Penn Medicine

Community Health Needs Assessment Implementation Plan

2019-2021

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Penn Medicine Mission
At Penn Medicine, we are dedicated to discoveries that advance science, to outstanding patient care throughout the world, and to the education of physicians and scientists who carry on our legacy of excellence.

We are a world-renowned academic medical center and strive to improve the health and well-being of people through research, education, clinical care and community service. We are proud of our commitment to service and strive to use discovery and rigorous research to benefit our neighborhoods, our city and our world. We embrace the opportunity to teach others, to learn from our partners, and to care for patients with skill and dignity. The 2019-2021 Community Health Needs Assessment Implementation Plan of University of Pennsylvania Health System (UPHS) represents a multi-campus health system consisting of the following three hospitals within UPHS which are collectively referred to here as **Penn Medicine:**

1. **Hospital of the University of Pennsylvania, (EIN: 23-1352685),** 3400 Spruce Street, Philadelphia, PA 19104
2. **Pennsylvania Hospital (EIN: 31-1538725),** 800 Spruce St, Philadelphia, PA 19107
3. **Presbyterian Medical Center of the University of Pennsylvania Health System d/b/a Penn Presbyterian Medical Center (EIN: 23-2810852**), 51 N 39th St, Philadelphia, PA 19104

Every three years, Penn Medicine conducts a collaborative community health needs assessment (CHNA) to meet IRS regulatory requirements and to identify and prioritize the health needs of Philadelphia area residents, particularly those who experienced health inequities.

The 2019 CHNA is built on the results of the previous Community Health Needs Assessment and includes extensive community engagement which includes: focus groups with community residents; interviews with key stakeholders from community-based organizations that serve special populations; interviews with clinical leadership and staff of Philadelphia Federally Qualified Health Centers; special interviews with hospital patient advisory groups, employees, and other stakeholders; feedback and input with public health departments.

The Penn Medicine 2019 CHNA Executive Summary and Full Report can be found here.

The focus area of the 2019-2021 CHIP is Philadelphia County, which represents Pennsylvania's largest city in the Commonwealth. Over 1.5 million Philadelphians makeup the City's population and according to the 2019 Robert Wood Johnson Foundation County Health Rankings Report is ranked last, 67 out of 67, for Health Outcomes, Health Factors, Quality of Life and Social and Economic Factors compared to other counties in the State.

As a group of three hospitals, our mission is to advance the health and well-being of our patient communities by addressing the social determinants of health and assist in removing barriers to accessing care.

Identifying expertise and data to drive new health outcomes measures was an important step in conducing the CHNA. Penn Medicine collaborated with other Philadelphia regional hospitals and public health departments to conduct the study. Because people only spend a fraction of their time in contact with the healthcare system, efforts to improve the health of our population focuses on actual medical care as well as the environments in which people are born, live, learn, work, play, worship, and age.

Southeastern Pennsylvania 2019 Community Health Needs Assessment Hospital Partners

Based on each hospital partner's expertise, our collaborative will build and focus on priority areas that compliment organizational strengths. This approach allows us to support other organizations as they develop their own strategies and maximize opportunities to collaborate in addressing community health needs. Together, we will continue to work with and strengthen the diverse network of partners within state and local public health systems.

The process for ranking the 2019 Community Health Needs Assessment priority areas was developed by examining:

- The severity and urgency of the health needs of the communities Penn Medicine serves;
- Areas where Penn Medicine has the most expertise and opportunity to make the biggest impact;
- Patients, community-based organizations and other stakeholders' perception of the importance the community places on addressing the need.

The Following Priority Areas Will Be Addressed

1. Substance/opioid use and abuse
2. Behavioral health diagnosis and treatment (e.g. depression, anxiety, trauma-related conditions, etc.)
3. Chronic disease prevention (e.g. obesity, hypertension, diabetes, and cardio vascular disease (CVD))
4. Maternal mortality and morbidity
5. Access to affordable primary and preventive care
6. Access to affordable specialty care
7. Healthy food access and affordability
8. Affordable and healthy housing
9. Healthcare and health resources navigation
10. Linguistically- and culturally- appropriate healthcare
11. Racism and discrimination in healthcare

Community Health Needs not the Focus of this Community Health Implementation Plan but for which Penn Medicine has on-going programming

Penn Medicine has many community-based activities in the community health need areas stated below. There are also other community-based organizations focused on the community health need areas stated below. Given that, Penn Medicine has determined it will not be directly focusing the needs identified below. However, Penn Medicine will continue to work with partners across the University of Pennsylvania and the Philadelphia region to support our collective impact, as we continue to grow and serve the community.

1. Sexual and reproductive health
2. Socioeconomic disadvantage (income, education, and employment)
3. Community violence
4. Neighborhood conditions (e.g. blight, greenspace, parks/recreation, etc.)
5. Homelessness

Penn Medicine also recognizes the significant importance of addressing the social determinants of health (SDOH) in all settings of care. As this Community Health Needs Assessment Implementation Plan was developed, we carefully considered programs, practices and activities that are currently serving our community and those that continue to grow. To support our efforts, our Center for Health Equity and Advancement has created a system wide task force on social determinants to deploy a new screening tool across UPHS. The tool will initially roll out to primary care and then later scale to other areas.

To reinforce our commitment to the community, we also have launched a robust community health worker program to reinforce our mission and commitment to advancing health. Our community health workers program, known as IMPaCT, is discussed in greater detail later in this report.

Advancing Care and Community Health by Addressing Social Determinants of Health:

Further, we will continue to grow the **Penn Medicine CARES Program** which offers support to individuals and programs through quarterly grants and may be used for the purchase of supplies and other resources needed to advance health equity work in the community. Since 2012, more than 500 projects have been funded totaling nearly $550,000. We look forward to continuing the inclusive and creative strategies faculty, staff, and students at Penn Medicine employ to meet community health needs and drive health equity.

Penn Medicine Principles for Community Health Advancement

1. Together, our three hospitals will build a common agenda to address the identified community health priorities and share the same vision for change.
2. Our work over the next three years will further collect data and create health outcomes measures.

3. We will continuously communicate with our internal and external community partners and advocates to build consensus and maximize trust and opportunity.

Logic Model Implementation Plan

Inputs	Activities and Process	Progress and Results
• Community partners • Clinical leaders • Community health action plan • Data • Community health advisory team • Backbone support • City health departments and Federally Qualified Health Centers partners • Monitoring and evaluation	• Communicate CHIP to all stakeholders • Develop shared roadmap in each identified community health priority area • Provide authentic investment to grow programs and scale • Support data capture and health outcomes measurement • Activate mutually reinforcing activities • Foster new partnerships to grow reach • Support evidence-based policies and practices – advocate for implementation	• Build capacity by strengthening neighborhood partnerships • Support and scale innovative solutions that address complex health and social needs • Increase measurement and track progress

Health Outcomes Measures

1. **Substance/opioid use and abuse:** Grow programmatic outreach to help reduce substance use overdoses, emergency department visits and deaths related to drugs and opioids.
2. **Behavioral health diagnosis and treatment:** Increase community provider partnerships and services for behavioral health patients, primary care and specialty care patients to expand access.
3. **Chronic disease prevention:** Expand programming and place-based activities to educate and advocate for chronic disease prevention.
4. **Maternal mortality and morbidity** Increase programmatic outreach and impact to reduce maternal and infant morbidity.
5. **Access to affordable primary and preventive care** & **Access to affordable specialty care:** Increase care coordination and navigation for medically complex patients using social determinants of health screen; growth of Connected Health, our range of telehealth services include virtual visits, virtual consultations and remote second opinions in a variety of specialties; grow partnerships with Federally Qualified Health Centers and

Philadelphia Ambulatory Health Centers to support care coordination and access to specialty care.

6. **Healthy food access and affordability:** Expand healthy food access programming and growth of partnerships to support place-based food initiatives for vulnerable populations.
7. **Affordable and healthy housing:** Grow programmatic outreach and impact to support home ownership and affordable rental units; development of programs to address healthy housing for vulnerable populations with chronic disease.
8. **Healthcare and health resources navigation** Grow strategies to connect patients to resources including the launch of a web-based services directory in partnership with our CHNA partner institutions.
9. **Linguistically- and culturally- appropriate healthcare** & **racism and discrimination in healthcare:** Expand Language and Cultural Services programmatic initiatives, including interpretation services, diverse spiritual support, and custom dietary options; growth and promotion of inclusive culture at Penn Medicine; growth of education initiatives to address implicit bias and to provide patient and family centered, culturally effective care. Continuation of system-wise initiatives to reduce unnecessary variations in care by personal characteristics: growth and promotion of inclusive culture at Penn Medicine; growth of education initiatives to address implicit bias and to provide patient and family centered, culturally effective care.

Priority Area #1 Substance/Opioid Use and Prevention

Outcome Measures: Grow programmatic outreach to help reduce substance use overdoses, emergency department visits and deaths related to drugs and opioids.

Hospitals addressing need: *Hospital of University of Pennsylvania, Pennsylvania Hospital and Penn Presbyterian Medical Center.*

The opioid crisis has severely impacted the Philadelphia community and has been identified by all stakeholders as the number one community health priority. Penn Medicine is committed to addressing the crisis through increasing access to care for Opioid Use Disorder (OUD) treatment, prevention, and community-based programming. We have dedicated significant resources to reduce opioid consumption, treat substance use disorders, and prevent overdoses, and will continue to develop new initiatives for our patients and the communities we serve. Below are programs that Penn Medicine will continue to grow and invest in to address this priority area.

National Academy of Medicine Action Collaborative on Countering the U.S. Opioid Epidemic: Penn Medicine is a committed Network Organization Member of the National Academy of Medicine Action Collaborative on Countering the U.S. Opioid Epidemic. To improve coordination and accelerate the pace of change, the National Academy of Medicine has partnered with the Aspen Institute and more than 100 other organizations to form an Action Collaborative on Countering the U.S. Opioid Epidemic. This one-of-a-kind public-private partnership comprises government, communities, health systems, provider groups, payers, industry, nonprofits, academia, and more – all committed to sharing knowledge, aligning ongoing initiatives, and advancing collective, multi-sector solutions.

Penn Medicine Opioid Task Force: The Penn Medicine Opioid Task Force was established in 2017 as a system-wide program in response to the nationwide opioid crisis. The principle objectives of the Task Force are to align opioid guidelines across Penn Medicine, reduce the total number of opioid doses prescribed, diminish dependence on opioids, and raise the standard of care for patients with acute and chronic pain. Initiatives led by Penn Medicine's Opioid Task Force include development of targeted behavioral strategies, including electronic medical records alerts to promote guideline concordant opioid dispensing for patients with acute conditions; routine naloxone co-prescribing for patients at elevated risk of unintended overdose; and controlled medication completion for indicated patients. Through alignment with Penn Medicine's enterprise-wide ERAS (Enhanced Recovery After Surgery) collaborative, the Opioid Task Force works to identify and promote opioid-sparing approaches to pain management after surgical cases and support evidence-based postoperative prescribing practices. The Task Force also guides on-going evaluation and optimization of pain protocols across every section of orthopedic surgery at Penn Medicine in order to keep the goals of pain management and dependency avoidance at the forefront of each pain management plan. In-development services include a dedicated unit for care of patients with long-term acute care needs related to sequelae of opioid use, such as osteomyelitis and endocarditis.

Center for Addiction Medicine and Policy: In 2019-2020, Penn Medicine will launch a new Center to bolster our already robust response efforts by preventing the development of OUD, offering evidence-based treatments for those suffering from it, and contributing to building a culture of destigmatization by caring for patients with these chronic medical conditions just as we would patients living with diabetes or hypertension.

The Center's specific focus will be harm reduction policies and addiction treatment initiatives. It will enhance clinical care by providing increased access to treatment initiation and continuity for patients with substance use disorders, improve patient outcomes through research and dissemination of evidence-based strategies, and mitigate the stigma of addiction by promoting education in substance use recognition and treatment. The Center will complement the ongoing efforts to address the opioid crisis by Penn Medicine's Opioid Task Force. UPHS' initiatives – which have reduced the number of prescribed opioids by millions of tablets in the past two years – included the adoption of "enhanced recovery" protocols to reduce opioid use in surgery patients, changes to default settings in electronic health records to encourage prescribers to choose alternative pain management strategies, as well as an alert system that reminds doctors to prescribe naloxone in those less common instances when higher doses of opioids are prescribed.

Center for Opioid Recovery & Engagement (CORE): Penn Medicine's emergency departments are at the front lines of this crisis. The CORE (Center for Opioid Recovery and Engagement) provides comprehensive peer support for individuals struggling with opioid use, as well as their loved ones. Our mission is to support all pathways to recovery, remove barriers, and inspire hope.

Treatments for opioid use disorder is evolving and Penn Medicine is a leader in increasing access to evidence-based treatments. Historically, rehab and detox were the standard treatments, but the success rate for these modalities alone is only 5-10%. However, medication-assisted treatment

(MAT), which utilizes medications like buprenorphine and methadone, are much more promising with success rates in the range of 60-80%.

We have transformed the way Penn Medicine delivers emergency department (ED) care to OUD patients, beginning with enhanced patient identification. Penn Medicine also employs Certified Recovery Specialists (CRS), who provide OUD patients with bedside counseling and peer support after discharge. Conservatively, we estimate that this work will prevent 187 overdoses each year. We will continue building upon this important area of work.

Primary Care Medication Assisted Treatment (MAT): Primary care providers are a critical part of our response to the opioid epidemic. The Department of Family Medicine and Community Health and the Division of General Internal Medicine have led efforts to address OUD in primary care and increase access to comprehensive Medication Assisted Treatment (MAT) in primary care. In 2018, two primary care clinics, Penn Family Care and the Penn Center for Primary Care initiated a campaign to increase the proportion of primary care faculty and residents who have a waiver to practice opioid dependency treatment with approved buprenorphine medications. As a result, 20 faculty providers in these two clinics and 49 resident providers care for patients living with OUD through MAT. In addition, both clinics have embedded weekly, dedicated MAT patient care sessions into their clinical operations. The goal of these patient care sessions is to increase access to high quality addiction care for patients while exposing residents to this vulnerable population and gaining comfort in prescribing MAT. We aim to change perceptions about MAT, decrease stigma, and have it truly integrated into the role of primary care. To date, 130 patients have been able to receive MAT at their primary care provider's office. Both clinics will continue to offer MAT and work with CORE and the ED providers to increase access to care.

The Healthy Library Initiative (HLI): Public libraries are free and accessible to all and are centers **of** community engagement and education, making them logical choices as partners for improving population health. Library staff members routinely assist patrons with unmet health and social needs. HLI is a collaboration between the University of Pennsylvania's Penn Center for Public Health Initiatives, Philadelphia's libraries, their programs, and staff who play a role in promoting healthy communities. With the information collected through community-based participatory research, HLI has developed health programming and trainings of employees throughout the library system that focuses on addressing social determinants of health. Two HLI initiatives target the opioid epidemic in Philadelphia:

> <u>Naloxone Trainings at Public Libraries, A Cross-Sectoral Partnership:</u>
> With the goal of developing a nationwide network of public libraries as community health sentinels, HLI conducted a survey of all Pennsylvania libraries to assess how libraries support the social, physical, and mental health of their patrons. In Pennsylvania, 12% of public libraries experienced overdoses on-site in 2016. Considering these findings, HLI partnered with the Philadelphia Department of Public Health (PDPH) and the Free Library of Philadelphia to develop and test library-based overdose prevention trainings for staff and patrons. These trainings have been in high demand and attracted more than 300 participants in the first year alone. Given the high demand, the program expanded from two initial libraries to 14 libraries throughout Philadelphia. PDPH is also

using Free Library branches for monthly "Narcan giveaway days," to distribute free naloxone to community residents. We will continue to support the development and implementation of evidence-based trainings for overdose reversal and the distribution of naloxone.

Center for Health Incentives and Behavioral Economics Naloxone Work*:* Based on interview data from the library-based naloxone trainings, we identified behavioral barriers and facilitators to naloxone acquisition and carrying following a training. Using this "behavioral diagnosis," we conducted two sequential pilot randomized trials, testing training enhancements that address those barriers using strategies such as commitment pledges and plans, framing, and tailored text message nudges. The goal of this study is to develop novel evidence-based interventions to increase naloxone uptake. In addition to the 140 participants our team trained to use naloxone during the study, we trained over 130 non-study participants, including staff at the Center for Healthcare Innovation, Student Health Services, and medical students.

Philly Respond: To raise public engagement in overdose prevention, faculty, staff and students from the Perelman School of Medicine of the University of Pennsylvania and the Center for Public Health Initiatives work with the Philadelphia Inquirer to lead Philly Respond--a project that incorporates community storytelling, visual images, and data analysis to shift social norms and reduce the stigma surrounding SUD. The Mission of Philly Respond is to reduce the toll of the overdose crisis by empowering Philadelphia citizens to carry naloxone and reverse overdoses. Philly Respond maintains a publicly available calendar of naloxone trainings, maintains an FAQ page on naloxone, and provides information on where to get naloxone. We also feature Story Slam, storytelling events where participants share stories about their personal experiences with naloxone in Philadelphia with the goal of using stories to engage Philadelphians to carry and use naloxone, to be part of our community's collective action to halt overdose deaths in our city.

The Bethesda Project: The University of Pennsylvania School of Nursing and Penn Medicine provide training to Bethesda Project staff on naloxone rescue for opioid overdoses. The intensive workshop includes a simulation training in the recognition of signs and symptoms of opioid overdoses and administration of intranasal naloxone. Over 50 staff and volunteers have completed the training with 75% of participants reporting a moderate to exceptional advancement in nine knowledge and competency areas. We will continue to support the Bethesda Project and their training needs.

Prevention Point Philadelphia (PPP): Penn Medicine is working with long-standing community organizations that care for individuals with substance use disorders. The mission of PPP is to promote health, empowerment, and safety for communities affected by drug use and poverty. Penn Medicine will continue this work allowing us to provide more addiction counseling services, case management, free and clean needle exchange, legal series and overdose prevention and reversal training. Faculty and residents from the Department of Family Medicine and Community Health are part of the care team at PPP and will continue to provide care for individuals with substance use disorders. In addition, Perelman School of Medicine students will

continue to volunteer at Prevention Point to support their care team and increase the number of community members who are served.

Mothers MATTER: Penn Presbyterian Medical Center and Maternity Care Coalition work together to increase access to MAT for pregnant women with OUD. As rates of maternal opioid use have surged over the past decade, so too have rates of adverse pregnancy outcomes. In fact, opiate use is associated with a six-fold increased risk for miscarriage, prematurity, delayed infant neurological development, and neonatal abstinence syndrome (NAS). Mothers MATTER offers comprehensive, compassionate care for pregnant and postpartum women whose lives have been impacted by opioid dependence. The program aims to reduce post pregnancy relapse rates by addressing social and psychological barriers to rehabilitation, which can complicate treatment for opiate dependence. Patients are screened by specialists and connected to behavioral health services and support they might need both during and after pregnancy.

Priority Area #2 Behavioral Health Diagnosis and Treatment

Outcome Measures: Increase community provider partnerships and services for behavioral health patients, primary care and specialty care patients to expand access.

Hospitals addressing need: *Hospital of University of Pennsylvania, Pennsylvania Hospital and Penn Presbyterian Medical Center.*

Behavioral health impacts thousands of Philadelphia residents and behavioral health care has been siloed and not well integrated with the larger health care system. More than 25% of adults in the United States experience some type of behavioral health disorder each year, according to the Centers for Disease Control and Prevention. While 29% of adults with a medical condition also have some type of mental health disorder, close to 70% of behavioral health patients have a medical co-morbidity.

Both conditions often exacerbate each other in a cycle of need and demand for one another, heightening the risk of that person with a chronic disease will develop a mental health disorder conversely. As providers look to design new models of care to treat patients mind, body and spirit, Penn Medicine continues to implement programs to address behavioral health care needs. Below are programs that Penn Medicine will continue to grow and invest in to address this priority area.

Primary Care Service Line Integrated Behavioral Health: Providing addiction and other mental health care in the primary care setting has been demonstrated to reduce health care costs, improve function and symptom outcomes for patients, and improve provider satisfaction. Collaborative care models have proven to be successful across the United States. The model has been shown to control costs, improve access to mental health care, improve clinical outcomes, and increase patient satisfaction in a variety of primary care settings – rural, urban, and among veterans. Collaborative care is also known to increase response to mental health and substance use treatments by 60 percent.

In 2018, the Penn Medicine Primary Care Service Line partnered with the Department of Psychiatry to develop and implement an integrated model of behavioral health care, the Collaborative Care Behavioral Health (CCBH) program. CCBH puts licensed clinical social workers (LCSWs) specially trained in mental health care into primary care offices. Five licensed social workers (LCSW) work in eight Penn Medicine primary care practices in West Philadelphia and Center City and are available to over 100,000 patients. These experts work with a primary care provider and a psychiatrist to assess and treat patients as needed during their primary care appointments Services range from screening for depression to supporting those who are struggling with addiction. Furthermore, if a patient is in acute distress or has a safety concern, such as suicidal thoughts or impulsive behavior, a physician will facilitate a warm handoff – a real-time transfer of care – to the LCSW for assessment risk-stratification, and referral to the appropriate level of care.

The program also works to proactively identify patients who are high risk or who may benefit from enrollment in CCBH due to comorbid medical and psychiatric issues. This population-health strategy emphasis prevention and access to ensure that patients' suffering is addressed early and often. The system also incorporates measurement tools to track quality treatment, and accountability metrics – such as timeliness of access to care, symptom remissions, and use of the emergency room. The CCBH will continue to grow to meet the care needs of our community.

Steven A. Cohen Military Family Clinic: The University of Pennsylvania's Steven A. Cohen Military Family Clinic provides no cost, high-quality, integrated mental health care for veterans and military family members in an independent, private setting. Our mission is to improve the quality of life for military families and veterans, including those from the National Guard and Reserves, regardless of role or discharge status. Services include personalized, evidence-based behavioral health care. Mental health treatment is available at no cost and with no long waits for veterans and their family members. The Clinic offers early morning and evening hours as well as transportation assistance and telehealth options in order to help military families access the care they deserve.

Trauma Program: Many children in our community are exposed to violence and trauma, which can have lifelong and devastating effects on their well-being. Penn Medicine will continue to invest in the Penn Center for Youth and Family Trauma Response and Recover, which provides a range of interventions for children and their families and address the physical and psychological systems associated with trauma. As the only provider in the Philadelphia area that offers effective early intervention for youth, the Center is an essential point of access to specialized behavioral health services for those in our community.

Hall-Mercer Community Mental Health Center: Hall-Mercer CMHC offers outpatient services ranging from psychotherapy to counseling through a variety of specialized programs for people with developmental disabilities, chronic mental illness, and related problems. The Center receives most of its support from the city and state, but Pennsylvania Hospital subsidizes a significant portion of its services. Many outpatient services are available on a sliding scale fee basis. Additional programs offered at Hall-Mercer CMHC include:

Early Childhood Program Hall-Mercer CMHC recently partnered with the Penn Center for Mental Health to bring Autism Services to children 3-5 years old. The Early Childhood Program serves as a therapeutic preschool for children who struggle with emotional and behavioral regulation, social communication skills, and play skills – making it difficult for them to learn in a traditional school environment. The program has the capacity to serve 32 children daily.

Child and Family Mental Health Services provides mental health evaluations and treatment to children and adolescents age 3-18 and their families, who are residents of Philadelphia.

Children's Community Based Service Department was established to bring together the community-based children's service programs that provide clinical and case management services in the community to children and their families. The department is made up of Children's Blended Case Management and Home-School Connection. The range of services includes clinical evaluations and referrals, individual and group therapy, family meetings, crisis intervention and case management services. These programs service children and adolescents. The range of services provided in the schools includes clinical evaluations and referrals, case management services, behavioral therapeutic services and groups.

PHIICAPS (Philadelphia Intensive In-home Child and Adolescent Psychiatry Service) provides intensive family treatment and case management to 40 families at a time. The child or adolescent is identified to be severely emotionally disturbed and at risk of hospitalization or out of home placement. Modalities include individual and family therapy and case management in the home, environment and school domains. PHIICAPS has 2 teams, each made up of 1 Master's level Clinician and 1 Bachelors level Mental Health Worker.

Behavioral Health Intellectual Disabilities programs provide an array of services to adults with intellectual disabilities and their families to support individual choice, community involvement, and use of traditional and natural resources. These include the Intensive Services Case Management Program (ISCM) and the Community Day Training Program for adults. The ISCM program is a city-wide program which works in collaboration with the Philadelphia Office of Intellectual Disabilities (IDS) to provide emergency supports coordination to adults with intellectual disabilities living in all catchment areas. The program operates 24 hours a day, 7 days per week and responds to emergency situations such as emergency placement due to abuse, neglect or death of a caregiver, moving individuals from substandard living conditions into a safe living environment. The ISCM program also assists underserved individuals in the community to become registered and receive services through IDS. The Community Day Training Program provides psycho-social habilitation services, behavioral shaping and supportive counseling services to adults diagnosed with intellectual disabilities and mental illness.

Services are designed to promote the development of optimal community adjustment and integration.

Adult Mental Health Services provides comprehensive outpatient mental health services in Center City, South Philadelphia and surrounding areas. Specific services include crisis intervention, evaluation, psychotherapy, pharmacotherapy, and social rehabilitation. Emphasis is on providing all persons who have severe and chronic mental illness with outstanding care in a pleasant environment and respectful manner.

Access Intensive Case Management is a targeted case management program which serves adults recovering from severe mental illness with possible co-occurring substance abuse issues. Many participants authorized to this program are homeless or may have a history of being homeless. A team approach and recovery-based model is used to connect participants with supportive services which encourage daily stability and reduced psychiatric hospitalizations.

Blended Case Management (BCM) participants require less intensive case management services than those enrolled in Access. A team approach and recovery-based model is used to connect participants with supportive services which encourage daily stability and reduced psychiatric hospitalizations. Hall Mercer also offers a Southeast Asian Blended Case Management program which provides BCM to adults who speak Cantonese, Mandarin, Vietnamese, Khmer, or Lao. Case managers in this program provide English interpretation to help participants connect to public benefits and other community supports.

Prevention and Recovery Services (PARS) is a 90-day service which serves adults recovering from severe mental illness with possible co-occurring substance abuse issues. Many participants in this program may have a history of homelessness. Case managers, through a team approach and recovery-based model, provide rapid intervention to assist individuals with connecting to supports which will allow them to reach the highest level of independent functioning possible.

Services at The Philadelphia Juvenile Justice Services Center (PJJSC)
Hall-Mercer provides behavioral health services at the Philadelphia Juvenile Justice Services Center (PJJSC). The clinical team at the PJJSC provides adjustment/crisis services, individual therapy for youth with extended length of stay, and psychiatric evaluation and medication management.

Healthy Minds Philly/Check-up from the Neck-up is a program that emphasizes that a healthy mind is as important as a healthy body. Hall-Mercer partners with the Philadelphia Department of Behavioral health and Intellectual disability Services to provide community-based mental health screening, education, and resources.

Priority Area #3 Chronic Disease Prevention

Outcome Measures: Expand programming and place-based activities to educate and advocate for chronic disease prevention.

Hospitals addressing need: *Hospital of University of Pennsylvania, Pennsylvania Hospital and Penn Presbyterian Medical Center.*

Chronic disease is a significant challenge for Philadelphia. Overall rates of cardiovascular disease continue to rise. Preventable cardiovascular disease deaths are two to three times higher in Philadelphia. Obesity impacts nearly 29% of Philadelphia residents and diabetes impacts 12.8% of adults. Philadelphia also scores low on the food environment index which means food is hard to access and not affordable for those living under the federal poverty level. Similarly, Philadelphians rank high in preventable hospital stays, high tobacco usage, and high rates of sexually transmitted infection. By deploying an ecosystem of care around our patient communities, we hope to improve these health statistics. Below are programs that Penn Medicine will continue to grow and invest in to address this priority area.

Colorectal Cancer Screening Outreach and Navigation Program: This innovative community-based program makes colon cancer screening convenient, accessible, and affordable. The program has expanded screening options offered at Penn Medicine reaching over 3,800 people in the community, including health centers, with a convenient at-home screening option for people who would not otherwise have been screened. This program has provided 763 patients with free colonoscopy and 43% were found to have one condition. Five patients were diagnosed with colorectal cancer and treated.

Penn Medicine Breast Health Initiative: In recognition of the barriers to screening and treatment for breast cancer, Penn Medicine offers breast screenings as well as diagnostic and treatment services to underserved and uninsured women in partnership with more than a dozen nonprofits and clinics in the region. Since the program's inception in 2014, it has provided free mammograms to over 3,000 women. Over 50% of the women in this program are Latina and 28% are African American; 56% do not speak English. To date, 35 cases of breast cancer have been identified and treated.

Can Prevent Cancer: Penn Medicine offers an annual community based conference focused on cancer education and awareness including colon, breast and lung cancer. This year 8,350 patients and caregiver participated in this educational event.

Save to Screen: This faith-based outreach program targets African American communities in Philadelphia. The goal is to provide diverse communities and faith-based leaders with cancer education, outreach and screening. This year Save to Screen hosted seven events which attracted 2,700 attendees. Further, our program provided 195 free on-site cancer screenings.

Stroke Community Education Program: In recognition that stroke is the number one preventable cause of disability, Penn Medicine offers community educational programming at every hospital. Stroke has many risk factors, including high blood pressure and diabetes. These factors are an identified need on the community health needs assessment, so efforts are made to

assist the community in combating these risk factors along with increasing the awareness of stroke symptoms.

Walk with a Future Doc (WWFD): This place-based program aims to promote physical activity and promote well-being in neighborhoods, targeting obesity, hypertension, and diabetes. Penn's Center for Public Health Initiatives, in partnership with medical students from the Perelman School of Medicine, created one of the first WWFD chapters in the country. These biweekly walks start with a short talk from a medical student on a relevant health topic, followed by a brief Q&A session. The one-hour walk around the neighborhood is very informal, and during the walk, medical students talk with the participants about health topics related to chronic disease. The Perelman School of Medicine faculty and medical staff of the Penn Medicine hospitals mentor the medical students and provide oversight for the educational content.

Community-Academic Partnerships to Increase Physical Activity (CAP-IPA) and Dance for Health: The University of Pennsylvania School of Nursing's student-led Community Champions program—which comprises 15 initiatives—brings Nursing students out of the classroom and into the greater Philadelphia community to share their skills and learn from their experiences. The Community Champions program is the vehicle by which the School of Nursing promotes healthy lifestyles and provides community members across the lifespan with health screening and information about nutrition and diet, physical activity, newborn care, breast cancer awareness, and sexual health. One program, Dance for Health, is a program for all ages that has engaged over 1,000 community members, four sites and offers free dance fitness classes aimed to empower community members. Classes are offered in concert with local community organizations.

Priority Area #4 Maternal Morbidity and Mortality

Outcome Measures: Increase programmatic outreach and impact to reduce maternal and infant morbidity.

Hospitals addressing need: *Hospital of University of Pennsylvania, Pennsylvania Hospital and Penn Presbyterian Medical Center.*

Pennsylvania ranks 16th in the nation in maternal mortality and Philadelphia still reports a maternal mortality rate of 27.4 deaths per 100,000 live births, which is worse than the rate of all but six states. To strengthen our efforts in this area, we will continue to grow services, increase care coordination and post-partum surveillance. Below are programs that Penn Medicine will continue to grow and invest in to address this priority area.

The Heart Safe Motherhood Program: For women that have been diagnosed with preeclampsia during their pregnancy, clinical recommendations encourage new moms to schedule a follow-up visit with their doctor within a week of delivery to have their blood pressure check. For many women, coming to coming to the office after having a newborn is difficult for a variety of reasons. This program is a first-of-its-kind text-message based program that makes postpartum blood pressure monitoring more convenient for women diagnosed with preeclampsia and other blood pressure disorders during pregnancy and promotes communication with their care team without visiting a doctor's office.

Obstetrics Care at Philadelphia Federally Qualified Health Centers (FQHC): Despite Penn Medicine's extensive network of inpatient and outpatient clinical services and partnerships, access issues to women's health services persist in our catchment area. To respond to this need, clinicians from the departments of Family Medicine and Community Health, and Obstetrics and Gynecology have established partnerships with FQHCs in West Philadelphia to provide timely prenatal care, family planning services, screening for cancer and sexually transmitted diseases including HIV, and urgent and emergency obstetric care. As a result of this partnership, 280 deliveries in the past year alone were facilitated through this partnership.

Safe Sleep Awareness for Every Well Newborn (S.A.F.E.): The University of Pennsylvania School of Nursing received a three-year grant from the Pennsylvania Department of Health to design and innovate a new program model for promoting safe sleep practices for newborns. To take our commitment further, the School rolled out the model to the Penn Medicine hospitals, as well as its community partners, community organizations and provide continuing education to cascade this important research.

Dickens Center for Women's Health: The Helen O. Dickens Center for Women in the department of Obstetrics and Gynecology is committed to providing personalized care to women of all ages, fulfilling Penn Medicine's philosophy of serving the community. Dr. Dickens was the first female African American doctor to become board certified in obstetrics and gynecology in Philadelphia as well as the first to be named a fellow of the American College of Surgeons. She worked to educate young women about their reproductive health in order to reduce the incidence of teen pregnancy and sexually transmitted diseases. The Dickens Center serves mainly Medicare, Medicaid and uninsured patients. Penn Medicine offers uncompensated and undercompensated care for those who qualify, based on financial counseling. The Center offers prenatal care, gynecology and colposcopy services. The Center has established working relationships and programs with city and community agencies, state-funded programs and managed care organizations, to ensure that women have access to the services that fit their educational, financial and psychosocial needs. The Center also provides care at the Philadelphia Department of Public Health's Health Center 3 and offers consultations and care for women with complex medical and obstetric conditions or fetal anomalies. The Center's integrated high-risk program combines care coordinators, physicians and nurse practitioners allowing us to provide a unique level of continuity for our patients.

Penn Maternal Fetal Medicine for High Risk Pregnancy: Obstetricians and midwives can care for most women during pregnancy. However, sometimes having a baby is more complicated. A pregnancy is considered high risk when there are potential complications that could affect the mother, the baby or both. Penn Medicine Maternal Fetal Medicine specialists work to evaluate diagnose and monitor high-risk pregnancies and develop initiatives.

> Penn Prematurity Prevention Program is dedicated to reducing preterm births across the Philadelphia community. Premature babies are at increased risk for newborn medical complications and face an increased risk of lifelong health problems. A premature delivery occurs before a mother has completed her 37th week of pregnancy. In the United States, about 12.8 percent of babies (more than half a million a year) are born

prematurely. The program's high-risk pregnancy specialists educate, evaluate, diagnose and treat women at risk for preterm delivery.

Penn Perinatal Diabetes Program is dedicated to serving woman who experience type 1 or type 2 diabetes during pregnancy. The goal of the Penn Perinatal Diabetes Program is to keep mother and baby healthy throughout the pregnancy. Pregnant women in this program receive intensive care coordination, nutrition education and maternal fetal medicine postpartum care.

Breastfeeding Support Services at Penn is a focused effort to provide education and literacy about the benefit of breastfeeding. Penn Medicine provides breastfeeding support via community classes, discussion groups, lactation consultants and a variety of community health literacy seminars.

The Penn Center for Women's Behavioral Wellness is a resource for women with perinatal depression. We offer clinical consultation, evaluation, diagnosis and treatment of behavioral issues across the lifespan. Specialists are available to discuss depression, mood and anxiety concerns, including treatment during pregnancy.

Ludmir Center for Women's Health: The Ludmir Center for Women's Health (LCWH) is an ambulatory healthcare facility that specializes in the provision of obstetrical, gynecologic and reproductive health services. LCWH provides quality medical care to all patients, regardless of their ability to pay. Most patients have low to moderate incomes. As a community based practice, LCWH offers more than traditional medical services. LCWH employees a full-time social worker who provides psychosocial support services. Additionally, LCWH addresses some of the diverse needs of its patients and their partners through the following services and programs:

Latina Community Health Services (LCHS) is an innovative program that offers prenatal and gynecologic services to women who are unable to obtain medical insurance. It is funded by grants and contributions and staffed by physicians, a nurse midwife, medical assistant and patient services coordinator from Clinical Care Associates of the University of Pennsylvania Health System. LCHS also partners with other entities such as Pennsylvania Hospital's Diabetes Education Center and Women's Services Department as well as the Health Promotions Council, a community organization, to coordinate and offer wrap-around services. These services include individual diabetic teaching, infant feeding classes and healthcare navigation assistance.

Childbirth Education Classes are taught by LCWH registered nurses who have also earned childbirth educator certification. The classes cover such topics as: what to expect from and how to recognize labor, relaxation techniques and medical options for pain relief in labor, the importance of post-partum care, and early infant care/development.

Male Partners Services: The male partners of LCWH female patients who tested positive for a sexually transmitted infection are able to receive treatment through this sensitive and confidential service.

Healthy Woman Program (HWP) is a Pennsylvania state-funded program that provides free cervical cancer and breast screenings (including pelvic examinations, clinical breast examinations, and Pap smear testing and diagnostic services) to uninsured women between the ages of 21-64.

Tobacco Smoking Cessation is offered in an effort to decrease tobacco smoking rates among pregnant women and mothers. Each LCWH nurse is certified by the Health Federation of Philadelphia in partnership with the Philadelphia Department of Health to provide counseling on smoking cessation and reduction in exposure to environmental smoke.

Priority Areas #5-6 Expanded Access to Affordable Primary Care and Specialty Care

Outcome Measures: Increase care coordination and navigation for medically complex patients using social determinants of health screen; growth of Connected Health, our range of telehealth services include virtual visits, virtual consultations and remote second opinions in a variety of specialties; growth of partnerships with Federally Qualified Health Centers and Philadelphia Ambulatory Health Centers to support care coordination and access to specialty care.

Hospitals addressing need: *Hospital of University of Pennsylvania, Pennsylvania Hospital and Penn Presbyterian Medical Center.*

UPHS will continue to expand access to primary care and specialty services in and outside of our direct catchment area by increasing coordination of services across Penn Medicine care networks, and in collaboration with community partners. Below are programs that Penn Medicine will continue to grow and invest in to address this priority area.

Primary Care Service Line: Since our FY16 implementation plan, Penn Medicine has established a Primary Care Service Line (PCSL) to advance collaboration between family medicine and internal medicine clinical services across the enterprise. We continue to measure and coordinate operational efforts to develop strategies for growth in our areas of greatest need. For example, in 2017, the Department of Family Medicine and Community Health increased access to primary care in South Philadelphia by opening the Penn Family Medicine practice at Pennsylvania Hospital (PAH). This site provides both family medicine, and non-operative sports medicine, including muscular skeletal (MSK) ultrasound services. The practice has grown to over 3,000 active patients, and regularly accepts new patients from the Penn Urgent Care site in South Philadelphia. The practice has also developed a strong relationship with the emergency department at PAH to ensure that patients who are at-risk for readmission have an opportunity to establish a primary care home.

Community Clinic/Provider Partnerships: For families and individuals who live in areas of the city where access to medical services is limited — and in many cases, nonexistent — a trip to the doctor can mean traveling across the city for basic care. To increase access of affordable

primary and specialty care outside of Penn Medicine's medical campuses, we will continue to engage with community-based partners to deliver care in areas with limited access and resources. Attending and resident physicians from the Departments of Medicine and Family Medicine and Community Health will continue to provide primary care health education, and health-related social services to members of the community regardless of their ability to pay. Our clinicians and learners provide care in many community-based settings including four FQHC partners across the city, the Philadelphia Department of Public Health's Ambulatory Health Centers, Prevention Point Philadelphia, and at Puentes de Salud, which focuses on the wellness of the Latino immigrant population in South Philadelphia, with over 10,000 patient visits per year.

In addition to providing primary care, Penn Medicine will continue to grow our cancer screening programs at FQHCs and ensure that patients have immediate referral care coordination to our hospital campuses. This effort builds on an existing partnership with the American Cancer Society that hosts free mammogram clinics, part of the Penn Medicine Breast Health Initiative, and cervical cancer screenings to uninsured or underinsured women in our community.

Dr. Bernett L. Johnson Jr. Sayre Health Center (SHC): Answering a dual mission to provide quality clinical care to all residents regardless of ability to pay and also provide health services education high school students, undergraduate, graduate and professional students, The University of Pennsylvania and Penn Medicine partnered with the Philadelphia School District's Sayre School to establish the SHC in a medically underserved community in West Philadelphia. SHC is a full-service, primary care health facility located at 59th and Locust Streets, behind Sayre High School, in the Cobbs Creek neighborhood of West Philadelphia. The Center has been serving the needs of area residents since the summer of 2006 and its services are designed to be sensitive to patients' needs, to inspire trust and engagement, and to be accessible to the most vulnerable and underserved members of its catchment area. The Department of Family Medicine and Community Health has physician service contracts to provide executive leadership for an interdisciplinary training program at SHC, supporting the Medical Director, and Director of Graduate Nursing for the site. The SHC has been recognized for its high adolescent immunization rates that exceed 95% for several vaccines. Additionally, SHC has one of the lowest missed vaccination rates in the City of Philadelphia and achieved one of the highest influenza vaccine uptake rates among African Americans. The University of Pennsylvania's School of Dental Medicine, Division of Community Oral Health provides dental care at SHC, bringing a much needed access point for the community.

The Pavilion: The Hospital of the University of Pennsylvania's new state-of-the-art hospital facility, slated to open in 2021, will increase access to specialty care for patients, enhance opportunities for collaborative care delivery, and advance telemedicine functionality that allows for remote monitoring and consultations between patients and their care teams.

Penn's School of Dental Medicine (PSDM): PSDM is committed to improving oral health for our community and operates a number of programs for patients traditionally underserved by dentistry, such as low-income adults and children, including pre-school and school age children, elderly, and those patients with medical complex conditions. The **Penn Dental Clinic** exists to provide access and low-cost dental care to Philadelphia residents. Every year the clinic continues to grow access to affordable dental care through its teaching clinics. PSDM operates the Penn

Smiles Bus, a mobile dental office providing dental care to children. **PennSmiles** visits elementary, middle and high school students in private and charter schools in West and Southwest Philadelphia. P**ennSmiles** also provides dental care at Mercy LIFE, a program of comprehensive care for low income elderly, and at Sayre Health Center, a comprehensive community health center. Each day the bus goes out, Penn's dental students and faculty provide care for up to 12 patients on the bus as other public health dental hygienists provide preventive dental care education. Since 1994, Penn Dental Medicine students and faculty have worked with Philadelphia school district officials to complete classroom education and mandated dental examination at 22 elementary and high school public and parochial schools.

Resident and Student Run Clinics that Promote Access and Collaboration: According to the Association of American Medical Colleges, compassion and service are essential components of being a doctor. The Perelman School of Medicine students' commitment to community service demonstrates this belief. Their service provides support to communities that too often are left out of the health care system, while allowing students to learn valuable skills.

The Refugee Clinic at the Penn Center for Primary Care is a collaborative effort between the Primary Care and Global Health tracks of the Internal Medicine Residency program in Penn Medicine, and our partner resettlement agency, HIAS Pennsylvania. Opened on October 15, 2010 as a partnership between PCPC and HIAS Pennsylvania, the clinic currently operates every Monday afternoon with over 20 rotating residents, and sees over 75 new arrivals each year. Five attending physicians precept in the clinic, all of whom are experienced in global health, travel medicine or infectious diseases. Over thirty different languages are spoken in clinic by refugee populations from Bhutan, Burma, Eritrea, Liberia, Darfur, South Sudan, Russia, Ukraine, the Democratic Republic of the Congo and many other countries. The clinic hosts a once-monthly Women's Health clinic specifically focusing on the health needs of refugee women and a weekly Latent Tuberculosis Infection (LTBI) clinic, run by a Pharmacist and pharmacy students, focusing on LTBI diagnosis and treatment.

Heart Health Bridges to Care (HHBC) is a free, student-run clinic that provides continuous care to patients from our local community living with hypertension and Type 2 Diabetes. This clinic provides care and navigation – assisting patients to acquire medical insurance and permanent long-term care. Student doctors work alongside supervising physicians to provide thorough, high quality care with individualized courses of treatment. HHBC offers patients medications to control their hypertension and diabetes, and referrals to other health services, such as optometry, podiatry, and dentistry to prevent any complications arising from their chronic conditions. Every year, this program continues to grow, and we will work to incorporate social determinants of health referral related services.

United Community Clinic (UCC) is a free health clinic coordinated weekly by University of Pennsylvania students from the Schools of Medicine, Dentistry, Nursing, and Social Work. UCC is an interdisciplinary student-run clinic that believes health is more than the absence of disease. It collaborates with residents and community partners to address the medical and social health needs, with the goal of building a stronger and

healthier community. Services include health physicals, acute care, dental care, eye care, social work resources, and health insurance assistance.

Unity Health Clinic is a free clinic that primarily serves uninsured Indonesian immigrants of Chinese descent. Medical student volunteers assist and shadow Penn faculty and residents. On clinic evenings, medical students are involved in medical scribing, taking patient histories, checking blood pressure, calculating BMI, retrieving medications, and more. Volunteers also give presentations to small groups of patients on basic topics in health and medicine.

CUT Hypertension Program is a program started by Penn Medicine's chapter of the Student National Medical Association (SNMA). Medical students and undergraduate volunteers provide blood pressure screenings and information about the risks of hypertension, especially among Black males, every Saturday in a barber shop in the heart of West Philadelphia.

Priority Area #7 Healthy Food Access and Affordability

Outcome Measures: Expand healthy food access programming and growth of partnerships to support place-based food initiatives for vulnerable populations.

Hospitals addressing need: *Hospital of University of Pennsylvania, Pennsylvania Hospital and Penn Presbyterian Medical Center.*

According to Feeding America, Hunger impacts nearly 20% of Philadelphia households which impacts 1 in 5 adults and 1 in 4 children. Penn Medicine plans to greatly increase its efforts in promoting healthy food access for needy communities in Philadelphia. The goal is to address food insecurity but also provide health education to reduce chronic disease. Below are programs that Penn Medicine will continue to grow and invest in to address this priority area.

The Agaston Urban Nutrition Initiative (AUNI): AUNI is a program of University of Pennsylvania's Netter Center for Community Partnership and was created to sustain healthy community by providing healthy food education and good nutrition in West Philadelphia. AUNI's activities are fully integrated into the University Assisted Community School model. AUNI organizes school day, after school and summer learning opportunities for more than 10,000 students and their families at 20 public schools and community centers in Philadelphia. AUNI's ecological approach to food and nutrition education includes hands-on experiences for program participants to grow, cook, consume and sell healthy foods. AUNI has School Food Education programs, Youth Development programs, and an Adult & Senior Nutrition Program.

The Urban Tree Connection (UTC) Community-Based Agriculture Program: UTC seeks to improve community health in Haddington - a neighborhood in West Philadelphia where 80% of the children live in families eligible for the Supplemental Nutrition Assistance Program (SNAP). Because the neighborhood lacks a high-quality supermarket, UTC produces more than 10,000 pounds of sustainably grown produce and distributes it to 850 low-income families each year. UTC works to support community based farm stands, improve community outreach, and provides stipends to community leaders who operate farm stands.

Supporting Older Adults at Risk (SOAR): SOAR assists senior patients who are experiencing food insecurity, by linking them to community resources in Philadelphia. A geriatric intake assessment is completed in the hospital by a case manager or social worker and patients are evaluated for food access programs such as the Supplemental Nutrition Assistance Program, Coalition Against Hunger, MANNA and more. Based on the program that best fits the needs of the patient, Penn Medicine staff work to link resources to the patient to address nutrition and hunger.

Good Food, Healthy Hospitals: This national hospital initiative takes strides to ensure food is aligned with a population health mission. Penn Medicine is committed to eliminating sodas, sport drinks, sweetened juices, and fast food that contribute to poor diet and chronic disease from its hospital campuses.

Priority Area #8 Affordable and Healthy Housing

Outcome Measures: Growth of programmatic outreach and impact to support home ownership and affordable rental units; development of programs to address healthy housing for vulnerable populations with chronic disease.

Hospitals addressing need: *Hospital of University of Pennsylvania, Pennsylvania Hospital and Penn Presbyterian Medical Center.*

Penn Medicine addresses homelessness in a variety of ways and in partnership with our community agencies. We believe models like Housing First are the first form of treatment for our homeless patients who often are experiencing multiple medical co-morbidities. We also work to provide multi-site comprehensive health care as a community benefit in shelters across the city to help improve health in a multitude of ways. Below are programs that Penn Medicine will continue to grow and invest in to address this priority area.

Penn's Neighborhood Preservation and Development Fund (NPDF): As University City increases in population of both homeowners and renters, there is a need for affordable rental apartments in West Philadelphia. With partners from the private real estate sector, the University of Pennsylvania invested $4.5 million to acquire 20 aged and declining apartment buildings that total 448 apartment units including 580 bedrooms. Enhancing them with new facilities and improved property management, Penn maintains affordable rental units for both residents and some students. As a result, these newly stabilized properties have set a new standard for other buildings, and their owners have helped lift entire blocks into vibrant areas.

People's Emergency Center (PEC): PEC provides shelter, education and training to support families experiencing homelessness**.** Penn Medicine partners with PEC to provide routine medical care and resident physicians participate in a community rotation. The goal of this partnership is to expand clinical care, health promotion, and public health experiences in order to produce future physicians who recognize the powerful effects that environment and socioeconomic status have on health quality.

Hall-Mercer Homeless Street Outreach: This program works to engage homeless individuals living on the street. Outreach workers offer emergency housing, treatment options, and other resources to help individuals meet their immediate survival needs. Outreach workers attempt to build reliable relationships with those living on the street in order to help them access or accept housing. Hall-Mercer is staffed with a homeless outreach team 365 days a year.

Rebuilding Together Philadelphia and **The Philadelphia Project**. Both initiatives provide home improvements not only to seniors, but also to vulnerable homeowners, many possessing medical and physical disabilities, in an effort to turn their houses into safer, healthier, and energy-efficient homes.

Medical Students Homeless Feeding and Outreach Program: Incorporated in 1987, University City Hospitality Coalition (UCHC) provides hot meals five nights a week and sandwiches on Saturdays for poor and homeless individuals in West Philadelphia. On Wednesdays, a medical clinic staffed by a doctor and medical students from the Perelman School of Medicine at the University of Pennsylvania delivers critically needed care, including blood pressure screenings, vaccinations, and general examinations, that may otherwise be unavailable to this population.

Priority Area #9 Healthcare and Health Resources and Navigation

Outcome Measures: Growth and connection of patients to resources by launching a web-based services directory in partnership with our CHNA partner institutions.

Hospitals addressing need: *Hospital of University of Pennsylvania, Pennsylvania Hospital and Penn Presbyterian Medical Center.*

Navigating healthcare services and other health resources, like enrollment in public benefits and programs, remains a challenge due to general lack of awareness, fragmented systems, and resource restraints. Additionally, financial costs and logistics associated with transportation can be a barrier to accessing care. Community members most affected by navigation are socioeconomically disadvantaged, the uninsured, and persons with disabilities. Below are programs that Penn Medicine will continue to grow and invest in to address this priority area.

Penn Medicine Center for Community Health Workers IMPaCT program: IMPaCT is a standardized, scalable community health worker (CHW) program in which Penn Medicine hires, trains and deploys trusted laypeople from local communities to help patients address the social determinants of health, including accessing behavioral health, addressing substance abuse, connecting to healthy food, housing, transportation, and engaging in chronic disease prevention. The program has been delivered to nearly 10,000 high-risk patients and proven in three randomized controlled trials to improve chronic disease control, mental health and quality of care while reducing total hospital days by 65%. In addition, CHWs facilitate meet up groups for community members which include things like cooking demonstrations, financial planning, bereavement support etc. (Patients choose the topics, CHWs arrange guest speakers and

facilitate). IMPaCT also supports the veteran community through creating community gardens, connecting them to Edison High School to do mentoring, bowling events, etc.)

More than 1,000 organizations have accessed our CHW toolkit and we provide technical assistance to help organizations around the country create, launch and sustain effective CHW programs.

Social Determinants of Health Screening and Referral Tool: In partnership with the Penn Center for Health Equity, a social determinants of health screening tool and referral program will launch in the first quarter of 2020. This free tool for the patient community will be built by our software partner and assist in our efforts to help provide resource information and healthcare services on the web for patients. Services and resource information will include locating food pantries, utility assistance, flu shot clinics, and more.

Philadelphia Promise Zone: Faculty and staff from across the University of Pennsylvania and Penn Medicine have been engaged in the West Philadelphia Promise Zone, one of twenty-two underserved areas in the country designated by the Obama Administration. The Promise Zone aims to reduce poverty and bring greater opportunity to people living and working in West Philadelphia. The initiative helps organizations work together to connect residents to high quality education, well-paying jobs, affordable housing, health services, and safe, economically healthy places to live. Led by the Mayor's Office of Community Empowerment and Opportunity, over 100 local partner organizations, including public agencies, service providers, civic groups, universities, and hospitals, meet monthly to advance work in areas that include education, economic opportunity, health and wellness, housing, and public safety.

Priority Area #10 and #11 Linguistically- and Culturally- Appropriate Healthcare and Racism and Discrimination in Healthcare

Outcome Measures: Grow language and cultural services programmatic initiatives, including interpretation services, diverse spiritual support, and custom dietary options; growth and promotion of inclusive culture at Penn Medicine; growth of education initiatives to address implicit bias and to provide patient and family centered, culturally effective care; continuation of system-wise initiatives to reduce unnecessary variations in care by personal characteristics; growth and promotion of inclusive culture at Penn Medicine; growth of education initiatives to address implicit bias and to provide patient and family centered, culturally effective care.

Hospitals addressing need: *Hospital of University of Pennsylvania, Pennsylvania Hospital and Penn Presbyterian Medical Center.*

Despite well-intentioned providers and advancements in medicine, health and healthcare disparities persist today. While disparities are often viewed through the lens of race and ethnicity, they can occur across many dimensions including socioeconomic status, age, geography (neighborhood), gender identity, sexual orientation, disability status, religious affiliation, primary language, and/or mental health status. Below are programs that Penn Medicine will continue to grow and invest in to address this priority area.

The Center for Health Equity Advancement (CHEA): CHEA is the cornerstone for advancing high quality patient/family-centered care for all, regardless of their personal characteristics, supports community partnerships to tackle barriers to achieving optimal health for all communities we serve, and aims to provide equitable healthcare within inclusive environments that support a diverse workforce and student body. In order to build support for and align mutually reinforcing equity initiatives across the enterprise, Penn Medicine incorporates its Center for Health Equity Advancement Blueprint for Equity and Inclusion (Appendix B) into its CHIP within the following initiative areas:

Care Transformation CHEA will establish system-wide structures for routine measurement and reporting of quality and patient experience metrics by personal characteristics as well as leverage existing quality and patient experience improvement infrastructure to address identified differences in care by personal characteristics.

Community Engagement CHEA will build community partnerships to address identified social needs at both the patient- and population-level and tie community facing initiatives to care transformation goals and improving health outcomes.

Workforce CHEA will continue to drive understanding of inclusive behaviors through alignment with current HR initiatives and policies and skills training and education on inclusive leadership.

Research and Evaluation CHEA will support evaluation and related scholarship of all activities described above and further, build research and development capacity to advance the science of health equity and inclusion.

Education and Training CHEA trains hundreds of clinicians annually and offers a variety of workshops. CHEA develops and deploys messaging campaigns on health equity and inclusion (HE&I) concepts and its alignment with health system operational goals and invest in related workforce capacity building and skills training. Training topics include: Foundations of Unconscious Bias; Beyond Bias: Advancing Diversity and Inclusion; Unconscious Bias for Leaders: Impact on Decision Making; Impact of Unconscious Bias: Faculty Search and Selection Process; Virtual Foundations of Unconscious Bias.

Penn OB/GYN Health Equity Taskforce Department of Obstetrics and Gynecology: The Penn Ob/GYN Health Equity Taskforce was formed in January 2019 to address reproductive health disparities in a meaningful way. The task force includes representation from all the divisions within the department. Our working group members serve as the leaders within the department for education on health equity, and for identifying areas of quality improvement and intervention that will reduce health inequities in our department.

Conclusion

Penn Medicine will continue to strive to meet its responsibility to be an engaged and committed community partner, eager to stimulate positive change and improve health outcomes for those throughout the Philadelphia community. Our vision for the next three years is to incorporate health outcomes measures so that we can further align and define our population health outreach and ensure everyone we encounter has the best opportunity to live their healthiest life possible.

We believe that by addressing the social determinants of health and improving access to care especially for patients experiencing complex health and social needs will allow us to greatly improve our community health outreach priority areas listed above. Further, our collaborations, partnerships and common agenda will allow us to ensure we are investing in the health of the entire region, dedicating resources to where they are needed the most.

Appendix A: Our Community Partners

Together, with our community partners, we will work to advance health equity with services and programs throughout the Philadelphia Community.

- ✓ Clinical Practices of the University of Pennsylvania
- ✓ University of Pennsylvania School of Nursing
- ✓ Healthy in Philadelphia Program of The Health Federation of Philadelphia
- ✓ The Southeastern Pennsylvania Collaborative Opportunities to Advance Community Health
- ✓ The City of Philadelphia
- ✓ Spectrum Health Center
- ✓ Bernett Johnson Sayre Health Center
- ✓ Get Healthy Philadelphia
- ✓ University of Pennsylvania Office of Government Relations
- ✓ University of Pennsylvania Netter Center for Community Partnerships
- ✓ Mercy LIFE - Living Independently for Elders
- ✓ Hospital of the University of Pennsylvania Nursing Community Outreach Advisory
- ✓ Health Promotion Council of Philadelphia
- ✓ Philadelphia Police Department District # 18
- ✓ United Block Captain's Association of Philadelphia
- ✓ Drexel University
- ✓ The Children's Hospital of Philadelphia
- ✓ University of Pennsylvania - Center for Public Health Initiatives
- ✓ The Southeastern Pennsylvania Collaborative Opportunities to Advance Community Health
- ✓ The Health Federation of Philadelphia and affiliated federally qualified health centers
- ✓ Mercy Philadelphia Health System
- ✓ University of Pennsylvania Police
- ✓ Mental Health Association of Southeastern Pennsylvania
- ✓ People's Emergency Center
- ✓ University City District
- ✓ West Powelton Concerned Citizens
- ✓ Friends of 40th Street
- ✓ West Philadelphia Community Center
- ✓ Hebrew Immigrant Aid Society and Council Migration Service
- ✓ Lutheran Children and Family Service-local shelter for women and children
- ✓ Sickle Cell Disease Association of America - Philadelphia Delaware Valley Chapter Delaware Valley Healthcare Council
- ✓ Enterprise Center Community Development Corporation
- ✓ Health Promotion Council of Philadelphia
- ✓ Community Legal Services
- ✓ Maternity Care Coalition
- ✓ Philadelphia Block Captain's Association
- ✓ Southwest Community Development Corporation
- ✓ Philadelphia Department Human Services
- ✓ United Clergy of West Philadelphia
- ✓ The Enterprise Center CDC
- ✓ Communities in Schools of Philadelphia, Inc.
- ✓ Action AIDS
- ✓ MANNA
- ✓ Youth Service, Inc.
- ✓ Health Start
- ✓ Family Practice & Counseling Network – Health Annex
- ✓ Lancaster Avenue Business Association

Appendix B:


BLUEPRINT
HEALTH EQUITY AND INCLUSION
Penn Medicine will provide high quality patient and family - centered care to ALL patients.
VALUE
Reduce Unnecessary Variations in Care by Personal Characteristics
ENGAGEMENT
Provide Patient and Family Centered, Culturally Effective Care
INCLUSION
Ensure a Diverse and Inclusive Clinical Learning Environment
IMPERATIVE
PRIORITY ACTIONS
Reduce Unnecessary Variations in Care by Personal Characteristics
1. Stratify institutional quality metrics by personal characteristics
2. Establish a customizable dashboard for ongoing reporting of equity metrics by department
3. Enhance systems to ensure accuracy and consistency of data collection of race/ethnicity, gender, and sexual orientation
4. Integrate equity into existing quality improvement efforts
5. Establish a multidisciplinary health equity taskforce of key stakeholders to guide strategic solutions
Provide Patient and Family Centered, Culturally Effective Care
1. Establish educational curricula for house staff and faculty on cultural humility and implicit bias
2. Require online training for employees that interface with patients on cultural humility and implicit bias
3. Include patient stakeholders on health equity taskforce
Ensure a Diverse and Inclusive Clinical Learning Environment
1. Establish training methods designed to improve recruitment, selection, evaluation, and promotions of a diverse body of house staff and faculty
2. Institute leadership training in holistic review and implicit bias for organizational change
3. Integrate inclusion and diversity efforts into wellness initiatives and professionalism standards
4. Collaborate with staff training initiatives that promote culturally effective and equitable care
5. Coordinate with and highlight efforts of the Office of Inclusion and Diversity (OID) and its graduate and undergraduate medical education anchor programs