Thomas Jefferson University Hospitals
Community Health Needs Assessment Implementation Plan

Introduction

Thomas Jefferson University Hospitals, Inc. (TJUHs) serves patients in Philadelphia and the surrounding communities in the Delaware Valley. TJUHs (the “Hospital”) conducted a community health needs assessment (a “CHNA”) of the geographic areas served by the hospital pursuant to the requirements of Section 501(r) of the Internal Revenue Code (“Section 501(r)”).1 The CHNA findings were approved by the Board in June of 2013 and were made available on the Hospital’s website.2 This implementation strategy (“Strategy”), also required by Section 501(r), documents the efforts of the Hospital to address and prioritize the community health needs identified in the 2013 CHNA.

The Strategy identifies the means through which the hospital plans to address needs that are consistent with the Hospital’s charitable mission as part of its community benefit programs from 2014 through 2016. Beyond the programs discussed in the Strategy, the Hospital is addressing many of these needs simply by providing care to all, regardless of ability to pay. The Hospital anticipates health needs and resources may change, and thus a flexible approach was adopted in the development of its Strategy to address needs identified in the 2013 CHNA. In addition, changes may be warranted by the publication of final regulations.

Overview of Implementation Strategy

1. Community Served by the Hospital
2. Hospital Mission Statement and Community Benefit Charge
3. Priority Community Health Needs
4. CHNA Implementation Strategy
5. Needs Beyond the Hospital’s Mission or Community Benefit Program

1. Community Served by the Hospital

The Hospital, located in Philadelphia, PA, serves a wide catchment area that encompasses three states: Pennsylvania, New Jersey, and Delaware. Although its principal service area (Region 1) is Center City/South Philadelphia, as illustrated in the map below, the Hospital draws from roughly a 60-mile radius from the Center City campus.

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1 The Patient Protection and Affordable Care Act (Pub. L. 111-148) added section 501(r) to the Internal Revenue Code, which imposes new requirements on nonprofit hospitals in order to qualify for an exemption under Section 501(c)(3), and adding new reporting requirements for such hospitals under Section 6033(b) of the Internal Revenue Code.
In order to allocate resources and maximize the effectiveness of community initiatives for the purpose of conducting a Community Health Needs Assessment, the Hospital chose to narrow the focus to neighborhoods that:

- Are geographically proximate to both TJUH and Methodist;
- Have a poverty rate >20%;
- Have assets and resources that are not linked and coordinated to the Hospital’s outreach;
- Have a density of high-risk patients who demonstrate poor health indicators (health disparities); and
- Have individuals and organizations with developed historical relationships with Jefferson staff or have the potential for partnering to address specific health and social issues.

As indicated in the map (below), 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).
Figure 2. Hospital Community Benefit Area.

TJUHs CHNA, 2013.

Table 1. Population Demographics, Philadelphia vs. Hospital Community Benefit Area

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Philadelphia</th>
<th>Hospital Community Benefit Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>1.5 million</td>
<td>354,000 (23% of Philadelphia residents)</td>
</tr>
</tbody>
</table>
| Projected population growth, 2012-2017 | 0.9%         | Center City: 6.4%  
Transitional Neighborhoods: 4.8%  
South Philadelphia: 2% |
| White, non-Hispanic             | 37%          | 40%                                                  |
| Non-Hispanic African American   | 42%          | 37%                                                  |
| Hispanic                        | 13%          | 13%                                                  |
| Asian                           | 6.6%         | Center City: 14.9%  
Southeast Philadelphia: 15.6%  
South Philadelphia: 10.4% |

Source: TJUHs CHNA, 2013.
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. 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 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.

2. Hospital Mission Statement and Community Benefit Charge

The Hospital has a long history of engaging our community in identifying health issues and implementing strategies to address needs. Our mission and vision states that “Jefferson is dedicated to improving the health and well-being of the community we serve by setting the standards for excellence in clinical care, medical education and research and serving as a model integrated health services organization providing fiscally responsible care through appropriate use of resources.”

In order to fulfill our mission, the Board of Trustees of Thomas Jefferson University Hospitals, Inc. directed management to institute a formal process for assessing and prioritizing the health needs of our community and to implement impactful programs to address those needs. This process also meets the requirement mandated by the Health Care Reform Act to conduct a Community Health Needs Assessment every three years and implement strategies to address priority needs. To undertake this initiative, the Hospital formed an internal Community Benefit Steering Committee (CBSC) led by the Jefferson Center for Urban Health with representation from various departments and disciplines. Specifically, the Committee was charged to:

- Develop a strategic plan based on a comprehensive needs assessment and aligned with the Hospitals’ Strategic Plan;
- Develop an implementation 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; and
- Communicate the plan to external and internal audiences.
3. Prioritizing Community Health Needs

The focus of the Community Benefit Implementation Strategy is the intersection of the scientific evidence, public support and political support.

Poor health status is due to a complex interaction of challenging social, economic, environmental and behavioral factors, combined with a lack of access to care. Addressing the root causes of poor community health can improve quality of life and reduce mortality and morbidity. Figure 3 (below) describes the community health needs identified through the 2013 CHNA as priorities. In order to maximize the resources available to the Hospital, the Strategy will focus first on the priority health needs listed as “Most Important,” as listed below, and will continue to evaluate opportunities to fund or partner for the other needs:

![Diagram showing the intersection of scientific evidence, public support, and political support]

Table 2. List of Priority Community Health Needs

<table>
<thead>
<tr>
<th>Domain</th>
<th>Priority Health Needs/Issues</th>
<th>Ranking Score</th>
<th>Priority Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Disease Management</td>
<td>Chronic Disease Management (diabetes, heart disease and hypertension, stroke, asthma)</td>
<td>20.5</td>
<td>Most Important</td>
</tr>
<tr>
<td>Chronic Disease Management</td>
<td>Obesity</td>
<td>20.0</td>
<td>Most Important</td>
</tr>
<tr>
<td>Access to care</td>
<td>ED Utilization and Care Coordination</td>
<td>19.5</td>
<td>Most Important</td>
</tr>
<tr>
<td>Access to care</td>
<td>Health Education, Social Services and Regular Source of Care</td>
<td>19.0</td>
<td>Most Important</td>
</tr>
<tr>
<td>Access to care</td>
<td>Language Access, Health Literacy and Cultural Competence</td>
<td>19.0</td>
<td>Most Important</td>
</tr>
<tr>
<td>Healthy Lifestyle Behaviors and Community Environment</td>
<td>Smoking Cessation</td>
<td>18.5</td>
<td>Most Important</td>
</tr>
<tr>
<td>Internal Organizational Structure</td>
<td>Workforce Development and Diversity</td>
<td>18.0</td>
<td>Most Important</td>
</tr>
<tr>
<td>Access to care</td>
<td>Health Insurance</td>
<td>17.5</td>
<td>Important</td>
</tr>
<tr>
<td>Access to care</td>
<td>Maternal and Child Health</td>
<td>17.0</td>
<td>Important</td>
</tr>
<tr>
<td>Healthy Lifestyle Behaviors and Community Environment</td>
<td>Access to Healthy Affordable Food and Nutrition Education</td>
<td>17.0</td>
<td>Important</td>
</tr>
<tr>
<td>Healthy Lifestyle Behavior and Community environment</td>
<td>Physical Activity</td>
<td>16.5</td>
<td>Important</td>
</tr>
<tr>
<td>Healthy Lifestyle Behaviors and Community Environment</td>
<td>Built Environment</td>
<td>15.0</td>
<td>Important</td>
</tr>
<tr>
<td>Healthy Lifestyle Behaviors and Community environment</td>
<td>Food Security</td>
<td>15.0</td>
<td>Important</td>
</tr>
<tr>
<td>Internal Organizational structure</td>
<td>Hospital Readmissions</td>
<td>15.0</td>
<td>Important</td>
</tr>
<tr>
<td>Healthy Lifestyle Behaviors and Community Environment</td>
<td>Youth Health Behaviors</td>
<td>14.5</td>
<td>Important</td>
</tr>
<tr>
<td>Healthy Lifestyle Behaviors and Community Environment</td>
<td>Community Safety</td>
<td>14.0</td>
<td>Important</td>
</tr>
<tr>
<td>Access to care</td>
<td>Mental Health Services</td>
<td>13.5</td>
<td>Important</td>
</tr>
<tr>
<td>Access to care and Community environment</td>
<td>Social and Health Care Needs of Older Adults</td>
<td>13.5</td>
<td>Important</td>
</tr>
<tr>
<td>Healthy Lifestyle Behaviors and Community Environment</td>
<td>Alcohol/ Substance Abuse</td>
<td>13.0</td>
<td>Important</td>
</tr>
<tr>
<td>Access to care</td>
<td>Access: Transportation</td>
<td>11.5</td>
<td>Less Important</td>
</tr>
<tr>
<td>Health screening and early detection</td>
<td>Colon Cancer</td>
<td>11.0</td>
<td>Less Important</td>
</tr>
<tr>
<td>Access to care</td>
<td>Medication Access</td>
<td>10.5</td>
<td>Less Important</td>
</tr>
<tr>
<td>Health screening and early detection</td>
<td>Women's Cancer</td>
<td>10.5</td>
<td>Less Important</td>
</tr>
<tr>
<td>Health screening and early detection</td>
<td>HIV</td>
<td>9.0</td>
<td>Less Important</td>
</tr>
</tbody>
</table>

Source: TJUHs CHNA, 2013.

4. CHNA Implementation Strategy

The Hospital has a strong tradition of meeting community health needs through its ongoing community benefit programs and services. The Hospital will continue this commitment through the strategic health priorities set forth below that focus primarily on four (4) high-priority health need domains, as well as other selected priority health needs as identified in the 2013 CHNA.
Not all programs provided by the Hospital that benefit the health of patients in the Hospital’s primary service area are discussed in the Strategy. Further, given evolving changes in health care, the Hospital maintains the right to change its strategies, and new programs may be added or eliminated. The Strategy laid out in this document has two major parts: implementing programs to address the priority needs from the CHNA, then evaluating the impact of those activities.

A. Identifying Areas of Impact and Planning to Evaluate Proposed New Community Benefit Programs

The 2014-2016 focus of the Hospital’s grant-funded community benefit and in-kind resources was identified based on the CHNA Report findings, the prioritized health needs and recommended initiatives to impact the health of the community.

The Strategy is organized according to the following domains:

- **Access to Care**
- **Chronic Disease Management**
- **Health Screening and Early Detection**
- **Healthy Lifestyle Behaviors and Community Environment**

Through implementing evidenced-based strategies to address these four domains of community health need, the Hospital anticipates the following positive impact and improvements in community health:

- Positive impact on disease management and disease prevalence, including rates of obesity and obesity-related diseases (including stroke, cardiovascular disease, and diabetes) and asthma;
- Improvement in community health status, including reduction in health disparities, increased physical activity, reduced rates of smoking, improved food security and improved health and nutrition status, improved community engagement, and improved maternal and child outcomes; and
- More appropriate use of health resources, including a reduction in unnecessary hospital admissions and use of some hospital services, including emergency department visits, and an increase in use of culturally appropriate primary care and health screenings.

These improvements will be evaluated through review and monitoring of existing data sources, which may include but are not limited to:

- Internal Hospital data, including HCAHPS, referral data, inpatient and outpatient service data, and TJUHs employee data;
- Public Health Management Household Health survey data;
- Surveys and key informant interviews with providers and clients;
- Reports from government, state and city agencies, which may include: Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), Philadelphia Department of Public Health and Maternity Care Coalition, CDC (including Youth Risk and Behavior Survey data), South Philadelphia Prevention Coalition; and
- External community data sources, including Farmer’s Market, CSA and Winter Harvest data, and school district data/reports.
B. Address Priority Health Needs through Hospital’s Existing and New Community Benefit Programs

The Hospital plans to provide community benefit programs responsive to the health needs identified in the 2013 CHNA. As part of this Strategy, the Hospital will focus first on those needs designated as “Most Important” between 2014 and 2016, and will continue to evaluate those needs that were designated as “Important” and “Less Important”. The recommended actions may be modified based on on-going input and recommendation from internal and external partners, identification of new partnership opportunities, changes in the healthcare and community environment and availability of resources. Throughout the implementation period, the Community Benefit Steering Committee and the Community Advisory Board will identify grants and internal and external funding sources as appropriate to support the strategies and activities. Resources to implement programs are provided in-kind unless otherwise noted.

The strategies/activities related to Special Populations (refugees/immigrants, the homeless, and LGBT) are integrated throughout the Implementation Plan.

**DOMAIN: ACCESS TO CARE**

The anticipated impact of the following actions may include: reduction in emergency department visits, increase in the number of insured adults, improvement in access to and utilization of culturally appropriate primary care, reduction of health disparities, improvement in maternal and child outcomes, improvement in the capacity of community-based organizations to address behavioral health issues among clients/program participants, and reduction in transportation barriers to receiving medication and care.

1. **Action: Encourage appropriate Emergency Department utilization through care coordination across community, hospital and primary care (Most Important)**
   - Assess non-emergent and ambulatory care use and develop strategies to reduce the use of emergency services for this population through community and hospital initiatives.
   - Explore models, such as health coaches and community partnerships, to address high utilizers/non-emergent care use and seek funding to support recommended model/intervention.
   - Continue to advocate and assist in identifying funding for creation of a City-wide database to track patients requesting pain medications and other drugs.

2. **Action: Improve access to Community Centered Social and Health Education Services and regular source of health care (Most Important)**
   - Explore feasibility of initiating a “Primary Care Center” in South Philadelphia for the Asian Community.
   - Continue the expansion of the partnership with St Elizabeth’s Wellness Center.
   - Assess need and feasibility of a Medical Legal Partnership at Jefferson and a Refugee Health Partners student-run clinic.
3. **Action: Improve Language Access, Health Literacy and Cultural Competence (Most Important)**

- Explore opportunities to expand cultural competence training for health care providers related to special populations such as immigrants/refugees, LGBT, older adults, mentally ill and the homeless.
- Explore the development of a program to train Community Health Workers (including refugees) for the immigrant/refugee community, the Project HOME Wellness Center, and to support discharged patients and high ED utilizers at Methodist and TJUH.
- Enhance availability of medical interpreter services by (1) increasing provider awareness about regulations pertaining to access to interpreters; (2) reviewing interpreter services/technology to assist non-English speaking people to schedule health care appointments and call the hospital or health care provider for information, guidance about procedures, etc.; (3) exploring partnerships with community based organizations to increase their staff and memberships’ capacity to serve as bilingual medical interpreters and community health coaches.
- Continue to provide interpreter services for Chinese patients though the Chinese Health Information Center.
- Continue to provide Health Literacy training for Jefferson Hospital and University staff, providers, students as well as other regional health systems. Continue to advocate for and support policies/system changes that mandate health literacy competence in all written and oral communication.
- Explore internal and external funding sources for medical interpreter and cultural competence training. Utilize existing funding from Healthcare Improvement Foundation.

4. **Action: Improve access to health insurance**

- Partner with community-based organizations to train community leaders to assist with enrolling community members into insurance programs.

5. **Action: Improve Access to timely Maternal and Child Health Services**

- Explore strategies to increase access to timely prenatal care such as use of community health workers.
- Pursue Baby Friendly Hospital status to promote breastfeeding.
- Explore “Maternity Care Passport” to reduce unnecessary patient re-testing in Philadelphia at time of service and/or labor and delivery.
- Identify opportunities for more formal relationships with community-based organizations to improve utilization of prenatal care, transitions home after birth and referrals to appropriate social services.

6. **Action: Improve Access to Behavioral Health Education and Services**

- Implement training workshops for community partners related to Trauma Informed Care, ADHD in children and anger management among youth.
- Explore feasibility of expanding depression screening in health care practices, the ED and community.
- Improve access to and awareness of behavioral health services through partnerships with CBOs, Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), and behavioral health collaborative with particular focus on non-English speakers and transportation.
7. **Action: Improve Access to Transportation to Health Care Services**
   - Raise awareness about LogistiCare transportation services for Medicaid patients among providers and the community.
   - Explore transportation issues related to accessing health care services and medications.

8. **Action: Improve Access to Medications**
   - Raise healthcare provider and community awareness about free/low cost medication access programs including PACE and options for home delivery of medications.
   - Support PDPH project to limit co-pays for hypertensive medications.

**DOMAIN: CHRONIC DISEASE MANAGEMENT**

The anticipated impact of the following actions may include: improved health behaviors, disease management and health status through greater continuity of care with health care providers (including improved adherence to treatment recommendations and improved communication with health care providers). We also expect to see increased utilization of palliative care/hospice services and reduced caregiver burden.

1. **Action: Improve the capacity of community based organizations and health care providers to support efforts related to chronic disease prevention and management (Most Important)**
   - Coordinate a faith-based advisory council that provides training for congregational nurses to address chronic disease management and community health programming.
   - Increase community and healthcare provider referral to existing chronic disease management programs and resources by centralizing and disseminating information.
   - In partnership with the CBOs that serve non-English speaking communities, build the capacity of bilingual staff to provide education on chronic disease prevention and management.
   - Provide information to all patients and community program participants about quit smoking resources including the Pennsylvania State QUIT line.
   - Provide and expand Chronic Disease Self-Management programs offered by TJUH at community sites.

2. **Action: Provide education and support programs to reduce diabetes prevalence and/or improve diabetes management (Most Important)**
   - Provide and expand DSME programs and support groups offered at community sites and at Jefferson.
   - Increase referral to diabetes management programs and support groups by health care providers and community organizations.
   - Refer pre-diabetic patients to YMCA Diabetes Prevention Programs and related educational programs offered by Jefferson and other community-based organizations.
3. **Action:** Provide education and support programs to reduce hypertension prevalence and/or improve hypertension management (Most Important)
   - Revise and expand current BP plus program in response to AHA (360 and Get to Goal campaign) and the Philadelphia Department of Public Health (Million Hearts campaign) to increase screening and adherence to treatment plan.
   - Develop database to track blood pressure screening participants and close communication loop with providers.

4. **Action:** Provide education and support programs to reduce asthma prevalence and/or improve asthma management (Most Important)
   - Explore collaboration with CHOP’s Community Asthma Prevention Program (CAPP) in Lower North and South Philadelphia.
   - Train faith-based nurses and bi-lingual community health workers to provide education and environmental assessments.

5. **Action:** Provide education and support programs to reduce stroke prevalence and/or improve stroke management (Most Important)
   - Provide blood pressure and stroke screening and raise public awareness about stroke prevention, early detection (FAST - Face, arms, speech, time) and TpA.
   - Explore opportunities to partner with CBOs, community centers and faith-based initiatives to assist stroke victims and caregivers in their communities.
   - Provide stroke support groups for patients and caregivers.

6. **Action:** Provide education and support programs to reduce obesity prevalence and/or improve obesity management (Most Important)
   - Explore the creation of a central database/promotion strategy to increase referrals by health care providers and community organizations to nutrition, physical activity, weight management and other wellness programs.
   - Promote healthy eating and weight management at worksites through collaboration with the Philadelphia Health Initiative (a worksite wellness coalition) and their Philly First Program (an academic medical center initiative) promote healthy eating and weight management at worksites.

7. **Action:** Address Needs of Older Adults Aging in Place
   - Explore creation of an Aging Coalition to coordinate and conduct an assessment of older adults’ health and social needs for aging in place.
   - Partner with community based organizations serving older adults to address the needs of older adults in our communities through education and screening and access to social services.
   - Educate community about Palliative Care and Hospice.

**DOMAIN: HEALTH SCREENING AND EARLY DETECTION**

The anticipated impact of the following actions may include: increased HIV screening rates in high-risk populations, increased colon cancer screening rates, and increased screening rates for breast and cervical cancer screening.
1. **Action: Increase HIV screening activities**
   - Continue HIV screening in ED and expand to JEFF HOPE site(s) and other community sites; raise community and provider awareness about HIV screening.
   - Utilize existing resources from Aids Activities Coordinating Office.

2. **Action: Improved Colon Cancer Screening Rates**
   - Coordinate education to increase screening in community benefit neighborhoods.
   - Utilize existing educational program.

3. **Action: Increase Women's Cancer Screening**
   - Provide supportive services for women with cancer including medical supplies, wigs and support groups.
   - Raise awareness within Jefferson and the community about the Pennsylvania’s Healthy Woman Program and Pennsylvania’s Breast Cancer and Cervical Cancer Prevention and Treatment Program to provide free cervical cancer screening and mammograms to uninsured and under-insured women.

**DOMAIN: HEALTHY LIFESTYLE BEHAVIORS AND COMMUNITY ENVIRONMENT**

The anticipated impact of the following actions may include: improved nutrition, increased physical activity, stress management, increased referral to and utilization of Farmers Markets, CSAs and Winter Harvest programs, improved food security and improved health and nutrition status, reduced smoking rates, policy changes reducing exposure to smoking, improved sense of community safety and engagement, reduced alcohol and marijuana use among South Philadelphia youth, and increased identification and referral of patients to addiction counseling and services.

1. **Action: Reduce Prevalence Of Obesity, Cardiovascular Disease, Diabetes, Cancer And Other Obesity Related Diseases (Most Important)**
   - Explore creation of a central database/promotion strategy to promote nutrition, physical activity, and other wellness programs to health care providers and community residents.
   - Increase referrals to community based healthy lifestyle programs by health providers and community partners.

2. **Action: Improve Smoking Rates (Most Important)**
   - Raise awareness among providers about community efforts and resources to reduce smoking rates.
   - Support PDPH policy efforts to reduce tobacco use in Philadelphia.
   - Encourage private insurers to cover smoking cessation programs/ counseling and nicotine.

3. **Action: Increase Access To Healthy Affordable Food And Nutrition Education**
   - Collaborate with the Food Trust to promote health screening, education/prevention activities and healthy eating at “Super Corner Stores”.
   - Provide nutrition education at community sites.
   - Raise awareness about farmers markets and other venues for healthy food among health care providers and community organizations.
   - Support urban gardening and agriculture efforts through employee and student participation, health education, evaluation and fund raising.
- Support and advocate for Farmers Markets, CSAs and Winter Harvest programs.

4. **Action: Reduce Intake of Sugar Beverages and Fast Food**
   - Expand the healthy vending machine initiative at TJUHs worksites.
   - Advocate for passage of a sugar beverage tax.

5. **Action: Routine Assessment of Food Security**
   - Explore screening inpatients and outpatients for food security, particularly at discharge from hospital – begin with JFMA service and provide food access resource guide.
   - Explore screening for SNAP eligibility when determining MA eligibility.
   - Promote food cupboards and other food assistance programs: conduct “healthy food” drives at TJUHs for area food cupboards in partnership with SHARE (increase access to foods lower in salt, sugar and whole grains).

6. **Action: Improve Access To Safe Places For Physical Activity**
   - Explore opportunities to support physical activity through partnerships with community organizations.
   - Explore partnership with the YMCA to train community residents to implement walking groups and other exercise programs.
   - Encourage physical activity among TJUHs employees through the Worksite Wellness initiative.

7. **Action: Enhance the Built Environment**
   - Support community beautification efforts and zoning efforts to increase access to healthy food and safe places to play, including community gardens and tree planting.
   - Assist the Philadelphia Department of Public Health in assessing parks/playgrounds in TJUHs community.
   - Support the Friends of Mifflin Square Park efforts to improve the park and playground facility and increase park utilization by the diverse surrounding community.

8. **Action: Improve Community Safety**
   - Support SEPC, United Communities, Diversified Community Services and the South Philadelphia Prevention Coalition to reduce community violence through reducing use of gateway drugs among youth, specifically alcohol and marijuana.
   - Screen for IPV and raise awareness about interpersonal violence and sources of help.
   - Work with Pennsylvania Immigrant Care Coalition’s Public Safety Committee.

9. **Action: Decrease Alcohol And Substance Use**
   - Support SEPC, United Communities and the South Philadelphia Prevention Coalition to reduce community violence through reducing use of gateway drugs among youth, specifically alcohol and marijuana.
   - Explore implementing evidence-based Alcohol Screening and Brief Intervention at TJUHs hospitals.
   - Explore creating a City-wide database to monitor ED patients who frequently ask for narcotics.

10. **Action: Improve Youth Health Behaviors**
    - Engage with the Philadelphia School District’s Office of Strategic Partnerships.
    - Build the capacity of youth to enter and succeed in health careers and other employment, such as PYN summer opportunities and training/tutoring in math and science, with the
goal of giving youth the skills they need to be considered for health careers and ultimately leading to a more diverse workforce.

- In collaboration with PDPH, School Wellness Councils and others, continue to raise awareness about and/or advocate for:
  - A school policy that requires a specific number of minutes of physical activity weekly in schools;
  - School food reform through policy and behavioral changes;
  - Regular classroom movement breaks and socialized recess;
  - Reducing screen time; and
  - Referring youth to smoking cessation resources such as the PA Quit Line.

D. Collaborate with Community Partners to Address Health Needs

The Strategy will be implemented in collaboration with other entities including, but not limited to:

- AIDs Activities Coordinating Office
- American Cancer Society
- American Diabetes Association
- American Heart Association
- Cambodian Association
- City Health Centers
- Community organizations involved with interpersonal violence
- Council for Relationships
- Delaware Valley Stroke Council
- Department of Recreation
- Federation of Neighborhood Centers
- Food Trust
- Friends of Mifflin Park
- Health Federation
- Health insurers
- Health Promotion Council
- Healthcare Improvement Foundation
- Intellectual disAbility Services (DBHIDS)
- Jeff HOPE
- LogistiCare
- MANNA
- Maternity Care Coalition
- Mazzoni Center
- Migrant Education
- Nationalities Services Center
- Pathways to Housing
- Pennsylvania Department of Health
- Pennsylvania Horticulture Society
- Pennsylvania Immigrant Care Coalition’s Public Safety Committee
- Pennsylvania Immigration and Citizenship Coalition
- Philadelphia Corporation on Aging
- Philadelphia Department of Behavioral Health
- Philadelphia Department of Public Health
- Philadelphia Emergency Departments
- Philadelphia Fire Department and community based organizations
- Philadelphia Health Coalition
- Philadelphia Housing Authority
- Philadelphia School District and School Wellness Councils
- Philly Rising
- Project HOME
- Refugee Behavioral Health Collaborative
- Restaurant Opportunities Center
- SEAMAAC
- SEPC
- SHARE
- Smokefree Philly
- South Philadelphia Prevention Coalition
- St Elizabeth’s Wellness Center
- United Communities
- Urban Tree Connection
- Visiting Nurses Association
- Women Against Abuse
- YMCA
Other non-profit agencies, community centers, schools, preschools, farmers, state associations and departments, city government, oral health professionals, community health care providers, resettlement agencies, transportation services, pharmacies, faith-based institutions and higher education.

5. Needs Beyond the Hospital’s Mission or Community Benefit Program

Addressing all of the health needs present in a large community will require resources beyond what any single hospital or social service agency can bring to bear. The Hospital is committed to fulfilling its mission as well as remaining financially viable so that it can continue its commitment to excellence in quality care and provide a wide range of community benefits. Between 2014 and 2016, the Hospital will focus its efforts in order to make a true and measurable impact, and thus plans to implement actions that will address those needs identified through the Community Health Needs Assessment as “Most Important”. The Hospital will continue to evaluate opportunities for funding or resources to commit to addressing the remaining needs.

The priority health issues related to the Hospital’s internal organizational structure, including workforce development and diversity, fall outside the scope of the hospital’s Community Benefit Program, and the CHNA recommendations related to internal organizational structure will be reviewed by Hospital and University senior leadership.