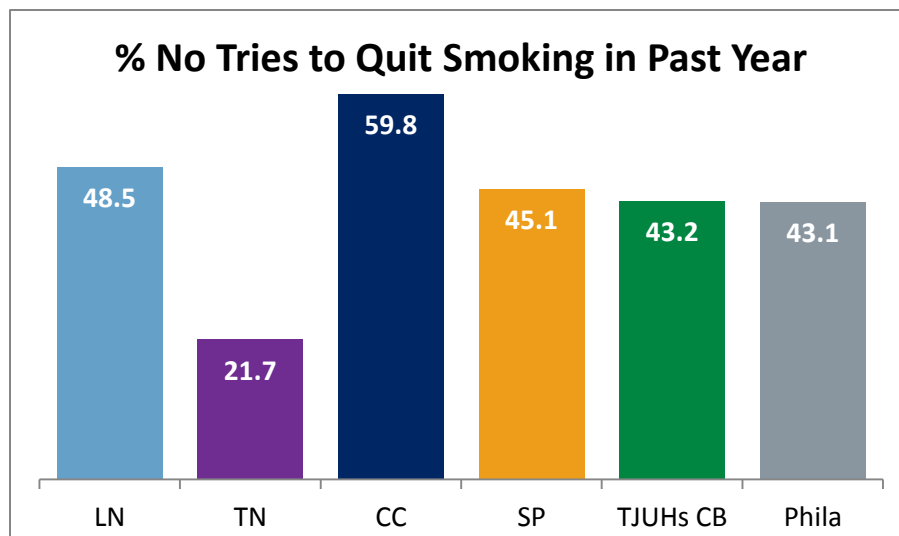
- Implementing and enforcing smoke-free policies in City-owned recreation centers and playgrounds, smoke-free campus policies for colleges, universities and workplaces
- Promoting 100% smoke-free environments in daycare facilities through educating daycare providers about second and third hand smoke and encouraging them to make policy and operational changes in line with smoke-free laws and policies
- Promoting smoke-free homes
- Increasing enforcement of current policies and penalties for retailers who sell tobacco products to minors. Implemented data warehouse to track permits and enforcement efforts
- Promoting Medicaid coverage for quit-smoking medications
- Expanding coverage for quit-smoking medications through employer sponsored insurance
- Providing one month of free nicotine patches and multi-session counseling to 5,000 Philadelphians annually through the PA Free Quitline.
- Multi-media social marketing campaigns
- Implementing a public health program to improve the ability of primary care providers to assist patients in quitting smoking



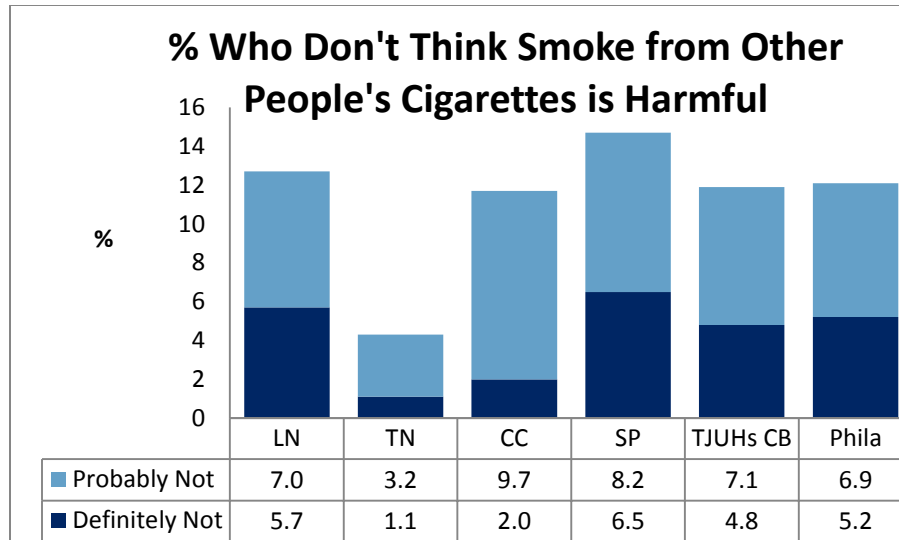
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Recommendations included:

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

Physical Activity

Regular physical activity is important to reducing overweight and obesity rates and has been shown to lower the adults' risk of early death, coronary heart disease, stroke, high blood pressure, Type 2 diabetes, breast and colon cancer, falls and depression. Among youth and adolescents, regular physical activity improves bone health, improves cardiorespiratory and muscular fitness, decreases body fat levels, and helps to reduce symptoms of depression. Even small increases in physical activity have been associated with benefits to health. People who are more physically active are more

likely to have higher education levels, income, self-efficacy, support from others, access to exercise/recreational facilities they find to be satisfactory, and live in neighborhoods that are perceived to be safe. Advancing age, low income, lack of time, lack of motivation, perception of poor health, overweight/obesity and being disabled negatively impact physical activity. Healthy People 2020 supports a multi-disciplined approach to addressing physical inactivity. These approaches include expanding traditional partnerships (schools, health care, recreational organizations such as the YMCA and biking coalitions) to include non-traditional partners such as transportation, zoning, streets departments (sidewalks, street crossings), parks and recreation departments, and city planning. Policies that promote physical activity in schools, workplaces and childcare as well as improvements to the environment that support physical activity are needed (Healthy People 2020). Healthy People 2020 includes the following objectives:

- Increase the proportion of adults who participate in moderate aerobic physical activity for 175 minutes per week to 47.9%
- Increase the proportion of adolescents who meet the current federal guidelines for physical aerobic activity to 20.2%
- Increase the proportion of public and private schools that require daily physical education in elementary schools to 4.2%; in middle schools to 8.6%; and high schools to 2.3%
- Increase the proportion of adolescents who participate in daily school physical education to 36.6%
- Increase the proportion of school districts that require regularly scheduled elementary school recess to 62.8%
- Increase the proportion of youth/adolescents who view television, videos or play video games for no more than 2 hours daily. The target for children age 2-5 is no more than 83.2%; for ages 6-14 to no more than 86.8%; and the proportion of adolescents in grades 9-12 to no more than 73.9%.
- Increase the number of States with licensing regulations for physical activity provided in child care
- Increase the proportion of the Nation's public and private schools that provide access to their physical activity spaces and facilities for all persons outside of normal school hours (that is, before and after the school day, on weekends, and during summer and other vacations)
- Increase the proportion of physician office visits that include counseling or education related to physical activity for children and adults to 8.7%
- Increase legislative policies for the built environment that enhance access to and availability of physical activity opportunities

In Philadelphia 46.5% of adults do not get the recommended daily amount of physical activity. Adults in Lower North Philadelphia are least likely to exercise regularly (3 or more times weekly for at least 30 minutes) and residents of Center City are most likely to meet this goal (68.5%). Thirty-five percent of Philadelphians say they exercise less than once per week compared to 21% of adults in Jefferson's CB areas. Almost 28% of adults in Lower North are physically active less than once weekly, compared to only 7.8% in Center City. This corresponds to the proportion of adults who are comfortable visiting an outdoor space or park during the day and to the percentage who play video games and/or use the computer more than 2 hours daily on average during leisure time. Residents of Center City are more comfortable being in an outdoor space or park during the day than are residents of Lower North Philadelphia (98.6% vs. 58.9%). Adults living in Lower North Philadelphia are more

likely than residents in Jefferson's CB area and Philadelphia to report playing video games for more than 2 hours daily (58.1%, 47.7% and 51.9% respectively) and more likely to use a computer during leisure time for 2 or more hours daily (26.7%, 24.0% and 22.6% respectively).

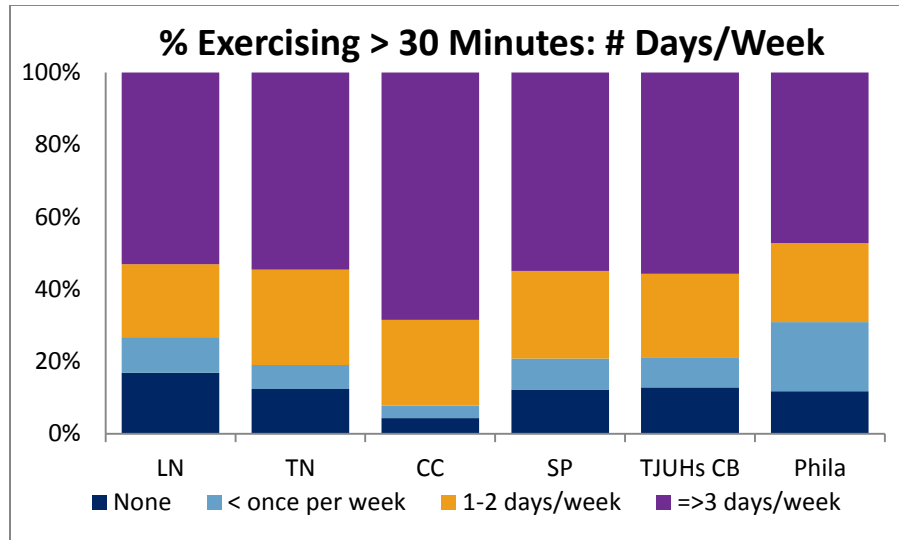
Philadelphia has been strategically working to improve the environment to increase opportunities for safe places for physical activity (See the Social Determinants section on the *Built Environment*). The PDPH, through *Get Healthy Philly*, plans to continue its efforts to enhance opportunities for safe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

- Connecting street and trail networks for walking and biking
- Implementing low-cost safety improvements to high-risk intersections and corridors
- Offering structured, quality physical activity in recreation center after school programs⁶²

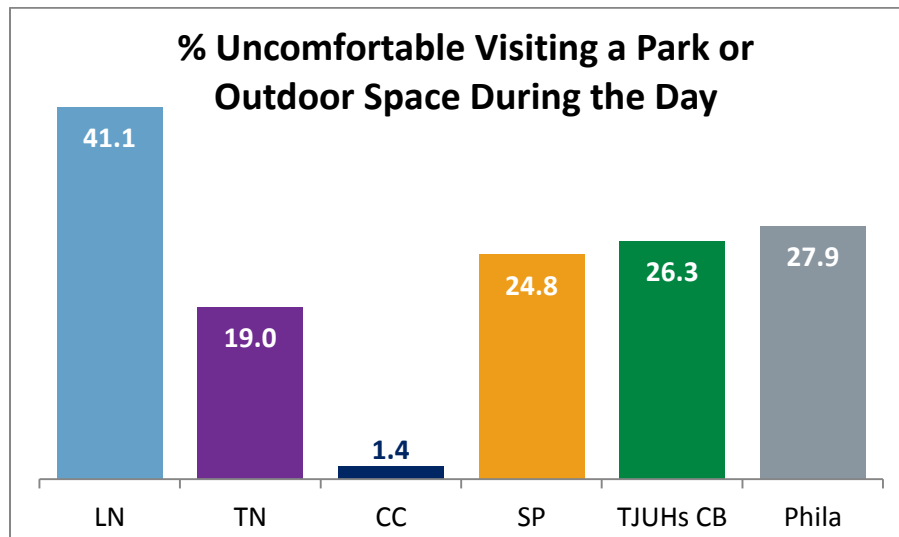
Between 2010 and 2012, 171 schools initiated Wellness Councils to improve school food and opportunities for physical education. Socialized recess and class room movement breaks were implemented in many schools. However, the PDPH plans to scale back involvement in these efforts. This provides an opportunity for TJUH to impact school and community health by becoming involved in Wellness Councils in Jefferson's CB area. In addition, the PDPH will be assessing parks and playgrounds in Philadelphia. This is a substantial undertaking and Jefferson has been asked to assist with this effort.

In addition, Jefferson, through the Philadelphia Urban Food and Fitness Alliance (PUFFA) has been active in helping the community surrounding Mifflin Square Park in South Philadelphia revitalize its park and increase park utilization. While PUFFA has ended, the Friends of Mifflin Square Park is continuing these efforts and provides an opportunity for Jefferson to continue its efforts through this organization.

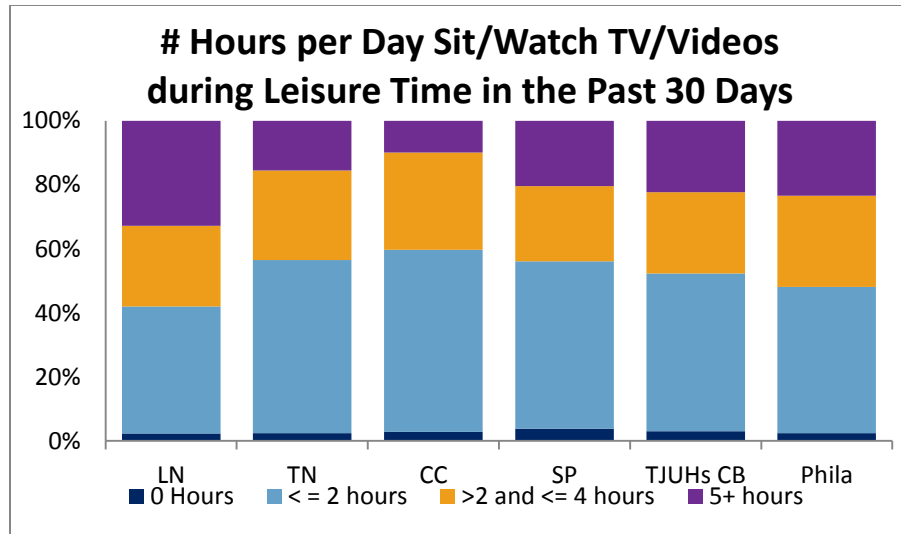
Finally, the city of Philadelphia, colleges and universities, and healthcare institutions are the largest employers in Philadelphia. TJUHs is initiating a worksite wellness program to encourage healthy lifestyles among its more than 15,000 employees, many of whom live in the communities that are part of the Jefferson CB area. The worksite wellness program should address strategies for increasing physical activity among employees. In addition, as an academic medical center, TJUH can influence TJU to initiate similar policies and strategies.



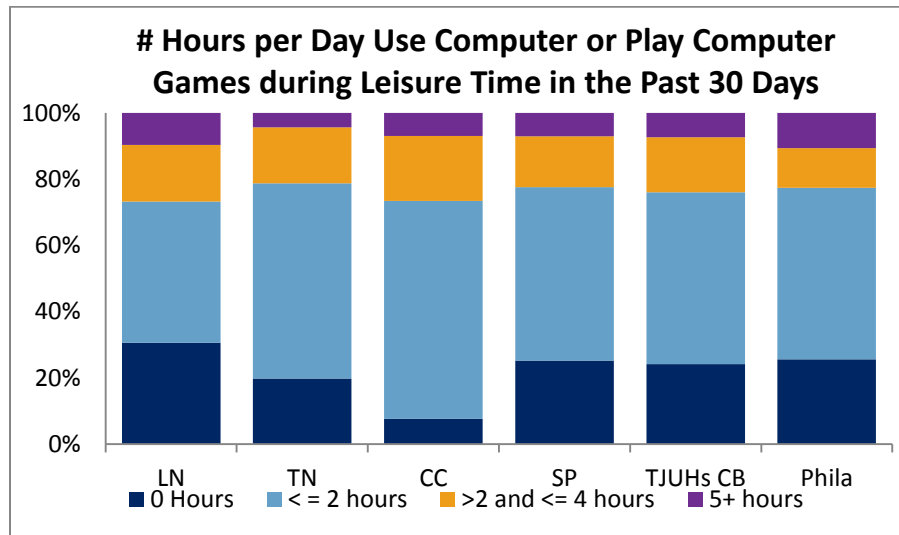
PHMC Household Health Survey 2012



PHMC Household Health Survey 2012



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

- **Lack of fitness facilities** in communities that are safe and affordable
 - *There is not a senior center in the neighborhood – there is no place for older adults to be physically active. They would like a place to go where you can learn to exercise safely (focus group)*

- *In addition, some South Philadelphia youth do not use the YMCA because of safety concerns (walking through certain neighborhoods is perceived as dangerous) (key informant).*
- The morbidity section on obesity also provides key informant and focus group comments about physical activity

Recommendations included:

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

Healthy and Affordable Food

As mentioned previously, obesity is a major cause for concern both nationally and in Philadelphia (see morbidity section on obesity). Among counties containing one of the largest U.S. cities, Philadelphia County has the highest prevalence of obesity, hypertension, and heart disease and the second highest prevalence of diabetes.⁶³ Interventions to address a healthier diet should include improving nutrition knowledge/attitudes and skills of individuals, and increasing access to healthy and affordable food through systems and policy changes and access to food assistance programs. For example, retail venues that sell healthier food can impact diet and nutrition. Low income communities may have less access to healthier food choices. Marketing also has a major influence on people's food choices (Healthy People 2020)

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

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

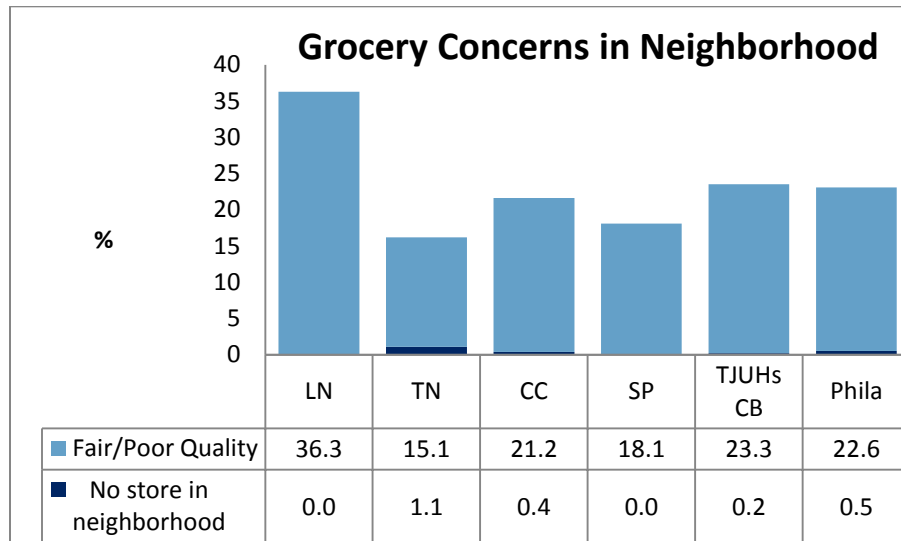
Since 2004, Philadelphia has been strategically addressing healthier dietary choices through nutrition education and access to healthy, affordable food. Led by the PDPH (*Get Healthy Philly*), School district of Philadelphia, Food Trust, Health Promotion Council and the Philadelphia Urban Food and Fitness Alliance (PUFFA), these efforts eliminated sugar beverages in schools, mandated nutrition education in schools, initiated Farm to School programs to increase fresh fruits and vegetables in school lunch programs, created a Healthy Corner Store initiative, increased the number of supermarkets in low income communities, increased the number of farmers markets in low income communities, involved youth in improving school food, revised twenty day cycle menus with recipes that meet USDA Nutrition guidelines for pre-plate and full service programs, expanded the USDA Meal program in recreation center afterschool programs, encouraged schools to remove junk food from classrooms and school fundraisers, incentivized SNAP (food stamps) in the Philly Bucks program, and implemented social marketing campaigns to change community norms about sugary drink consumption. Due to the efforts of the Food Trust and PDPH, Philadelphia now boasts the largest network of Healthy corner Stores in the U.S. and 10 new farmers markets have been created in low income communities (including several in Jefferson’s CB areas). The largest improvements in walkability to healthy food in high poverty neighborhoods (availability of healthy food within 0.5 miles) occurred in Lower North, Upper North and South Philadelphia Planning Districts.⁶⁴ In addition, some schools are interested creating school gardens and garden clubs⁶².

Get Healthy Philly plans to scale back its efforts for School Wellness Councils, breastfeeding promotion in workplaces and its sugary drinks media campaign. However, *Get Healthy Philly* will continue its efforts and partnerships to promote healthy eating in the following ways⁶²

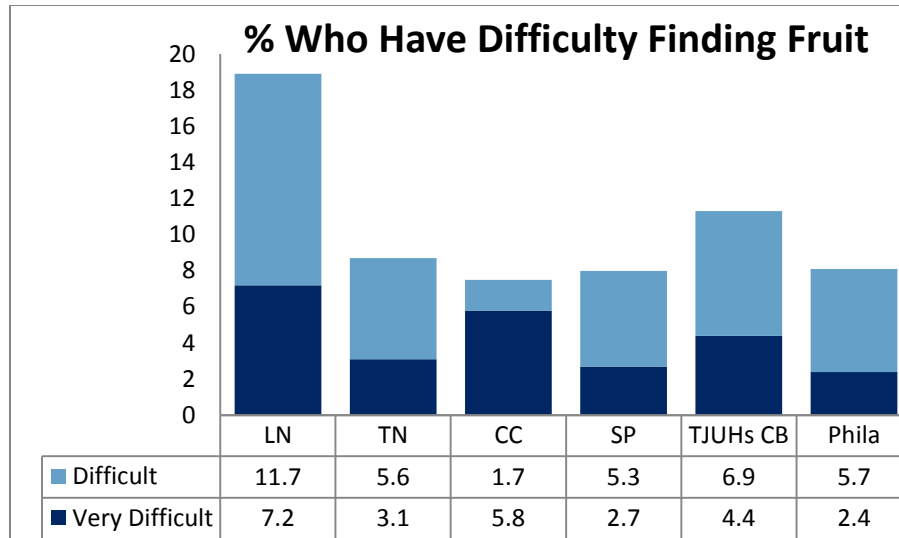
- Incentivizing healthy food sales through zoning and planning
- Offering free/low cost breakfast through breakfast carts in schools
- Offering the USDA meal program in recreation centers
- Implementing food and fitness standards in afterschool programs
- Encouraging healthier food and beverage vending options in work place settings
- Enforcing the menu labeling law
- Maintaining support for the Healthy Corner Store Initiative
- Promoting breastfeeding in birthing hospitals
- Continuing the Philly Bucks program in 10 low income communities
- Continuing to improve the nutritional quality and taste of school food
- Reducing sodium content of foods sold in 200 Chinese take-out restaurants
- Implementing a certification program for corner stores to incentivize healthier food choices and decrease promotion and availability of sugary drinks, junk food and tobacco.
- Develop a Healthy Supermarket to incentivize healthier food choices and decrease promotion and availability of sugary drinks, junk food and tobacco

TJUHs have also been active in improving access to healthy, affordable food. Jefferson initiated a Farmers Market on its campus, initiated a CSA for employees, is a Winter Harvest site, and has increased locally grown fruits and vegetables at the Atrium through a partnership with the Common Market’s Farm to Institution program. In addition, an educational program is being piloted to increase healthier food choices at vending machines on campus. The Food Trust has asked TJUHs Center for Urban Health to provide screening and health education at 6 of their “Super” Healthy Corner Stores that receive conversions.

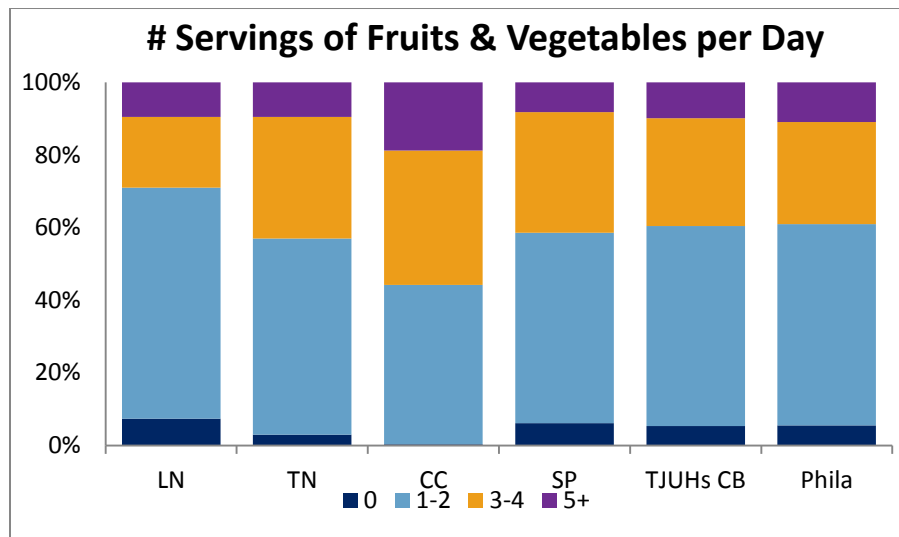
PHMC Household Health Survey 2012 findings demonstrate that progress has been made in improving access to healthy affordable food; however, the quality of food is still a concern in some neighborhoods in Jefferson’s CB area, particularly in Lower North Philadelphia where 36.3% of adults report fair or poor food quality. With the exception of Lower North Philadelphia, residents in Jefferson’s CB areas report similar rates to the rest of Philadelphia in terms of difficulty finding fruit in their neighborhood (7.5% to 8.1% say fruit is difficult or very difficult to find). In Lower North Philadelphia 18.9% of residents report finding fruit in their neighborhood is difficult or very difficult. These factors may be associated with lower consumption of fruits and vegetables among residents in Lower North Philadelphia. Seventy-one percent of people living in Lower North Philadelphia say they eat less than 3 servings of fruit and vegetables daily compared to 58% of South Philadelphia residents, 57% of Transitional Neighborhood residents, and 44% of Center city residents. Residents of Center City are almost twice as likely to eat 5 or more servings of fruits and vegetable daily compared to Jefferson CB area as a whole (19% vs. 10%).



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Philadelphia has tried, but failed to pass legislation to tax beverages with added sugar. The Philadelphia branch of the American Heart Association support passage of this legislation as do many others. In Philadelphia 20.7% of adults report having one or more sodas daily and 35.4% have soda and/or juice one or more times daily. In Jefferson’s CB area 19.4% report drinking 1 or more sodas daily. While only 8.7% of adult residents in Center City drink soda daily, 25.1% of Lower North Philadelphia and 19.3% of South Philadelphia adults are daily soda drinkers. The rate for adults who have soda and/or juice more than one time daily is 34.3%, slightly less than in Philadelphia. The range of daily soda and/or juice drinkers is 15.9% in Center City to 35.6% in South Philadelphia and

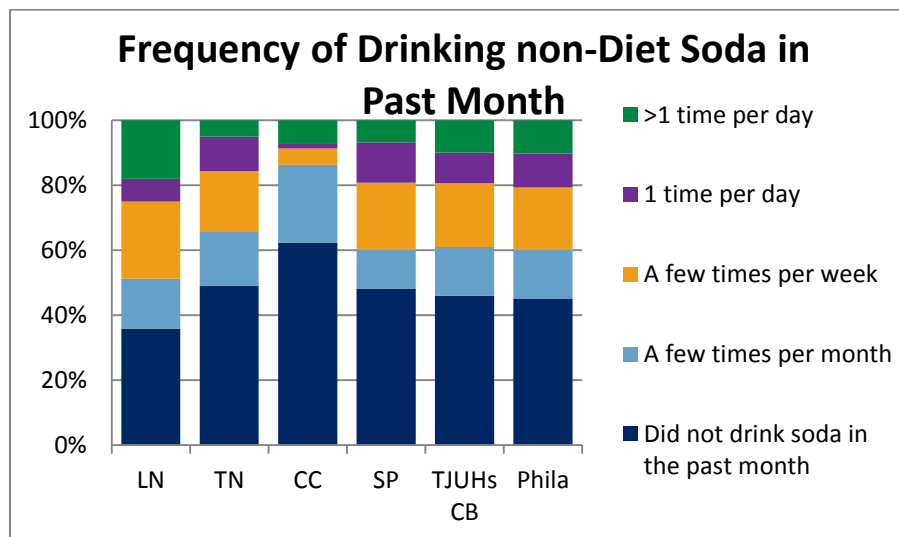
45.3% in Lower North Philadelphia. Adults in Lower North Philadelphia are also more likely to eat food from a fast food restaurant compared to adults in Philadelphia and Jefferson’s CB area. More than 12% of adults in Lower North Philadelphia ate fast food 3 or more times in the previous week compared to 7.9% in Jefferson’s CB area and 8.7% in Philadelphia. Finally, adults in Jefferson’s CB area are more likely to make lower calorie choices due to menu labeling than are Philadelphians (48.35 vs. 38%). However, this is mainly due to Center city and South Philadelphia residents who report menu labeling influenced them to make lower calorie choices (73.3% and 59.9% respectively). Lower North Philadelphia residents were least likely to be influenced by menu labeling (36.6%). Using menu labeling to choose lower calorie foods was less common among people whose income is less than 200% FPL compared to those with income levels greater than this level (31.8% vs. 43.6%). These findings support the higher obesity rates found among Lower North Philadelphia adults.

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

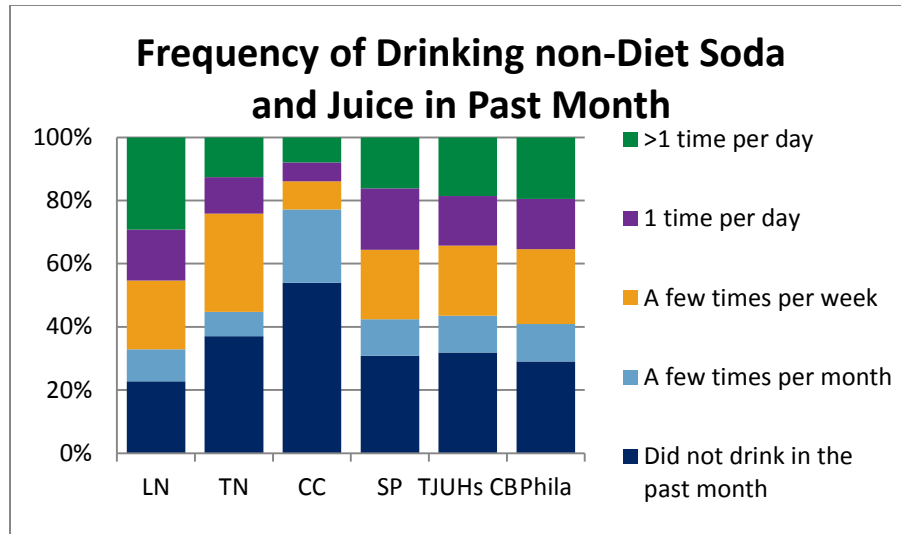
Healthy Eating Behaviors by Poverty and Race/Ethnicity in Philadelphia

	< 200% FPL	> 200% FPL	% White non-Hispanic	% Black non-Hispanic	% Hispanic
Ate less than 3 servings of fruit/vegetables daily in past week	68.5	55.4	51.9	68.4	68.0
Difficult/very difficult to find fruit in neighborhood	12.8	6.8	4.9	11.7	13.6
Had soda and/or juice daily	43.3	29.7	27.8	41.3	45.4

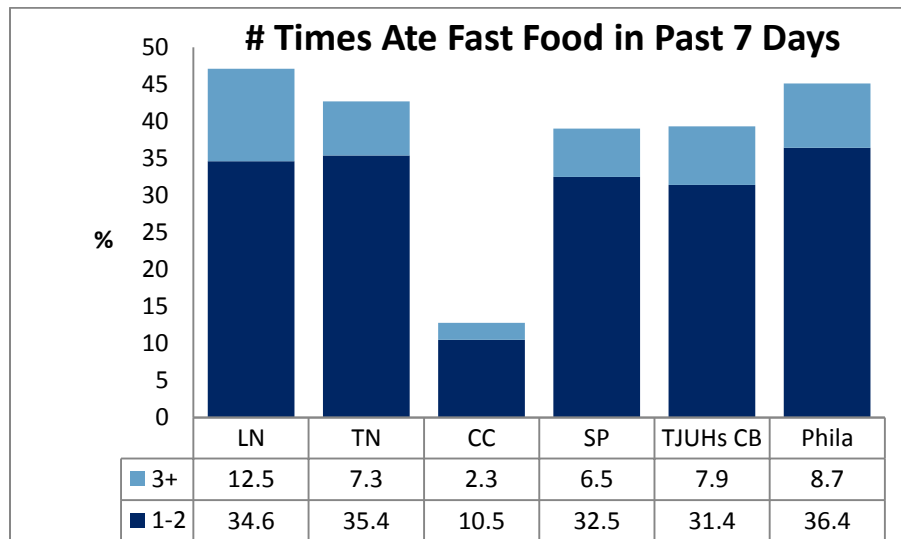
PHMC Household Health Survey 2012



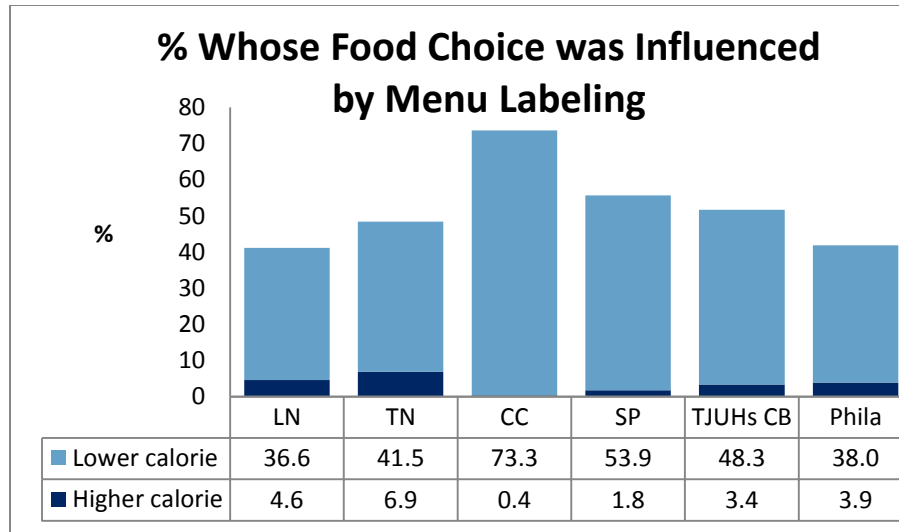
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Issues, challenges, unmet needs and priorities identified by key informants and focus group participants related to healthy eating included:

- **Nutrition education**
 - Philadelphia has done a great job with childhood obesity- we need to continue efforts (Key informant interview)
 - Need to learn to prepare healthy food and shop economically(Key informant)
 - Prevention is a difficult concept for folks...motivating people is really difficult (key informant).
 - Provide healthy eating initiatives (taste testing and nutrition education). Provide healthy meal options in cafeterias and at meetings.(focus group)
 - Some people don't know how to cook healthy foods (focus group)
 - There is a farmers market at the prison (19th and Parish). This is a good place to do programs and screening (focus group)
- **Advocating for a sugar beverage tax legislation**
- **Increasing access to healthy, affordable food**
 - We need affordable healthy grocers, markets and nutrition education, The only supermarket is Whole foods which is expensive. There is nothing within walking distance particularly for people on a fixed income. (focus group)
 - Start more gardens (focus group)
 - Fried rice costs less than fruit and eggs (focus group)
 - It's cheaper to buy oodles of noodles and eat for four days than to buy vegetables (focus group)
 - Some people don't have gas and can't shop (focus group)
 - The morbidity section on obesity also provides key informant and focus group comments about healthy eating

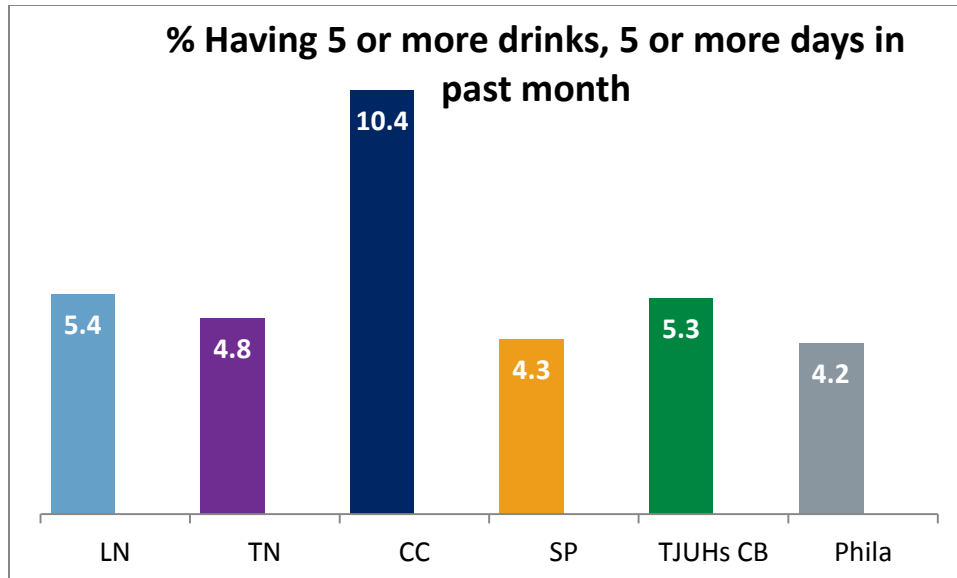
Recommendations included:

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

Alcohol and other Substance Abuse

Almost 95 percent of people with substance use problems are considered unaware of their problem and as a result many do not seek care. Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse significantly contribute to costly social, physical, mental, and public health problems including teenage pregnancy, HIV/AIDS, other sexually transmitted diseases, domestic violence, child abuse, motor vehicle crashes, physical fights, crime, homicide and suicide (Healthy People 2020). Binge drinking is particularly problematic. The Healthy People 2020 objective for binge drinking is to reduce the proportion of adults aged 18+ who engaged in binge drinking in the past 30 days to 24.4%. For adolescents age 12 to 17 the Healthy People goal is to reduce the proportion of students who report using alcohol or any illicit drug in the past 30 days to 16.6%. According to the 2011 YRBS for Philadelphia, 32% of Philadelphia adolescents reported using alcohol in the past 30 days and 15% reported binge drinking. Healthy People 2020 also desires to increase the number of Level I and Level II trauma centers and primary care settings that implement evidence-based alcohol Screening and Brief Intervention.

In Philadelphia, 16.2% of adults had 5 or more drinks on at least one occasion in the past month. In Jefferson's CB area the binge drinking rate is 22 percent. The Transitional Neighborhoods have the highest binge drinking rate (25.3%) followed by Center City (23.9%), South Philadelphia (21.6%) and Lower North Philadelphia (20.2%).



PHMC Household Health Survey 2012

Issues, challenges, unmet needs and priorities identified by key informants and focus group participants related to alcohol and other substance use included:

- **Need to address alcohol and marijuana use** among youth (key informants and focus groups)
 - There are “bars and churches on every corner” (key informant)
 - *Young adults are using and selling drugs on corners – even across from Methodist* (focus group)
- **Mental health issues** such chronic stress, anxiety and depression can lead to addictions
- **Violence and crime**
 - *I am concerned about my male family members because when you live someplace where selling drugs is so normal people assume if they see money exchanged then a drug deal is going down. A cop saw me giving money to my nephew and assumed that because I had a prescription drug that she was selling (she was actually giving her nephew money for gas). People call her for prescriptions for pain and say they can't come in. Are they addicted or selling drugs? Percocet is sold on the street. Percocet combined with Zanax makes you high.* (focus group)
 - *In Point Breeze-Grays Ferry seniors living in senior housing and who use the garden are selling drugs...There is a drug house across from the Houston Center near the community garden, there was a shooting there at 3pm. Police don't do anything. Philly Rising is working on violence by addressing substance use among ages 12 and older.* (key informant)
 - *People drink in the park and leave their bottles on the ground. Thanks to the Friends of the Park group, police are patrolling regularly now and it has gotten better* (key informant).
- **Screening for alcohol abuse**
 - *There is evidence that alcohol use is not screened for upon discharge and may be partially responsible for readmissions to the hospital* (key informant).

- **City-wide database to monitor ED patients who frequently ask for pain killers and other drugs**
 - There currently is no way to track patients who frequent EDs for pain killers and other drugs. A city-wide data base would enable better control of these substances

Recommendations included:

- 1. Greater law enforcement for drug dealers**
- 2. Partner with the Safe Schools Coalition in South Philadelphia (Philly Rising) that is addressing alcohol and marijuana use in adolescents**
- 3. Increase access to constructive activities for youth and adolescents**
- 4. Implement evidence-based alcohol Screening and Brief Intervention at TJUHs**
- 5. Create a city-wide database to monitor drug requests of patients for painkillers and other drugs**

Health Behaviors and Adolescents

The information provided in this section is based on the School District of Philadelphia Action Plan v1.0 dated January 7, 2013²⁶ and the 2011 Youth Behavior Risk Survey (YBRS)⁶⁵. This data is being used because it is self-reported by youth, not their parents and is therefore more likely to represent actual behaviors of adolescents in Philadelphia.

According to DR. William Hite, Jr., the new Superintendent of the School District of Philadelphia (SDP), the SDP is establishing an Office of Strategic Partnerships to cultivate and sustain partnerships with the broader community. In the Action Plan, DR. Hite writes:

The city of Philadelphia is replete with generous people who are passionate about improving the quality of schools, and who have continuously supported public schools. In an age of fiscal austerity, it is even more important to take full advantage of and align the resources made available from philanthropists, businesses, non---profits, higher education, and elsewhere.

The School District of Philadelphia currently has 149, 535 students enrolled in 242 schools; 82% are economically disadvantaged; and the racial/ethnic make-up is African American (54.5%), Asian Pacific Islander (7.8%), Caucasian (14.3%), Hispanic (18.6%), and Multiracial (4.5%). According to the SDP, there are 35, 870 (21%) students with asthma; 2,363 (1.5%) with birth defects; 2,774 (1.7%) with cardiovascular conditions; 2,107 (1.4%) with neurological and seizure disorders; 439 students with Type I Diabetes and 160 students with Type II Diabetes.

The leading causes of illness and death among adolescents and young adults are largely preventable. During adolescence behavioral patterns are established that can affect their current health status and

impact their risk for developing chronic diseases in adulthood. Social and environmental factors such as family, friends, school, neighborhood, and social norms can support or challenge adolescent's health and well-being. Addressing the positive development of young people facilitates their adoption of healthy behaviors and helps to ensure a healthy and productive future adult population.

Healthy People 2020 objectives for adolescents include:

- Increase the proportion of adolescents who have had a wellness checkup in the past 12 months to 75.6%
- Increase the proportion of adolescents who participate in extracurricular and/or out-of-school activities to 90.6%
- Increase the proportion of students who graduate with a regular diploma 4 years after starting 9th grade to 82.4%
- Decrease school absenteeism among adolescents due to illness or injury by 10%
- Reduce the proportion of students who report using alcohol or any illicit drug in the past 30 days to 16.6%.
- Reduce the proportion of adolescents who have been offered, sold, or given an illegal drug on school property to 20.4%
- (Developmental) Increase the proportion of middle and high schools that prohibit harassment based on a student's sexual orientation or gender identity
- (Developmental) Reduce the proportion of counties and cities reporting youth gang activity
- Reduce the percent of adolescents aged 12 to 19 years who are considered obese to 16.1%
- Increase fruit and vegetable consumption
- Reduce the percent of adolescents in grades 9 through 12 who smoked cigarettes in the past 30 days to 16%
- Increase the percent of adolescents who meet the current physical activity guidelines for aerobic physical activity to 20.2%
- Increase the percent of adolescents in grades 9 through 12 who viewed television, videos, or played video games for no more than 2 hours a day to 73.9%
- Increase the percent of adolescents in grades 9 through 12 who used a computer or played computer games outside of school (for non-school work) for no more than 2 hours a day to 82.6%
- Reduce the percent of students in grades 9 through 12 who reported that they engaged in physical fighting in the previous 12 months to 28.4%
- Reduce the percent of students in grades 9 through 12 who reported that they were bullied on school property in the previous 12 months to 17.9%
- Reduce the percent of students in grades 9 through 12 who reported that they carried weapons on school property during the past 30 days to 4.6%
- Increase the percent of motor vehicle drivers and right-front seat passengers that used safety belts to 92%

The Youth Risk Behavior Survey (YRBS) was administered in spring 2011 to approximately 1,539 high school students from 29 randomly selected public schools in Philadelphia. Ninety four percent of the randomly selected high schools and 78% of the randomly selected students in grades 9 to 12

voluntarily agreed to participate in the survey, allowing data to be weighted such that it is representative of all 9th – 12th grade students throughout the School District of Philadelphia.

The prevalence of health risk behaviors self-reported by Philadelphia high school students during the 2011 administration of the YRBS are summarized below. Behaviors that have met the HP2020 objectives are bolded:

Tobacco Use

- **10% of students report being current smokers**, down from a high of 35% in 1999.
- 3% of students report smoking 10 or more cigarettes per day
- 10% of students report initiation of smoking before age 13
- 45% of students report lifetime smoking, down from 76% in 1991

Alcohol Use

- 32% of students reported alcohol use within the last 30 days
- 15% reported binge drinking
- 64% reported lifetime alcohol use

Use of other drugs

- 21% of students report current marijuana use
- Use of heroin (3%). Methamphetamines (3%), ecstasy (4%), cocaine (3%) and use of steroids without prescription (4%) remains infrequent
- 26% of students reported being offered or sold drugs on school property in 2011

Body Weight, Nutrition and Physical Activity

- 17% of students are classified as obese based on self-reported height and weight
- 18% are classified as overweight based on self-reported height and weight
- 20% reported eating fruits and vegetables five or more times per day
- 25% report daily consumption of non-diet soda
- 21% reported zero days of ≥ 60 minutes of physical activity in the past week, including more females than males
- 46% watched three hours or more of TV daily including more African American students (52%) than Hispanic (39%) and non-Hispanic whites (35%)

Safety and Violence

- 26% never or rarely wore seat belts
- 92% of students report never or rarely wearing a bicycle helmet while riding a bike
- 23% of juniors and 22% of seniors report ever texting or emailing while driving
- **4% carried a weapon on school grounds**
- 42% were in a physical fight during the last year
- 9% stayed home from school within the past year due to safety concerns
- **14% reported being bullied at school**
- 10% reported being bullied electronically
- 10% reported bullying due to GLBT issues
- 14% considered suicide
- 11% reported a suicide attempt within the last year

Sexual Activity

- 61% report ever having sexual intercourse
- 15% report becoming sexually active prior to age 13
- 32% report abstinence commitments including 45% of females and 18% of males
- *Among sexually active students:*
 - 60% used a condom during last sexual intercourse
 - 15% used birth control, 7% reported use of Depo-Provera by self or partner
 - 18% reported use of alcohol and/or other drugs prior to last sexual intercourse

In surveys conducted for the Federal Youth Risk Behavior Survey, a higher percentage of Philadelphia high school students described themselves as sexually active than did students in 20 other urban jurisdictions. Philadelphia also had the highest percentage of students reporting intercourse with four or more partners during their lives. In response to these and other statistics, city health officials have put condom dispensers in 22 high schools. The aim is to reduce the incidence of sexually transmitted diseases.²²

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

- **Increased access to constructive activities**
 - *Young people need constructive things to do. Several of the community centers have closed and as a result kids don't have enough constructive things to do (key informant)*
 - *There is a lack of community programs, services, facilities, positive role models for teens resulting in teens engaged in non-directed activities in 19122 and 19133. It's a breeding ground for trouble... they are involved in fighting (focus group)*
 - *Raise awareness about community programs (focus group).*

- **Mental and behavioral health issues**
 - Resources are needed for teens to address (1) conflict and anger management training for teens; (2) mental and behavioral health issues (key informant)
- **Mentoring and investment in positive activities**
 - Adolescents could benefit from mentoring (key informant)
 - *Help youth without parental support understand how they are going to make it. Kids don't believe in anything anymore* (focus group)
 - *Work with schools to train teens as "peer educators" as part of their required community service* (key informant)

Recommendations included:

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

Special Populations – Older Adults, Homeless, Immigrants and Refugees, LGBT

Older Adults

Older adults are among the fastest growing age groups, and the first “baby boomers” (adults born between 1946 and 1964) will turn 65 in 2011. Older adults are at high risk for developing chronic illnesses and related disabilities including diabetes mellitus, arthritis, congestive heart failure and dementia and may lose the ability to live independently at home. Illness, chronic disease, and injury can create physical and mental health limitations in older adults, affecting their ability to remain at home. Regular physical activity is a protective factor for such declines. While most adults want to age in place and remain in their homes for as long as possible, the supports they need to do so may not be available. Caregivers are often family members or friends who volunteer and may not be prepared for the stressors of caregiving. Elder abuse by a caregiver has unfortunately become more common with up to 2 million older adults affected. (Healthy People 2020).

The Healthy People 2020 objectives on older adults focus on:

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

Philadelphia Corporation for Aging (PCA)⁶⁶ is a non-profit organization established in 1973 to serve as the Area Agency on Aging (AAA) for Philadelphia. PCA is required by the Pennsylvania Department of Aging (PDA) to produce an Area Plan for Aging Services every four years. For the years 2012-2016, PDA established five priority themes: Innovation for Services; Communities to Age and Live Well; Revitalization and Rearchitecting of Services; Promotion of Health and Wellbeing; and Effective and Responsive Management.

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

Population trends: Philadelphia’s seniors experience poverty at a rate almost double that of Pennsylvania and the nation. More than 117,000 of them have trouble paying for one of life’s basic necessities; 23,000 report skipping a meal for lack of money. The number of older Philadelphians suffering from poverty, hunger, and chronic illness will continue to grow. The population of foreign-born and non-English-speaking elders is also increasing, placing new demands on service providers for interpretation, translation, and cultural sensitivity.

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

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

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

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

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

Other trends identified by PCA include:

Gender : No significant changes in the gender distribution of older persons are expected in the near future. That means that most very old, very poor, and very frail Philadelphia elders will continue to be women.

Education and health literacy: Twenty-six percent (26%) of older adults have less than a high school education. The number becomes higher, 42%, when looking at those seniors with incomes less than 100% of the poverty level. The reading level of older adults is becoming more critical as the amount of information provided via the Internet and other electronic sources increases. As people age they

suffer from more chronic illnesses, require more medications, and have more hospitalizations. The ability to read prescriptions and understand written discharge plans will be a challenge for those less literate or unable to read English. Older adults are proportionately more likely to have below basic health literacy scores than any other age group. Almost two-fifths (39%) of people aged 75 and over have a health literacy level of below basic compared with 23% of people aged 65-74 and 13% of people aged 50-64 (US Department of Education, Institute of Education Sciences, 2003, National Assessment of Adult Literacy). People with lower health literacy are at greater risk for hospital readmissions, longer length of stay, medication errors, and non-adherence to treatment guidelines and medical test preparation

Living arrangement: Thirty-eight percent (38%) of older Philadelphians live in one-person households. As more of these older adults live into very old age, it is likely there will be fewer co-resident caregivers. This may lead to greater reliance on the formal aging care system for assistance.

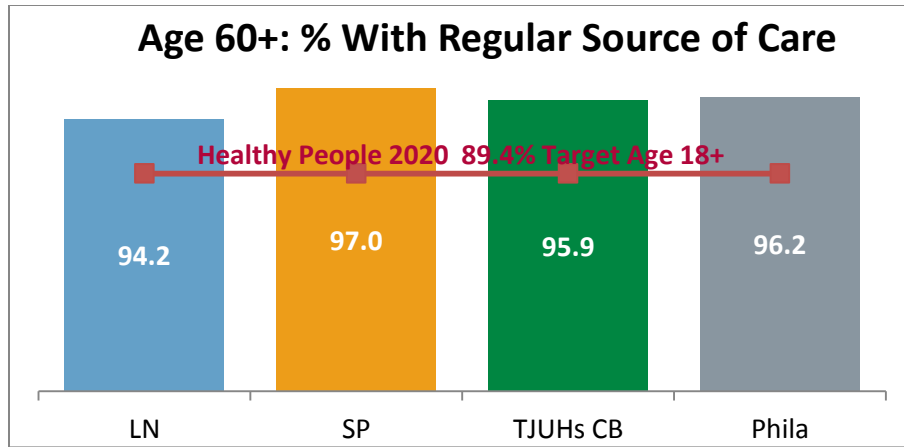
Income: According to 2010 census data 20% of older adults in Philadelphia live below 100% of the Federal Poverty Level (FPL) and 45% live below 200% of the poverty level. In Jefferson's CB area the rate is 46.6%. Almost 52% of older adults in South Philadelphia live below 200% FPL. Research shows that 200% FPL is a more appropriate measure of functional poverty. To qualify for programs that assist low income older adults, an individual's income is often required to be below 100% poverty. This means that many older adults who are deemed "functionally poor" will not be eligible for these services. This will place additional demands on the aging services care system for older adults.

Health Status:

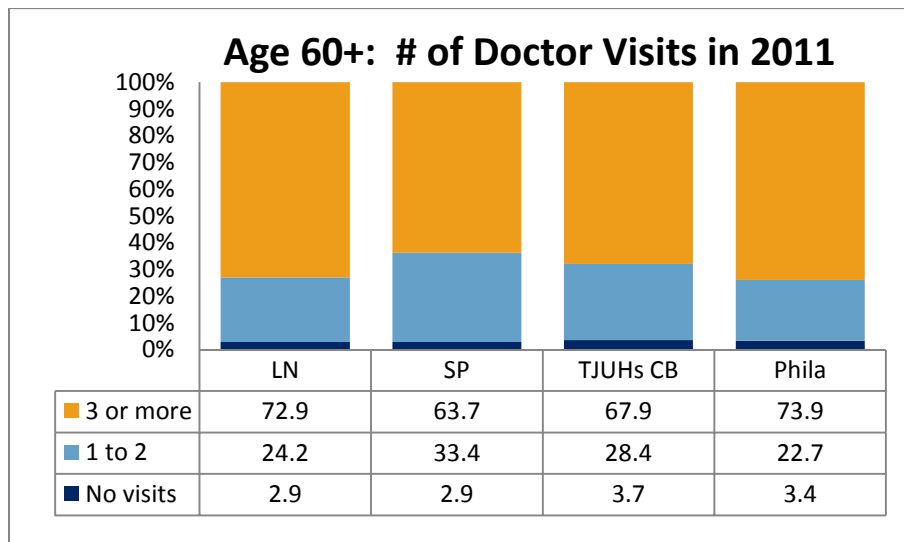
Health status data for older adults is from the PHMC Household health Survey conducted in 2012. Data is not available for Center City and Transitional neighborhoods because the number of older adults who participated in the survey from these neighborhoods was too small to be included.

Access to Care:

Almost all older adults in Philadelphia report having a regular source of care and the majority (67.9%) saw their doctor three or more times in the previous year. Very few adults (3.7%) living in Jefferson's CB area did not see a doctor in the past year.

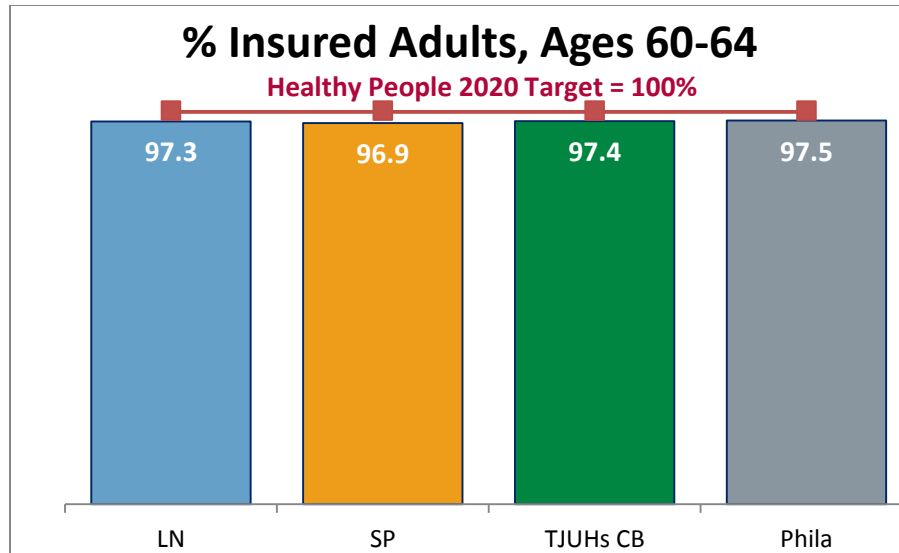


PHMC Household Health Survey 2012

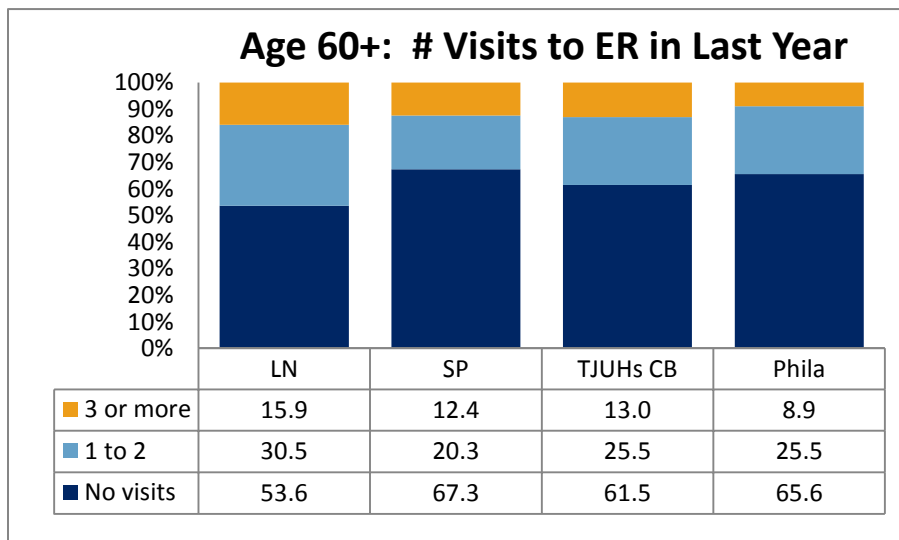


PHMC Household Health Survey 2012

Almost all adults between the ages of 60 and 64 have health insurance and are close to achieving the Healthy People goal of 100%. Approximately one in four older adults in Jefferson’s CB area has Medicaid (24.5%), which is similar to the rate in Philadelphia (24.4%). Older adults living in Lower North Philadelphia were more likely to have gone to the ED (46.4%) in the past year compared to older adults in South Philadelphia (32.7%) and Philadelphia (34.4%). Older adults in Lower North Philadelphia were also more likely to have had 3 or more visits to the ED compared to Philadelphia (15.9% vs. 8.9%)



PHMC Household Health Survey 2012



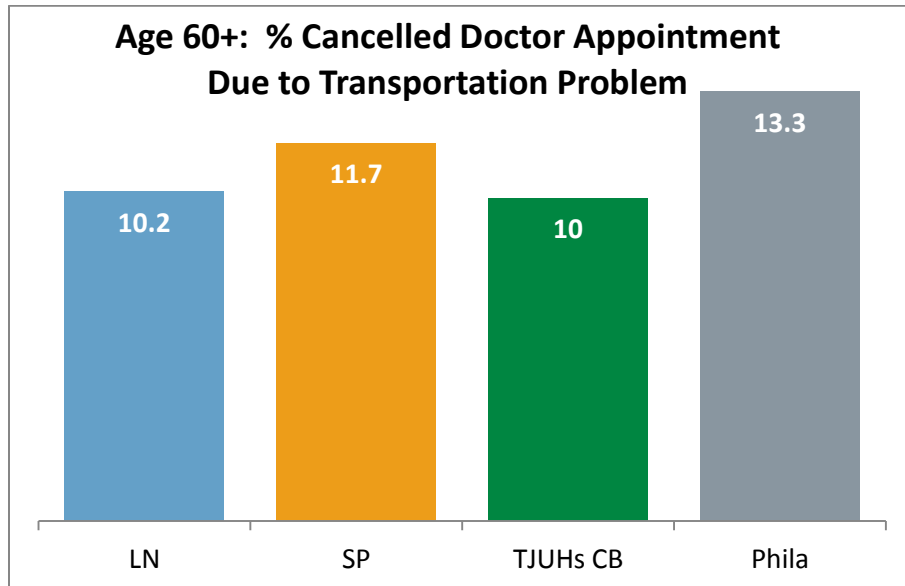
PHMC Household Health Survey 2012

The lack of access to transportation for seniors is significant:

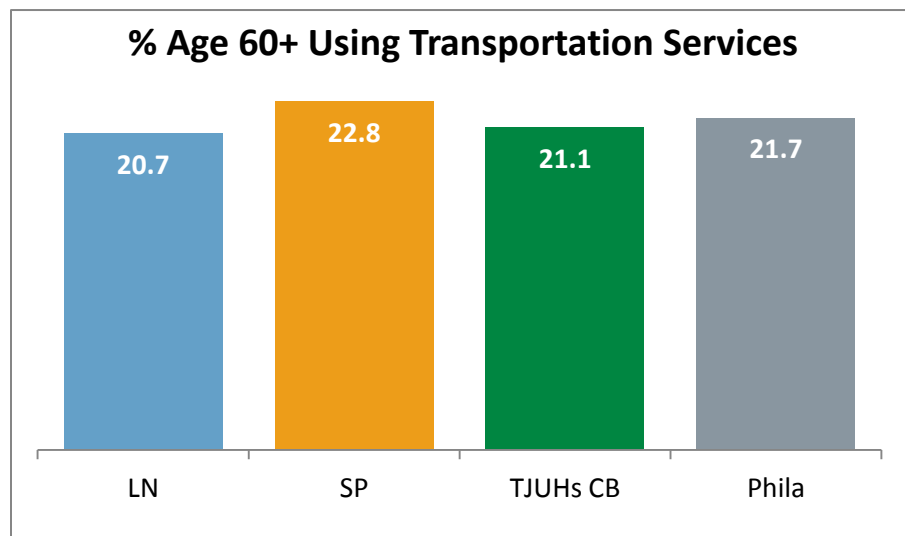
- 55% of low-income seniors in the city do not have access to an automobile in their household.
- 46% of seniors who report at least one ADL or IADL disability do not have access to an automobile in their household.
- 42% of seniors who speak English poorly, or not at all, do not have an automobile in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

Ten percent of adults age 60+ reported cancelling a doctor's appointment because of transportation problems. On average 20% of older adults in Philadelphia use transportation services; however, approximately 16% are unaware of transportation services. Cost of health care and medications was

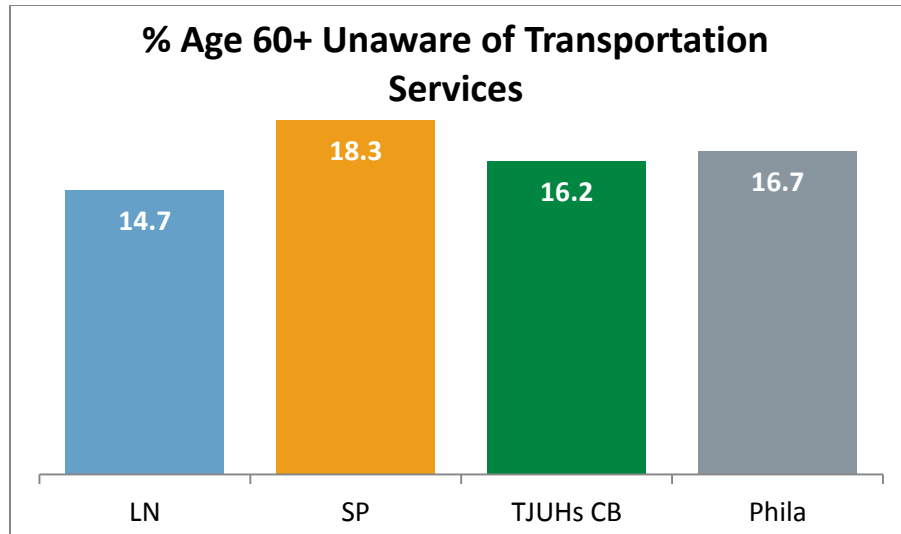
also problematic for some older adults in Jefferson’s CB area. Almost 10% of older adults in South Philadelphia did not see a doctor when they were sick due to cost, twice the rate in Philadelphia (9.7 vs. 4.8). Approximately 1 in 10 adults did not purchase needed medication due to cost; almost one in four older adults in Jefferson’s CB area (24.2%) was not aware of PACE.



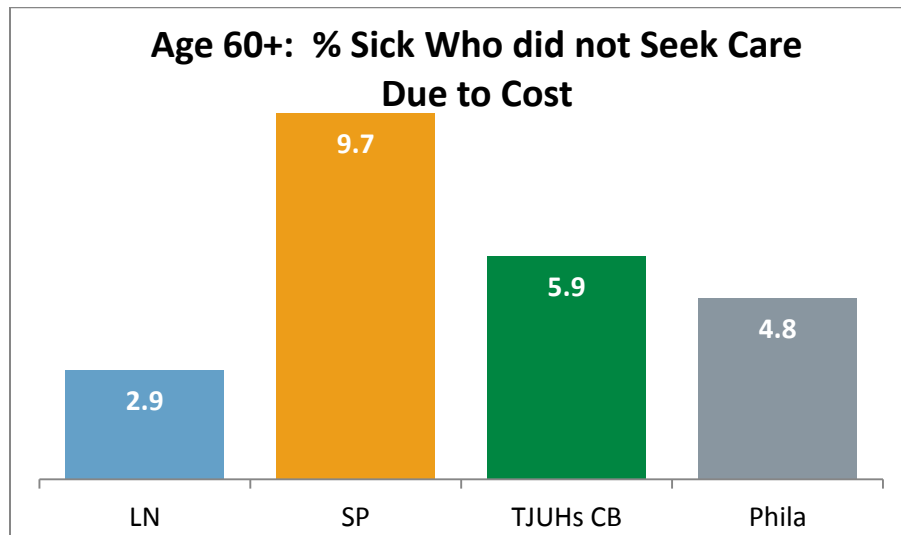
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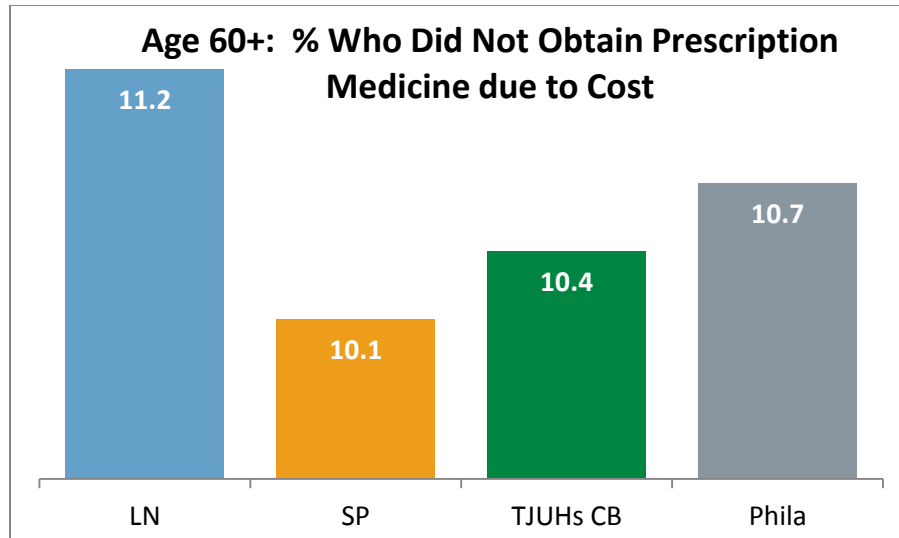
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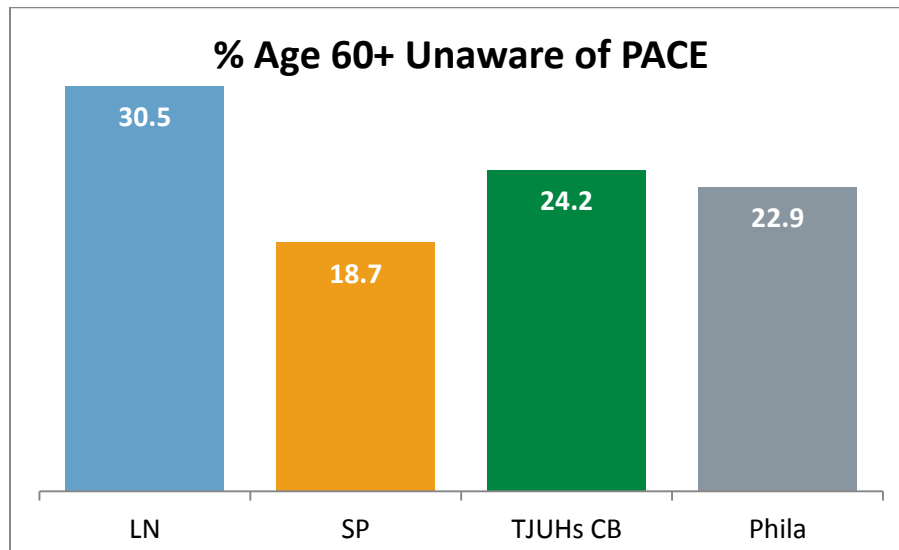
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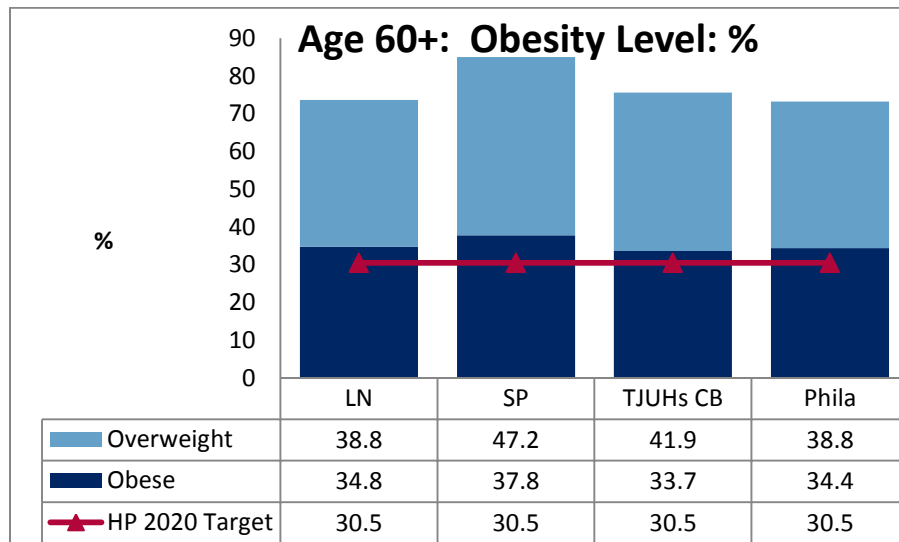


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Chronic Disease:

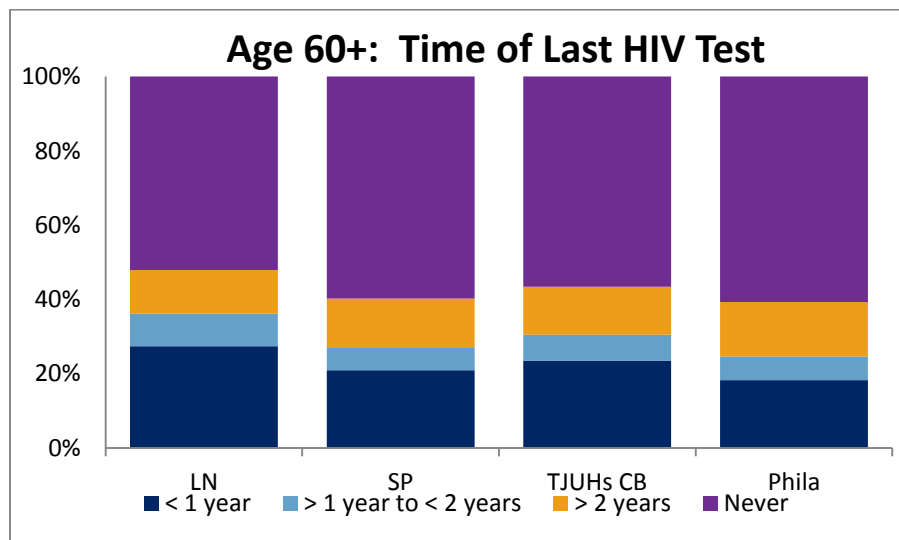
Obesity is an underlying cause of hypertension, heart disease, cancer, asthma and diabetes. Rates of chronic disease among older adults in Jefferson's CB area are similar to those in Philadelphia:

- Obesity (33.7% vs. 34.4%) Obesity rates among older adults in South Philadelphia (47.2%) exceed the rate in Philadelphia and Healthy People 2020.
- Asthma (14.6% vs. 13.2%)
- High blood pressure (33.2% vs. 66.9% vs. 69.2%)
- Diabetes (33.2% vs. 34.3%). The diabetes rate among older adults in Lower North Philadelphia is 68.3%

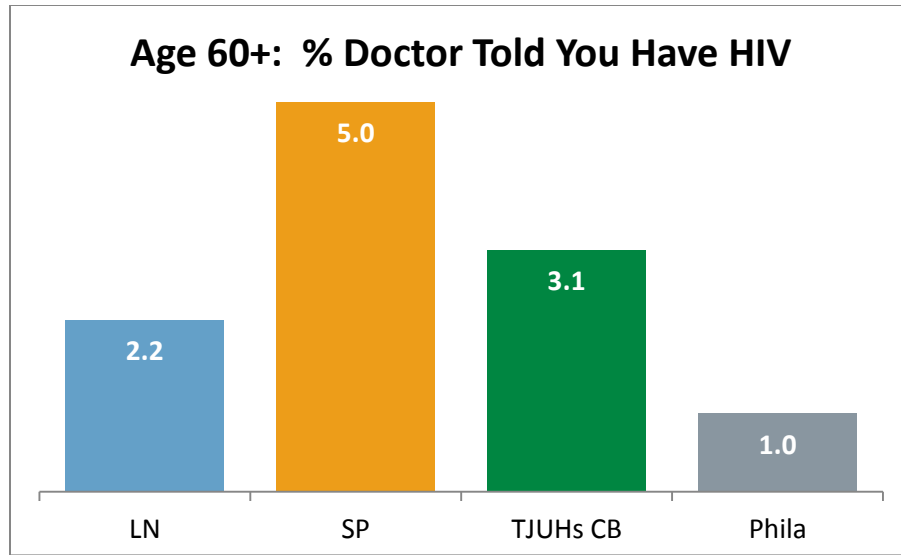


PHMC Household Health Survey 2012

HIV is a growing concern among older adults. The rate of HIV among older adults in South Philadelphia is five times the rate in Philadelphia (5% vs. 1%) and most older adults have never been tested for HIV (56.6% in Jefferson’s CB area, 59.8% in South Philadelphia and 60.7% in Philadelphia). HIV screening in the older adult population may be warranted.

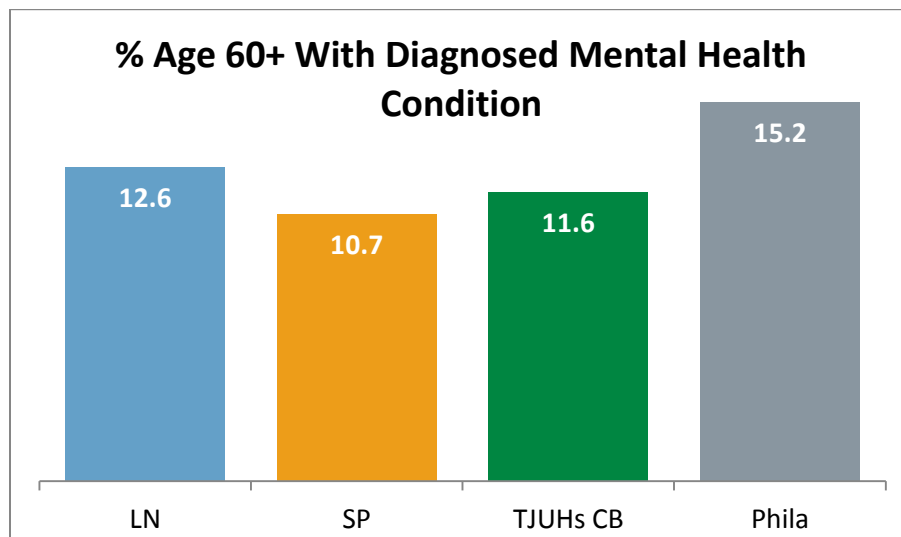


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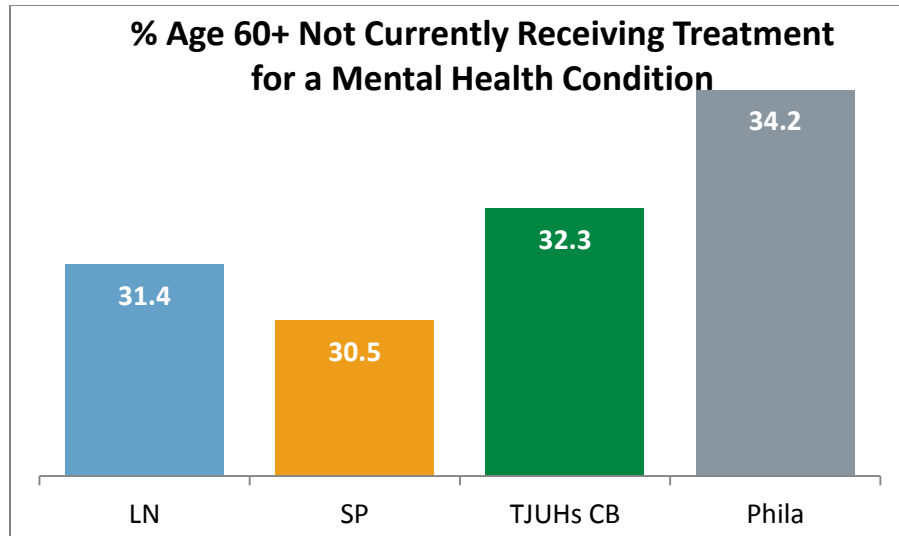


PHMC Household Health Survey 2012

Older adults in Jefferson’s CB are less likely to have a diagnosed mental health condition compared to Philadelphia (11.6% compared to 15.2%). However, approximately one-third of older adults with a mental health condition are not currently receiving care for their condition. One in five older adults has signs of major depression and in Lower North Philadelphia this rate approaches 25%. The rate in South Philadelphia is lower with only 15% of older adults having signs of major depression. The inability of the formal aging system to respond to mental health issues will remain a barrier to serving the older adult population.



PHMC Household Health Survey 2012

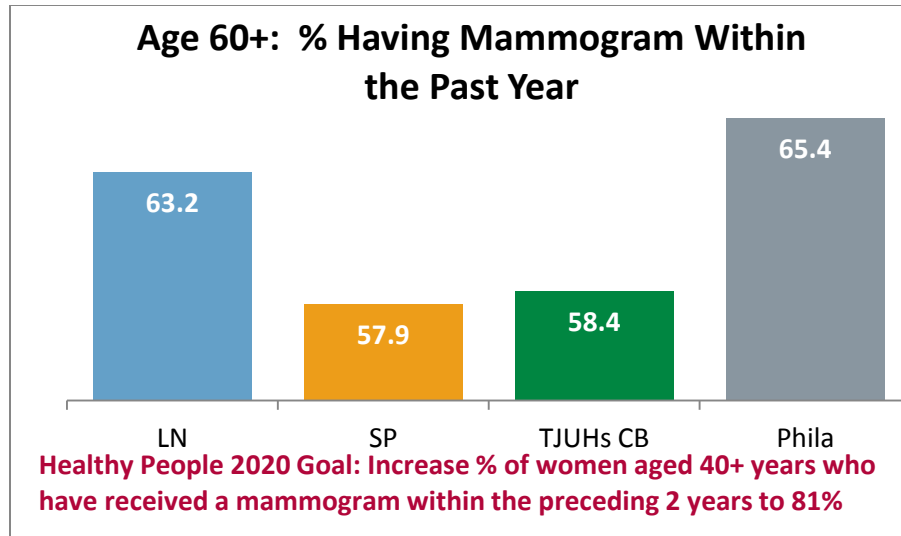


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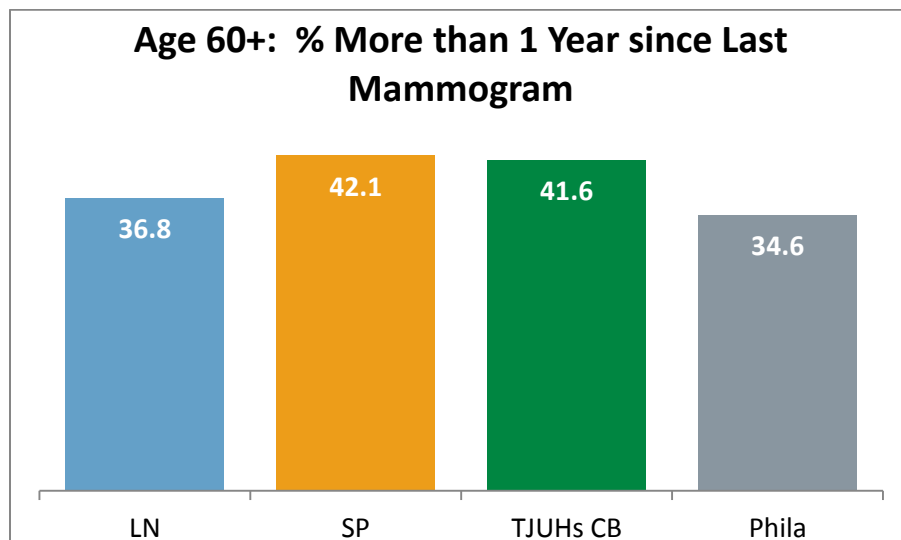
Ethnic minority background and income area associated with risk for functional health impairments, and the combination of poverty and ethnic minority background appears to increase that risk. More than a third of older adults in Philadelphia have an IADL that limits their everyday functioning. This rate is lower than that of Jefferson’s CB area (37.2%), South Philadelphia (36.7%) and Lower North Philadelphia (42.5%). Twenty percent of older adults in Jefferson’s CB area have at least one ADL that limits their functioning.

Preventive Health Care Services

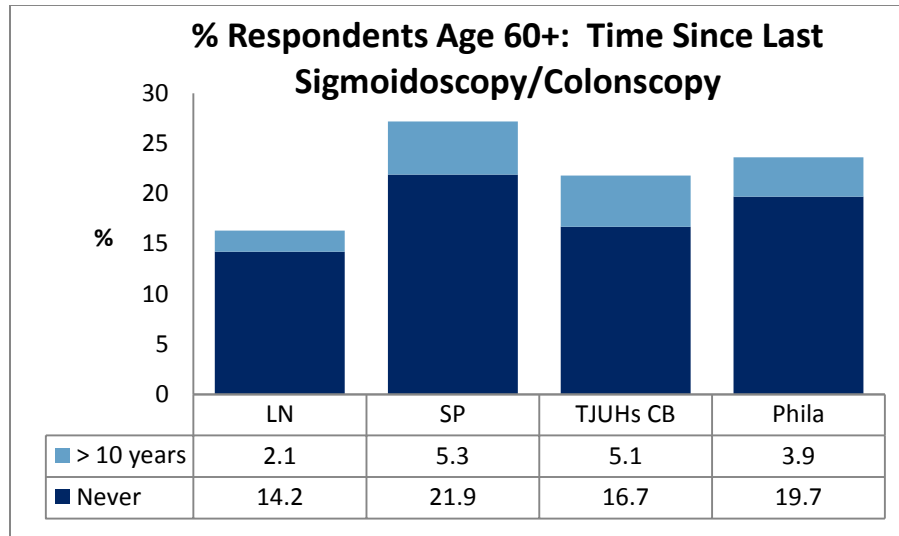
Women over age 60 in Jefferson’s CB were slightly less likely to have had a PAP test in the previous year than were women in Philadelphia (42.8% compared to 45.6%). However, only 29.1% of older women in South Philadelphia had a PAP test done. The findings for breast exams by a health care provider were similar. Only 56% of South Philadelphia women aged 60+ had a breast exam in the prior year compared to 72.2% of older women in North Philadelphia and 68.7% of older women in Philadelphia. This trend continues for mammograms. Older adult women in South Philadelphia were least likely to have had a mammogram in the previous year (57.9% vs. 65.4% in Philadelphia). These findings suggest that health care providers need to recommend preventive screening to their older patients living in South Philadelphia.



PHMC Household Health Survey 2012

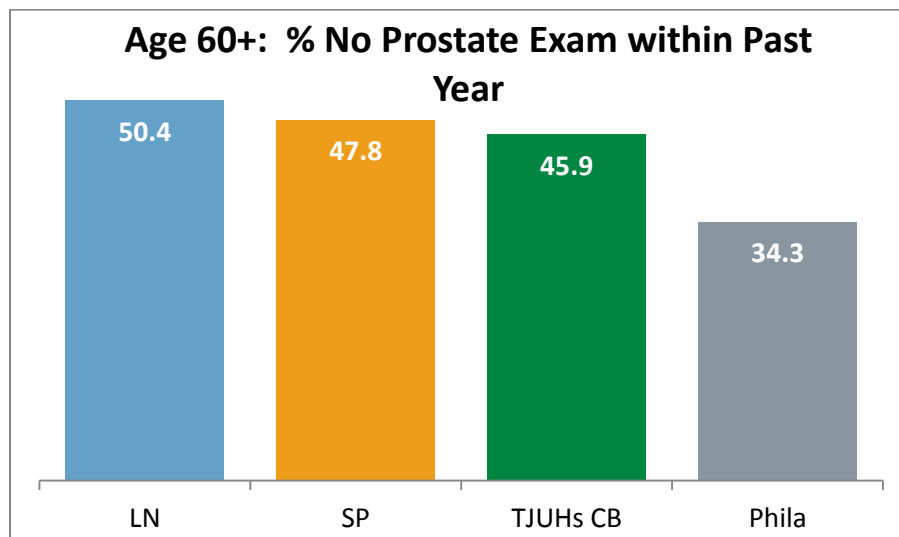


PHMC Household Health Survey 2012



PHMC Household Health Survey 2012

Older adults in South Philadelphia were also less likely to have had a colonoscopy in the past 10 years compared to adults in Lower North Philadelphia and all of Philadelphia (72.8% vs. 83.7% and 76.4% respectively). Older adult males in Jefferson’s CB area were less likely than other men in Philadelphia to have had a prostate exam in the past year (54.1% vs. 65.7%).

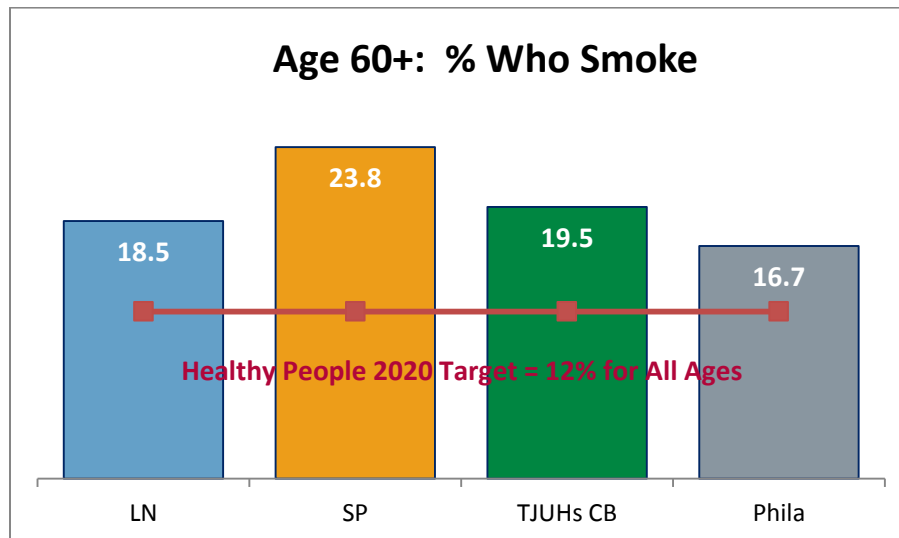


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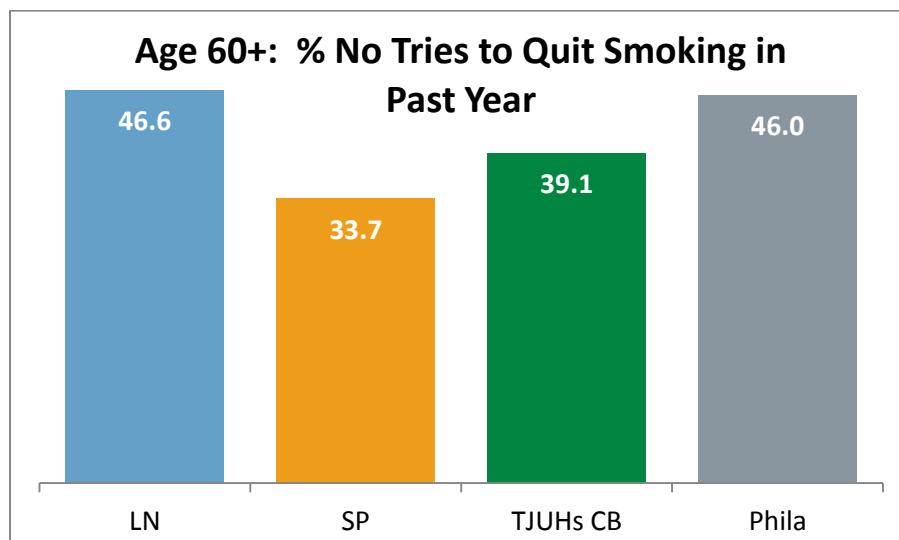
Health Behaviors

Smoking

Older adults in Jefferson's CB area are more likely to be smokers than are older adults in Philadelphia as a whole. Almost one in five older adults in Jefferson's CB area smoke (19.5%); and the rate in South Philadelphia approaches one in four adults (23.8%). Smokers in Jefferson's CB area were less likely to have tried to quit smoking compared to Philadelphia (39.1% vs. 46%). Physicians should refer patients to state and local free programs including FAX to QUIT and the Pennsylvania QUIT line.



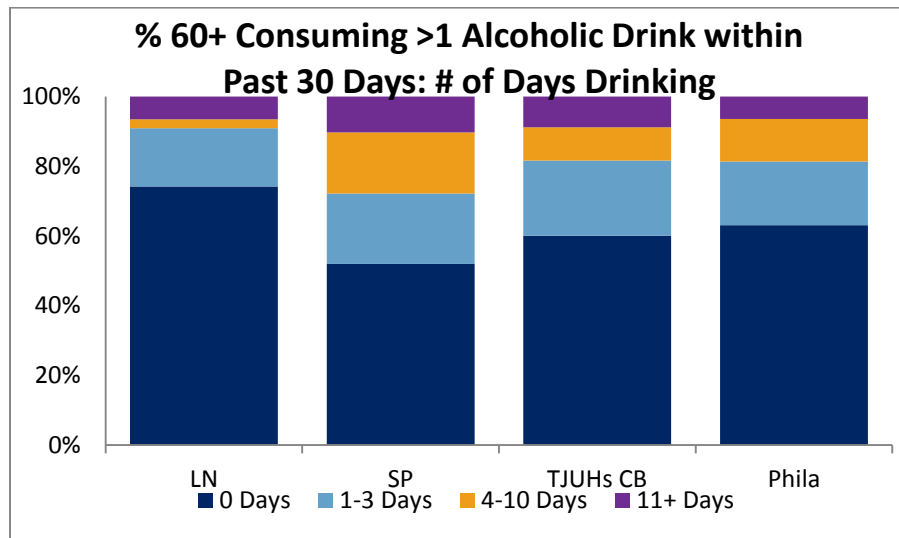
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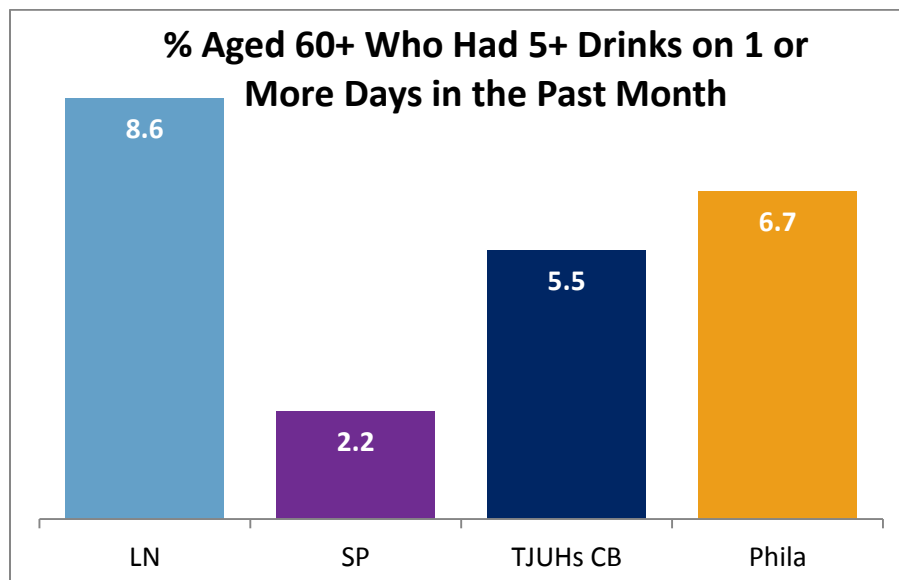
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Alcohol Use

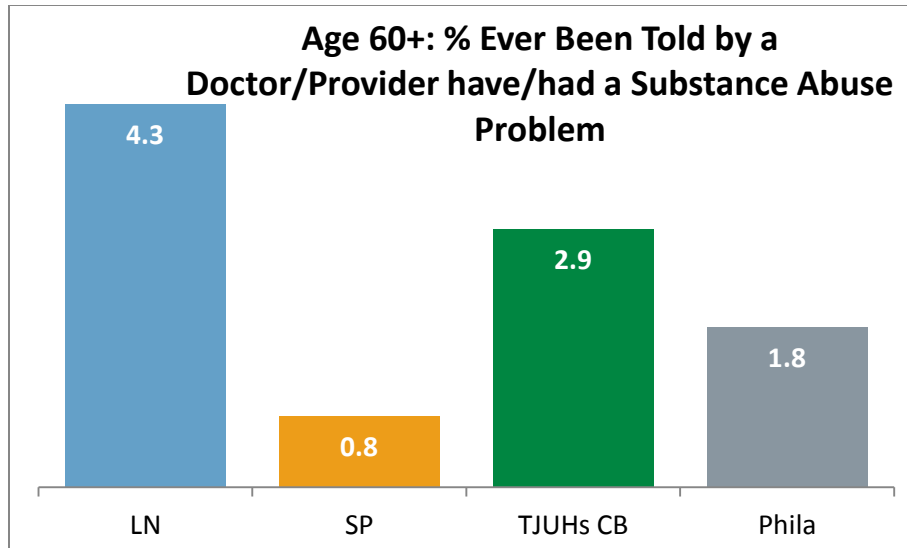
Older adults in Jefferson's CB area are more likely to have 2 or more drinks on 11 or more days in the past month than were older adults in Philadelphia (8.8% vs. 6.4%) and 10.3% of older adults in South Philadelphia consumed this amount of alcohol. Binge drinking (5 or more drinks on any one day) was more common in Lower North Philadelphia (8.6%) vs 5.5% in Jefferson's CB area and 6.7% in Philadelphia. Given the high rate of chronic disease among older adults, alcohol use could be problematic among older adults who are taking medications. Compared to Philadelphia, older adults in Jefferson's CB area are more likely to have been told they have a substance abuse problem particularly those living in Lower North Philadelphia (1.8%, 2.9% and 4.3% respectively).



PHMC Household Health Survey 2012



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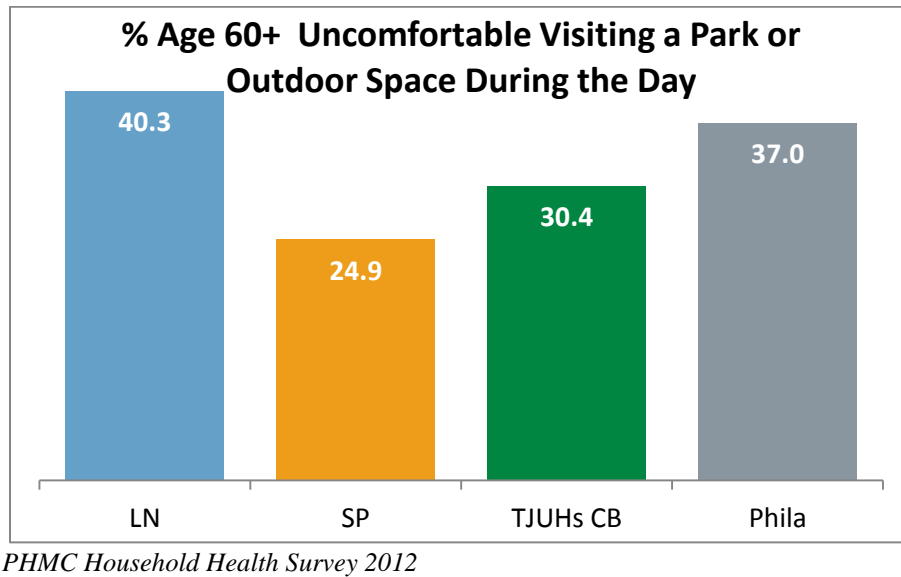
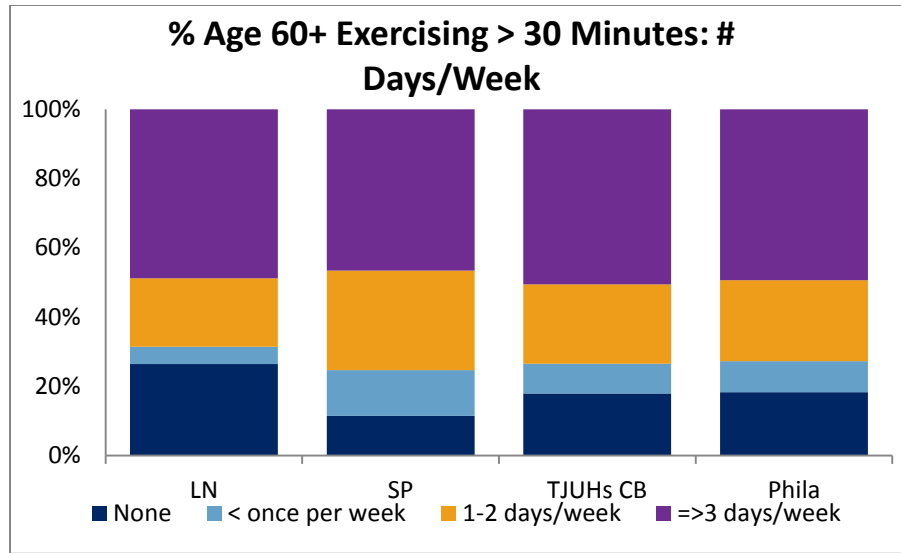


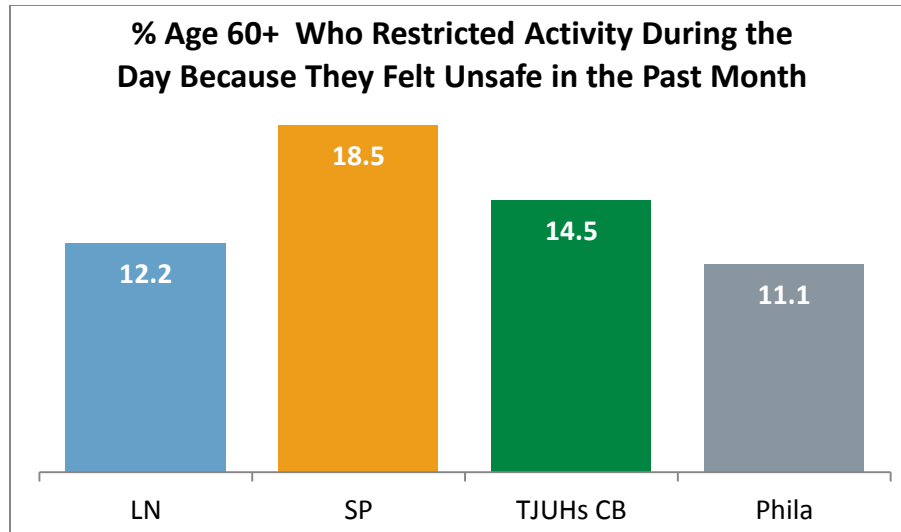
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Physical Activity

Physical activity is important to healthy aging. It maintains muscle strength, bone density, helps to prevent weight gain and depression. Compared to other neighborhoods in Jefferson’s CB area, older adults in Lower North Philadelphia are more likely not to have been physically active even once weekly (31.4%) vs. 27.3% in Philadelphia and 26.5% in Jefferson’s CB area. Inactivity in Lower North Philadelphia may correspond to being more uncomfortable visiting a park or outdoor space during the day compared to Philadelphia older adults (40.3% vs. 37%). On the other hand, older adults in South Philadelphia were more likely to report they restricted their activity in the past month because they did not feel safe (18.5% compared to 14.5% in Jefferson’s CB area and 11.1% in Philadelphia). Perceived lack of safety can limit physical activity and isolate older adults aging in place in the community. According to the 2012-2016 Area Plan developed by Philadelphia Corporation for Aging (PCA), a majority of older Philadelphians do not use the city’s many parks or recreation facilities.

“In most cases the older adult lives near one but chooses not to use it. When surveyed, older adults said that they would like to use city parks more often but were concerned about safety (too much crime, too many cars, too many bikes) and the lack of amenities (bathrooms and benches). Concerns about safe and accessible transportation to-and-from parks are another reason older adults are reluctant to use parks. When seniors use the city’s public spaces, they gain an opportunity to become engaged in the community, which combats isolation and helps build social capital.”

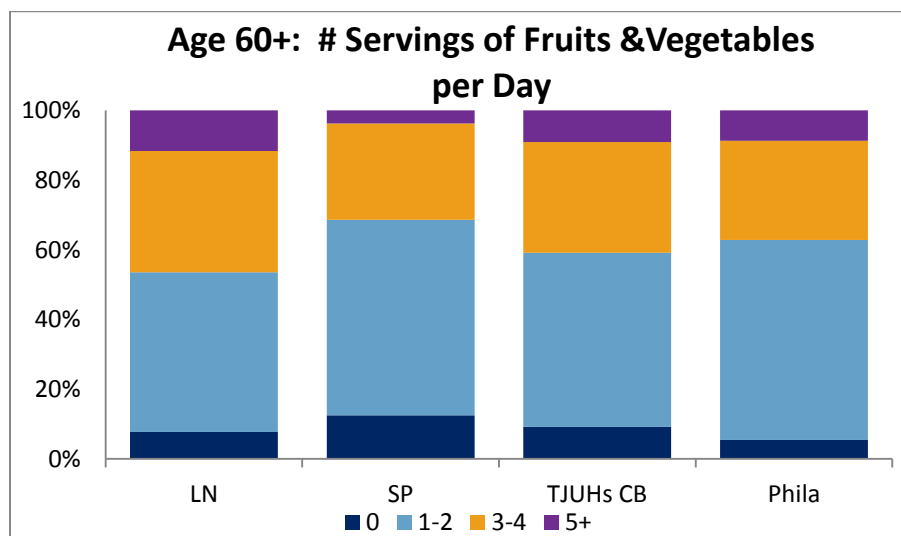


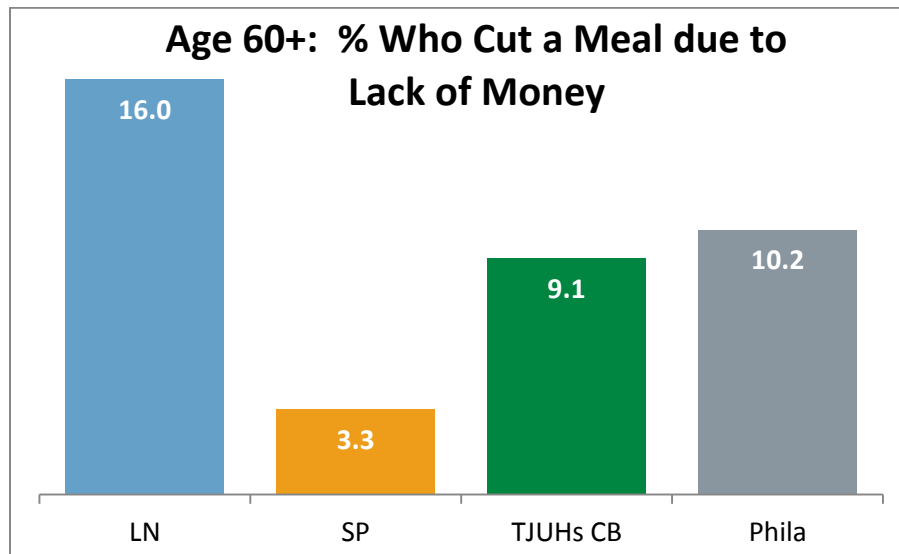


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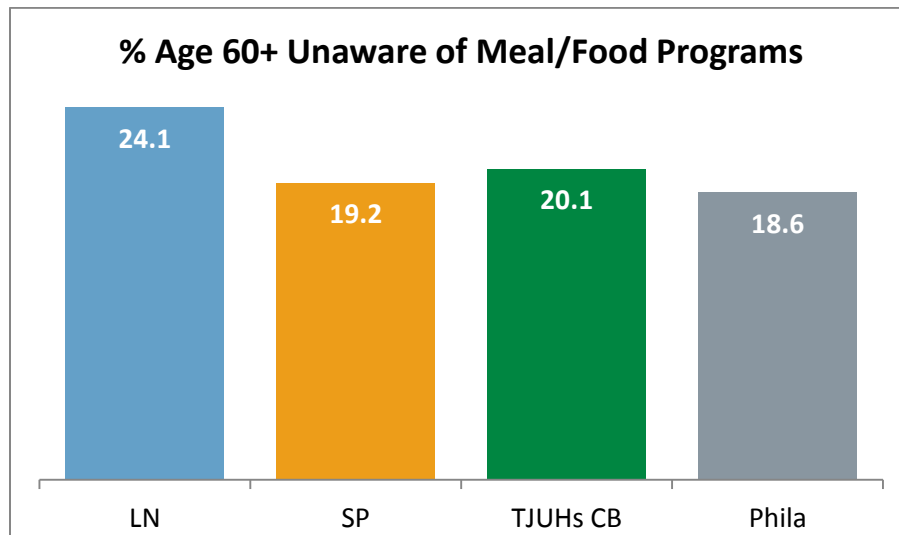
Nutrition and Food Access

Seventy-five percent of older adults in Jefferson’s CB area are overweight or obese. Access to healthy affordable food can play a role in the overall health of seniors. Fifteen percent of adults in Jefferson’s CB area say the quality of food in their neighborhood is fair or poor and for those in Lower North Philadelphia more than 23% find this to be the case. It is important to note that one in six older adults in Lower North Philadelphia cut a meal in the past month due to lack of money. This is a sign of food insecurity. Nearly one-fourth of seniors in Lower North Philadelphia were not aware of a meal or food program; the rate in Jefferson’s CB area was 20.1%. People taking medicine often need to take medicine with food. Lack of food security may impact medication adherence. Given that only 5.9% of older adults in North Philadelphia report using a food/meal program, and 16% skipped a meal due to cost, raising awareness about these programs is essential.

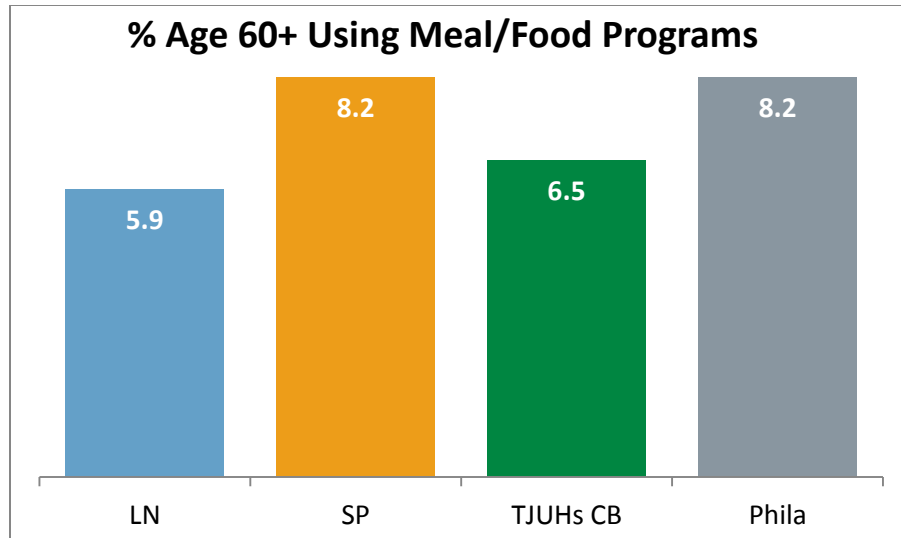




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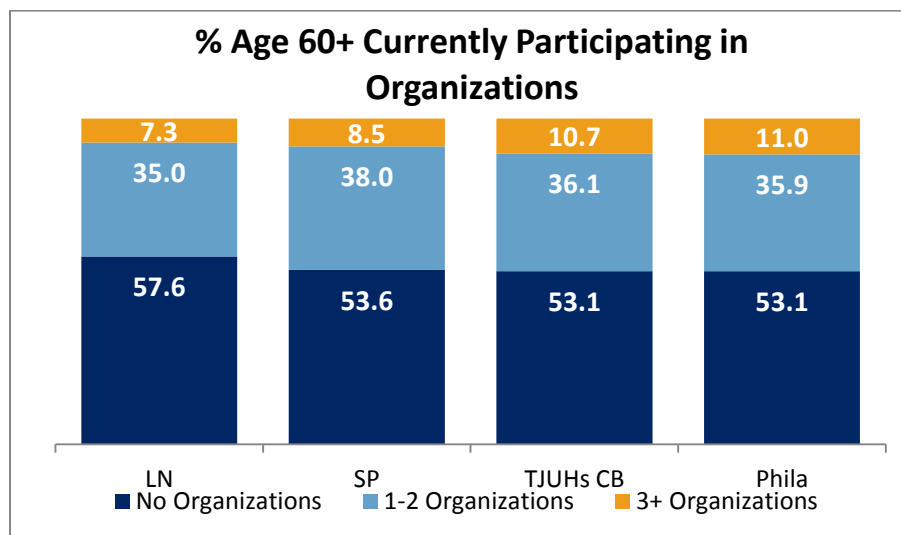
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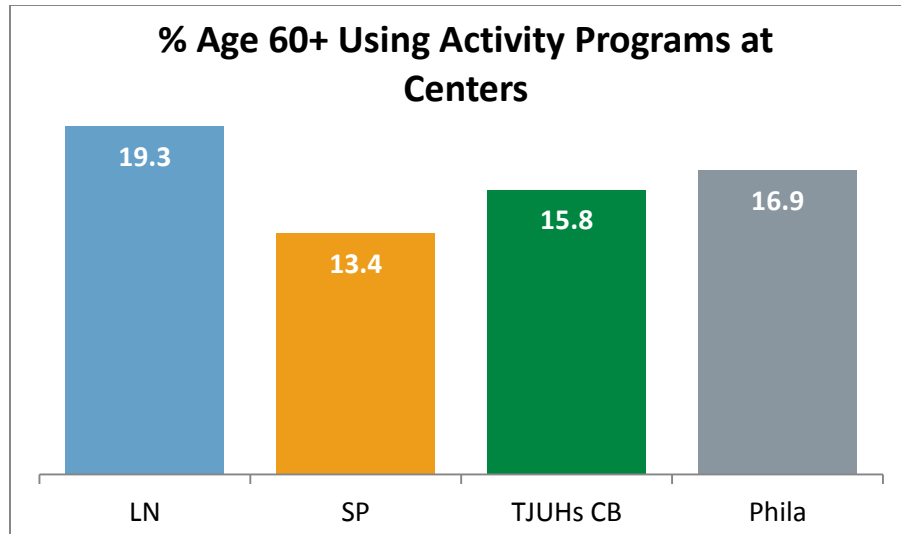
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Social Connectedness

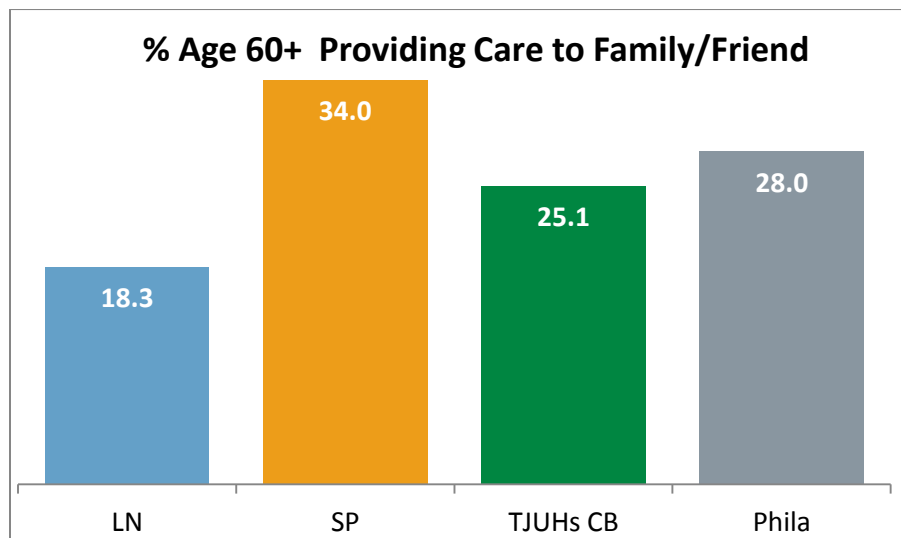
Feeling you are connected to the community is important to prevent isolation and depression in seniors. Social networks are protective factors for health and wellness. Forty-seven percent of older adults in Jefferson’s CB area and in Philadelphia currently participate in at least one organization and 10.7% participate in 3 or more organizations. Almost 20% of older adults in Lower North use activity programs at community centers; however this rate drops in South Philadelphia to just over 13% and may be due to safety concerns mentioned earlier. Finally, 25% of older adults in Jefferson say they are caring for a family member or friend; in South Philadelphia this is true for one-third of older adults. Finally, the vast majority (80% to 90%) of older adults in Jefferson’s CB communities are caring for another older adult. This may reflect a need for caregiver supports such as respite care.



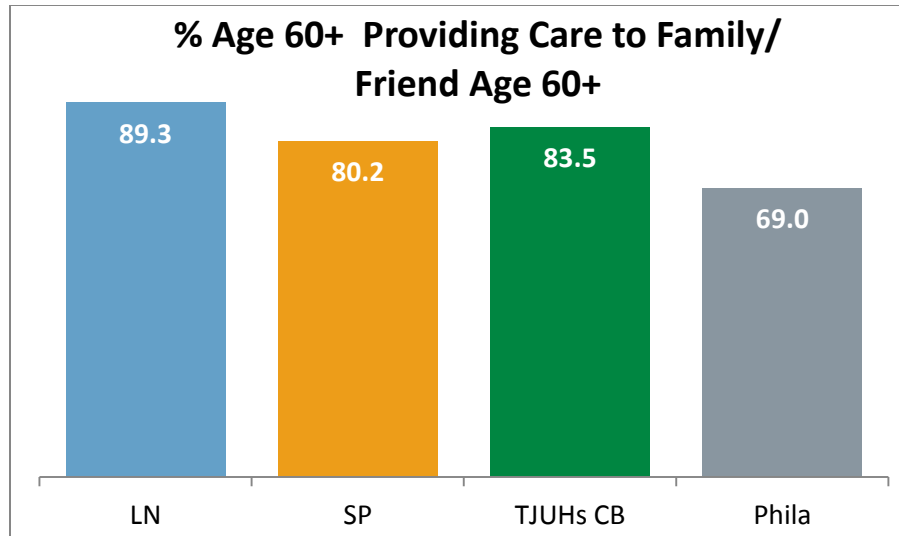
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Housing

Many older adults in Philadelphia are faced with home repairs that are not possible due to low fixed incomes. For elders who want to age in place, remaining in their homes for as long as possible is important emotionally and economically. Older homes in Philadelphia have stairs and are often multiple dwellings. Having a home on the first floor is often not possible. These barriers affect seniors' ability to take care of basic needs and to participate fully in the community.

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

- **Well Elderly**
 - Need opportunities for socialization and places where they can be physically active safely.
 - Need to understand what the well elderly need to stay in their homes as long as possible.
 - Need to raise awareness about fall prevention. Physical therapists could do fall and gait assessments and home environmental assessments
 - Need education about how to manage chronic disease
- **Care Coordination**
 - Lack of coordinated care across health system and CBOs
 - Lack of awareness by Seniors about services for family with dementias
 - Lack of knowledge of providers about community/neighborhood resources available to support discharged patients
 - *Confusion among the elderly about what tests they are having done. Their kids work and can't accompany them to the hospital or to doctor's appointments. There is no caregiver to bring them to the hospital and help them*

- *Hospitals and other community resources should partner to provide services and access to resources in community*
- *There is a need for care managers in the community*
- *Funding is needed to support more community health nurses to make home visits to elderly, shut-ins and others in need. Pool nurses could do home visits in order to assist patients with scheduling appointments and addressing barriers*
- **Isolation**
 - *Elder isolation: difficulty accessing healthcare due to lack of finances, and transportation; may not have had care for some time; no community resources to exercise, socialize; no senior center; need basic services; rely on family (if there is any); friends and neighbors for help*
 - *Elder care and other resources for elderly: many elderly live alone and need help in home and with meeting basic needs e.g., grocery shopping, getting and taking medication, getting to physicians. Family members are busy with their own lives*
 - *In this community family and older adults live near each other. There is support, but elders are aging in place and cared for by their aging children. Some may be isolated (shut-ins) and need geriatric care, home care and have difficulty traveling*
 - *There is a need for adult day care and services in communities (e.g. Mercy LIFE). St Agnes had a program but it is now closed. Mercy Life is open to the community for group meals (lunches).*
 - *We should work with churches and religious communities to provide support for elderly and those in need*
 - *The elderly need help getting to the doctor, getting groceries. The need support in the home so they can remain in their homes*
 - *The hospital has a volunteer visiting program for those without families. We should consider something similar for those who are aging in place and isolated.*
 - *Lack of local pharmacies in neighborhoods*
- **End of Life care - Palliative Care and Hospice**
 - *Lack of understanding of palliative care and hospice*
 - *Need to raise awareness of doctors about follow through on Living Will wishes of the patient*
 - *Need to raise awareness among care providers and the community about end of life issues*
 - *Need to understand the cultural beliefs associated with end of life*
- **Care Giver Stress**
 - *Caregivers need help and support to deal with stress*
- **Transportation** to offices and hospital
 - *Transportation and pharmacy issues are also important*
 - *Partner with local pharmacies to deliver medications*
 - *The elderly need help getting to the doctor, getting groceries. They need support in the home so they can remain in their homes*
 - *Many children and parents are working full-time and can't come in themselves or take family members to visits or tests.*
 - *Confirm status of van services from home to hospital for elderly and underserved populations seeking non-emergent care. Consider hospital partnership to provide van services. This could cut down on readmissions*

- **Education**
 - *Tremendous need for healthcare providers and staff to explain and educate medical information to patients.*
 - Medication awareness
 - *Elder care – need additional help at home including taking medications properly*
- **Food insecurity**

Recommendations included:

- 1. Form Community Council consisting of organizations serving older adults to address needs of seniors. Start in South Philadelphia.**
- 2. Pharmacy students could do medication reviews in community locations**
- 3. Care coordination with community organizations**
- 4. Tie Community Health Workers to hospital discharge**
- 5. Transportation - Van transport to and from hospital for appointments**
- 6. Food security - Screen patients for food security, when signing up patients for MA, also sign them up for food stamps; Refer to community food cupboards (or consider giving person voucher to the Atrium or area food markets**
- 7. Coordinate with TJUHs departments already doing screening such as JHN stroke screening, TJU Nursing, Breast Screening Program, Nurse magnate, pharmacy, Physical therapy, etc.**
- 8. Conduct an assessment of older adults health and social needs for aging in place**
- 9. Provide home visiting for isolated seniors**
- 10. Support caregivers to reduce stress and burnout**
- 11. Educate community about Palliative Care and Hospice**
- 12. Assisting LGBT Seniors access services at Mazzoni Center and other organizations serving the LGBT community**
- 13. Educate seniors about chronic disease management and healthy lifestyles**
- 14. Raise awareness about opportunities for socialization and physical activity**

Immigrants and Refugees

Immigrants

According to the Delaware Valley Regional Planning Commission⁶⁶ of Philadelphia's total population of 1,504, 950, 88.5% are native(1,332,535) and 11.5 % (172,415) Foreign Born (Foreign Born; naturalized citizen 46.4%, Foreign born – not a U.S. Citizen – 53.6%). Approximately 65,000 immigrants have arrived in Philadelphia since 2000. While Philadelphia's immigrant community has a higher percentage of adults with graduate and professional degrees (11.9%) compared U.S. natives in Philadelphia (8.8%), they are also more likely not to have graduated from high school (28.5% vs. 19.3%). The median income for foreign born non- citizens is less than the median income for

Philadelphia. Interestingly, foreign born residents of Philadelphia are more likely to have a motor vehicle than are native born residents (71.1% vs.65.8%); however, only 65% of non-citizens have a motor vehicle. The majority of immigrants coming to Philadelphia since 2000 are from Asia (40%) and Latin America (30%).



Southeast Asians have been seen to differ significantly from more acculturated Asian ethnic groups, especially in their immigration patterns. Unlike the more upwardly mobile East and South Asian immigrants who immigrated to the U.S. for economic and social reasons, the vast majority of Southeast Asians arrived in the U.S. as political refugees from Vietnam, Cambodia, and Laos, beginning in the 1970s. Many Southeast Asians were forced to leave their homes to preserve their lives and escape persecution, leaving without preparation or knowledge of the country of their settlement. Since then, the U.S. government has resettled many Southeast Asians in places where they are culturally and linguistically isolated. These cultural and linguistic differences have created a number of structural and behavioral barriers to health care for these populations.

In 2013, Mayor Nutter announced the formation of the Mayor’s Office of Immigrant and Multi-Cultural Affairs to “promote the full participation of Philadelphia’s diverse cultural and linguistic communities in the economic, social, and cultural life of the City by strengthening the relationship between those communities and the City.”

National health surveys such as NHIS and BRFSS are the preferred methods of gathering information about the health of the population. In Philadelphia, PHMC conducts a bi-annual, telephone survey that is based on these national surveys. In 2004, PHMC oversampled the Asian community in Philadelphia to gain a better understanding of their health needs. However, this survey was not conducted in any of the Asian languages. Therefore, only Asian residents who spoke English well enough to do a 30 minute survey and had a telephone could participate. In 2007 SEAMAAC, in partnership with Dr. Nguyen (University of Pennsylvania) and Dr. Yuen (Thomas Jefferson University School of Population Health), undertook a survey to assess the health needs of the Southeast Asian community in Philadelphia⁶⁸. This survey was conducted in native languages by trained SEAMAAC staff who are trusted by the community. Significant differences were found between the standard community health survey (SCHS) conducted by PHMC and the community-based health survey (CBHS) conducted by SEAMAAC. Demographically, the SEAMAAC sample was less likely to be employed, more than twice as likely to be living in poverty, and more likely to

be elderly compared to the PHMC sample. In general, the demographic makeup of the SEAMAAC sample more closely mirrored what is known about Southeast Asians in the U.S. overall (low employment, low educational attainment, high poverty). Compared to the PHMC sample, SEAMAAC respondents reported higher rates of poverty (50.5%), higher rates of non-citizenship (57.2%), more limited English proficiency (94.3% speak a language other than English at home; 2.4% say their main language is English and 22% speak no English), lower rates of employment (56%) and lack of education (43% did not graduate from high school), access to health insurance may be out of reach for many SEAMAAC respondents (48% lacked health insurance). These factors are known to limit access to health care services.

Health Status of SEAMAAC Asian Health Survey 2007 compared to 2004 PHMC Household Health Survey Findings

	% SEAMAAC	% PHMC Asians
Lack Health Insurance	51.1	17.2
Lack prescription coverage	55.9	18.6
Fair/poor health	45.0	13.5
Has a chronic condition	22.0	9.7
Asthma	6.2	9.4
Cancer	1.5	3.5
Heart Disease	6.9	6.0
Diabetes	8.1	7.0
Hypertension	18.1	7.0
High cholesterol	14.5	18.8
Mental Health Condition	7.1	3.7
Obesity - (BMI>30)	13.4	9.6
Obese - WHO Asian Standard (BMI> 27.5)	20.7	15.3
Report Smoking:		
• Male	38.8	65.4
• Female	4.0	42.5
No doctor's appointment in past 2 years	26.5	18.4
Because of cost went without:		
• Medical care	24.9	12.3
• Prescription	22.7	12.9
• Dental care	29.8	23.7
• Mental health care	7.9	2.6

	% SEAMAAC	% PHMC Asians
Within past 2 years had:		
• PAP	62.6	75.7
• Breast Exam	67.3	72.2
• Mammogram	80.9	77.1
• Prostate exam	23.7	37.0
• Dentist appointment	31.8	74.1
• Eye exam	38.5	69.3
• Blood pressure checked	64.7	86.9
• Cholesterol checked	56.3	76.7
• Flu vaccine	35.0	43.0
• Hepatitis vaccine	16.8	
Never had:		
• PAP	22.5	18.8
• Breast Exam	21.8	20.8
• Mammogram	10.5	10.2
• Prostate exam	66.4	40.8
• Dentist appointment	37.7	3.2
• Eye exam	43.2	12.8
• Blood pressure checked	22.8	7.1
• Cholesterol checked	32.2	15.7
• Flu vaccine	49.2	47.2
• Hepatitis vaccine	53.1	
No healthcare services in Native Language	68.0	57.0
No health resources in Native language	76.0	43.2

Sources: PHMC Household Health Survey 2004

The top five reasons reported as to why the respondent did not have insurance were:

- Not eligible due to health or other problems (58.2%)
- Could not afford/too expensive (13.5%)
- Employer did not offer (11.8%)
- Respondent was “healthy” (3.8%)
- Lost public program coverage (Medicaid/Medicare) (2.9%)

The data above points to many discrepancies between the two studies of Asian Health in Philadelphia. First, the population reached in the two studies varied in many important ways that

impact data findings. In most cases the health and access to care were understated in the PHMC data compared to the SEAMAAC data. The SEAMAAC data shows significantly higher rates of hypertension and mental health conditions, but also reported lower rates of insurance coverage and less health care utilization. Access to healthcare services is not available in respondent's Native language for 68% in the study and health resources in Native languages was not available for 76% of those surveyed. This provides challenges for those seeking health care and disease self-management. Preventive health care practices may also be challenged as a result of differing health paradigms related to health beliefs and medical practices. Health care providers may lack the awareness and competency to address these differences. There is a general lack of appropriate and accessible mental health services for the Southeast Asian population, and concepts of mental health diagnosis and treatment may differ among population subgroups.

Southeast Asians clearly lack much-needed access to health care and experience diminished quality of health care because of their socioeconomic status, lack of citizenship, and limited English proficiency. Improving services such as those that address resettlement needs, insurance, and social service options are needed to help these populations access health care services.

Undocumented Immigrants: Restaurant Workers

According to the Philadelphia Restaurant Opportunities Council, the restaurant and food service sector is the largest sector of the American Economy. Currently 10 million people work in this sector. Philadelphia is the nation's 5th largest restaurant industry with 140,000 workers. The restaurant industry grew through the Great Recession and is expected to employ an additional 2 million workers across the country in the next decade.

At least 40% of the workers in the industry are undocumented immigrants. The median wage in the industry is \$16,000 per year. The "tipped wage" in Pennsylvania is \$2.83/hour. The Department of Labor recently reported that of the 10 lowest paid jobs in the nation, 6 of them are in food production and food service. Five of those lowest paid jobs are in restaurants.

The Philadelphia Restaurant Opportunities Council's (ROC) study called "Serving While Sick" found a high rate of work place injuries among restaurant workers yet 94.3% of workers in this sector lack the option of getting health care through their employer; almost half (49.6% do not have health insurance; 92.8% do not have paid sick leave and 64.6% report handling or serving food while sick. Almost 12% of restaurant workers have gone to the emergency department without being able to pay⁶⁹.

Behind the Kitchen Door: The Hidden Reality of Philadelphia's Thriving Restaurant Industry is a project of the Philadelphia Restaurant Industry Coalition—a broad gathering of academics, progressive organizations, restaurant workers and restaurant employers. According to the report they released in October 2012⁷⁰, some employers run successful restaurants by setting fair wages, benefits and working conditions, thereby fostering employee satisfaction, lowering turnover costs, and increasing worker productivity. However, the research also shows that Philadelphia restaurant jobs are far more frequently bad jobs, characterized by low wages, little or no benefits, and abusive working conditions. Some of the findings in the report include:

- 62.1% of Philadelphia restaurant workers fall below the poverty line for a family of three

- Average annual real wages in Philadelphia restaurants decreased by 11% between 2001 and 2011, while earnings for the total private sector increased by 8%
- Whereas white workers' median wage is \$11.29, the median wage for workers of color is \$9.00. The wage gap is even greater when comparing women's median wages: \$11.47 for white women and \$8.00 for women of color
- Nearly two-thirds of Philadelphia restaurant workers (64.6%) have worked while sick; 71.7% of those that worked while sick said that they could not afford to take the day off without pay, and almost half (46.4%) said that they were afraid of being fired or penalized for staying home.
- More than 2 of 5 workers (42.3%) reported they sneezed or coughed while handling customers food.
- More than one-third of workers believe they have caused co-workers to become sick
- Low wages and a lack of benefits available to restaurant workers has resulted in nearly 12% of restaurant workers relying on emergency room care when they are unable to afford medical care.
- 19% of Philadelphians in the restaurant industry rely on public health insurance.

Refugees

For the past several years, nearly 800 refugees from multiple countries arrived in Philadelphia each year. Local resettlement agencies are responsible for ensuring that refugees are able to access health care within the first 30 days of arrival. All refugees must receive a basic health screening (immunizations, TB & other infectious diseases, parasites, PTSD) within this 30 day period. In addition, 38% of refugees will arrive with a **known** pre-existing health problem that requires care within the first 30 days of arrival. Refugees are eligible for 8 months of Medical Assistance. Local resettlement agencies must also provide orientation to US health care system.

The Philadelphia Refugee Health Collaborative (PRHC)⁷¹, a regional coalition consisting of Philadelphia's three refugee resettlement agencies and eight refugee health clinics, was formed in September 2010. The core mission of the Collaborative is **to create an equitable system of refugee health care in the Philadelphia region that ensures a consistently high standard of care for all newly arrived refugees**. Each year, PRHC provides domestic health screenings, primary care (including newborn, pediatrics, adult medicine, geriatric, obstetric and gynecologic care) and access to laboratory, radiology and subspecialty services to 800 newly arrived refugees. PRHC also provides ongoing primary care and women's health services to established refugee patients.

Jefferson's Center for Refugee Health has seen ~ 800 individual clients since 2007, from multiple countries – including - Karen (from Burma), Iraq, Liberia, Vietnam Cuba, Haiti, Nepal, Eritrea, and Sudan. To date, the majority of refugees seen have come from Iraq (36.1%), Myanmar (Burma) (19.3%), and Nepal (17.5%). Of those seen between 2007 and 2011, 14.2% are current smokers, 13.1% have been diagnosed with hypertension, 1.6% newly diagnosed diabetics, and 6.15% with a cardiac condition.

Refugee Health Partners (RHP) is a Jefferson Medical College student volunteer organization that works closely with TJU's Departments of Family and Community Medicine and Emergency Medicine. In partnership with Migrant Education, RHP holds monthly evening clinics at the Houston

Community Center in South Philadelphia. RHP is committed to addressing the unique, multifaceted challenges associated with refuge and immigrant health and takes a multidisciplinary approach to help refugees and immigrants overcome barriers to health and provides ambulatory health services, health education and advocacy services. The clinic serves as an important source of care for the refugees after their medical assistance benefits end at eight months post arrival in the United States. RHP involves Jefferson medical students, nursing students, public health students and students from the School of Health Professions. Students provide navigation services and home visits as needed and some are assigned to assist/mentor families longitudinally.

The **Bhutanese American Organization of Philadelphia (BAOP)** is a community organization established January 2013. The main goals are to unify and empower the Bhutanese community of South Philadelphia. Currently, Jefferson's interaction with BAOP is only through Refugee Health Partners (RHP) in a collaborative effort with Nationalities Services Center (NSC) to launch a Community Advocate Training program. The first session was held in February 2013. RHP hopes to foster a closer relationship with BAOP in the coming months as the organization grows and develops.

The results of a Needs Assessment of Refugee Communities from Bhutan and Burma⁷² conducted in 2010 by Temple University's Center for Intergenerational Learning (Patient Listening: Health Communication Needs of Older Immigrants) identified the following issues: –

1. Unmet Expectations

Expectations of the newly arrived refugees are often not met. Feelings of confusion and disappointment about their resettlement experience were evident in all focus groups and were attributed to: 1) misinformation and misinterpretation in the pre-departure stage, 2) the perception of differential treatment from resettlement agencies upon arrival, and 3) the economic reality of life in the United States during a recession

2. Existing Community Support

Three types of community organizing efforts are in place to meet resettlement challenges of newly-arrived refugees: 1) personal help to provide informal support, 2) volunteers (neighbors, churches, and family members) to supplement or fill in the gaps of resettlement services, and 3) community organizing to advocate for systemic change. Despite their struggles, refugees from Bhutan and Burma are trying to generate self-help efforts within the community.

3. Accessing Mainstream Services

There exists a strong sense of anxiety and confusion regarding experiences with organizations and institutions beyond resettlement agencies, such as health care agencies, employment services, public schools, and the police.

4. Role of 'Bridge Builders'

Many refugees rely on "bridge builders" who help them connect and navigate mainstream services. Bridge builders include both mainstream organizations and those led by refugees from Bhutan or Burma, as well as individuals from both refugee and mainstream communities.

5. Community Building Structures

Three types of community building structures were visible in these refugee communities: 1) ethnic churches, 2) professional networks, and 3) community support groups formed and carried over from the refugee camps.

6. Community Leadership

Refugee members were able to identify a group of influential people who help and represent their community in the United States. Descriptions of these people included “committed and care about the community,” “educated” and “speak English.” These “community leaders” function as sources of information, problem solvers, and advocates for the community.

In 2012, a needs assessment of the Burmese and Bhutanese refugees in South Philadelphia was conducted by the CUH and medical students. Cultural differences in how good health is defined are apparent. *“Health for us is traditionally if you can sleep well, eat well, look a bit fat, and walk.”* (Burmese key informant). The findings of these assessment and recent key informant interviews and focus groups with internal and external stakeholders follow.

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

- **Health Insurance**

- *After losing their insurance, some people, depending on their income, may qualify for Medicaid. However many people do not know how to apply and instead choose not to go to doctors. For those who decide to apply, the process is tedious, and there is confusion on how to know which plan to select, which doctor to select and which doctors accept their insurance. Also, those without insurance had the options of going to health centers that do not have interpreters, or to the emergency room, which is incredibly costly.*
- *While refugees have MA for the first 8 months they may become uninsured after this time. Need assistance with continuity of care (transfer to City Health Clinics or other providers) after the first 8 month transition time. Many immigrants lack health insurance.*
- *Many refugees lose health insurance after 8 months. How refugees manage health care after losing their MA is not well understood.*
- *The Welfare office has a centralized refugee office with 4 case workers who only work with refugees during first 2 years after they arrive. They provide assistance with filling out MA. Appears to be working well. City Health Centers - have connections with hospitals to make specialty appointments.*
- *Many immigrants lack health insurance. Some do not receive health insurance from employers; some are eligible for health insurance but are not applying for it. ACA will create challenges for non-English speakers in signing up for insurance. PICC is going to train community health workers to assist non-English speakers in completing forms. Cost for services for those without insurance is prohibitive*

- **Language Access**

- *All immigrants need assistance completing forms, insurance, navigating the health care system*
- *Non-English speakers need access to interpreters who are trained medical interpreters. Main concern is that there is no consistency within institutions. For example, Jefferson lacks consistency across Departments caring for immigrants/refugees in terms of access to language line particularly for specialty care.*
- *Need bilingual, culturally competent providers. While phone translators are better than nothing they are not the solution.*
- *ACA will create challenges for non-English speakers in signing up for insurance. PICC plans to train community health workers to assist non-English speakers in completing forms.*
- *Pastors report that they often serve as language interpreters for their congregation. Some hospitals use family members, often children. The Southeast Clinic may not have interpreters on-site. Health Center 2 has Cambodian and either Burmese or Bhutanese interpreters. Some refugee clinics use in person interpreters. These clinics contract for services with residents (trained community members); others use phone interpretation. Phone interpreters may not be trained in medical interpretation. Medical documents need to be translated. Videos might be a good way to educate given low literacy levels.*
- *Ground level staff need training in using interpreters and phone lines particularly in specialty care. Need training for TJUH staff who interface with non-English speakers such as finance, front line staff.*
- *Interpretation is a major issue. The fact that Refugees don't follow through with treatments plans/ medication therapy is related to language barriers. Interpreters for mental health issues is sometimes problematic...availability of interpreters can be unreliable; that is, there may not be an interpreter available who knows a needed language or dialect.*
- *Not all dialects are available (Karen, Chin etc)*
- *No addiction services are available in other languages.*
- *JUP and other practices may need cultural competence and language interpreter/ language line training. Hospital needs training on documenting use of interpreter in EMR. Need for documenting interpreter number.*
- *Approximately 20% of the daily volume of radiology and the Emergency Department at Methodist is non-English speaking. Scheduling does not have translators or access to interpreter lines.*
- *Need language access to help prep for medical procedures*
- *Investigate whether language assistance lines could be accessed by non-English speakers in order to help them call the hospital to schedule appointments, ask questions, etc.*
- *Several pastors serving the immigrant/refugee community indicated that they often assist their congregation members in navigating care and attend medical appointments to assist with interpretation.*
- *The Chinese Health Information center at Jefferson provides interpretation services for Chinese and Vietnamese refugees/immigrants. They also have stroke materials*

available in Chinese. There is a need for more bilingual education on chronic disease management and non-traditional medicines

- Assess how retail pharmacists educate non-English speaking residents
- **Primary Care**
 - Emergency services - some are using this for primary care because the wait is too long at other clinics and some providers are not taking new clients.
 - NSC teaches how to access 911 during orientation and overseas they are also taught how to do this. However, they are not taught appropriate use of the emergency department. Uninsured likely to use the ED for primary care particularly due to work schedules and concerns about co-pays.
 - Pastors shared that refugees need a note from the doctor when they are sick to show their employer. However, they are often unable to see a doctor immediately and by the time they get an appointment they are feeling better. Therefore they don't see the doctor because that would mean missing more work, and the employer does not pay them. The RHP student clinic could help with this but it is only open one day per month.
 - The Chinatown clinic that is run by Dr Lao (Drexel) and Dr Zarro (TJUH). They see refugees, immigrants and undocumented. People need help getting specialty care appointments. TJUH nursing goes to the clinic weekly with nursing students and help to translate. 90% of those who go to the Chinatown Clinic are restaurant workers. Also two attorneys provide assistance with emergency MA. Need centralized information about how to navigate the health care system such as who to call if you need transportation.
 - Refugee Health Partners do home visits. There are monthly group meetings to discuss the issues they are seeing. Greatest need identified during home visits is need for employment. Health is not even on their radar screen. Students need interpretation assistance during home visits.
 - Lack access to health education and chronic disease management programs due to language barriers.
 - Need access to care during non-working hours
- **Mental Health**
 - *Refugees and immigrants may have cultural issues around medication/therapy for mental health issues. They don't link mental and physical health. For many people, including refugees and immigrants, behavioral health issues are not a priority and may be less valued. While clients go to therapy, when interpretation is needed therapy often falls apart.*
 - *Depression among women is a problem. They don't take meds due to cost or cost shifting (need money to pay rent, feed children, etc.). Behavior providers say that more clinical behavioral care is needed. Need bilingual, culturally competent providers. While phone translators are better than nothing they are not the solution. Healthcare workers/providers need to be culturally competent (lack of respect in how women are treated)*
 - *Hesitant to talk about it (mental health issues) - not sure how to take medications and /or don't take because of cultural stigma related to mental health conditions.*
 - **Depression** in the refugee community not understood or identified
 - Assess cultural perceptions of mental health (what works and what doesn't)

- **Lack of support for prenatal and post natal care and breastfeeding**
 - There is a need for more education on pre and post natal health. There was a misconception of breastfeeding not being the best thing for a baby, as well as the need for multivitamins for mothers after giving birth because many of the mothers are malnourished.
 - *Preventive care needs include PAPs and STD testing. Also, preconception counseling doesn't happen (smoking, vitamins, emotional readiness, financial readiness, diabetes etc), contraception counseling and pregnancy termination information is needed for women. Post reproductive prevention for women 40-65 need basic screenings and menopause management information. Women also need more support for breastfeeding.*
 - *"Heart breaking". Many get late or no prenatal care. In Philadelphia the Health Centers will provide care for undocumented, but women fear deportation and they do not have insurance to cover hospital charges for birth of the baby (enter through ED). Limited access to food stamps, support for child care etc.*
 - *Seeing an increase in teen pregnancy under age 13 (possible link to IPV)*
- **Access to specialty care**
 - *Access to specialty care is challenging because of insurance issues (no insurance or don't accept MA and language). Navigating the health care system is confusing (primary care, pharmacy, specialty care, referrals, testing etc.). Hospitals should collaborate in identifying and addressing the most common access issues to specialist health care.*
 - *The City Welfare office has a centralized refugee office with 4 case workers who only work with refugees during first 2 years after they arrive. They provide assistance with filling out MA. Appears to be working well. City Health Centers have connections with hospitals to make specialty appointments. They are good at getting emergency MA and specialty care.*
 - *Uninsured and undocumented immigrants have increased in the rehab. They do not have money for medications (BP, pulmonary). They need assistance with Medicaid applications. They do not have money for canes/walkers. The hospital pays for these things so that patients can leave.*
- **Patient Navigators/ Community Health Workers**
 - *Train community people as patient navigators. The Refugee Academic Mentoring Program (NSC program) helps people get the skills needed to get health related employment. (example Burmese nurse)*
 - *The hospital needs navigators to bridge between the hospital and the community.*
 - *RHP students provide navigation services and home visits for Burmese and Bhutanese refugees. They need assistance with interpretation during home visits.*
 - *Train community health workers/patient navigators such as Nepali, to assist peers with navigating health care.*
- **Limited or misunderstood Transportation options**
 - *Some refugees do not know how to use the SEPTA token system, and were scared to try it. Some people also do not know what bus to take. It was also noted that tokens were too expensive especially for families with many children. This resulted in people choosing walking over using the bus even in very hot or very cold conditions.*

- *Cost of transportation and long waits. Paratransit can be unreliable. While paratransit will take physically impaired people to appointments, transportation for those with mental health issues is limited. It is often difficult for those who are mentally ill to take a bus. More home-based and community based services are needed.*
- **Interpersonal Violence**
 - *Interpersonal violence among Asians can be very secretive. Migrant Education sees clients daily. They do care management for factory workers and provide daycare for their children. There is fear among immigrants about deportation so therefore they may not report IPV. In addition, some cultures do not see IPV as inappropriate behavior culturally. Information about IPV is needed in other languages. In general, the community "takes care of it". Cultural leaders need education about resources etc.*
 - *Huge problem, particularly in Mexican women. 3 years ago this wasn't on the radar. Immigration status reduces IPV reporting.*
- **Lack of knowledge of community resources**
 - *Need to take care of social needs such as transportation, how to get tokens, assistance with resumes, library cards etc. Need to help people develop and use community networks for transportation, getting employment*
- **Caregiver Support**
 - *Older adults need caregiver support, respite care, end of life discussions. These are concerns in the near future because of aging populations particularly the Bhutanese. 20% have significant issues needing hospitalization and/or tests. Elderly are cared for by someone in the Bhutanese community who doesn't work - caring for the elderly person is seen as their job. Given that this is seen as their job, they may not receive community support. In addition, the family loses the earning potential of the person who is caring for the elderly person. PCA assesses the need for caregiving and if caregiving is essential and the caregiver meets income guidelines, then the caregiver can receive up to \$20/hr. through JEVS for providing care.*
- **Excessive smoking**
 - *There was some concern about smoking in both the Burmese and Bhutanese communities. There was also a lot of tobacco chewing among the Burmese as they had been doing it in the camps. The need for education on the dangers of smoking was highlighted. Also, one of the Key Informants stated how the kids knew smoking was bad, but it was disrespectful for them to correct their parents and grandparents on the dangers of smoking because of the belief in the role of children and how it is not their place to correct their elders.*
- **Alcohol and substance abuse**
 - *"There is a lot of drinking because it is easily accessible and cheap"*
- **Health education**
 - *Health education needed (Hep B, Healthy pregnancy, nutrition, (church could provide translator)*
 - *Need health education and chronic disease management programs*

Recommendations included:

- Screen patients for food security; when signing up patients for MA, also sign them up for food stamps; Refer to community food cupboards (or consider giving person voucher to the Atrium or area food markets)
- Partner with the Cambodian Association and others to explore feasibility of initiating a Wellness center in South Philadelphia for the Asian Community
- Train bilingual immigrants/refugees as community health workers/patient navigators
- Train community health workers and individuals in health professions to provide health education and chronic disease management programs
- Partner with AHEC, NSC RAMP program, Jefferson Human Resources and TJU Office of Diversity and Minority Affairs to develop a health professions pipeline for youth and adults
- Support Jefferson's Refugee Health Center, and the student run Refugee Health Partners
- Medical interpreter training for community based organizations and refugees trained as navigators
- Develop cultural competence training for TJUH and JUP staff. Need training for TJUH staff who interface with non-English speakers such as finance, front line staff.
- Improve adherence to language access requirements for limited English speakers particularly in specialty care.
- Review existing TJUH health education and signage to enhance language accessibility and wayfinding. Create bilingual forms and health education materials
- Connect TJUH Psychiatry Department to South Philadelphia immigrant/refugee community
- Interface with the Mayor's Office of Immigrant and Multi-Cultural Affairs
- Continue partnership with ROC Philadelphia
- Advocate for paid sick leave and living wage
- Assess health needs and health care utilization after initial 8 months of medical assistance has ended
- Work with key stakeholders in developing a Medical Legal Partnership
- Assist in enrolling refugees/immigrant into health insurance (Enroll America)
- Partner with community organizations to raise awareness about community resources.

Homeless

In Philadelphia, official counts find that on a given evening, 6,304 people were homeless. Of these, 3,250 were in families, all of whom were sheltered at the time. The remaining 3,054 were individual adults, of whom 506 were unsheltered on that night. On average, throughout 2012, there were 424 people living on the streets of Philadelphia on any given night, of whom approximately a quarter had a serious and persistent mental illness. For some portion of this population, their mental illness involves a personality disorder that makes them averse to being around and living with other people. The street population is made up almost exclusively of single adults, as emergency housing programs

are utilized to a greater extent by families, especially single mothers with children. The causes of homelessness and the characteristics of the homeless differ greatly across subpopulations.

The City of Philadelphia's current system is based on the concept of creating a "Continuum of Care," which seeks to help homeless people by moving them through a sequence of housing and service models in which consumers are gradually moved from shelter through transitional housing and, eventually, into permanent housing. The Continuum of Care has been the "predominant service delivery model designed to address the needs of this chronically homeless population." Moving through this continuum and into permanent housing requires consumers to meet the goals of each program in order to demonstrate that they are "ready" to progress to the next level. Independent, permanent housing is offered as a 'rewards' for more normatively acceptable behavior. This Continuum of Care approach has been successful in helping a significant portion of homeless households, generally single-parent families who need a safe, affordable place to live while they resettle their lives and gain additional skills and abilities that will allow them to support themselves.

Among those individuals that this system has been unable to help are service-resistant chronically homeless people with serious mental illness. While these people make up a relatively small proportion of the homeless population, they are the most frequent and expensive users of the system. Characterized by serious mental illness, substance abuse and personality disorder, this subset of the homeless population is adverse to being around and living with other people. For people suffering from personality disorder as part of their mental illness, living alone on the streets is preferable to being around other people, much less abiding by a strict set of externally imposed rules. Understanding this aversion to be around other people provides an opportunity to help them. Nationally, there is a move away from the Continuum of Care approach to dealing with the service-resistant, seriously mentally ill homeless. This emphasis has led to interest among practitioners in the Housing First approach to serving this population. The City of Philadelphia has also moved in this policy direction by supporting initiatives to move individuals into permanent housing.

100,000 Homes Campaign

During three nights in May 2011 the *100,000 Homes Campaign*¹² Volunteers administered a survey to 528 people living on the street, 412 of whom met the "chronic" criteria. Of the 528, 268 (51%) were deemed vulnerable, and at increased risk of death. Vulnerable is defined as individuals who have been homeless or at least six months, and have one of more of the following markers – more than three hospitalizations or emergency room visits in a year, aged 60 or older, cirrhosis, end-stage renal disease, history of frostbite, or hypothermia, HIV/AIDS, and tri morbidity (co-occurring psychiatric, substance abuse and chronic medical condition).

TJUH and TJU have strong relationships with two agencies serving the homeless – Pathways to Housing and Project H.O.M.E. In addition, TJUHs and DFCM faculty have been working with the homeless for the past 20 years, through the Jeff H.O.P.E program

Pathways to Housing (PTH)⁷³ was invited to Philadelphia by City of Philadelphia officials in the summer of 2008 to implement their Housing First, scattered-site housing model. By the end of that summer, Pathways had a program and staff in place and began serving chronically homeless Philadelphians with severe and persistent mental illness and co-occurring disorders. Pathways to

Housing, originally developed and implemented in New York City, followed a Housing First approach, blending together Assertive Community Treatment (ACT) Team and Supported Housing models. This program was specifically designed to serve people who are chronically homeless. The cornerstone of this model is the emphasis on consumer choice: consumers choose the neighborhoods they want to live in, how their apartments are furnished, and all other decisions regarding the use of their homes. The housing is permanent and is held for the individual during relapse, psychiatric crisis or short incarcerations. Consumers also determine the frequency, duration, and intensity of the support and treatment services they receive.

Dr Lara Weinstein, a DFCM faculty member who provides integrated primary care to PTH clients and colleagues reported on the chronic physical disease burden of people entering the program. Their evaluation confirmed significantly higher rates of chronic disease (60%) and fair/poor self-reported health status (47%) than the general urban population of Philadelphia. The majority of clients reported they wanted to address both medical (67%) and mental health (68%) problems, but a much lower percentage reported wanting to reduce substance use (23%) or take psychiatric medications (25%). They concluded that formerly homeless entrants to Housing First programs have a high burden of chronic disease with complex health-related needs.

Project H.O.M.E.

The mission of the Project H.O.M.E.⁷⁴ community is to empower adults, children, and families to break the cycle of homelessness and poverty, to alleviate the underlying causes of poverty, and to enable all of us to attain our fullest potential as individuals and as members of the broader society. Project H.O.M.E. achieves its mission through a continuum of care comprised of street outreach, a range of supportive housing, and comprehensive services. Project H.O.M.E addresses the root causes of homelessness through neighborhood-based affordable housing, economic development, and environmental enhancement programs, as well as through providing access to employment opportunities; adult and youth education; and health care.

The St. Elizabeth's Wellness Center of Project H.O.M.E. is staffed by faculty and residents from TJU and is committed to addressing the health and wellness needs of people living in the community, including residents of Project H.O.M.E.-sponsored housing, people living in North Philadelphia, and people who are currently homeless. These health services, located within the St. Elizabeth's Community Center in North Philadelphia (located at 23rd and Berks), include primary medical care, behavioral health care, and care coordination services.

Services are offered regardless of health insurance status, and include:

- Primary medical care for adults.
- Behavioral health services for children and adults, including individual, couple and family therapy, adult support groups, play therapy groups known as the House of Hope and Peace, peer support for people struggling with addiction, and linkage to psychiatry.
- Care coordination services including assistance with applying for medical assistance, obtaining transportation to medical appointments, applying for free or low-cost medications, and scheduling appointments with specialists.
- Support services for a healthy lifestyle, including one-on-one nutrition teaching with our RN, diabetes self-management classes through Jefferson's Center for Urban Health, and therapeutic healing touch for stress reduction by Sr. Catherine Ginther, a Franciscan sister.

In 2011, St. Elizabeth's Wellness Center formed the St Elizabeth's Wellness Collaborative with other behavioral health providers to increase access to trauma-informed counseling services for patients of St. E's and members of the wider community. The coalition, led by a therapist from Women Against Abuse, received a grant from the City's Dept. of Behavioral Health. Through this grant, the following agencies and their staff are able to provide on-site services at St. E's:

- Women Against Abuse
- House of Hope and Peace
- Council for Relationships:
- PRO-ACT
- Jefferson Psychiatry
- Jefferson Family and Community Medicine

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

- **Affordable housing** is a critical need
- Many individuals with **chronic disease and serious mental illness**
 - Need culturally relevant health education for homeless and formerly homeless
- **Care Coordination**
 - *Need for improved communication and care coordination between the hospital, homeless/social service agencies, behavioral health and primary/specialized medical care.*
 - *Lack of coordination results in duplication of services (tests, screening, labs, etc.). Care transitions after discharge from hospital are critical. Need to improve communication at discharge between hospital and social service agency.*
 - Develop and implement Community Health Worker Training to enhance care coordination and transition
 - *Social service/homeless organizations/ agencies should provide training for healthcare providers around culturally competent care for homeless individuals who also have mental health issues (dual diagnosis). Need to decrease the stigma and stereotyping of homeless mentally ill among health care staff.*
 - Need better coordination of care for formerly homeless and those in D&A treatment
 - *Co-locate primary care and behavioral health services*
 - *Need more formal psychiatry services offered on-site at a central location that meets the holistic needs of homeless. Substance abuse support should also be provided at a centralized service site. Currently Belmont is providing these services at another site.*
 - Need case management services for patients at Wellness Center
 - Need access to timely behavioral health services
- **ED utilization**
 - Working with TJUH ED to coordinate care across Jeff HOPE and Wellness Center

Recommendations included:

- Partner with community based organizations serving the homeless such as PCA, PDPH, WAA
- Support advocacy issues such as affordable housing, workforce development and economic development
- Support health education efforts for clients at PTH and Project H.O.M.E.'s Wellness Center. Coordinate with TJUHs departments already doing screening such as JHN stroke screening, TJU Nursing, Breast Screening Program, Nurse Magnet, and the Pharmacy.
- Community Health Worker Training to enhance care coordination and transition
- Culturally relevant health education for homeless and formerly homeless
- Working with TJUH ED to coordinate care across Jeff HOPE and Wellness Center
- Case management services for patients at Wellness Center
- Provide training to TJUH faculty and staff to improve cultural competence in treating homeless/sheltered individuals
- Improve access to behavioral health services through centralization of services and care coordination with primary care

LGBT

Mazzoni Center⁷⁵ is the only health care provider in the Philadelphia region specifically targeting the unique health care needs of the lesbian, gay, bisexual, and transgender communities. Founded in 1979, it is the oldest AIDS service organization in the Commonwealth of Pennsylvania, and the fourth-oldest in the nation. As the organization grew and evolved to meet the needs of our constituents, Mazzoni Center has combined HIV/AIDS-related services and health services. With over 30,000 individuals benefiting annually from their services, they are a leader among community-based organizations in the greater Philadelphia area, and have developed a reputation for excellence and innovation in service delivery. Mazzoni Center offers a full array of primary health care services, mental and behavioral health services, and LGBT legal services, as well as HIV and STD testing, food bank and housing subsidies for families and individuals affected by HIV, support groups, outreach and education programs

Three faculty from the Department of Family and Community Medicine staff the Mazzoni Center.

Issues, challenges unmet needs and priorities identified by key informants and focus group participants related to the LGBT community included

- **Insurance**
 - *Many LGBT are uninsured*
- **Respect**
 - *Many physicians and office staff who don't understand the needs of LGBT patients - perceived or actual "disrespect" based on LGBT experiences. LGBT may have to explain their sexuality issues to others over and over again.*
 - Cultural competence training in treating LGBT in hospital.
- **Literacy** –

- Many need assistance in making phone calls for appointments and actually going to the appointments
- Navigators to assist.
- Lack of wellness programs on **nutrition, weight management and smoking cessation**
- **Care coordination** - Case managers at Mazzone accompany clients to doctors' appointments and visit patients daily who are hospitalized.

Recommendations included:

1. **Cultural competence training in treating LGBT in TJUHs**
2. **Need for assistance in making appointments and going to specialty appointments**
3. **Provide wellness programs in partnership with the Mazzone Center**

Recommendations:

To address the community health needs identified in the CHNA, recommendations for initiatives were prioritized based on secondary data findings, primary data gathered through key informant interviews, and focus groups with community residents. Participants in key informant interviews and focus groups were asked to identify the health needs of the community and were then asked to identify those they felt were most important to address. They were also asked to recommend potential initiatives to address these needs.

The identified priority health needs and recommended initiatives were then grouped into the following domains:

- Internal organizational structure
- Access to care
- Chronic disease management,
- Health screening and early detection
- Healthy lifestyle behaviors and community environment

To further prioritize these initiatives, a subcommittee of the Community Benefit Steering Committee developed ten criteria with weighted values and then ranked each health need/issue using the agreed upon criteria. Scoring could range from 0-3 depending on the assigned weighted value. Criteria scores were then summed for each identified health need/issue. These criteria and weighted values are provided below:

Criteria	Weighted Value
Doesn't meet HP 2020 and regional/national priority	2
Disparity exists compared to Philadelphia	3
Focus groups and key informants perceive problem to be important	2
Sub-population is special risk	3
Problem not being addressed by other agencies	1
Has great potential to improve health status	3
Positive visibility for TJUHs	1
# People affected	2
Feasibility/resources available/existing relationships	2
Links to TJUHs strategic plan	2

The prioritization and rankings inform the Implementation Plan and the timeline for phasing in these interventions. The Table below summarizes the results of the prioritization process:

Domain	Priority Health Needs/Issues	Ranking Score	Priority Level
Chronic Disease Management	Chronic Disease Management (diabetes, heart disease and hypertension, stroke, asthma)	20.5	Most Important
Chronic Disease Management	Obesity	20.0	Most Important
Access to care	ED Utilization and Care Coordination	19.5	Most Important
Access to care	Health Education, Social Services and Regular Source of Care	19.0	Most Important
Access to care	Language Access, Health Literacy and Cultural Competence	19.0	Most Important
Healthy Lifestyle Behaviors and Community Environment	Smoking Cessation	18.5	Most Important
Internal Organizational Structure	Workforce Development and Diversity	18.0	Most Important
Access to care	Health Insurance	17.5	Important
Access to care	Maternal and Child Health	17.0	Important
Healthy Lifestyle Behaviors and Community Environment	Access to Healthy Affordable Food and Nutrition Education	17.0	Important
Healthy Lifestyle Behavior and Community environment	Physical Activity	16.5	Important
Healthy Lifestyle Behaviors and Community Environment	Built Environment	15.0	Important
Healthy Lifestyle Behaviors and Community environment	Food Security	15.0	Important
Internal Organizational structure	Hospital Readmissions	15.0	Important
Healthy Lifestyle Behaviors and Community Environment	Youth Health Behaviors	14.5	Important
Healthy Lifestyle Behaviors and Community Environment	Community Safety	14.0	Important
Access to care	Mental Health Services	13.5	Important
Access to care and Community environment	Social and Health Care Needs of Older Adults	13.5	Important

Domain	Priority Health Needs/Issues	Ranking Score	Priority Level
Healthy Lifestyle Behaviors and Community Environment	Alcohol/ Substance Abuse	13.0	Important
Access to care	Access: Transportation	11.5	Less Important
Health screening and early detection	Colon Cancer	11.0	Less Important
Access to care	Medication Access	10.5	Less Important
Health screening and early detection	Women's Cancer	10.5	Less Important
Health screening and early detection	HIV	9.0	Less Important

In addition, the Community Benefit Steering Committee recommended that an external Community Advisory Group be created and coordinated by TJUHs. This group would meet quarterly and include key stakeholders from the community, including residents, as well as our collaborating partners. This will provide an opportunity to share information, coordinate efforts, and modify efforts as needed. It will also help to promote partners programs throughout the community and better engage the community in health promotion efforts. They also recommended that an internal TJUHs Community Benefit Group be created to more fully coordinate TJUHs and TJU current and future community benefit activities. An Interdisciplinary Council that spans the Jefferson Academic Medical Center should be formed to coordinate efforts across the university and hospitals. Current activities lack common focus, are fragmented, are not strategically focused on TJUHs CB areas and lack coordinated approach for measurement and evaluation.

Finally, all Community Benefit activities should integrate and coordinate service, educational, clinical and research community-based opportunities to support Health Professional education between community, hospital and University. This will be coordinated by the internal Community Benefit group in collaboration with the external Community Advisory Group.

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