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

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

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

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

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

The CHNA Implementation Plan will be developed by Senior Administration / CHNA Oversight Committee, the Center for Urban Health, the Community Advisory Group and key partners.
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.

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

“Jefferson”

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

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

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

Jefferson Health also includes 16 outpatient and urgent care centers as well as numerous physician practices located in Bucks, Montgomery, and Philadelphia counties in Pennsylvania, and Camden County in New Jersey. Outpatient and community-based services are delivered through an extensive network of owned and affiliated physician practices, satellite medical and surgical centers, outpatient laboratories, imaging centers, and retail pharmacies.
Thomas Jefferson University Hospital (TJUH) is Magnet®-designated and is one of only 14 hospitals in the country that is a Level 1 Trauma Center and a federally designated Regional Spinal Cord Injury Center. Jefferson’s Regional Spinal Cord Injury Center of the Delaware Valley, in affiliation with Magee Rehabilitation Hospital, is designated as one of the nation's Model Spinal Cord Injury Centers by the National Institute on Disability and Rehabilitation Research. TJUHs has 951 licensed acute care beds and provides the full range of clinical care, both in inpatient and ambulatory settings and in all specialties and subspecialties.

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

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

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

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

The Community Health Needs Assessment will focus on Thomas Jefferson University Hospital, Jefferson Hospital for Neurosciences, and Methodist Hospital.

Models Used for Conducting the Community Health Needs Assessment

With the growing burden of chronic disease, the medical and public health communities are reexamining their roles and opportunities for more effective prevention and clinical interventions. The potential to significantly improve chronic disease prevention and impact morbidity and mortality from chronic conditions is enhanced by adopting strategies that incorporate a social ecology perspective, realigning the patient-physician relationship, integrating population health perspectives into the chronic care model, and effectively engaging communities.
Jefferson highly values the principles of community engagement articulated by the Centers for Disease Control and has built its community benefit efforts on a community engagement model.

**Principles of Community Engagement**

<table>
<thead>
<tr>
<th>Principle</th>
<th>Key elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Set Goals</td>
<td>• Clarify the purposes/goals of the engagement effort</td>
</tr>
<tr>
<td></td>
<td>• Specify populations and/or communities</td>
</tr>
<tr>
<td>Study Community</td>
<td>• Economic conditions</td>
</tr>
<tr>
<td></td>
<td>• Political structures</td>
</tr>
<tr>
<td></td>
<td>• Norms and values</td>
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<tr>
<td></td>
<td>• Demographic trends</td>
</tr>
<tr>
<td></td>
<td>• History</td>
</tr>
<tr>
<td></td>
<td>• Experience with engagement efforts</td>
</tr>
<tr>
<td></td>
<td>• Perceptions of those initiating the engagement activities</td>
</tr>
<tr>
<td>Build Trust</td>
<td>• Establish relationships</td>
</tr>
<tr>
<td></td>
<td>• Work with the formal and informal leadership</td>
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<tr>
<td></td>
<td>• Seek commitment from community organizations and leaders</td>
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<tr>
<td></td>
<td>• Create processes for mobilizing the community</td>
</tr>
<tr>
<td>Encourage self-determination</td>
<td>• Community self-determination is the responsibility and right of all people</td>
</tr>
<tr>
<td></td>
<td>• No external entity should assume that it can bestow on a community the power to act in its own self-interest</td>
</tr>
<tr>
<td>Establish partnerships</td>
<td>• Equitable partnerships are necessary for success</td>
</tr>
<tr>
<td>Respect diversity</td>
<td>• Utilize multiple engagement strategies</td>
</tr>
<tr>
<td></td>
<td>• Explicitly recognize cultural influences</td>
</tr>
<tr>
<td>Identify community assets and develop capacity</td>
<td>• View community structures as resources for change and action</td>
</tr>
<tr>
<td></td>
<td>• Provide experts and resources to assist with analysis, decision-making, and action</td>
</tr>
<tr>
<td></td>
<td>• Provide support to develop leadership training, meeting facilitation, skill building</td>
</tr>
<tr>
<td>Release control to the community</td>
<td>• Include as many elements of a community as possible</td>
</tr>
<tr>
<td>Make a long-term commitment</td>
<td>• Adapt to meet changing needs and growth</td>
</tr>
<tr>
<td></td>
<td>• Recognize different stages of development and provide ongoing technical assistance</td>
</tr>
</tbody>
</table>

Jefferson also recognizes the value of an Expanded Chronic Care Model as a framework for addressing chronic disease in a comprehensive way that respects clinical care, the health system, community and patients as equal partners in meeting the Triple Aim of improving population health, the patient experience, and reducing per capita costs.
Figure 1 – Expanded Chronic Care Model

Community

Health System

Delivery System

Decision Support

Information

Self-Management

Build Healthy Policy

Create Supportive Environment

Strengthen Community Action

Productive Interactions and Continuous Relationships

Activated Community

Activated Patient

Activated Team

Proactive Community
The Community Benefit Steering Committee described below 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 plan.

**Clinical/Community Population Health Intervention Model**

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<table>
<thead>
<tr>
<th>Inquiry</th>
<th>Assessment</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Collection</td>
<td>Identify Priority Health Issues</td>
<td>Environmental &amp; Policy Change</td>
</tr>
<tr>
<td>Partnership Formation</td>
<td>Comprehensive Strategy Development</td>
<td>Coordinated Clinical &amp; Community Prevention Activity</td>
</tr>
</tbody>
</table>

**Outcomes**

- Improved Health
- Cost Savings
- Evidence-Based for Effective Practice
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**Purpose of the Community Health Needs Assessment (CHNA)**

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

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

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

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

Four principles are guiding the development of a strategy for leveraging community benefit programs to increase their influence: defining mutually agreed-on regional geographic boundaries to align both community benefit and accountable health community initiatives, ensuring that community benefit activities use evidence to prioritize interventions, increasing the scale and effectiveness of community benefit investments by pooling some resources, and establishing shared measurement and accountability for regional population health improvement.

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

Members of the internal CBSC are listed below:

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

Specifically, the CBSC was charged to:

• Develop a strategic plan based on a comprehensive needs assessment and align the plan with TJUH’s Strategic Plan
• Develop an implementation plan and budget
• Monitor plan implementation and institute corrective measures if needed
• Conduct ongoing evaluation of community benefit structure and processes
• Evaluate the effectiveness of individual projects and the impact of community benefit initiatives as a whole
• Communicate the plan with external and internal audiences

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

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

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

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

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

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

Philadelphia and TJUH Community Benefit Area Demographics

According to the official 2010 census, Philadelphia is the fifth largest city in the country with 1.56 million people. After declining for more than half a century, Philadelphia's population is growing, adding almost 72,000 residents in 8 years.
The city's residents are a diverse population: 37% non-Hispanic White, 42% non-Hispanic African American\textsuperscript{1}, 13% Hispanic or Latino\textsuperscript{2}, and almost 7% non-Hispanic Asian.\textsuperscript{vi}

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

<table>
<thead>
<tr>
<th>Area</th>
<th>ZIP Codes</th>
<th>Sub Area</th>
<th>ZIP Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower North Philadelphia (LN)</td>
<td>19121, 19122, 19132, 19133</td>
<td>Lower North East of Broad</td>
<td>19122, 19133</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lower North West of Broad</td>
<td>19121, 19132</td>
</tr>
<tr>
<td>Transitional Areas (TN)</td>
<td>19123, 19125, 19130</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Center City (CC)</td>
<td>19102, 19103, 19106, 19107</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Philadelphia (SP)</td>
<td>19145, 19146, 19147, 19148</td>
<td>South Phila East of Broad</td>
<td>19147, 19148</td>
</tr>
<tr>
<td>TJUH Community Benefit areas (TJUH CB)</td>
<td>19121, 19122, 19132, 19133, 19135, 19137, 19141, 19142, 19143, 19144, 19145, 19146</td>
<td>South Phila West of Broad</td>
<td>19145, 19146</td>
</tr>
</tbody>
</table>

\textsuperscript{1} The terms black or African American are both used in this document depending on the source of the data. According to the Census Bureau website, these terms are used interchangeably and refer to people having origins in any of the black racial groups of Africa. (https://www.census.gov/prod/cen2010/briefs/c2010br-06.pdf)

\textsuperscript{2} The terms Latino and Hispanic are both used in this document depending on the source of the data. According to the U.S. Census Bureau "Hispanics or Latinos" are those people who classified themselves in one of the specific Spanish, Hispanic, or Latino categories ... "Mexican," "Puerto Rican," or "Cuban"-as well as those who indicate that they are "another Hispanic, Latino, or Spanish origin." ... The terms "Hispanic," "Latino," and "Spanish" are used interchangeably."
The map that follows displays these areas. Each area has been assigned a color which will be used throughout this report in graphs to depict that specific area. Data throughout the CHNA is based on zip code and/or Philadelphia planning districts. The majority of TJUHs CB area is encompassed within three planning districts, Lower North, Central and South. A map depicting the overlap between zip codes and planning districts is provided in the appendices.

**Philadelphia and TJUH’s CB Area**

Almost 420,000 people live in TJUH’s CB area. This represents 27% of all residents of Philadelphia.
Process and Methods Used to Conduct the CHNA

Literature Review and Secondary Data Sources

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

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

TJUHs Strategic Plan

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

Interviews and Meetings

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

The table below lists the organizations and clinical departments of those interviewed, the sector they represent (community or Jefferson), and the focus of the interview/meeting based on area(s) of expertise.

<table>
<thead>
<tr>
<th>Organization</th>
<th>Community/ Jefferson</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCESS Matters</td>
<td>Community</td>
<td>Family Planning; Maternal Health</td>
</tr>
<tr>
<td>The Augustinian Defenders of the Rights of the Poor (ADROP)</td>
<td>Community</td>
<td>Immigrant Health; Social Determinants of Health</td>
</tr>
<tr>
<td>American Diabetes Association</td>
<td>Community</td>
<td>Diabetes</td>
</tr>
<tr>
<td>American Heart Association</td>
<td>Community</td>
<td>Heart Disease/Stroke</td>
</tr>
<tr>
<td>Asian Chamber of Commerce of Greater Philadelphia</td>
<td>Community</td>
<td>Immigrants</td>
</tr>
<tr>
<td>Bhutanese American Organization-Philadelphia (BAO-P)</td>
<td>Community</td>
<td>Refugee Health and Social Services</td>
</tr>
<tr>
<td>Broad Street Ministries</td>
<td>Community</td>
<td>Homeless</td>
</tr>
<tr>
<td>Cambodian Association</td>
<td>Community</td>
<td>Immigrants</td>
</tr>
<tr>
<td>Chinatown Community Development Corporation</td>
<td>Community</td>
<td>Immigrant Health; Social Determinants of Health</td>
</tr>
<tr>
<td>City Councilman 1st District</td>
<td>Community</td>
<td>City Government</td>
</tr>
<tr>
<td>Coalition Against Hunger</td>
<td>Community</td>
<td>Food Access/ Food Security</td>
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<tr>
<td>Congreso de Latinos Unidos</td>
<td>Community</td>
<td>Latino Health and Social Needs</td>
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<tr>
<td>Council for Relationships</td>
<td>Community</td>
<td>Behavioral Health</td>
</tr>
<tr>
<td>Delaware Valley Regional Planning Council</td>
<td>Community</td>
<td>Built Environment; Social Determinants of Health</td>
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<tr>
<td>Organization</td>
<td>Community</td>
<td>Focus</td>
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<td>------------------------------------------------------------------------------</td>
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<tr>
<td>Department of Behavioral Health and Intellectual Disabilities</td>
<td>Community</td>
<td>Behavioral Health</td>
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<tr>
<td>Diversified Community Services</td>
<td>Community</td>
<td>Neighborhood Community Center</td>
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<td>Food Trust</td>
<td>Community</td>
<td>Food Security; Access to Food; Nutrition; Obesity</td>
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<td>Greater Philadelphia Business Coalition on Health</td>
<td>Community</td>
<td>Work Place Wellness</td>
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<tr>
<td>Greater Philadelphia Health Action; Chinatown Medical Services</td>
<td>Community</td>
<td>Pediatrician, Federally Qualified Health Center; Asian Health</td>
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<td>Hispanic Association of Contractors and Enterprises (HACE)</td>
<td>Community</td>
<td>Immigrant Health; Social Determinants of Health</td>
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<tr>
<td>Healthy Rowhouse Initiative</td>
<td>Community</td>
<td>Housing; Social Determinants of Health</td>
</tr>
<tr>
<td>Health Federation</td>
<td>Community</td>
<td>Federally Qualified Health Center</td>
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<tr>
<td>Health Promotion Council</td>
<td>Community</td>
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<tr>
<td>Healthcare Improvement Foundation</td>
<td>Community</td>
<td>Health Literacy</td>
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<td>Hepatitis B Foundation</td>
<td>Community</td>
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<tr>
<td>Legal Clinic for the Disabled</td>
<td>Community</td>
<td>Medical Legal Partnership</td>
</tr>
<tr>
<td>Lutheran and Children’s Services</td>
<td>Community</td>
<td>Immigrant/Refuge; Behavioral Health</td>
</tr>
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<td>Metropolitan Area Neighborhood Nutrition Alliance (MANNA)</td>
<td>Community</td>
<td>Food Access and Nutrition</td>
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<tr>
<td>Mayor's Office of Immigrant and Multicultural Affairs</td>
<td>Community</td>
<td>Maternal Child Health; Social Determinants of Health</td>
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<td>Maternity Care Coalition</td>
<td>Community</td>
<td>Maternal Child Health; Early Childhood Development; Social Determinants of Health</td>
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<td>Mayor’s Office on Planning</td>
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<td>City Planning; Built environment</td>
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<td>LGBT</td>
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<td>Methadone Clinic</td>
<td>Community</td>
<td>Addictions</td>
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<td>Nationalities Services Center</td>
<td>Community</td>
<td>Immigrant/Refuge</td>
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<td>Nemours Pediatrics</td>
<td>Community</td>
<td>Children</td>
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<td>Norris Square Community Alliance Head Start</td>
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<td>Philadelphia Association of Community Development Corporations</td>
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<td>Older Adult Health and Social Services</td>
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<td>Philadelphia Department of Public Health</td>
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<tr>
<td>Philadelphia Housing Authority</td>
<td>Community</td>
<td>Low Income Housing; Social Determinants of Health</td>
</tr>
<tr>
<td>Organization</td>
<td>Community/ Jefferson</td>
<td>Focus</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>--------------------------------------------------------------</td>
</tr>
<tr>
<td>Philadelphia Police Department</td>
<td>Community</td>
<td>Community Violence; Social Determinants of Health</td>
</tr>
<tr>
<td>Philadelphia Refugee Mental Health Collaborative</td>
<td>Community</td>
<td>Behavioral Health; Immigrant Health; Social Determinants of Health</td>
</tr>
<tr>
<td>Philadelphia Reentry Coalition</td>
<td>Community</td>
<td>Prison Re-entry</td>
</tr>
<tr>
<td>Philadelphia School District</td>
<td>Community</td>
<td>Education and Health Services</td>
</tr>
<tr>
<td>Project Home and Steven Klein Wellness Center</td>
<td>Community</td>
<td>Homeless; Primary Care</td>
</tr>
<tr>
<td>Refugee Health Partners</td>
<td>Community</td>
<td>Immigrant/Refugee</td>
</tr>
<tr>
<td>Schools: Independence Charter School; Southwark School</td>
<td>Community</td>
<td>Children grades K-8</td>
</tr>
<tr>
<td>Southeast Asian Mutual Assistance Associations Coalition (SEAMAAC)</td>
<td>Community</td>
<td>Immigrants/Refugees</td>
</tr>
<tr>
<td>Self-Help and Resource Exchange (SHARE)</td>
<td>Community</td>
<td>Food Access/ Food Security</td>
</tr>
<tr>
<td>South Philadelphia Aging Coalition</td>
<td>Community</td>
<td>Older adults</td>
</tr>
<tr>
<td>United Communities Southeastern Philadelphia</td>
<td>Community</td>
<td>Neighborhood Community Center; Immigrant/Refuge; Behavioral Health; Youth, Addictions</td>
</tr>
<tr>
<td>Veterans Multi-Services Center</td>
<td>Community</td>
<td>Veterans</td>
</tr>
<tr>
<td>Jefferson Obstetrics and Gynecology Associates (JOGA) clinic</td>
<td>Jefferson</td>
<td>Maternal Health</td>
</tr>
<tr>
<td>Stroke Center/Neurosciences</td>
<td>Jefferson</td>
<td>Stroke</td>
</tr>
<tr>
<td>Cancer Patient Services</td>
<td>Jefferson</td>
<td>Cancer; Social Determinants of Health</td>
</tr>
<tr>
<td>Cancer Research</td>
<td>Jefferson</td>
<td>Cancer</td>
</tr>
<tr>
<td>Cardiovascular Health</td>
<td>Jefferson</td>
<td>Heart Disease/Stroke</td>
</tr>
<tr>
<td>Case Management Social Work</td>
<td>Jefferson</td>
<td>Social Determinants of Health</td>
</tr>
<tr>
<td>Jefferson Elder Care - Occupational Therapy</td>
<td>Jefferson</td>
<td>Fall Prevention – Older Adults</td>
</tr>
<tr>
<td>Diabetes Center</td>
<td>Jefferson</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>Jefferson</td>
<td>Emergency Medicine, Injury Prevention, Chinatown Clinic</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>Jefferson</td>
<td>Primary Care</td>
</tr>
<tr>
<td>Family Medicine – Geriatric Clinic</td>
<td>Jefferson</td>
<td>Family Medicine; Geriatrics</td>
</tr>
<tr>
<td>Family Medicine - Refugee Health Clinic</td>
<td>Jefferson</td>
<td>Refugee; Family Medicine</td>
</tr>
<tr>
<td>Family Medicine - Social Work</td>
<td>Jefferson</td>
<td>Social Determinants of Health</td>
</tr>
<tr>
<td>Hospitalists</td>
<td>Jefferson</td>
<td>Inpatient Healthcare</td>
</tr>
<tr>
<td>Maternal Addiction Treatment Education &amp; Research (MATER)</td>
<td>Jefferson</td>
<td>Pregnancy and Addictions</td>
</tr>
<tr>
<td>Methodist</td>
<td>Jefferson</td>
<td>General</td>
</tr>
<tr>
<td>Myrna Brind Center for Integrative Medicine</td>
<td>Jefferson</td>
<td>Stress Management</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>Jefferson</td>
<td>Disabilities, Older Adults, Refugees</td>
</tr>
</tbody>
</table>
Community Input: Focus Groups

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

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

Identification and Prioritization of Community Health Needs

Phase I

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

- Access to care
- Chronic disease management
- Health screening and early detection
- Healthy lifestyle behaviors
- Social and built environment

To further prioritize these initiatives, the Community Health Needs Assessment Survey Team from the Center for Urban Health reviewed the prioritization criteria and weights used in the 2013 Health Needs Assessment. An additional three criteria were added for a total of thirteen. Weighted values were assigned and used to assess each health need/issue based on secondary data and input from key informants and focus groups. Scoring could range from 0-3 depending on the assigned weighted value. A maximum score of 30 was possible for each health need/issue. These criteria and weighted values are provided in the Table below:

### Prioritization Criteria

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Maximum Weighted Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not meet HP 2020</td>
<td>2</td>
</tr>
<tr>
<td>Regional priority (SHIP and CHIP priority)</td>
<td>3</td>
</tr>
<tr>
<td>Disparity exists compared to Philadelphia</td>
<td>3</td>
</tr>
<tr>
<td>Focus groups and key informants perceive problem to be important</td>
<td>3</td>
</tr>
<tr>
<td>Sub-population is special risk</td>
<td>3</td>
</tr>
<tr>
<td>Problem not being addressed by other agencies</td>
<td>1</td>
</tr>
<tr>
<td>Has great potential to improve health status</td>
<td>3</td>
</tr>
<tr>
<td>Positive visibility for TJUH</td>
<td>1</td>
</tr>
<tr>
<td># people affected</td>
<td>3</td>
</tr>
<tr>
<td>Feasibility/resources available/existing relationships in place</td>
<td>2</td>
</tr>
<tr>
<td>Links to TJUH strategic plan and/or service line plan</td>
<td>2</td>
</tr>
<tr>
<td>Sustainability</td>
<td>2</td>
</tr>
<tr>
<td>Collaboration opportunities</td>
<td>2</td>
</tr>
</tbody>
</table>

Scores for each health issue were summed across the raters. The mean value was then calculated and used to rank health issues/concerns overall.

### Community Health Needs Assessment Survey Team Prioritization

#### Phase II

In Phase II, the Community Benefit Steering Committee (CBSC), composed of TJUHs Senior Leadership, prioritized the health needs and issues identified by the Center of Urban Health using criteria linked to TJUHs strategic planning process. These criteria included Impact, Importance and Investment and used a scale of 1 to 5. A maximum score of 15 was possible. Scores for each health issue were summed across the raters. The overall mean value was then calculated and used to determine and prioritize CHNA health issues/concerns in relationship to TJUHs strategic plan. The following are the health issue / need that will be addressed in the CHNA Implementation Plan:
The following are the health issues/needs that will not be addressed specifically in the CHNA Implementation Plan but does not mean that programs in place will not continue. These additional domains will be considered based on existing, or new relationships/collaborations; funding opportunities; regional or local public health priorities; and identified innovative projects/programs. Many of the health related concerns below are underlying root causes or behaviors that impact the prioritized domains above:

### HEALTH ISSUE/NEED NOT ADDRESSED BY CHNA IMPLEMENTATION PLAN

<table>
<thead>
<tr>
<th>Health Issue/Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
</tr>
<tr>
<td>Community Safety</td>
</tr>
<tr>
<td>Alcohol and Substance Abuse</td>
</tr>
<tr>
<td>Behavioral Health</td>
</tr>
<tr>
<td>Maternal &amp; Child Health</td>
</tr>
<tr>
<td>Access to Safe Places for Physical Activity</td>
</tr>
<tr>
<td>Transportation</td>
</tr>
<tr>
<td>Youth Health Behaviors (Obesity will be addressed)</td>
</tr>
<tr>
<td>HIV</td>
</tr>
<tr>
<td>Access to Healthy Foods</td>
</tr>
<tr>
<td>Smoking</td>
</tr>
</tbody>
</table>

The prioritization and rankings inform the Implementation Plan and the timeline for phasing in these interventions. The following recommendations should be considered in the development of the CHNA Implementation Plan:

- The Community Health Needs Assessment Survey Team recommended that an external Community Advisory Group be created and coordinated by TJUHs. This group, consisting of collaborating partners and key community stakeholders and residents, would meet quarterly, or as needed, to share information, help to coordinate efforts, and provide insight into the development, implementation and evaluation of proposed interventions. It will also help to promote partners programs throughout the community and better engage the community in health promotion efforts.
• The Community Benefits Steering Committee (Senior Administration) that spans TJUHs and TJU will coordinate efforts across the university and hospitals. Community Benefit activities should integrate and coordinate service, educational, clinical and research community-based opportunities to support Health Professional education between community, hospital and University.

• The CBSC recommended integrating the CHNA priorities and recommendations for implementation into TJUHs Strategic Planning Work Groups where appropriate and relevant.