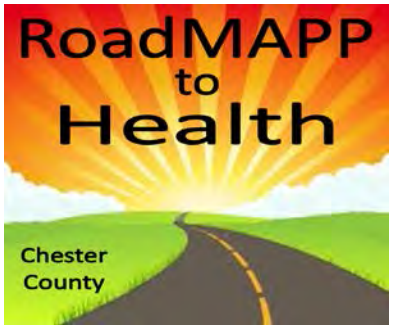


RoadMAPP to Health

Community Health Improvement Plan

Assessment - Plan - Action

Delaware Valley Regional Planning Commission
February 11, 2015

Community Health Improvement Plan

BACKGROUND

The Journey


Jun 2011: First key leaders meeting
Nov 2012: Assessments completed
Dec 2012: Strategic Issues Identified
Feb 2013: Assessment Findings Community Presentation
May 2013: Strategic Issue Teams began meeting
Jun 2013: Advisory Council began meeting
Dec 2014: CHIP complete
Oct 2013: Assessment Report complete
Dec 2014: Community CHIP Presentation
2015: Repeat assessment

The Goal

To better serve the people of Chester County by collaborating with organizations that take action, make an impact, and work to improve health and quality of life throughout the county

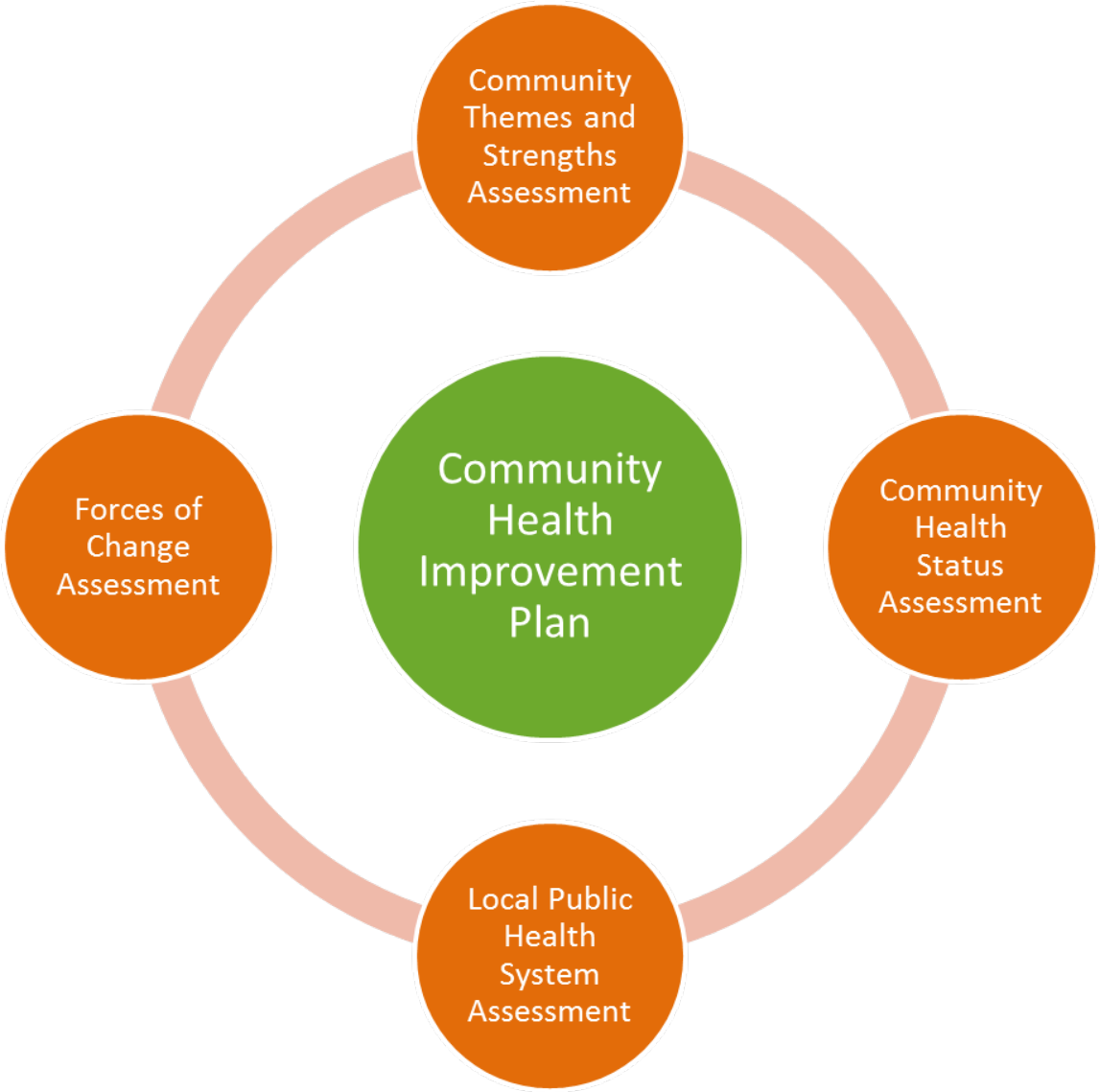
RoadMAPP to Health
Chester County

The Vision

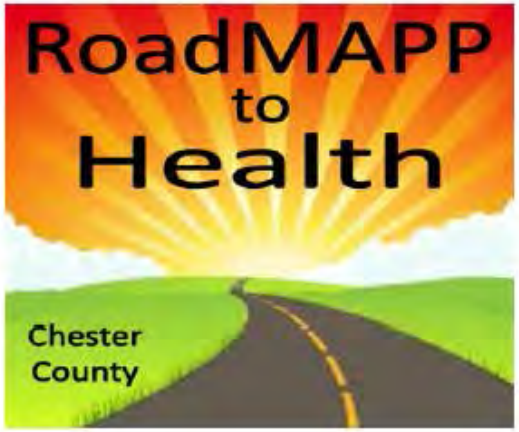
To become a community where partners assure conditions in which individuals can be healthy and individuals are empowered to manage their own health

RoadMAPP to Health
Chester County

The Assessments



The Findings

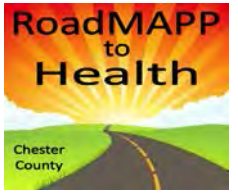


RoadMAPP to Health
Chester County

Community Health Assessment

Summary Report

July 2013

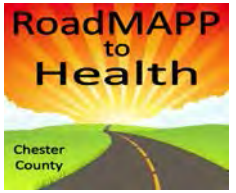


The Priorities

- Cultural Competence and Health Disparities
- Behavioral and Physical Health Coordination
- Awareness of Community Resources
- Individual Health Management and Disease Prevention
- Safe and Healthy Environments

Community Health Improvement Plan

THE PLAN



The Framework

- Action-oriented
- Provides framework, but is not prescriptive
- Supports partnership building
- Working towards common goals
- Collective impact

RoadMAPP to Health
Chester County

Community Health Improvement Plan

PRIORITY 1: CULTURAL COMPETENCE AND HEALTH DISPARITIES

Paul Huberty, The Chester County Hospital
Joseph Younge, MLK Community Development Corporation

Cultural Competence & Health Disparities

Goal 1.1:

Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs

---

Objective 1.1.1

Advance positive health equity and outcomes in the Chester County community by raising the awareness and meaning of cultural competency

Objective 1.1.2

Advance positive health equity and outcomes in the Chester County community by adopting a set of actionable recommendations to build the ability to interact within health institutions, networks, and systems of care

---

RoadMAPP to Health

Chester County

Cultural Competence & Health Disparities

Goal 1.2:

Reduce health disparities within Chester County

Objective 1.2.1

Reduce birth disparities by increasing access to early and adequate prenatal care to women living in Chester County

---

Community Health Improvement Plan

PRIORITY 2: BEHAVIORAL AND PHYSICAL HEALTH COORDINATION

Donna Carlson, Chester County Department of Human Services
Dr. Kimberly Stone, Chester County Health Department

Behavioral & Physical Health Coordination

Goal 2.1:

Improve behavioral and physical health through a well coordinated network of services that enables providers to adequately identify and address both behavioral and physical health issues

---

Objective 2.1.1

Identify actionable recommendations that advance the coordination of services addressing individuals' physical and behavioral health needs

---

RoadMAPP to Health
Chester County

Community Health Improvement Plan

PRIORITY 3: AWARENESS OF COMMUNITY RESOURCES

Barbara Mancill, United Way of Chester County
Kathy Brauner, Chester County Department of Human Services

Awareness of Community Resources

Goal 3.1:

Increase awareness of and education about available health and social services among residents throughout Chester County

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Objective 3.1.1

Expand provider participation in existing information and referral resources in Chester County

Objective 3.1.2

Increase efforts to effectively promote available health and social services throughout Chester County

---

RoadMAPP to Health
Chester County

Community Health Improvement Plan

PRIORITY 4: INDIVIDUAL HEALTH MANAGEMENT AND PREVENTION

JOAN HOLLIDAY, ACTIVATE CHESTER COUNTY RESOURCE TEAM
BARBARA MANCILL, UNITED WAY OF CHESTER COUNTY

Individual Health Management & Prevention

Goal 4.1:

Strengthen the capacity for local *ACTIVATE Chester County* initiatives to initiate and sustain promising practices that encourage and support moving more, eating smart and creating supportive environments.

Objective 4.1.1

Increase opportunities for local ACTIVATE Chester County initiatives to seek and receive support for educating, mobilizing, and sustaining communities toward individual health management

---

RoadMAPP to Health
Chester County

Community Health Improvement Plan

PRIORITY 5: SAFE AND HEALTHY ENVIRONMENTS

JEANNE CASNER, CHESTER COUNTY HEALTH DEPARTMENT

Key Question

- What is the role of non-health organizations in advancing the health of our community?

National Importance

- Urban Land Institute's *Building Healthy Places* Initiative
  - Shaping projects and places in ways that improve the physical, mental, and social well-being of people and communities

Urban Land Institute

RoadMAPP to Health
Chester County

National Importance

- Centers for Disease Control and Prevention's Department of Physical Activity, Obesity and Nutrition
  - National survey of community-based policy and environmental supports for healthy eating and active living

National Importance

- Department of Health and Human Services' National Prevention Strategy's Strategic Directions
  - Healthy and Safe Community Environments
  - Clinical and Community Preventive Services
  - Empowered People
  - Elimination of Health Disparities

RoadMAPP to Health
Chester County

Local Importance

- Chester County Strategic Business Plan
  - Healthiest County
  - Promote physical health

Safe and Healthy Environments Partners

- Department of Community Development
- Department of Emergency Services
- Department of Parks
- Planning Commission
- Water Resources Authority

RoadMAPP to Health
Chester County

Safe & Healthy Environment

Goal 5.1:

Strengthen environmental supports that promote health and safety

Objective 5.1.1	Objective 5.1.2
Provide a broad range of services that address the housing and workforce needs of Chester County residents	Enhance existing infrastructure that supports healthier and safer communities

Take Aways

- All of us have a responsibility to make the healthy choice the easy choice
- Supportive environments empower people to make healthy choices
- Engaging health experts allows community leaders to explore how they can help create supportive social and environmental conditions that impact overall health
- Success will depend highly on how communities are planned, designed, and built as much as on changes in individual behavior

RoadMAPP to Health
Chester County

Thank You to our RoadMAPP Partners!

American Heart Association
Brandywine Health Foundation
Bridge of Hope
Cerebral Palsy Association
ChesPenn
Chester County Food Bank
Chester County Intermediate Unit
Child Guidance Resources Center
Coatesville Center for Community Health
Community Members
Department of Aging
Department of Drug and Alcohol
Department of Human Services
Devereux
Drug and Alcohol Services
Empowerment Resources Associates
Gaudenzia
Holcomb Behavioral Health Systems
Jarrett A. Jackson, LLC
Lincoln University
Maternal and Child Health Consortium (MCHC)
MLK Community Development Corporation
Penn Home Care
Phoenixville Hospital
Private Practice Psychologists and Physicians
The Chester County Hospital
United Way of Chester County
Water Resources Authority
West Chester University
YMCA of the Brandywine Valley

ACTIVATE Chester County
Brandywine Hospital
Capacity for Change, LLC
Cerebral Palsy Association of Chester County
Chester Counseling Center
Chester County Hospital
Chester County Library System
Children, Youth, and Families
Community Care Behavioral Health
Community Volunteers in Medicine
Department of Community Development
Department of Emergency Services
Department of Juvenile Probation
Downingtown Senior Center
Drug and Alcohol Services
Fellowship Health Resources
Health Department
Human Services, Inc.
La Comunidad Hispana
Main Line Health
Mental Health/Intellectual and Developmental Disabilities (MH/IDD)
Pam Bryer Consulting
Phoenixville Healthcare Access Foundation
Planning Commission
Reshaping Nutrition
The Clinic
Volunteer English Program
West Chester Mayor's Office

Planning & Health Partnerships for a Healthier Chester County

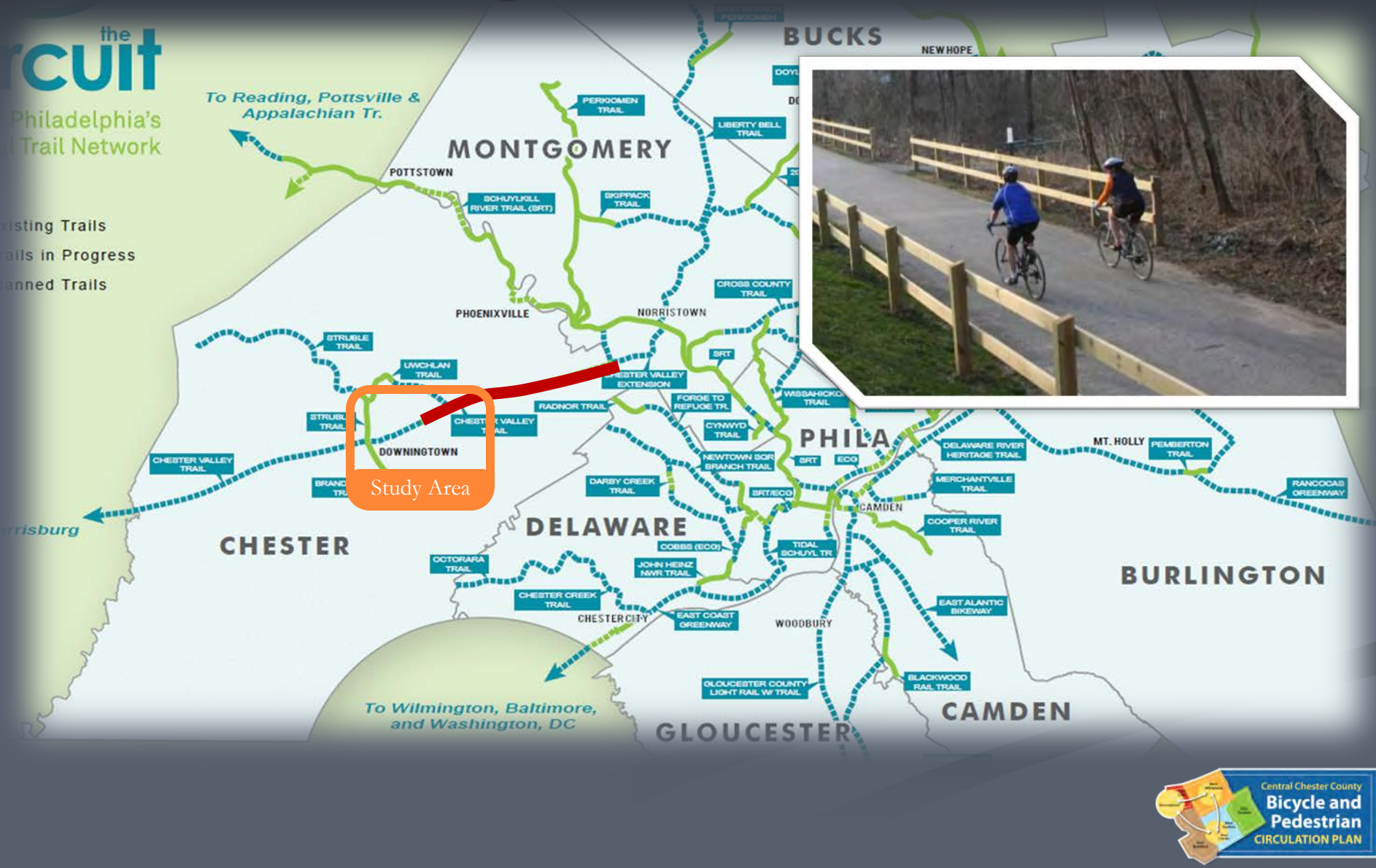
Randy Waltermyer, AICP
Chester County Planning Commission
February 11, 2015

Why? The Good.

Central Chester County
Bicycle and Pedestrian
CIRCULATION PLAN

The Bad & the Ugly.

Regional Context



Central Chester County
Bicycle and
Pedestrian
CIRCULATION PLAN

Project Approach

- 18-month project
- Planning Commission + Health Department
- 10 advisory committee meetings
- Individual stakeholder interviews
- 5 public meetings

Plan Recommendations

Bicycle Facilities

Shared Roadway (no shoulder)

Motor vehicles and bicycles are intended to use the same travel lane.

Shared Roadway (paved shoulder)

A wide, paved shoulder available for bicycles to use.

Bike Lane

A striped travel lane for non-motorized vehicles.

Bicycle Boulevard

Shared roadways with low traffic volumes which are suitable for bicycle travel.

Cycle Track

Travel lane for non-motorized vehicles with a barrier to other traffic. May be designed for one-way or two-way travel.

Pedestrian-Only Facilities

Signalized Intersection Improvements

Treatments targeted to improve pedestrian safety and comfort.

High Visibility Crosswalk

Pavement markings that are easily seen by motorists from their vehicle.

Supplemental Striping & Signage

Share the Road signs

Alert motorists of increased potential for bicycle traffic.

Sharrow

Pavement marking used to indicate increased bicycle traffic.

Signed Bike Route

Way-finding treatment that indicates the facility has been designated for bicycle use.

Shared-Use Facilities

Multi-Use Trails

Off-road facilities, intended for multiple user modes.

Sidepath

A multi-use trail that parallels a roadway.

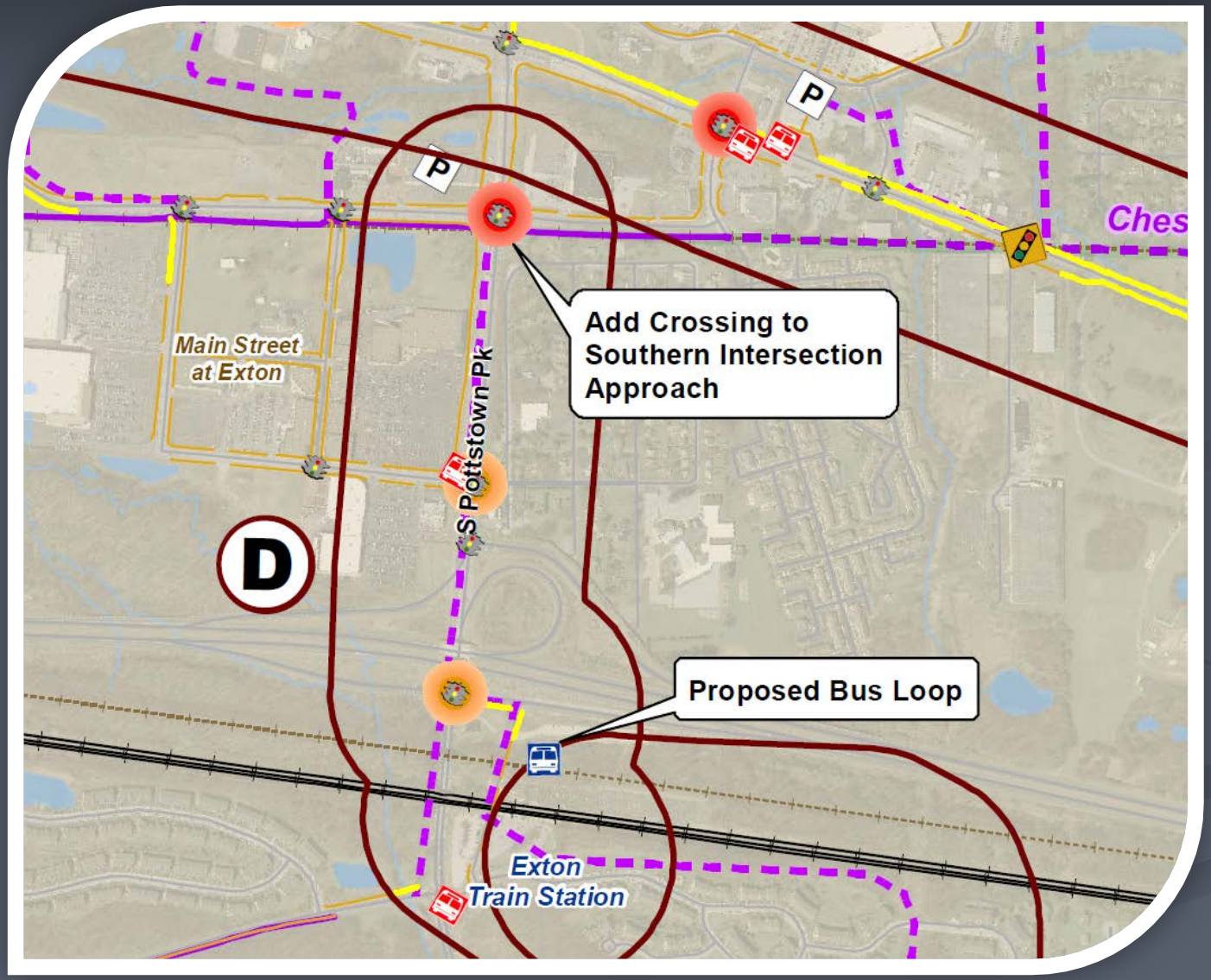
Use-Restricted Trails

Off-road facilities, only certain modes are accepted.

Mid-block Crossing

Allows users to cross a road safely at a location other than an intersection.

Improvement Plan



Improvements

- Multi-Use Trails
- Restricted-Use Trails
- Proposed Sidewalks
- Trail Parking
- Add Transit Shelter
- Priority Corridors

Intersections Improvements

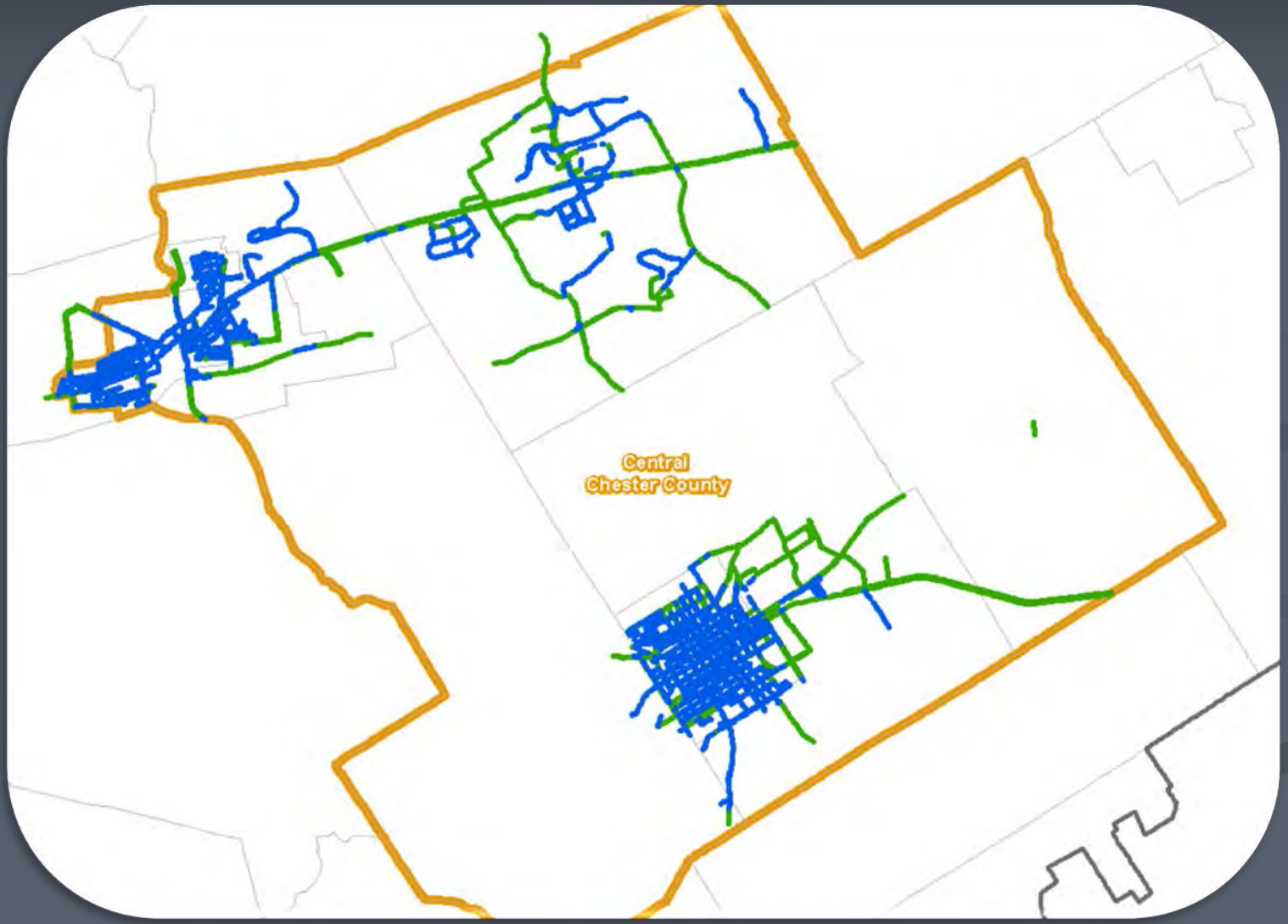
- Update Crosswalks/Ped. Signals
- Add Crosswalks/Ped. Signals
- Mid-block Crossing
- Signalized Trail Crossing

Central Chester County Bicycle and Pedestrian CIRCULATION PLAN

Sidewalks

Existing Sidewalks

Existing and Proposed Sidewalks



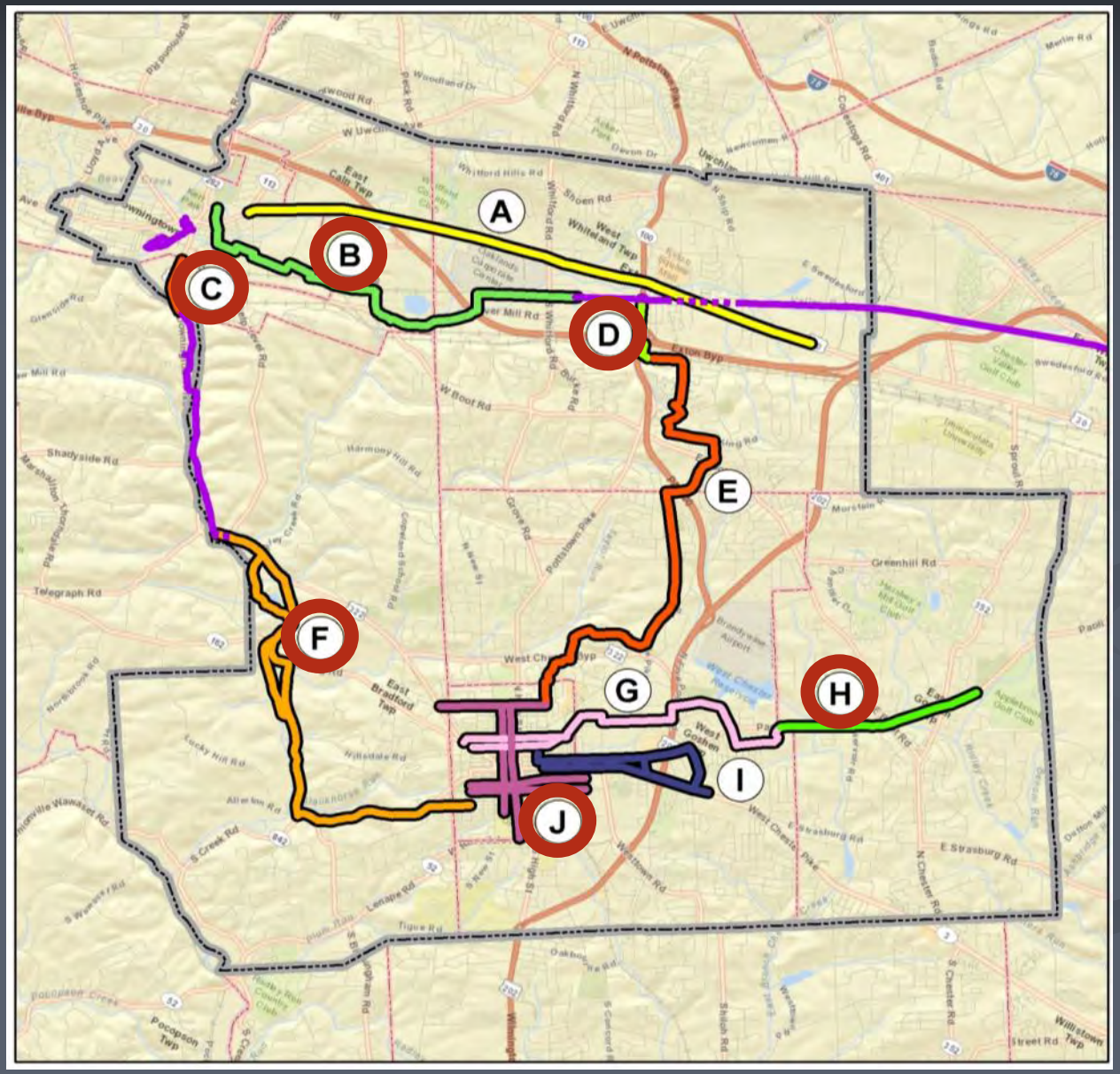
Signed Bicycle Boulevards

Intersection Upgrades

Fly-Through Videos

Central Chester County
Bicycle and
Pedestrian
CIRCULATION PLAN

Priority Projects



Central Chester County
Bicycle and Pedestrian
CIRCULATION PLAN

Don’t forget the other E’s!

- Education
- Enforcement
- Encouragement
- Evaluation

Central Chester County Bicycle and Pedestrian CIRCULATION PLAN

"Top 10" Programs

- Driver's Education
- Education & Enforcement
- Police Partnerships
- Route Signage & Mapping
- Maintenance Planning (Bike Lane Sweeping)
- Employer Incentives
- Yield to Pedestrian Devices
- Walking School Bus
- Bicycle Share Programs
- Bike Rodeos

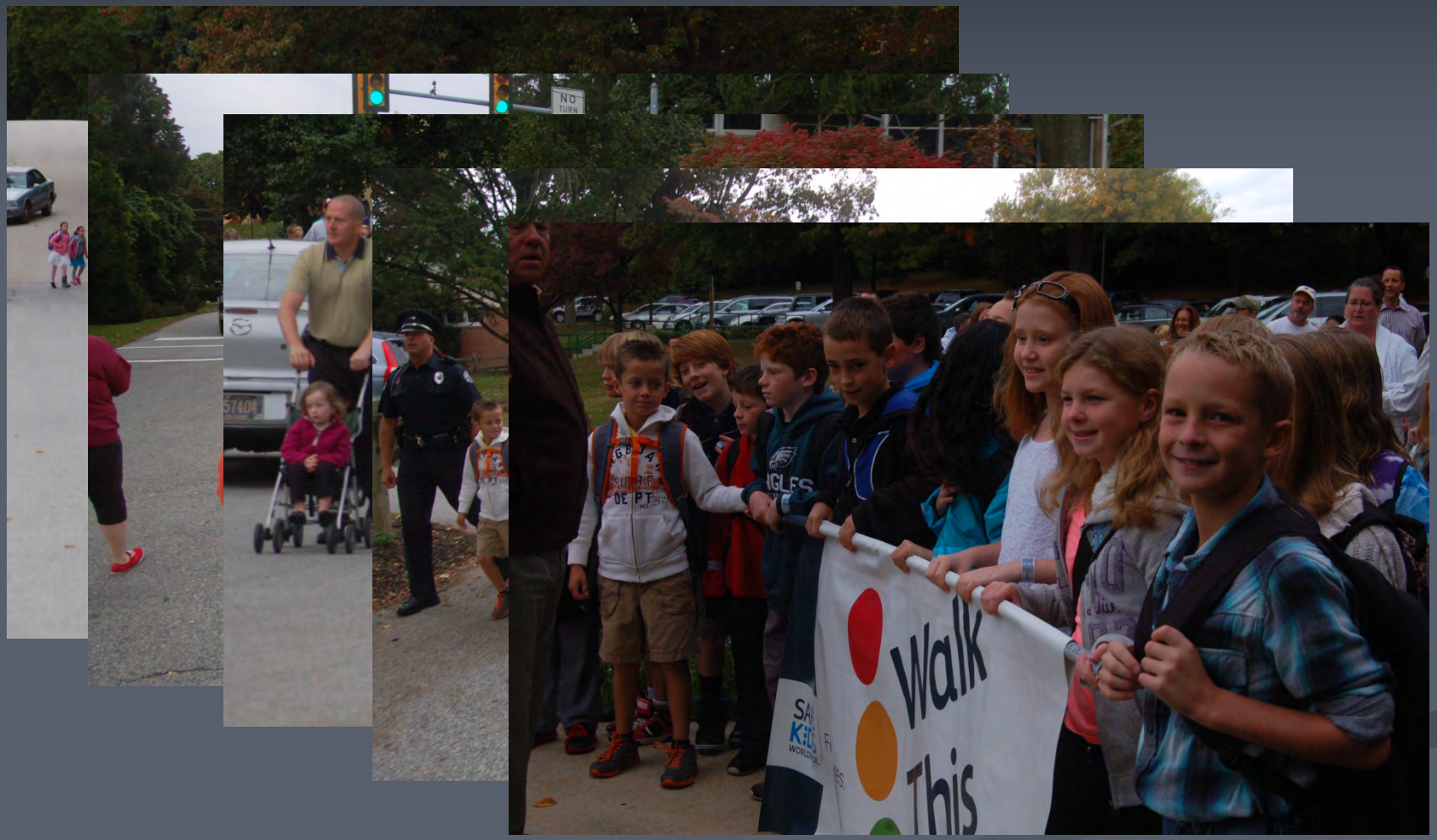
Central Chester County Bicycle and Pedestrian CIRCULATION PLAN

Walking School Bus

Central Chester County
Bicycle and
Pedestrian
CIRCULATION PLAN


7:55 am
7:50 am
8:00 am
8:08 am
8:08 am
8:04 am
7:59 am
7:55 am
Coopersmith Park
Goshen Terrace Apartments
Strasburg Court Apartments
West Chester Pike
E Strasburg Rd
Strasburg Rd
Kingsway Rd
Queen Ln
Joy Ln
Box Elder Dr
Hawthorne Ln
Ellis Ln
Mark Dr
Baldwin Dr
Spring Valley Cir
Rolling Rd
Farmington Ln
W Warren Rd
Elton Cir
Warren Rd
Rockland Ave
Boulder Ln
Falcon Ln
Sylvan Rd
David Ln

Walking School Bus

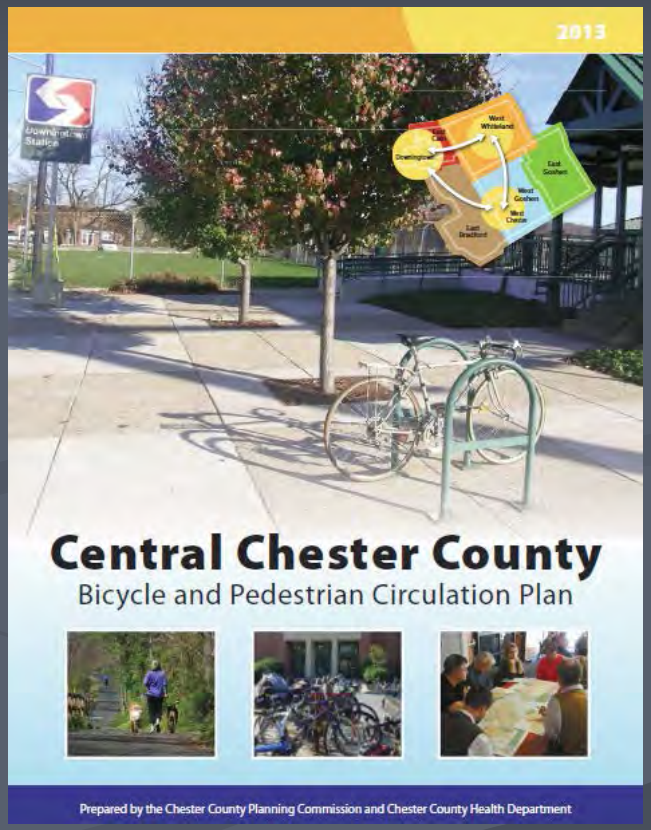


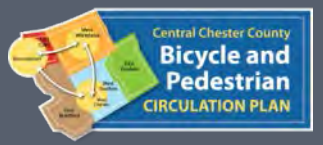
Central Chester County
Bicycle and
Pedestrian
CIRCULATION PLAN

More Information

- www.chesco.org/planning/cccbikeped

- Randy Waltermyer, AICP
- Chester County Planning Commission
- rwaltermyer@chesco.org





Community Health Needs Assessment and Implementation

Rickie Brawer, PhD, MPH, MCHES
Jefferson University and Hospitals
Center for Urban Health

DVRPC Healthy Communities Task Force
February 11, 2015

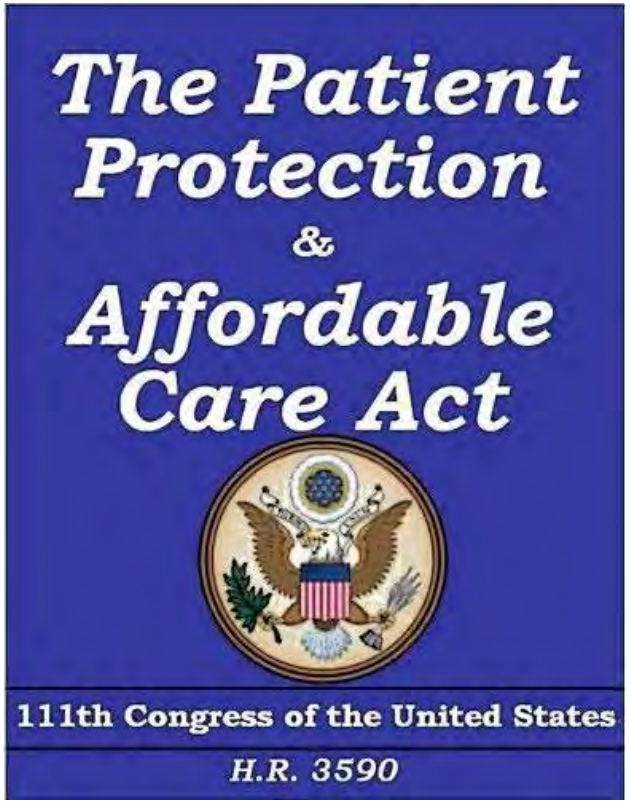
Health Systems and Community Health Improvement – Real and Potential Synergies

- Participants in this session will be able to:
  - Understand the significance of the Patient Protection and Affordable Care Act and requirements to assess and evaluate community health needs
  - Integrate opportunities to partner with health systems to improve the health of communities

The Affordable Care Act (ACA)

Two broad areas of policy change:

1. Insurance or payer reform
2. System or delivery reform



ACA: Greater Focus on Prevention and Public Health

- Prevention and Public Health Fund (PPHF)
- Community Transformation Grants
- Accountable Care Organizations (ACO)
- Patient-Centered Medical Homes (PCMH).
- Patient-Centered Outcomes Research Institute (PCORI) established to specifically address the mandates for improvement of quality and efficiency

Shared National Health Priorities

Community Transformation Grant Priorities	National Prevention Strategy Strategic Directions and Priorities	Healthy People 2020 Leading Health Indicators Priorities
Tobacco-free living	Tobacco Free Living	Tobacco Environmental Quality (i.e. childhood exposure to second-hand smoke)
Healthy Eating and Active Living	Healthy Eating and Active Living	Physical Activity and Nutrition
Clinical and other preventive services to prevent and control high blood pressure and high cholesterol	Clinical and Community Preventive Services	Access to Health Services/ Clinical Preventive Services
Social and emotional wellness	Mental and Emotional Well-Being	Mental Health

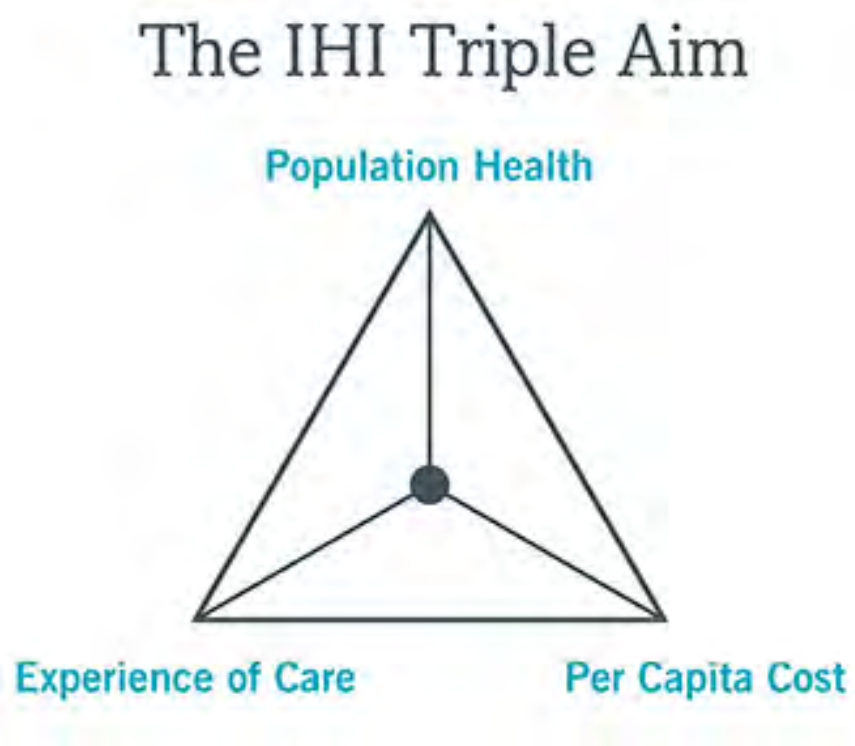
Making Healthy Living Easier, Community Transformation Grants Program Fact Sheet, http://www.cdc.gov/communitytransformation/pdf/ctg-factsheet.pdf

National Prevention Council, National Prevention Strategy, Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General, 2011., http://www.healthcare.gov/prevention/nphpc/strategy/report.pdf

HHS Healthy People 2020 Leading Health Indicators, http://www.healthypeople.gov/2020/LHI/default.aspx

ACA Triple Aim

- Achieving the Triple Aim means addressing population health – CHNAs and implementation plans are designed to help do that

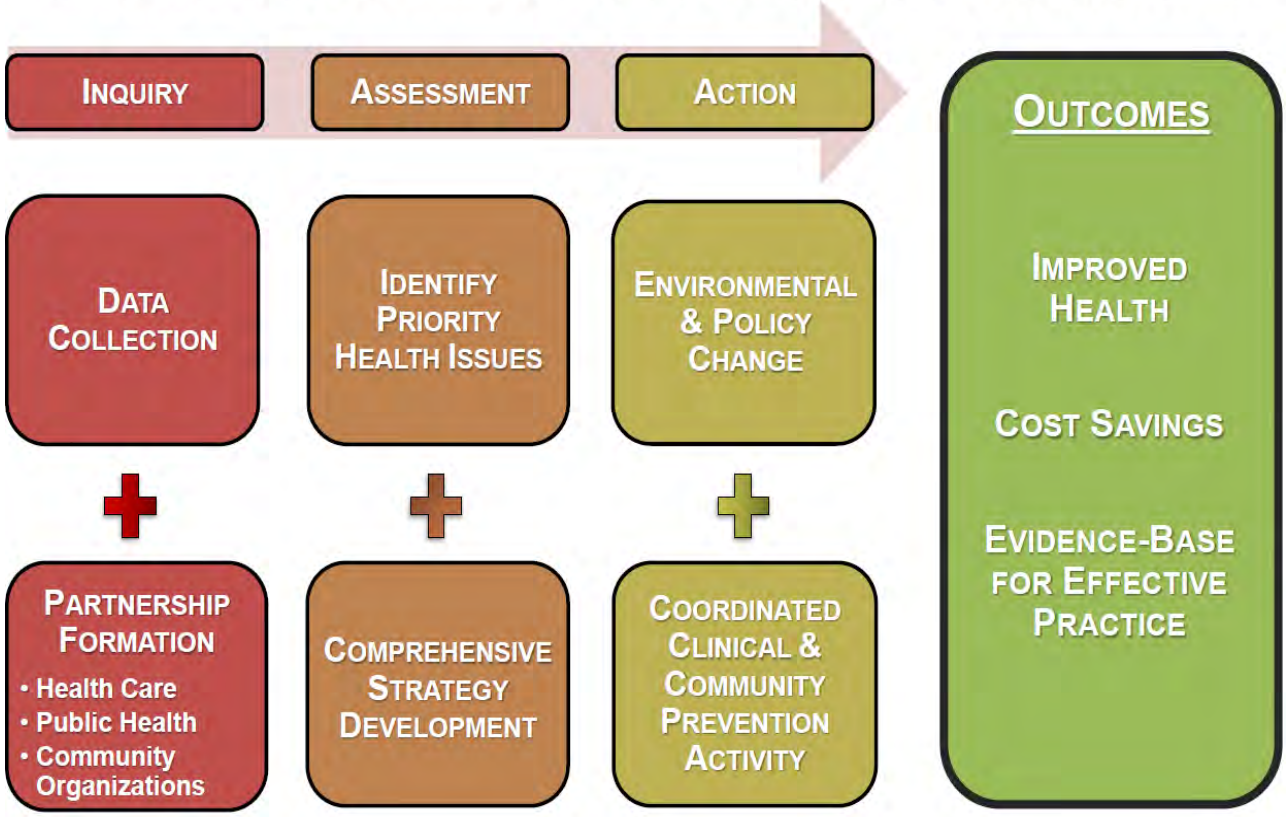


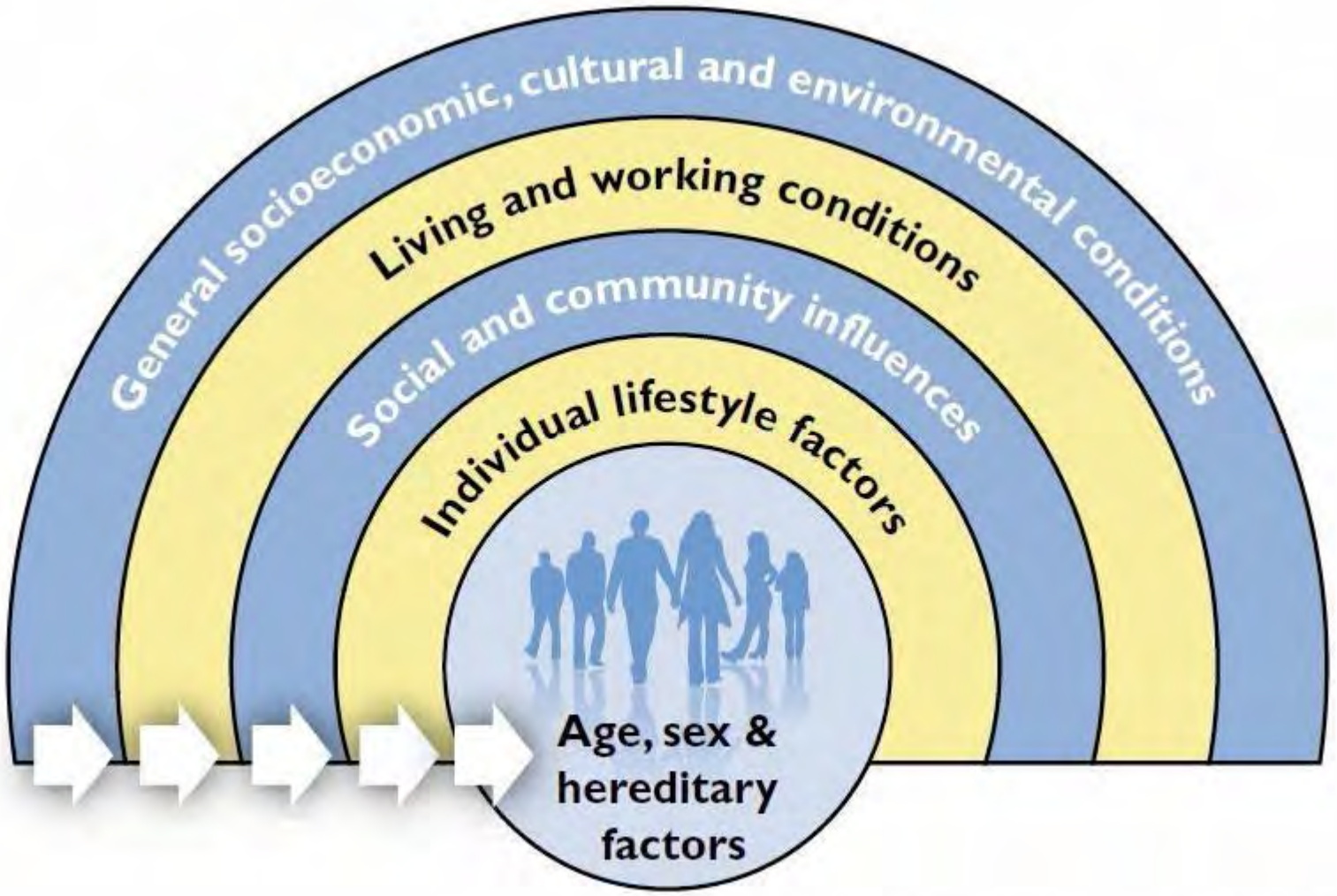
Community Centered Health Homes:

An evolving approach to health

The Prevention Institute
www.preventioninstitute.org

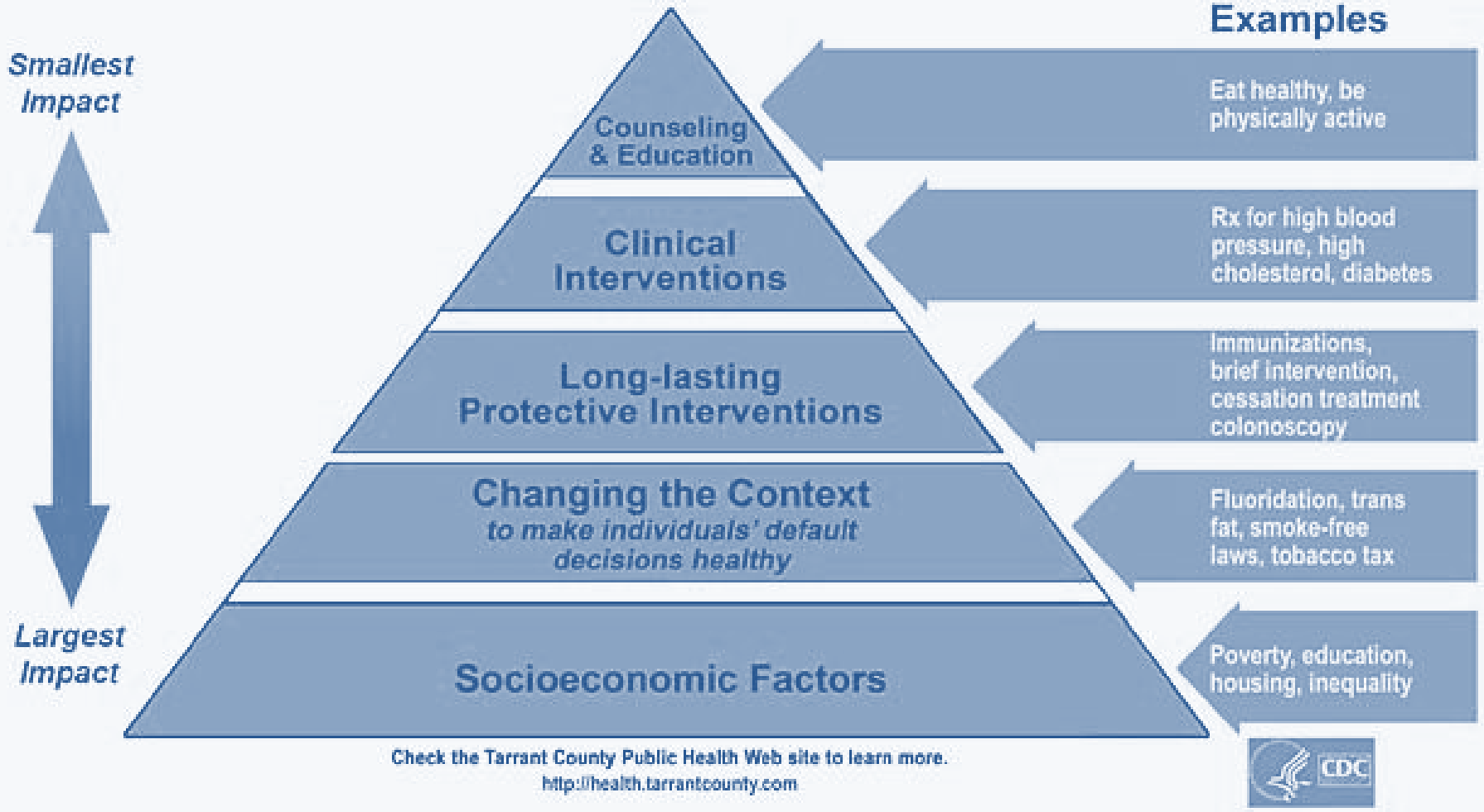
Clinical/Community Population Health Intervention Model





Health Determinants Model

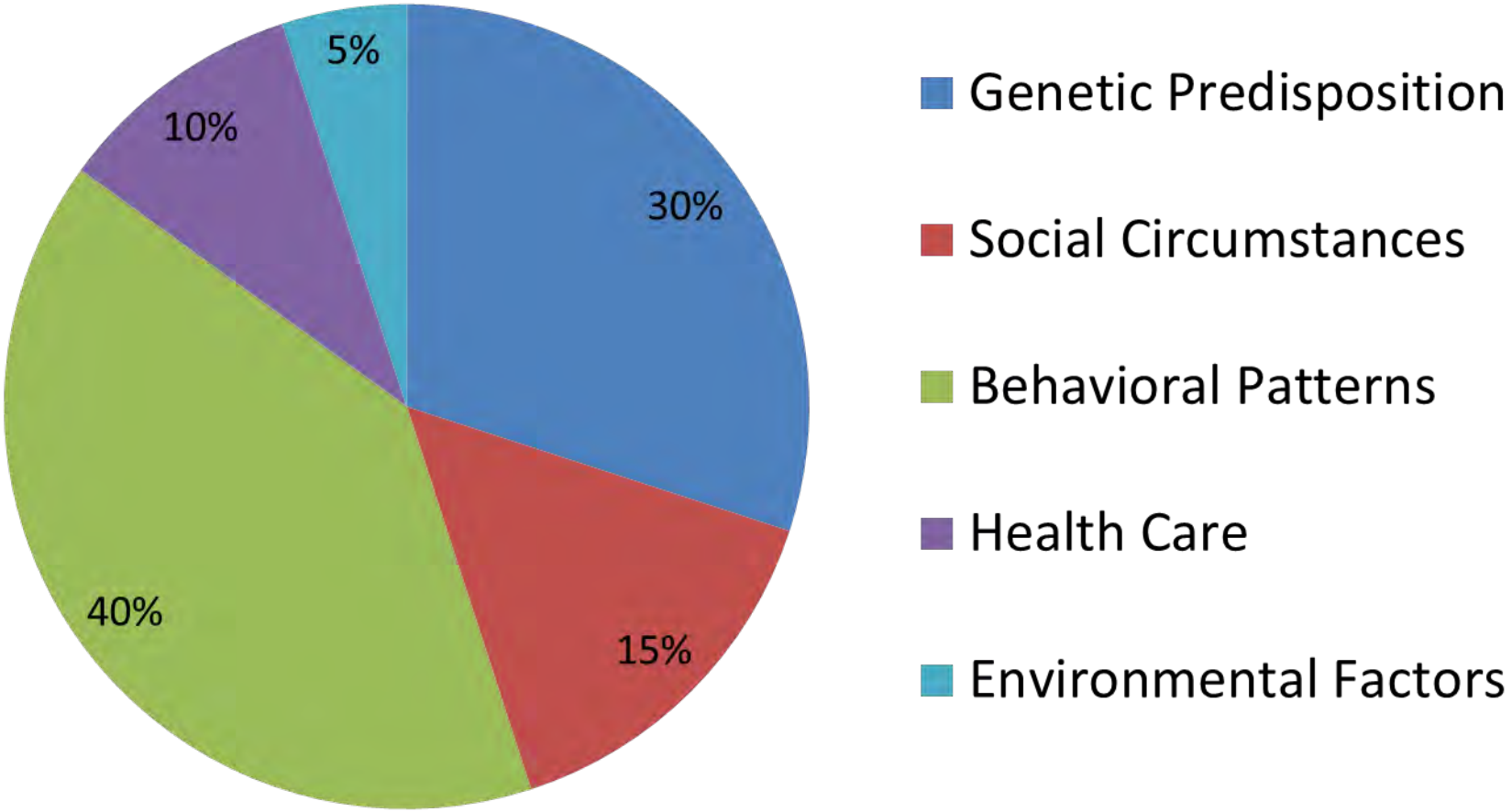
CDC Health Impact Pyramid
Factors that Affect Health



Check the Tarrant County Public Health Web site to learn more.
http://health.tarrantcounty.com

CDC

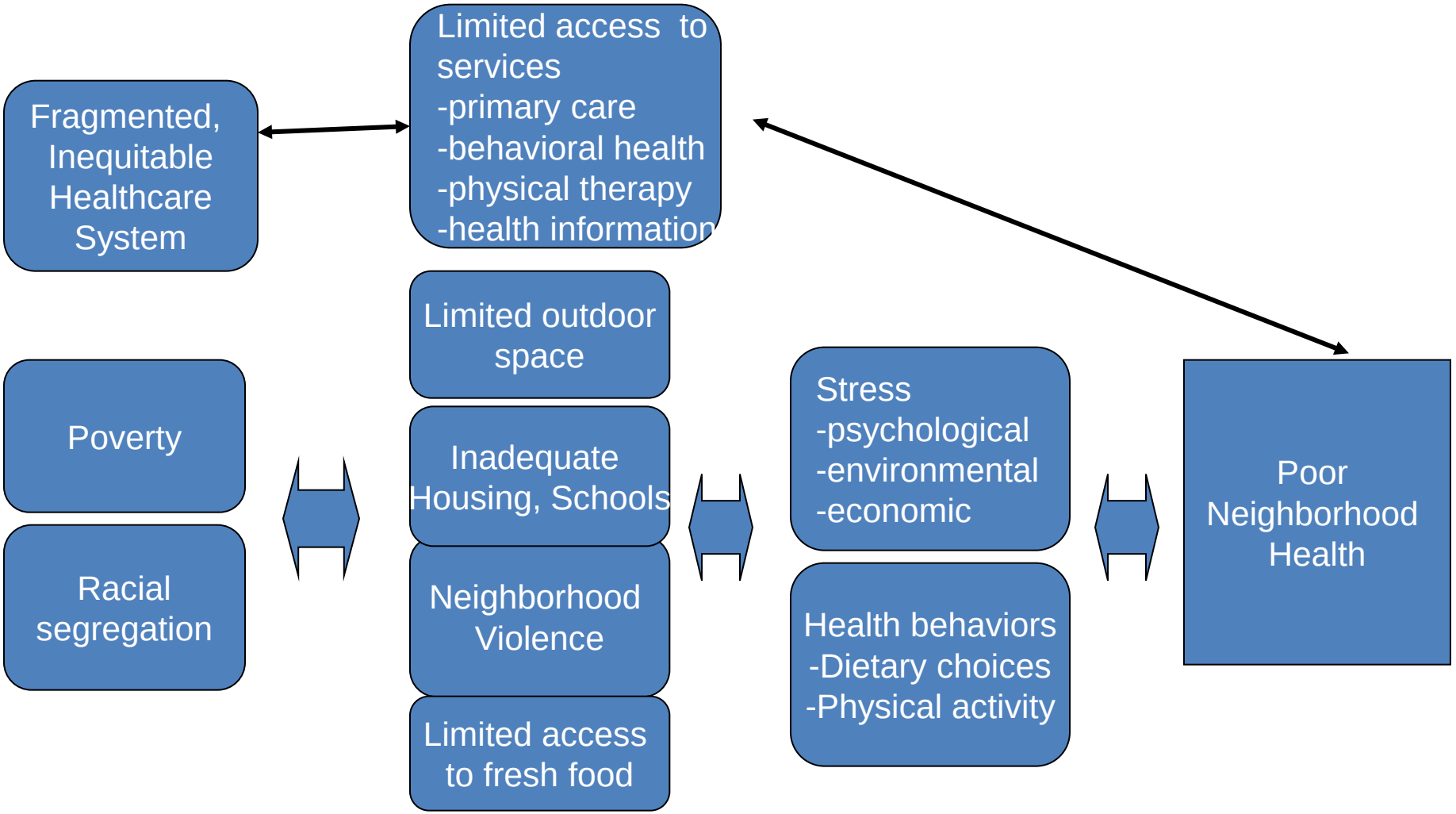
Determinants of health and their contribution to premature death



PDPH May 2014 CHNA
Adapted from: McGinnis et al. 2002

Barriers to Health

(Schulz, Kannon 2005; Schulz, Zenk 2005)



Healthy People 2020 organizes the social determinants of health around five key domains:

Economic Stability – Poverty, Employment, Food Security, Housing Stability

Education - High School Graduation, Enrollment in Higher Education, Language and Literacy, Early Childhood Education and Development

Health and Health Care - Access to Health Care, Access to Primary Care, Health Literacy

Neighborhood and Built Environment - Access to Healthy Foods, Quality of Housing, Crime and Violence, Environmental Conditions

Social and Community Context - Social Cohesion, Civic Participation, Perceptions of Discrimination and Equity, Incarceration/Institutionalization

Current State: Similar but Nonaligned Community Health Improvement Frameworks

Public Health Accreditation, HRSA 330 Grants, United Way, & Other Community Assessments

Community Health Assessment Tools (MAPP, Community Tool Box, etc.)

Philanthropy, Federal/State grant making (CDC/CTGs, HUD, etc.)

HDs/FQHCs/ Community Agencies → Community Health Assessment → Community Health Improvement Plan → Community Investments → Improved Community Health Outcomes?

Hospitals → CHNA + Implementation Strategy → "Plan" → Hospital Community Benefit Projects → Improved Community Health Outcomes?

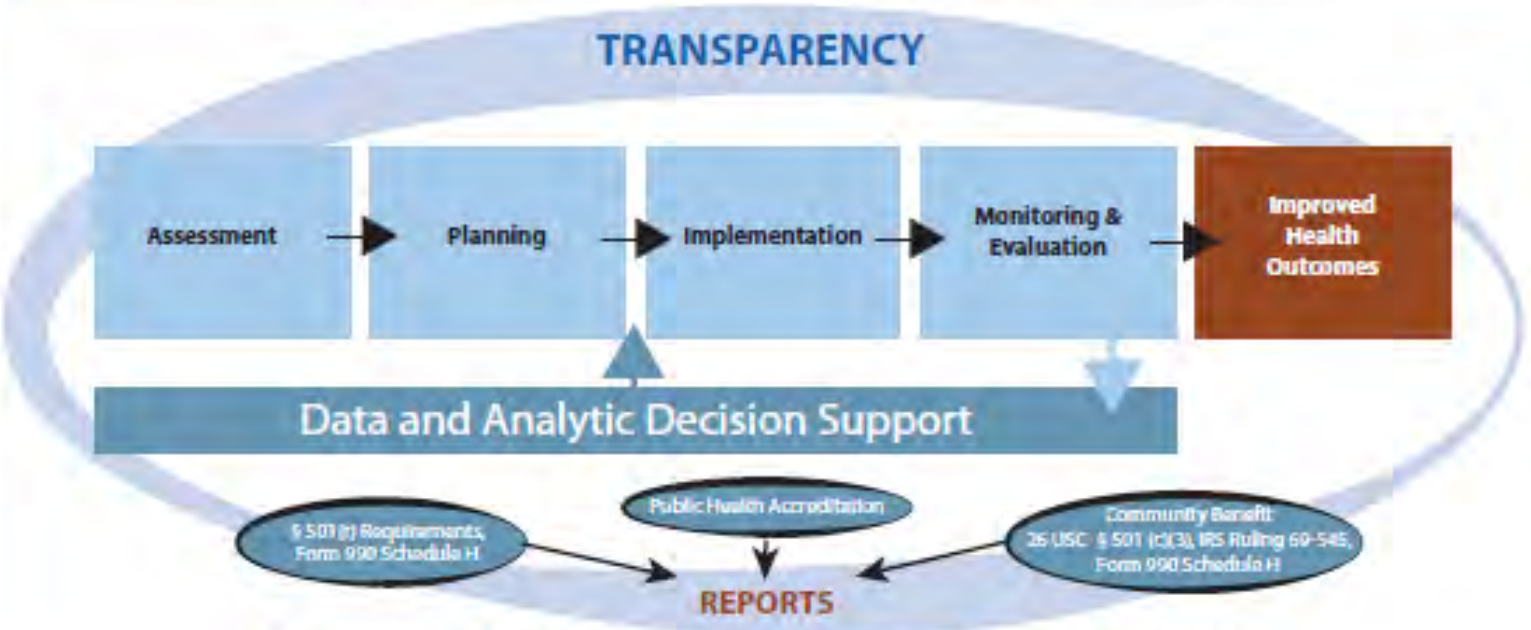
Catholic Health Assoc. Guide
ACHI (AHA) Toolkit
Private Vendors

IRS Hospital Community Benefit Compliance, State & Local Activities

501(r) Requirements, Form 990 Schedule H

26 USC 501(c)(3), IRS Ruling 69-545, and Form 990 Schedule H

Desired State: A Unified Community Health Improvement Framework Supporting Multiple Stakeholders



Community Engagement and Assuring Shared Ownership

Key Issues to Address to Promote Alignment between Accreditation, NP Hospital CB, and Other Community-Oriented Processes

- Arranging Assessments that Span Jurisdictions
- Using Small Area Analysis to Identify Communities with Health Disparities
- Collecting and Using Information on Social Determinants of Health
- Collecting Information on Community Assets
- Using Explicit Criteria and Processes to Set Priorities (use of evidence to guide decision-making)
- Assuring Shared Investment and Commitments of Diverse Stakeholders
- Collaborating Across Sectors to Implement Comprehensive Strategies
- Participatory Monitoring and Evaluation of Community Health Improvement Efforts

New Federal Mandate

Patient Protection and Affordable Care Act of 2010,

Section 9007 contains requirements that non-profit hospitals must meet to maintain its 501(c)3 charitable organization status.

- Completion of a **community health needs assessment (CHNA) every three years** ***by an individual with special knowledge or expertise in public health***.
- Development of **community benefit implementation plan that addresses identified needs**
- Formal **adoption** of the community benefit strategic and implementation plan **by the hospital's governing body**
- **Publication** of the CHNA findings and community benefit plan so that it is widely available **to the public**.
- **Demonstration of effectiveness** of community benefit efforts

What is Community Benefit?

- **Community benefits should meet an identified community need and meet at least one of the following community benefit objectives:**
  - Improve access to healthcare
  - Improve community health
  - Advance knowledge through education or research
  - Relieve a government burden

- **Community Benefits include providing:**
  - free or low-cost medical care (charity care)
  - care to low-income Medicaid beneficiaries
  - services designed to improve community health and access to care

IRS Update: CHNA

IRS changes allow multiple hospital facilities to complete one CHNA, and one implementation plan, for a community

- Each hospital collaborating must be clearly identified, and the CHNA must be adopted by an authorized body for each collaborating hospital. Although hospital organizations can collaborate when conducting CHNAs and developing implementation strategies, each facility must have a separately documented CHNA and implementation strategy.
- Collaboration can lead to funding opportunities
- Collaboration can lead to opportunity to leverage partnership assets and reduce duplicative efforts

HHS Region III and Hospital Association of Pennsylvania Leadership

HHS Region III:

- Has convened stakeholder group (hospitals, HAP/DVHC of HAP, county health departments, community organizations) around CHNA
- Is facilitating collaboration with Federal agencies (CDC, HRSA, CMS) to identify CHNA support resources and potential funding sources
- Is working with HAP to pursue partnerships with other Mid-Atlantic institutions
- Provides opportunity for ***Accountable Health Communities*** using a collective impact model to prioritize and align initiatives, increase scale and effectiveness through pooled resources, develop shared measurement and accountability

Components of the Written CHNA

- Description of the community served by the hospital and how it was determined.
- Description of the process and methods used to conduct the assessment, including a description of the sources and dates of the data and other information used in the assessment and the analytical methods applied to identify community health needs.
- Description of how the hospital took into account input from persons who represent the broad interests of the community.
- A prioritized description of all of the community health needs identified through the CHNA, including a description of the process and criteria used in prioritizing such needs.
- A description of the existing health care facilities and other resources within the community available to meet the community health needs.

How is *Community* Defined?

- By geographic location (city, county, metropolitan region)
- By target populations served (e.g., children, women, aged)
- By a hospital's principal function (e.g., specialty area or disease)
- May not be defined in a way that excludes certain populations served by the hospital (for example, low-income persons, and minority groups)

The Implementation Strategy

- Includes a written plan that prioritizes and addresses each of the community health needs identified through the hospital CHNA process
- The plan must include:
  - How the hospital plans to meet the health need, or
  - Why the hospital does not intend to meet an identified health need
  - A description of the programs and resources the hospital intends to commit)
- Must be adopted by the hospital's governing body

Other Provisions:

IRS Notice 2011-52

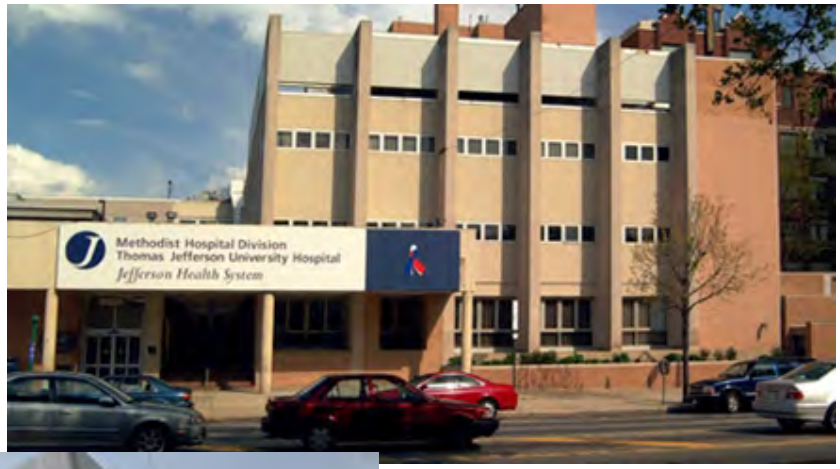
IRS Form 990 Schedule H

Hospital must report on its IRS Form 990, a description of the following:

- how the organization is addressing the needs identified in its CHNA
- any needs not being addressed together with the reasons why they are not being addressed.
- How and where CHNA and Implementation Plan are being made publically available
- Failure to comply will result in a $50,000 excise tax penalty that will be applied to each hospital facility in the organization that fails to satisfy the requirements.

Community Benefit At Jefferson

TJUH

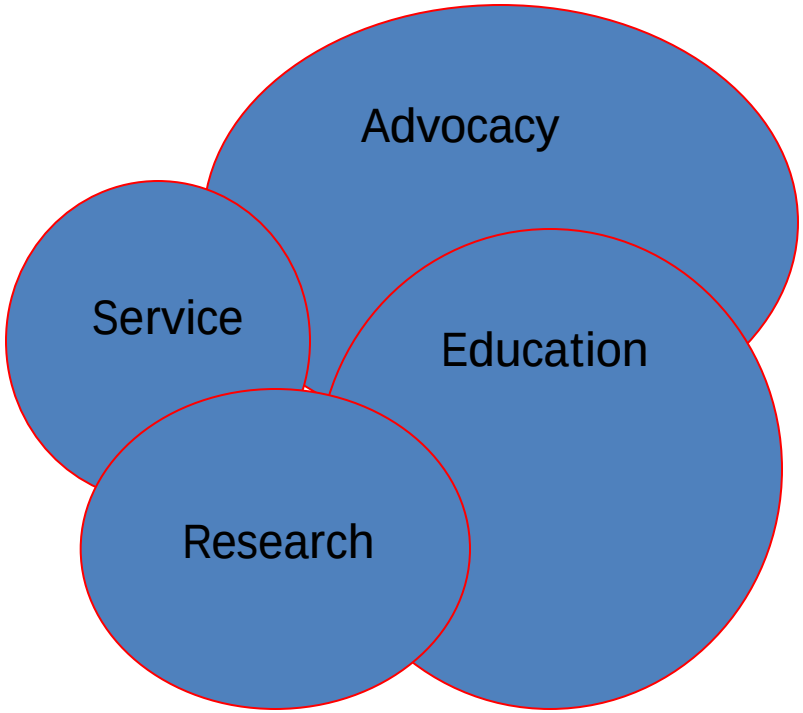


Methodist

Jefferson Hospital of Neurosciences

Center for Urban Health

The mission of the Center for Urban Health is to marshal the resources of the Department of Family and Community Medicine (DFCM), Thomas Jefferson University (TJU) and Jefferson University Hospitals (JUH) to strengthen the capacity of diverse urban individuals, families, organizations and communities to address issues that improve health.



CHNA Advisory Leadership

- Interprofessional Internal Leadership Hospital and University

- External Leaders (United Way, Achievability, KPMG and Vanguard)

Community Benefit Principles

- **Reduce health disparities**.
- **Build on Jefferson strengths and resources**
- **Involve two or more of our mission elements**: patient care, education & research
- **Embrace community engagement and partnerships**
- **Sustainability,** economically and programmatically, over time

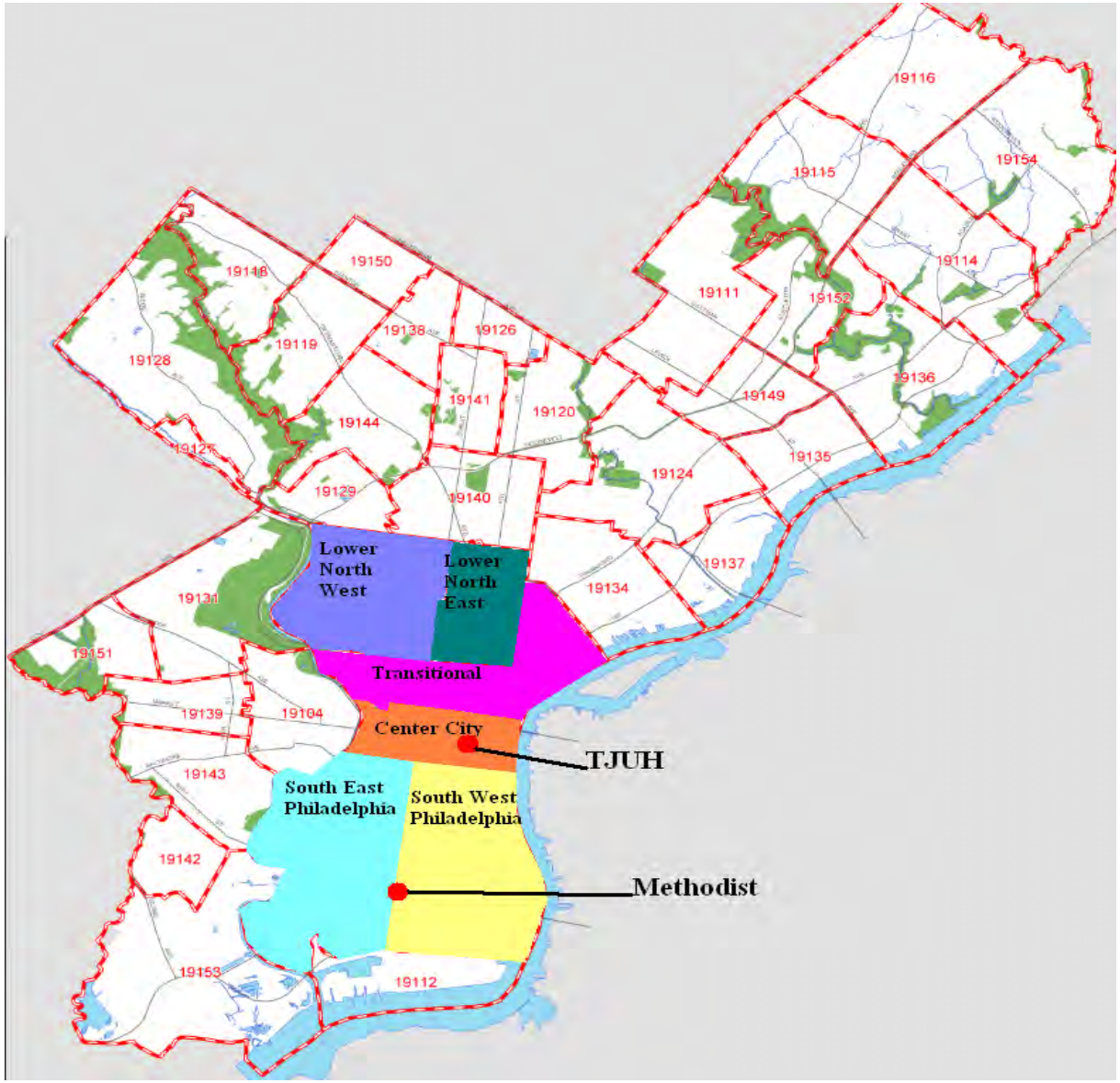
Additional factors in determining a neighborhood focus to maximize effectiveness:

- Are geographically proximate to both TJUH and Methodist.
- 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 harnessed synergistically
- Have individuals and organizations with developed historical relationships with Jefferson staff or have the potential for partnering to address specific health and social issues

Jefferson Community Benefit Area

Nearly 354,000 people

23% of all Philadelphia residents.



Assessment Methods

Secondary Data and Literature Review

- Healthy People 2020
- Reports from PDPH, MCC, PCA, Pew State of the City, Philadelphia School District, and others
- Public Health Management Corporation- Household Health Survey (2008 -2012)
- Census 2010 data with updates from Claritas
- County Health Rankings and Roadmap 2013
- Pennsylvania Department of Health State and other local data
- Community Preventive Services Taskforce Guidelines

Assessment Methods

Primary Data

- **Key Informant Interviews**
  - **More than 65 internal and external 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.
  - Includes TJU and TJUHs faculty and staff
- **Focus Groups with employees who live in TJUHs CB area**
  - **4 focus groups** were held; **35 employees** participated

Assessment Content Areas

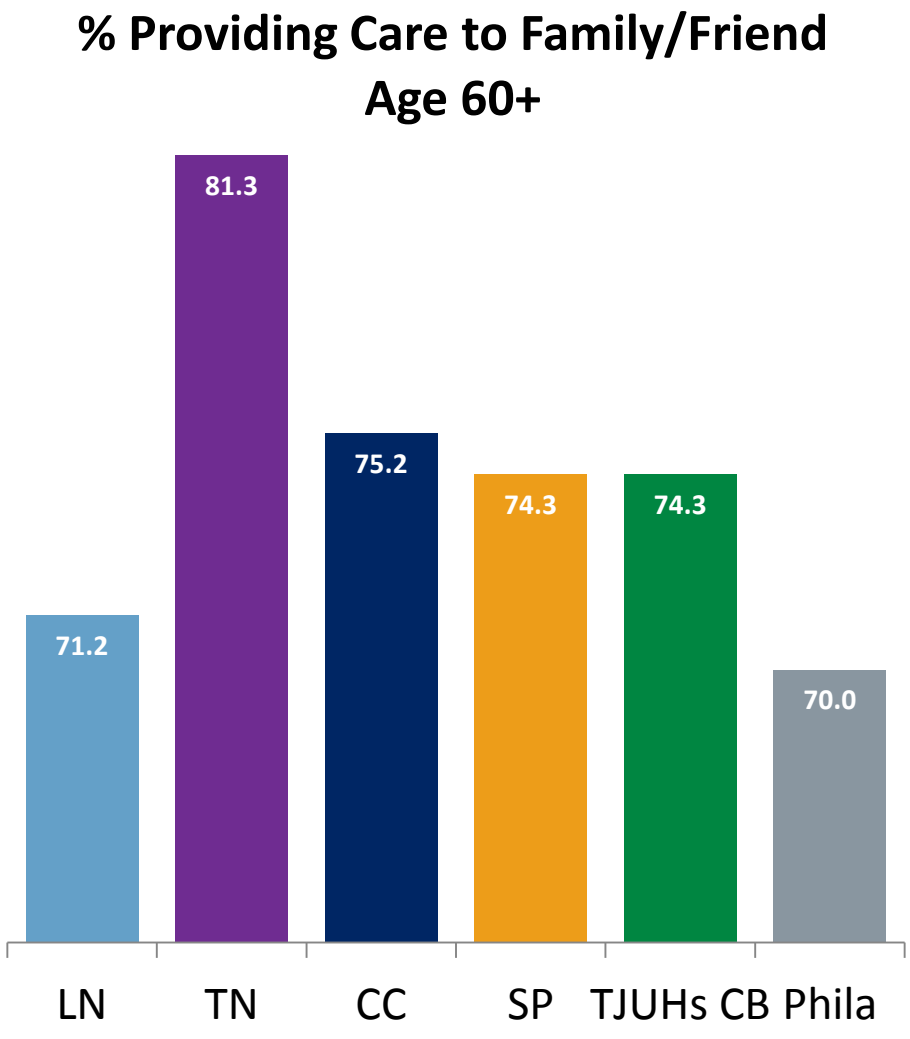
- **Demographics**
- **Mortality**
- **Morbidity**
- **Health Behaviors**
- **Healthcare access**
  - Health insurance
  - Transportation
  - Literacy
  - Culture and language
- **Social Determinants of Health**
  - Education
  - Income and poverty
  - Access to healthy and affordable food
  - Employment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

“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.” (CBO)

“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.” (CBO representative).

“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.” (CBO)

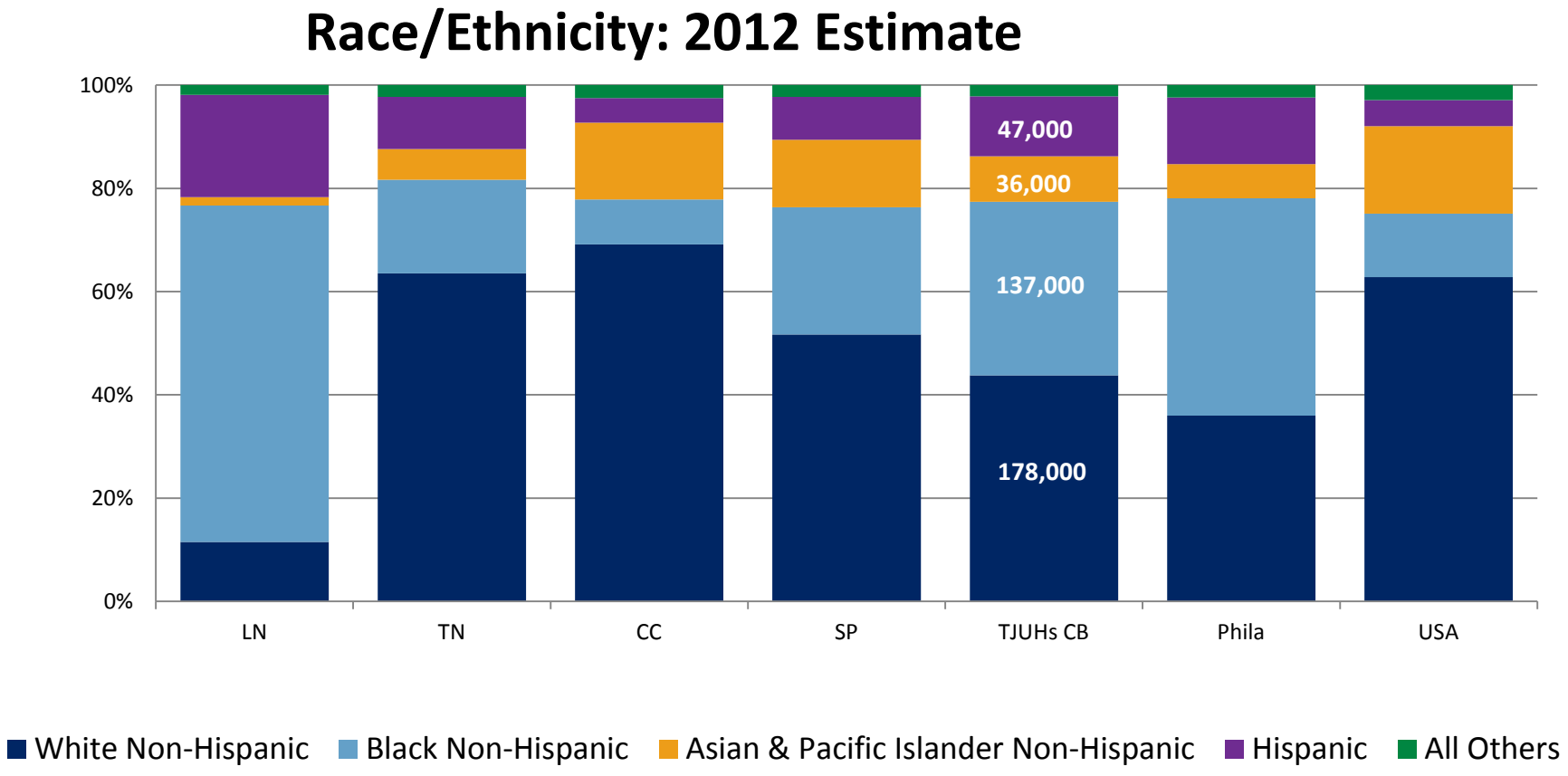
"There is not a senior center in the community and there is no place for older adults to go to be physically active. They need a senior center that is within walking distance. They would like a place to go where you can learn to exercise safely and that provides opportunities for socializing. A lot of people are older and have lived in the neighborhood al 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)



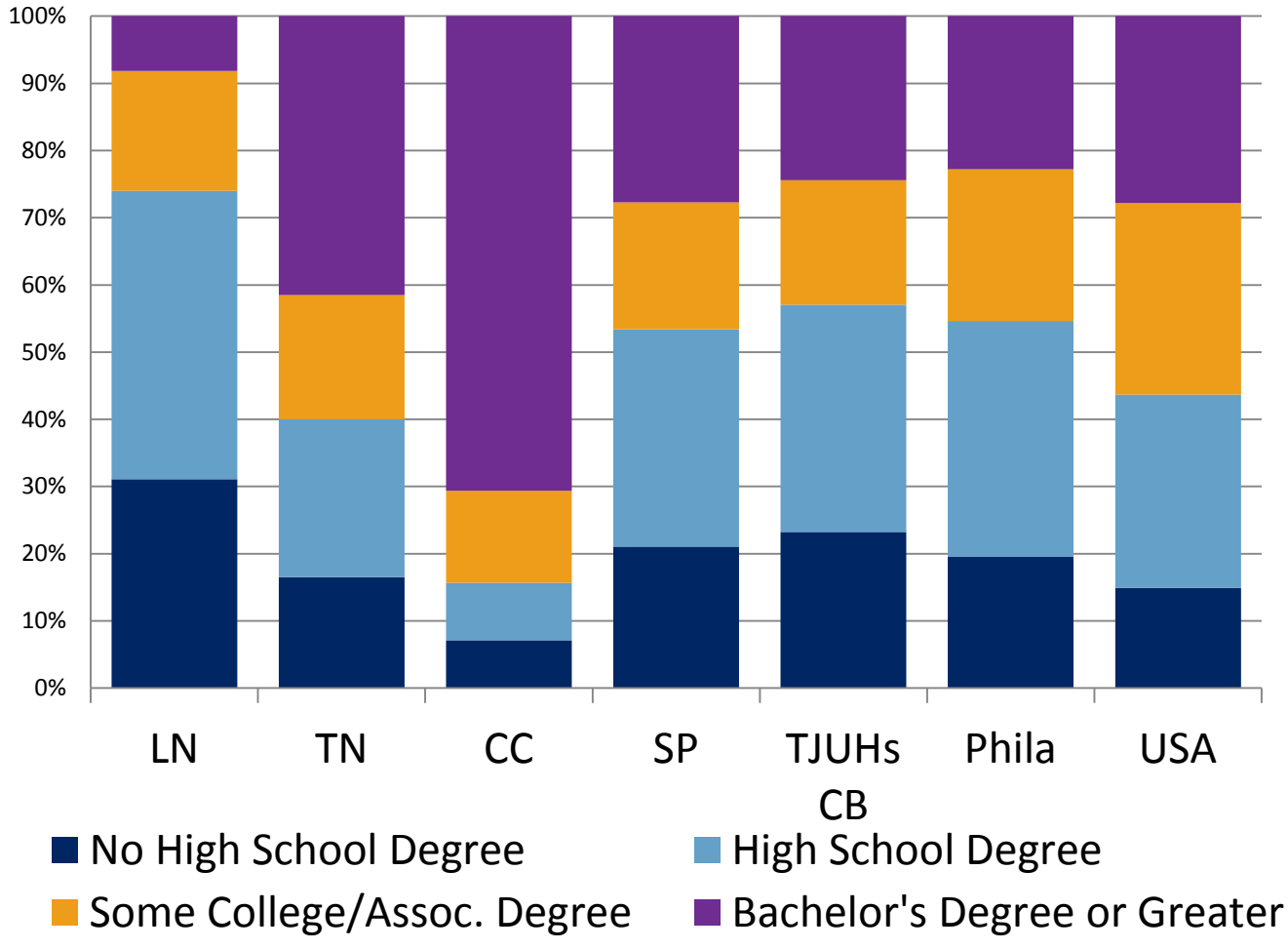
Poverty

Zip	Neighborhood	% 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	**Between 16.2 and 16.6**
19103	Center City West	**13.5**
19106	Center City – Society Hill	**7.1**

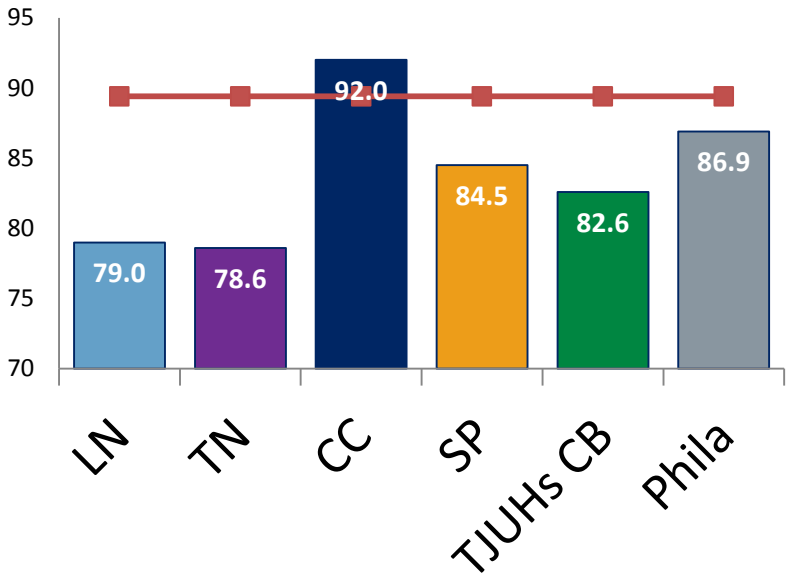
Key Findings: Demographics



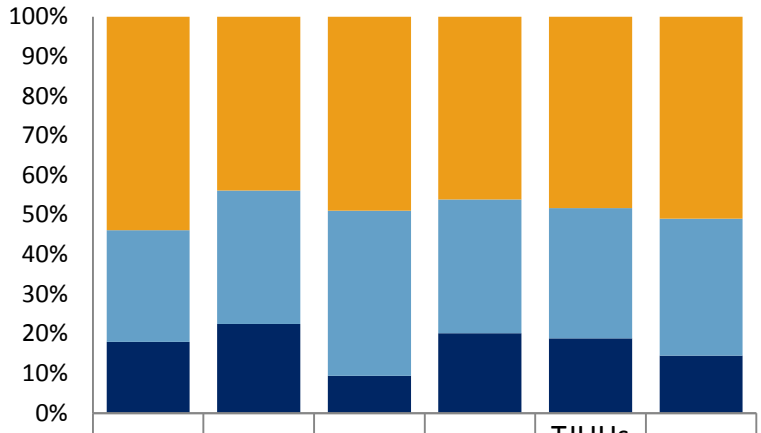
Adult Education Level: 2012 Estimate



% With Regular Source of Care



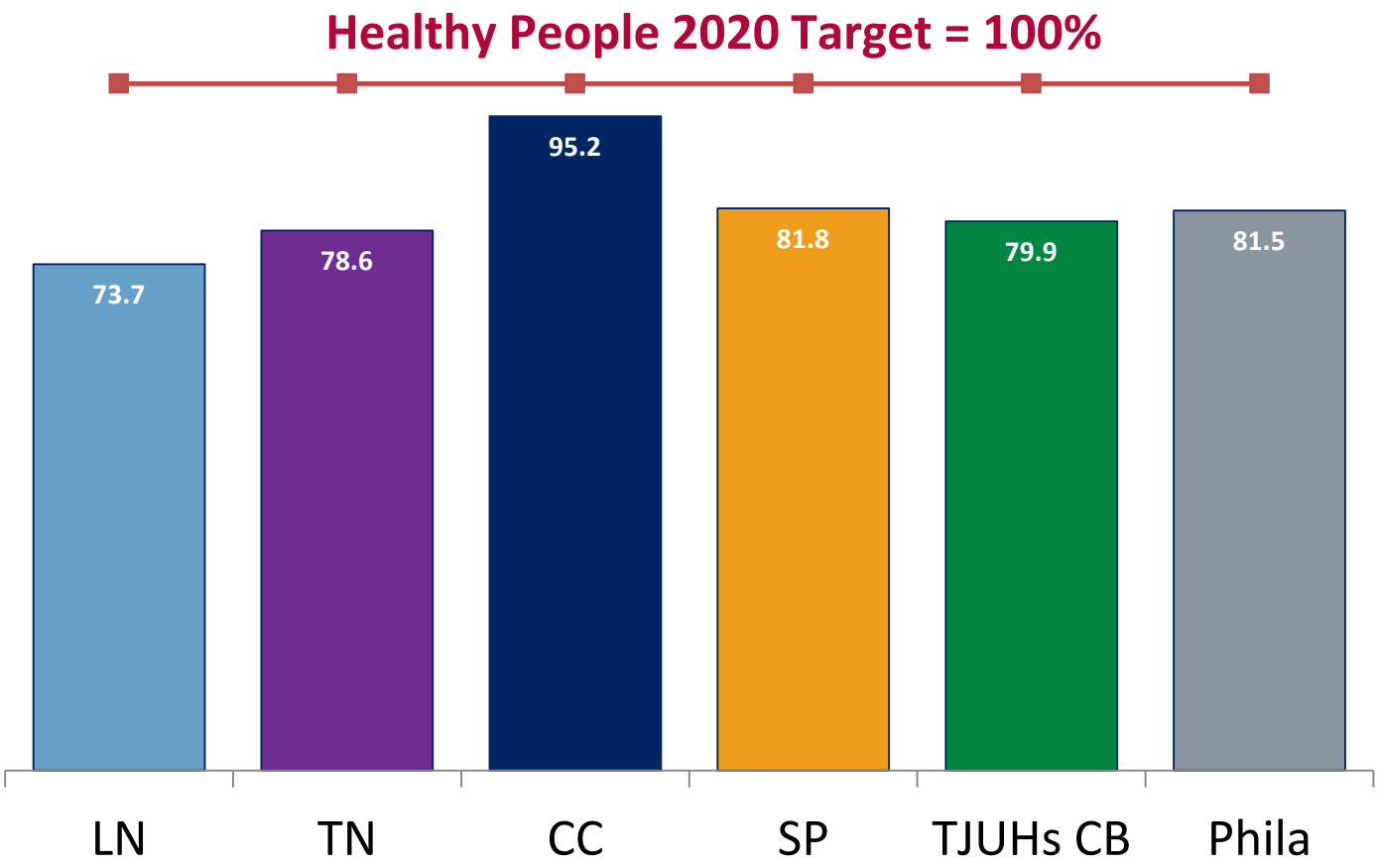
of Doctor Visits in 2011



	LN	TN	CC	SP	TJUHs CB	Phila
3 or more	53.8	43.8	48.9	46.1	48.3	50.9
1 to 2	28.2	33.7	41.7	33.7	32.9	34.6
No visits	18.0	22.5	9.4	20.2	18.9	14.5

Health Insurance

% Insured Adults, Ages 18-64

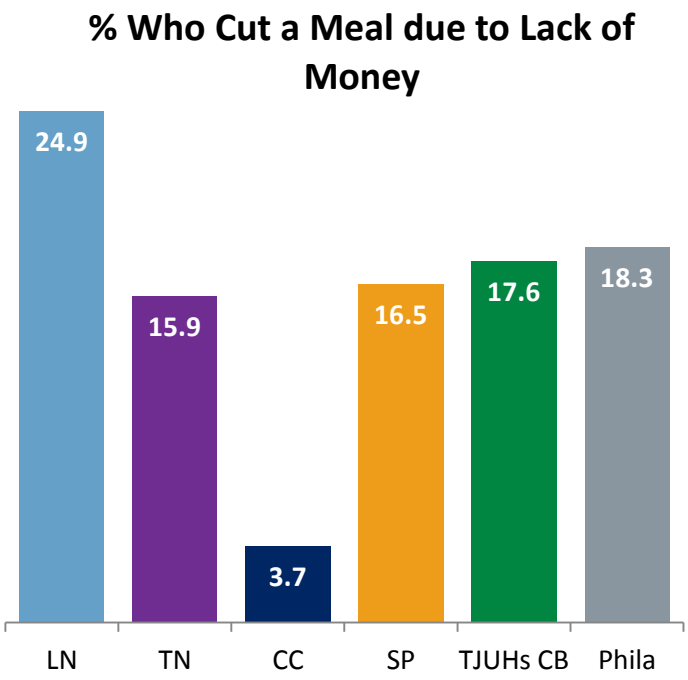


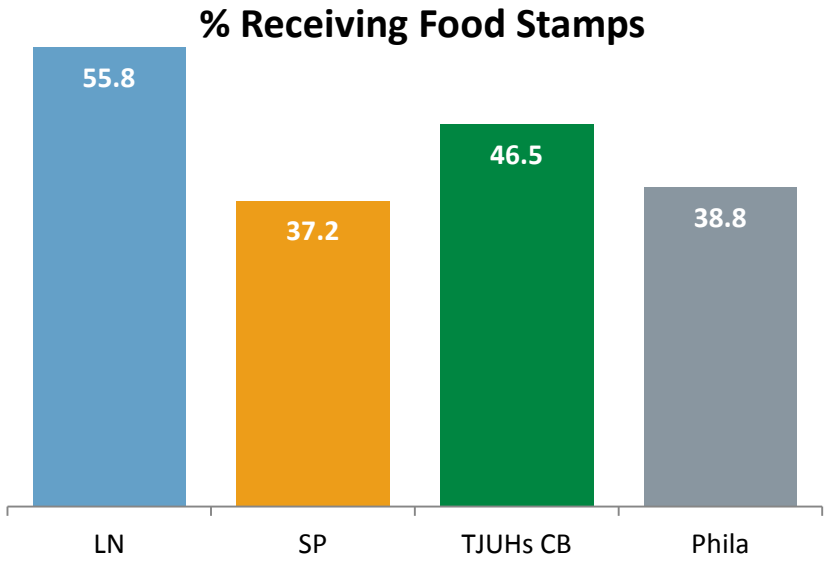
Community Need Index

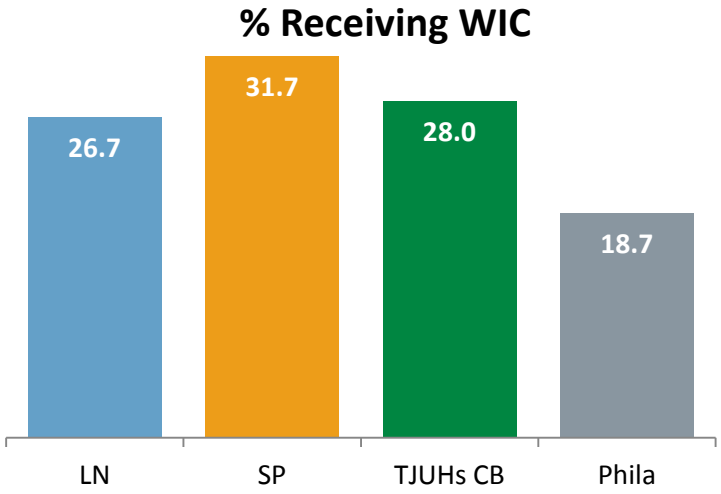
Highly needy communities experience admission rates almost twice as often as the lowest need communities for conditions where appropriate outpatient care could prevent or reduce the need for hospital admission such as pneumonia, asthma, congestive heart failure, and cellulitis.

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

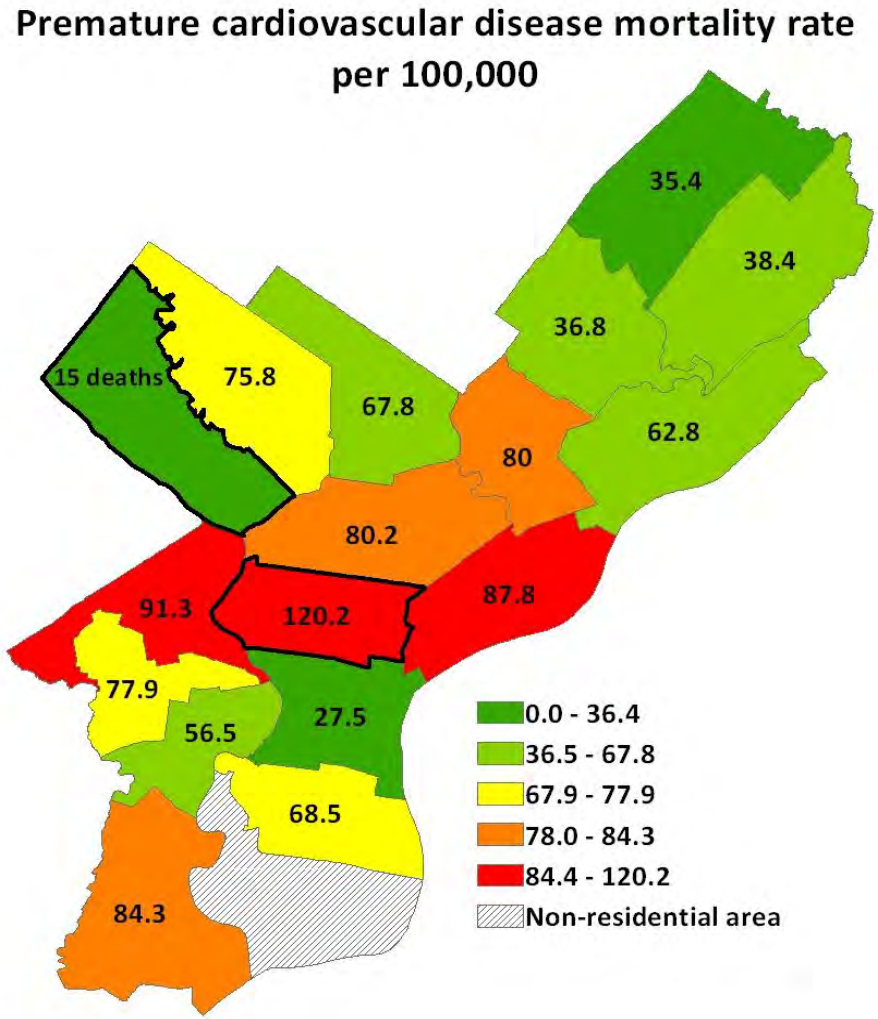
Food Security





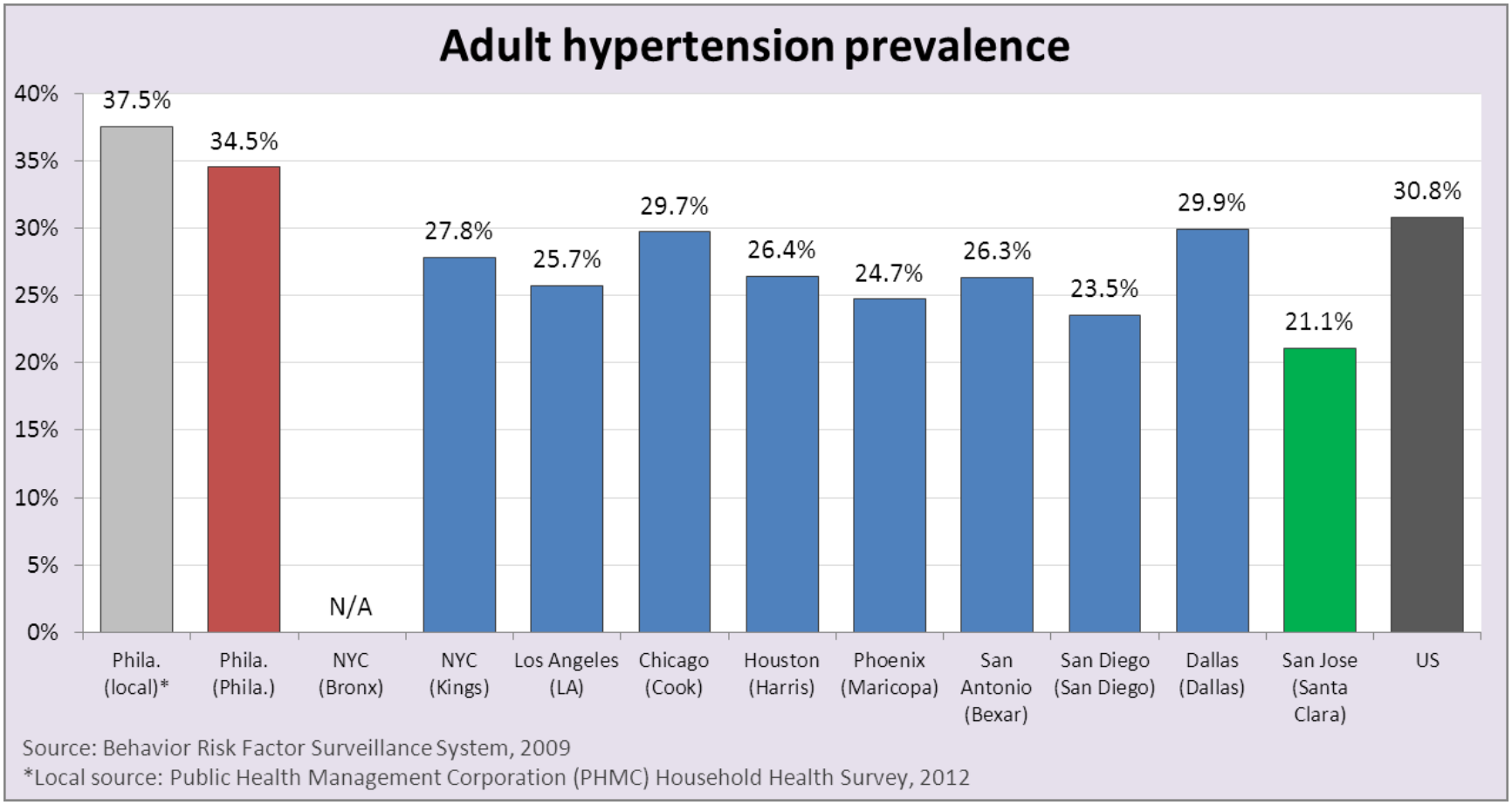


Cardiovascular Disease

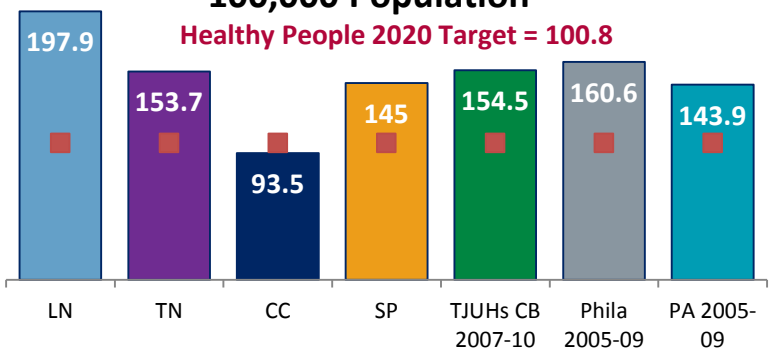


Source: Vital statistics, 2010

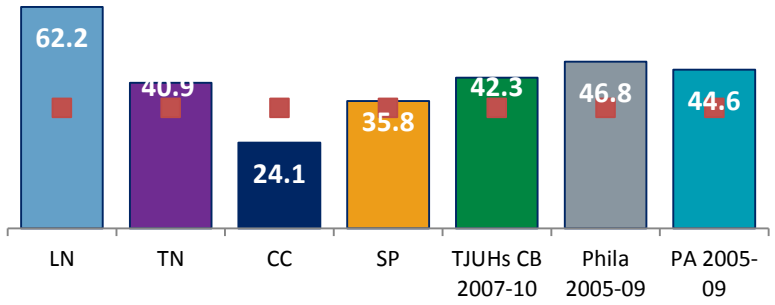
Hypertension



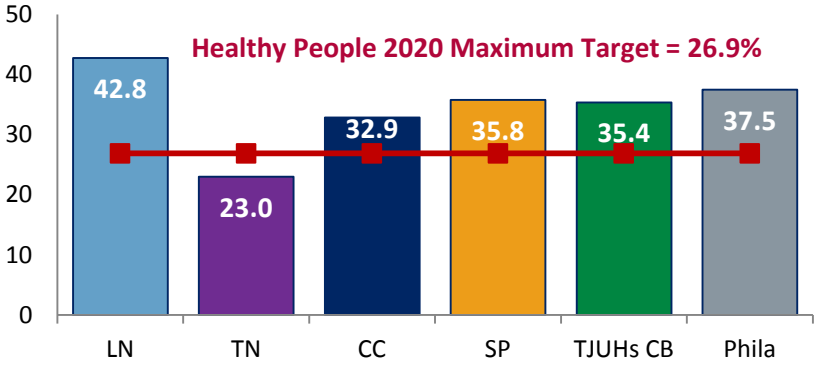
Coronary Heart Disease Death Rate per 100,000 Population



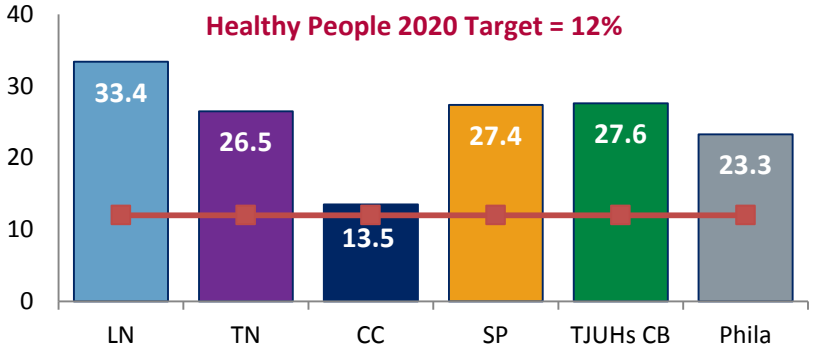
Stroke Death Rate per 100,000 Population



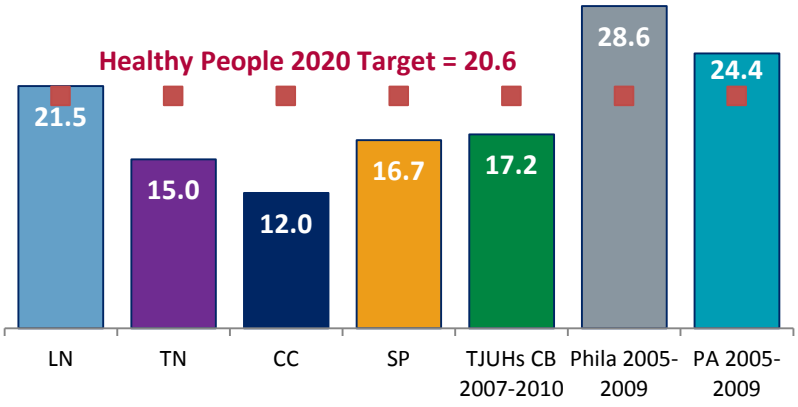
% Doctor Ever Told Have High BP



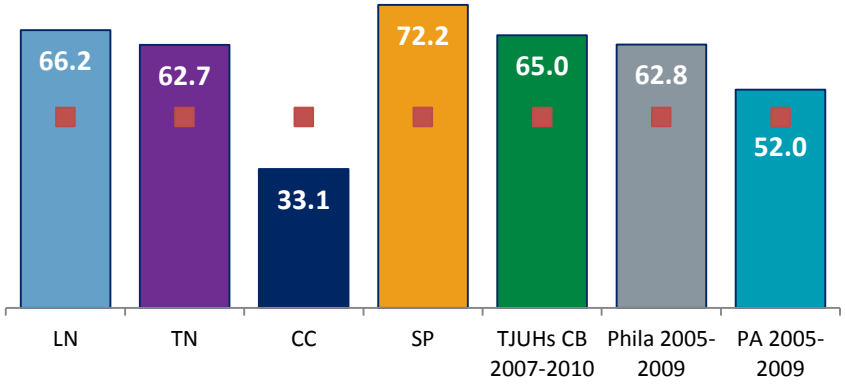
% Who Smoke



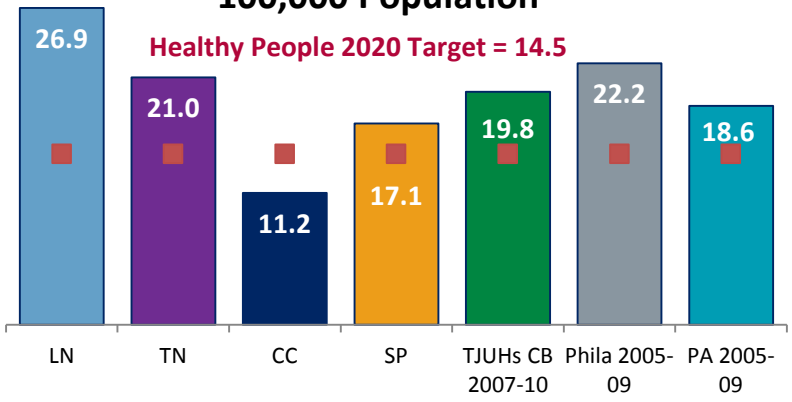
Breast Cancer Death Rates per 100,000 Population



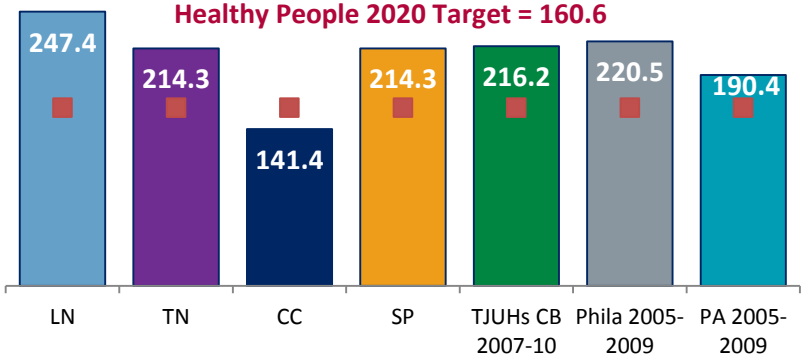
Lung Cancer Death Rates per 100,000 Population



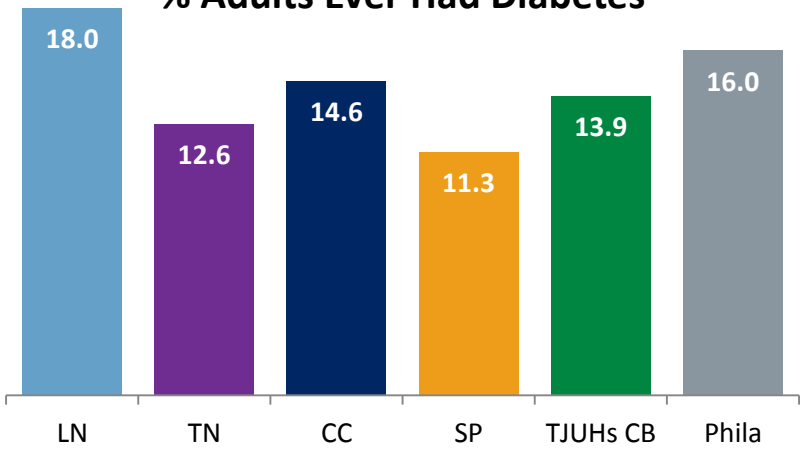
Colorectal Cancer Death Rates per 100,000 Population



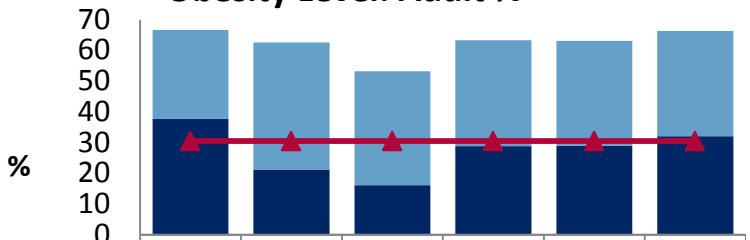
All Cancers Death Rates per 100,000 Population



% Adults Ever Had Diabetes

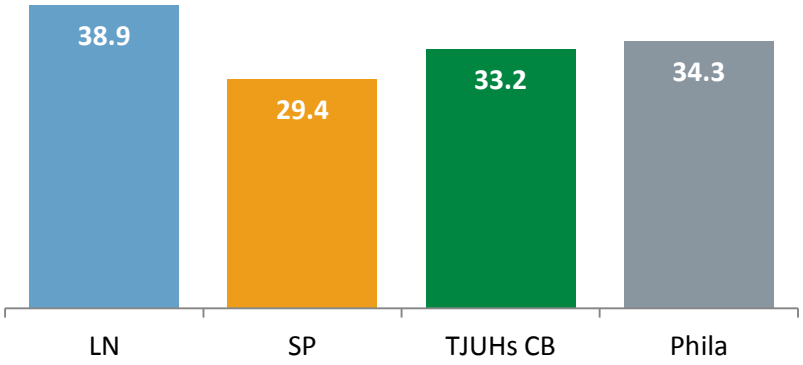


Obesity Level: Adult %

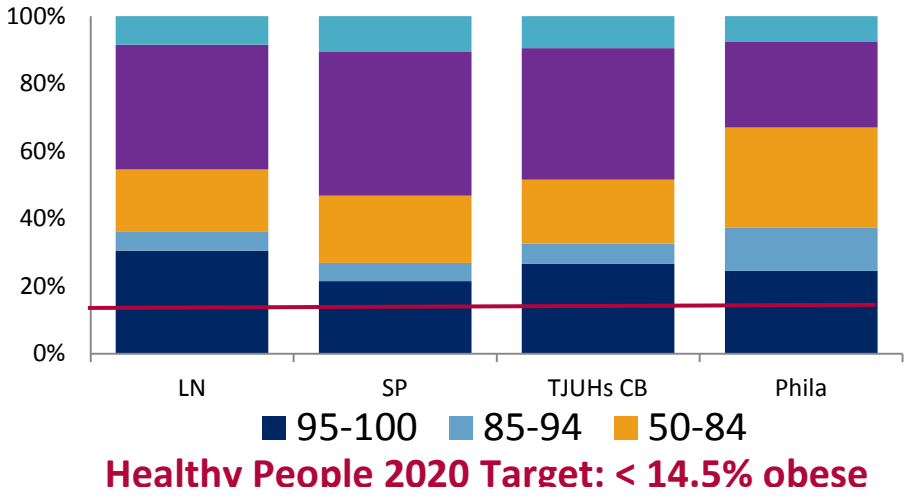


	LN	TN	CC	SP	TJUHs CB	Phila
Overweight	28.8	41.4	37.1	34.5	34.2	34.2
Obese	37.8	21.2	16.1	28.8	28.9	32.1
HP 2020 Target	30.5	30.5	30.5	30.5	30.5	30.5

Age 60+: % Ever Had Diabetes

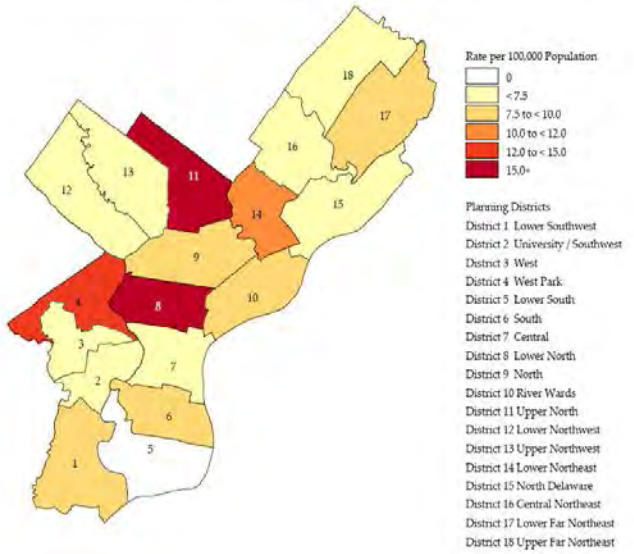


Child BMI for Age Percentile

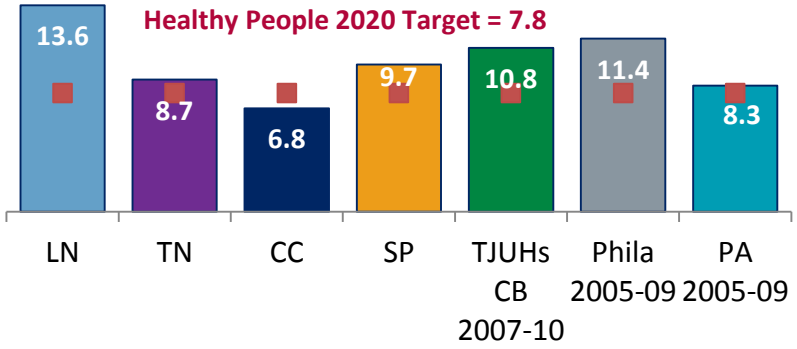


Healthy People 2020 Target: < 14.5% obese

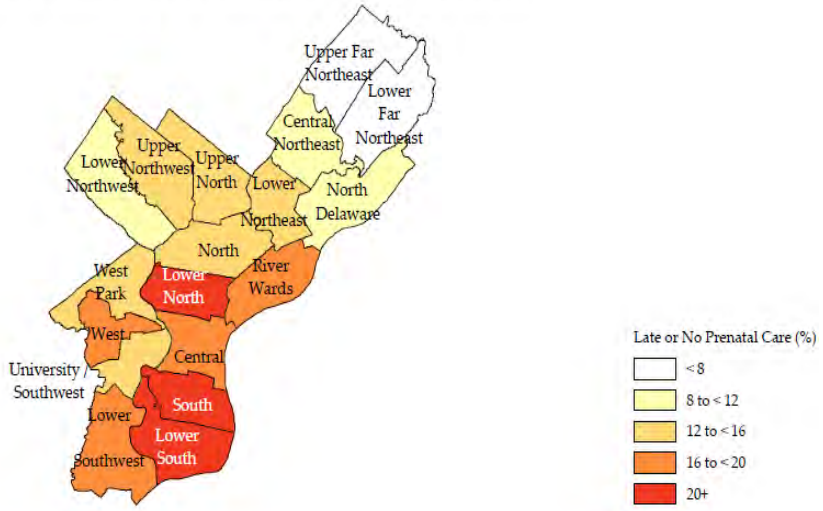
Infant Mortality per 1,000 Live Births by Planning District: Philadelphia, 2010



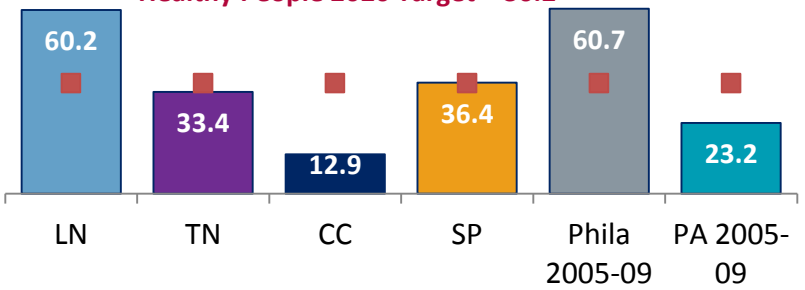
% Low Birth Weight Infants



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



Pregnancy Rate per 1,000 among 15-17 Year Olds



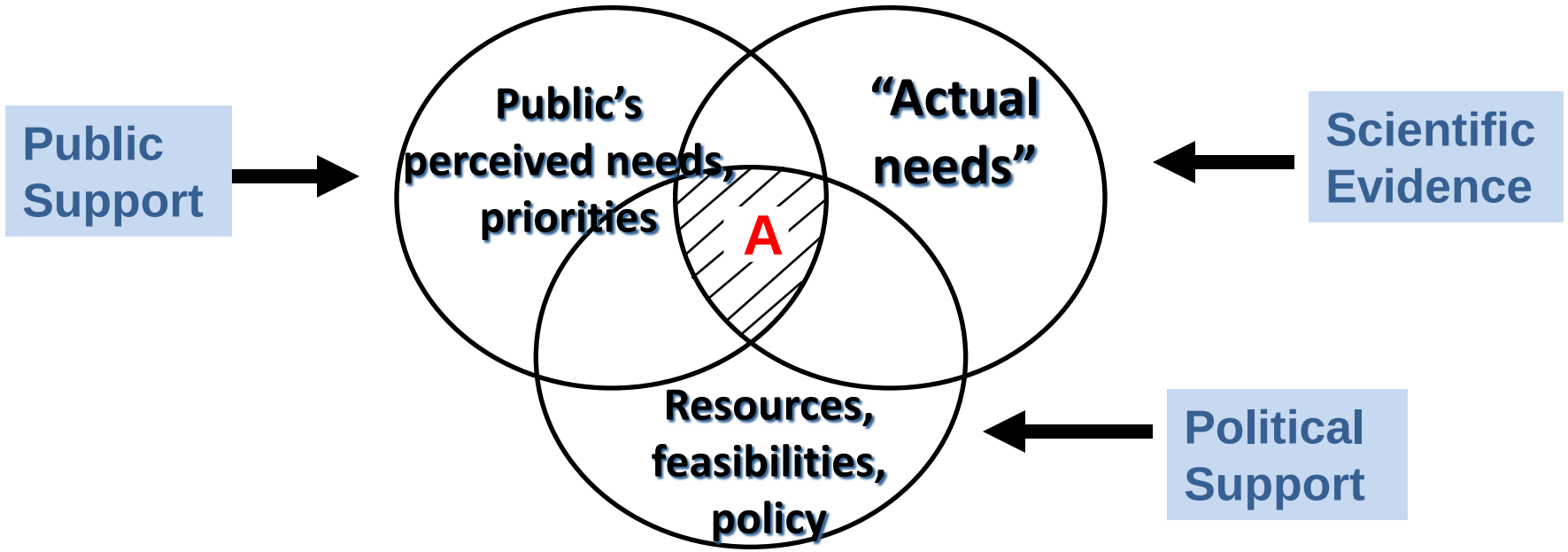
Need to connect to community supports/ resources for support such as food, caregiving, and transportation

- *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)

Key Findings and Priorities

- Lack internal coordination of outreach activities
- Cultural competence
- Language assistance
- Low health literacy
- Workforce diversity
- Food Security
- Transportation
- Community safety
  - Substance use
  - Interpersonal Violence
  - Built environment
- Access to care
  - Health Insurance
  - ED use
- Chronic disease prevention and treatment
  - Obesity, diabetes, hypertension, stroke, cancer
  - Smoking, diet, exercise
- Maternal and Child Health
- Mental Health Care
- Lack of care coordination across the continuum
- Older Adult health and well-being

Closing the Gaps Between Public's & Practitioners' Perception of Needs, and Scientific & Policy Assessments



A – Community has the greatest potential for mobilization of resources and action

Green & Kreuter, *Health Program Planning,* 4th ed., NY: McGraw-Hill, 2005, Fig 2-3, p. 40.

Weighted Ranking Criteria

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

Priority	Ranking	Priority Level
Chronic Disease Management	20.5	Most Important
Obesity	20.0	Most Important
ED Access and Care Coordination	19.5	Most Important
Social Services and Regular Source of Care	19.0	Most Important
Language Access and Cultural Competence	19.0	Most Important
Smoking Cessation	18.5	Most Important
Workforce Development and Diversity	18.0	Most Important
Health Insurance	17.5	Important
Maternal and Child Health	17.0	Important
Access to Healthy Affordable Food and Nutrition Education	17.0	Important
Physical Activity	16.5	Important
Built Environment	15.0	Important
Food Security	15.0	Important
Hospital Readmissions	15.0	Important
Youth Health Behaviors	14.5	Important
Community Safety	14.0	Important
Mental Health Services	13.5	Important
Social and Health Care Needs of Older Adults	13.5	Important
Alcohol/ Substance Abuse	13.0	Important
Access: Transportation	11.5	Less Important
Colon Cancer	11.0	Less Important
Medication Access	10.5	Less Important
Women's Cancer	10.5	Less Important
HIV	9.0	Less Important

Recommendations

- **Create and coordinate a Community Advisory Group**
- **Create a TJUHs Community Benefit Group in order to more fully coordinate TJUHs/TJU community benefit activities**
- **Involve Health Professions students in community benefit activities**
- **Mental Health**
  - Community Training in Trauma Informed Care for leaders and CBOs
  - Provide community training in ADHD and managing behaviors
  - Provide training in anger management for teens
  - Screen inpatients for alcohol use
  - Depression screening

Recommendations

1) Access to care:

- **Insurance enrollment:** Training; Enroll America; TJUH Finance
- **Transportation:** Appointments; medications
- **Primary Care:** Asian Clinic; Project HOME Wellness Center
- **Language Access and Cultural Competence:** Training; medical interpretation; Refugee Health Partners; CHWs/ Health Coaches; Universal Precautions; Health Literacy training/system changes
- **Emergency Department:** Database; HIV screening; reduce non-emergent / ambulatory care; JHN Stroke robot program expanded to rural areas
- **Maternal Child Health:** Breastfeeding; prenatal care; Maternity Care Passport; refer to MCC
- **Geriatric Initiatives**: Create an Aging Coalition; Conduct an assessment of older adults health and social needs for aging in place; Educate community about Palliative Care and Hospice; create opportunities for socialization

Recommendations *(cont.)*

2) Chronic disease management

- BP+; Million Hearts campaign with PDOH (BP screen and follow-up linked to primary care providers); AHA 360 and Get to Goal campaign
- YMCA - Walking groups (train leaders)
- Train bilingual health providers to lead DSME and CDSM groups
- Diabetes Self-Management; Diabetes support Groups
- Diabetes prevention program
- Obesity/ weight management
- Chronic disease self management classes
- Asthma education and environmental assessment
- Stroke awareness
- Nutrition Education
- Breastfeeding support
- Smoking Cessation

Recommendations *(cont.)*

3) Prevention and Early Detection of Disease

- Breast and cervical cancer- education and free screening
- Colorectal cancer- education
- Prostate cancer – education
- Stroke and Heart Attack – signs and symptoms

4) Community Safety

- Substance abuse
- Violence prevention through Substance abuse (Philly Rising)
- Raise awareness about Interpersonal Violence and community resources
- Built environment

5) Productive land use

Support community gardens; tree planting. park beautification (Mifflin Square Park); assist PDPH to assess parks and playgrounds; provide health education at community gardens/farms

Recommendations *(cont.)*

6) Prevention:

- **Healthy Lifestyles** – education on diet, stress, physical activity; partner with School Wellness Councils; create faith based council; work through internal and external partnerships; School Food Reform; beverage tax; support parks and recreation
- **Access to healthy affordable food** – Food Trust Partnership with corner stores; farmers markets including TJUH; urban agriculture/gardens; Farm to School; Farm to Institution
- **Food security** – screen patients; sign up for SNAP; healthy food drives
- **Smoking Cessation** – refer to PA QUIT Line/ FAX to QUIT; access to affordable nicotine replacement products; smokefree philly.org; enforce no smoking campus regulations

Recommendations *(cont.)*

7) Workforce Development and Pipeline

- Medical Interpretation training
- Career Awareness and skill building opportunities for youth
- Community Health Worker/ Navigator/Coach Training
- WorkReady - PYN
- Career Support Network for low-resourced individuals
- Partner with AHEC, NSC RAMP, TJUH HR, TJU Office of Diversity and Minority Affairs

8) Medical Legal Partnership

- Refugee Health Partners
- Jefferson

Collaborations

- Create an Advisory Group with community
- Maintain and expand community relationships by connecting with community groups and coalitions
- Collaborate with community partners on
  - grant/funding opportunities
  - research and evaluation of programs and initiatives

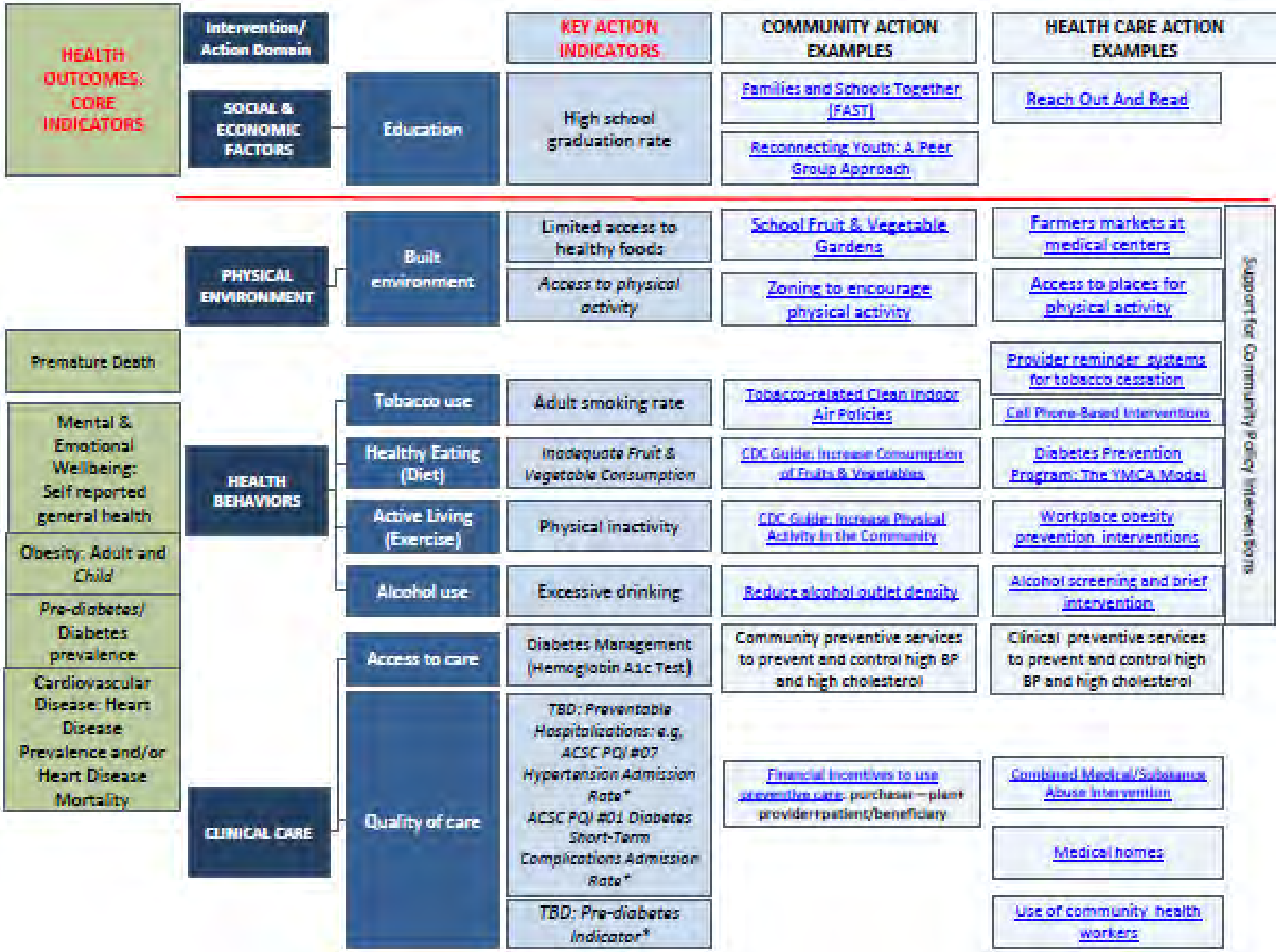
Jefferson Resources:

- Emergency Department
- Employees from target area
- Grant funding
- JNH stroke outreach
- Legislation liaison
- Marketing department
- Nurse Magnet Program
- Pharmacy
- Registered dieticians
- TJU students and residents
- TJUH certified diabetes educators
- TJUH/JHN support groups
- Pastoral Care
- Finance
- Human Resources

Potential Community Partners

Community relationships including:

- Cambodian Association
- Common Market
- Dixon House
- Faith Based Organizations
- Federation of Neighborhood Centers
- Food Trust
- Mamie Nichols Center
- Maternity Care Coalition
- Norris Square Civic Association
- Philadelphia Department of Public Health
- PACDC
- SHARE
- Coalition Against Hunger
- Southeast Asian Mutual Assistance Associations Coalition
- Southeast Philadelphia Coalition
- United Communities of Southeastern Pennsylvania
- Urban Tree Connection
- YMCA
- Schools
- CUSP
- Project HOME
- Nationalities Services Center
- Health Care Improvement Foundation
- PICC
- FPAC
- Welcoming Center


HEALTH OUTCOMES: CORE INDICATORS
Intervention/ Action Domain
KEY ACTION INDICATORS
COMMUNITY ACTION EXAMPLES
HEALTH CARE ACTION EXAMPLES
SOCIAL & ECONOMIC FACTORS
Education
High school graduation rate
Families and Schools Together (FAST)
Reconnecting Youth: A Peer Group Approach
Reach Out And Read
PHYSICAL ENVIRONMENT
Built environment
Limited access to healthy foods
Access to physical activity
School Fruit & Vegetable Gardens
Zoning to encourage physical activity
Farmers markets at medical centers
Access to places for physical activity
Premature Death
Mental & Emotional Wellbeing: Self reported general health
Obesity: Adult and Child
Pre-diabetes/ Diabetes prevalence
Cardiovascular Disease: Heart Disease Prevalence and/or Heart Disease Mortality
HEALTH BEHAVIORS
Tobacco use
Adult smoking rate
Tobacco-related Clean Indoor Air Policies
Provider reminder systems for tobacco cessation
Call Phone-Based Interventions
Healthy Eating (Diet)
Inadequate Fruit & Vegetable Consumption
CDC Guide: Increase Consumption of Fruits & Vegetables
Diabetes Prevention Program: The YMCA Model
Active Living (Exercise)
Physical inactivity
CDC Guide: Increase Physical Activity in the Community
Workplace obesity prevention interventions
Alcohol use
Excessive drinking
Reduce alcohol outlet density
Alcohol screening and brief intervention
CLINICAL CARE
Access to care
Diabetes Management (Hemoglobin A1c Test)
Community preventive services to prevent and control high BP and high cholesterol
Clinical preventive services to prevent and control high BP and high cholesterol
Quality of care
TBD: Preventable Hospitalizations: e.g. ACSC PQI #07 Hypertension Admission Rate*
ACSC PQI #01 Diabetes Short-Term Complications Admission Rate*
Financial incentives to use prevention care: purchaser—plan provider/patient/beneficiary
Combined Medical/Substance Abuse Intervention
Medical homes
TBD: Pre-diabetes Indicator*
Use of community health workers
Support for Community Policy Interventions

CHNA Resources

- http://www.countyhealthrankings.org/
- http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/addressing-determinants
- The CHNA toolkit is a free web-based platform built to assist hospitals and organizations seeking to better understand the needs and assets of their communities as well as collaborate to make measurable improvements in community health and well-being. http://www.communitycommons.org/chna/

CHNA Resources

- **Other Tools**
  - CDC Resources

    Implementing the Community Health Needs Assessment Process
  - CHIP Collaborative Handbook

    Community Health Improvement Planning
  - Stakeholder Health

    Transforming Health Through Community Partnership
- **Regulations**
  - Community Health Needs Assessments for Charitable Hospitals

    Summary - Notice of Proposed Rulemaking on CHNA for Charitable Hospitals
  - Proposed IRS Regulations

CHNA Resources

- **Plans and Collaborative Models**
  - Successes and Challenges in Community Health Improvement: Stories from Early Collaborations

    Association of State and Territorial Health Organizations (ASTHO) Issue Brief:
  - New Opportunities for Prevention

    Chicago Hospitals and the Affordable Care Act:
  - Community Health Improvement Plan 2014-2018

    City of Philadelphia
  - The Road to Health

    Health Care Council of the Lehigh Valley
  - Community Health Improvement Plan

    Greater Worcester Region
  - San Francisco Health Improvement Partnership