

A plan to build sustainable, effective linkages between residents, healthcare providers, community organizations, and public health and human service agencies to improve the health of Philadelphians



Department of
Public Health

CITY OF PHILADELPHIA

Overview

Philadelphia's 2018-2022 Community Health Improvement Plan (CHIP) was developed through a planning process led by the Philadelphia Department of Public Health (PDPH) in partnership with the Drexel University Dornsife School of Public Health (Drexel). Leveraging a network of over 173 engaged and involved stakeholders and community leaders invested in the health of Philadelphia, and focusing on data from Philadelphia's 2017 Community Health Assessment (CHA), the Drexel/PDPH team used a similar process from the previous CHIP, which was successfully implemented in 2014. The 2018 process resulted in the identification of two overarching priority areas to be addressed through a comprehensive set of objectives and strategies to improve the health of Philadelphians over the next four years.

Summary of Priorities and Objectives

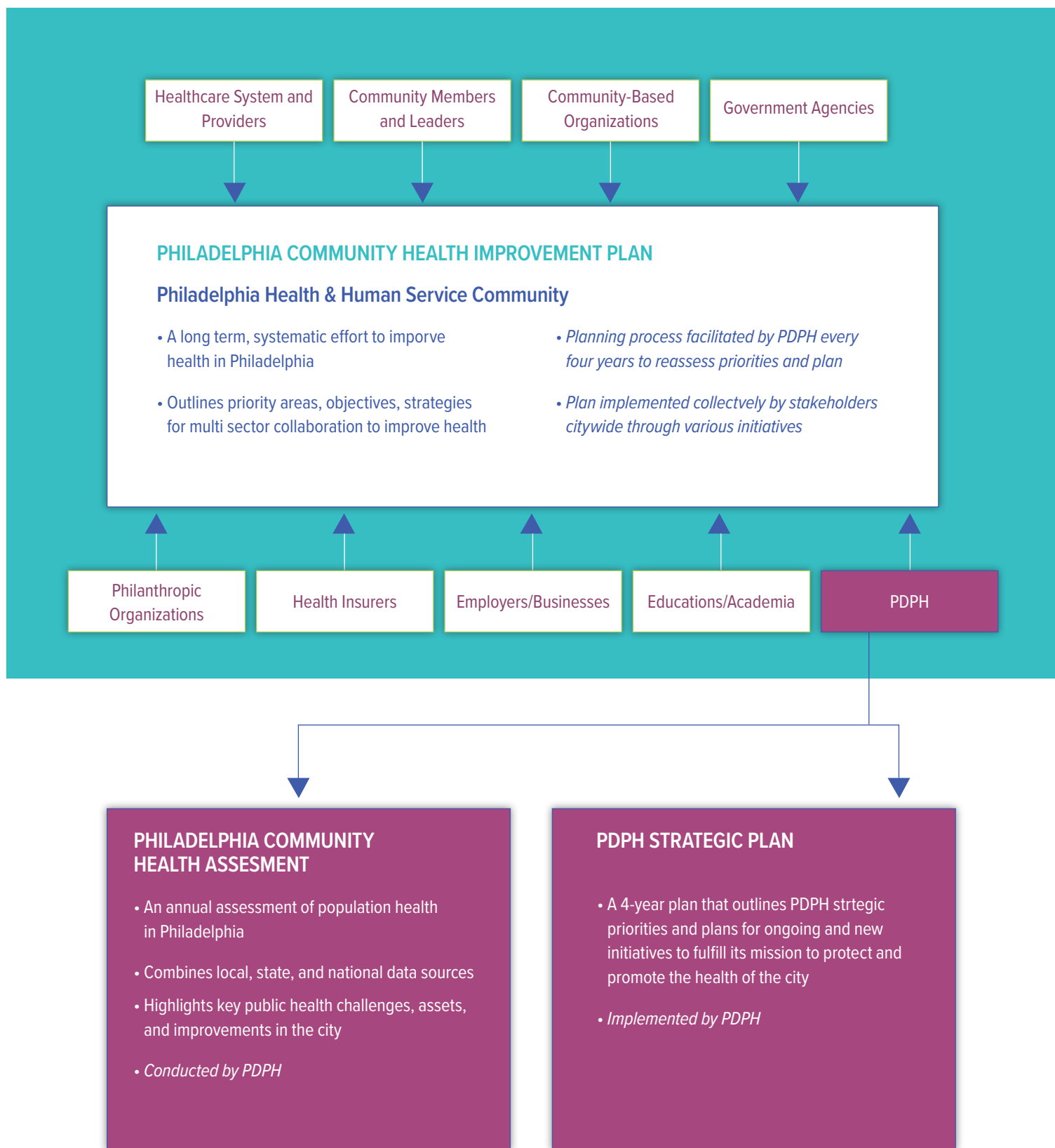
Priority 1: Improve access to and utilization of primary care

Objective 1	Increase Medicaid and Marketplace enrollment for eligible uninsured
Objective 2	Improve availability of primary care services in targeted neighborhoods and communities with inadequate access
Objective 3	Increase utilization of primary care services among targeted neighborhoods and communities with low utilization

Priority 2: Improve clinical linkages to community-based services that address social and economic determinants of health of residents

Objective 1	Increase screening for social and economic needs in healthcare settings
Objective 2	Increase referrals to and use of community-based services that address social and economic needs
Objective 3	Increase formal and informal partnerships among population health initiatives

Philadelphia's CHIP was developed as part of a comprehensive planning effort including the development of a CHA and the PDPH 2018 -2021 Strategic Plan. Together, these documents—along with a rich array of other community plans and resources—create a blueprint for public health action in Philadelphia. There are several areas of overlap between the CHIP and the PDPH Strategic Plan, identifying opportunities for action for government and non-governmental stakeholders to improve primary care access and address social determinants of health. The PDPH Strategic Plan also includes specific, high-priority actions to address other major public health priorities, including: infectious illnesses like, influenza, HIV, Hepatitis C, and syphilis; the opioid epidemic; childhood asthma and lead exposure; smoking cessation and prevention; obesity; and air pollution. More information about these other initiatives can be found at www.phila.gov/health.



A | Community Values and Guiding Principles

The CHIP planning process identified several shared values and guiding principles:

- » Improving health requires both *programmatic* and *policy* solutions.
 - » Improving health requires strong coordination between *public health and health care*.
 - » Understanding the role of *social determinants of health* is critical to improving health outcomes.
 - » All interventions to improve health in Philadelphia must address the stark *racial and ethnic health disparities* that exist.
 - » Priority should be given to those issues that require, or would benefit from, *collective action*.
 - » Priorities should be chosen that have the potential to *make an impact* on health broadly, rather than narrowly focus on a particular issue or population.
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B | The Health of Philadelphia

The CHIP process was guided by data on the health of Philadelphians. Philadelphia is the sixth largest city in the U.S., with a population of over 1.5 million. It is the poorest of the 10 largest cities with approximately 25% of all residents and nearly 40% of children living below the federal poverty level. Philadelphia is diverse: 42% of the population is Black; 35% White; 14% Hispanic; 7% Asian. Nearly 1 in 5 Philadelphia births in 2015 were to women born outside of the U.S.

Over the last 10 years, mortality rates for most major causes have declined steadily, including a 55% decline in deaths from HIV, a 48% decline for influenza and pneumonia, a 26% decline for heart disease, and a 21% decline for cancer. Overall life expectancy has increased for men from 69 to 73 years and for women from 76 to 80 years. Nearly two-thirds of the CHA's core health indicators have shown improvements in the last decade, including third grade reading proficiency, youth and adult smoking, child obesity, new HIV diagnoses, breastfeeding initiation, childhood immunizations, restaurants passing food safety inspections, and homicides.

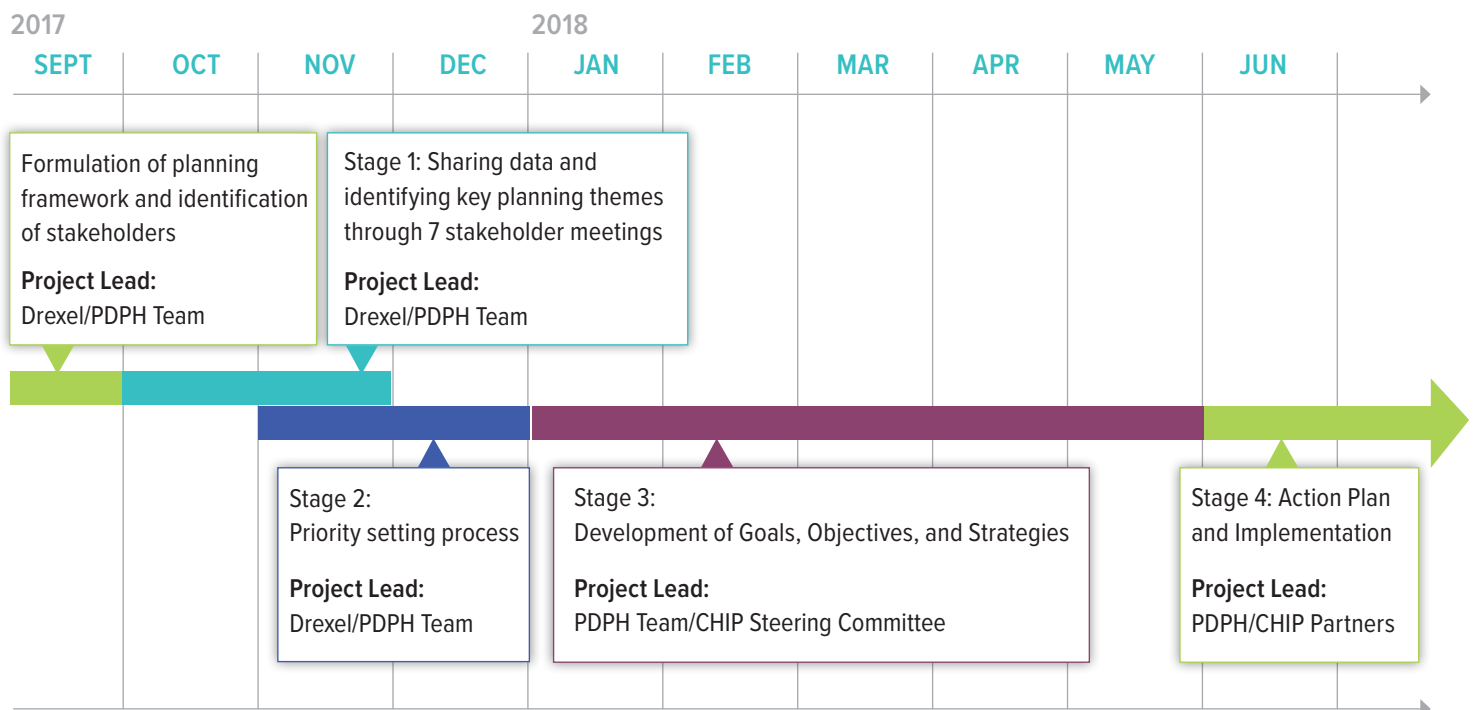
Despite these gains, some health indicators are moving in the wrong direction, and racial/ethnic and geographic disparities are common. For example, rates of diabetes, hypertension, and adults with mental health conditions have increased consistently since 2000. The infant mortality rate recently dropped below 10 deaths per 1,000 live births, but is still among the highest rates in the United States. Black infants in the city are three times more likely to die than White infants in their first year of life. The life expectancy difference between Black men and Asian men is 16 years. Hispanic adults are the most likely to be uninsured, and Hispanic children have the highest levels of obesity. Neighborhoods with large racial/ethnic minority populations—particularly North and Lower North Philadelphia—have the poorest health outcomes across a range of issues, including poverty, educational attainment, premature death, teen births, breast cancer screening, and homicide.

The CHIP Process

A | Roles and Timeline

The planning process was conducted as a partnership between PDPH and Drexel. Together, PDPH and Drexel developed and refined the planning framework, created a schedule and agenda for stakeholder meetings, identified key themes, and developed the priority setting process. PDPH and Drexel communicated throughout the process, continuously refining and improving it as it unfolded. A CHIP Steering Committee of key stakeholders and potential partners was formed to help inform and shape the goals, objectives and strategies included in the final plan.

THE CHIP PROCESS: ROLES & TIMELINE



B | CHIP Planning Framework

The PDPH/Drexel team implemented a four-stage CHIP Development Process similar to the 2013 CHIP process, based on the Mobilizing for Action through Planning and Partnerships (MAPP) model. Key MAPP elements that were emphasized in the process include:

- **Organizing:** Broad stakeholder involvement; assessed resource needs; developed planning process and timeline
- **Assessments:** PDPH completed and presented CHA data. Community themes and strengths were gathered through stakeholder meetings and priority setting meeting process. Other strategic plans and health planning documents were reviewed.
- **Strategic issues:** priority setting meetings/voting.
- **Goals and Strategies:** Developed by planning team and CHIP steering committee.
- **Action Cycle:** links three activities—Planning, Implementation, and Evaluation.

Using this modified MAPP process, the planning team convened seven stakeholder meetings over the course of two months to present and get feedback on CHA data, hear themes and concerns about health in Philadelphia, share current programs and interventions, and set public health priorities for the CHIP.

PARTICIPANTS IN THE PLANNING PROCESS

As part of the CHA and Strategic Planning processes, the PDPH Health Commissioner's Office generated a list of stakeholders to engage in the CHIP planning process. Feedback was solicited from PDPH Division Directors and staff involved in community/partner engagement to identify key community partners and stakeholders in each of the core areas of the CHA. Broad representation was sought from a variety of sectors, including public health, health care, social service, community, education, business, housing, transportation, and academia; and organizations that contributed data to the CHA.

Stakeholders included:

- » **Government agencies**, including the Philadelphia Department of Behavioral Health and Intellectual disAbility Services, Office of Homeless Services, Office of Community Empowerment and Opportunity, Philadelphia City Planning Commission, School District of Philadelphia, the Pennsylvania Department of Health, and the Region III Office of the U.S. Department of Health and Human Services;
 - » **Hospital partners**, including those involved in the development of their own Community Health Needs Assessments (CHNA);
 - » **Community representation**, including community leaders and consumers of public health services (e.g., PDPH health center community boards, Philly Powered ambassadors, School District of Philadelphia Parent Advisories);
 - » **Academic partners**, including representation from the university-based schools and programs of public health in Philadelphia;
 - » **Non-profit public health and community organizations**, representing a range of experts in content areas including HIV/STD, chronic disease, maternal and child health, access to care, reproductive health, environmental health;
 - » **Federally qualified health centers** and other community-based primary care providers;
 - » **Insurers**, including representatives from the regional Medicaid managed care providers;
 - » **Employer and business groups**;
 - » **Existing coalitions**, including those engaged in obesity prevention, tobacco control, and HIV planning; and
 - » **Public health leadership**, including the Philadelphia Board of Health and the College of Physicians Section on Public Health.
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Following the initial meetings, a Qualtrics electronic survey was sent to all relevant stakeholders (including those who could not attend) to rank themes discussed at the meeting and write in other issues that were not listed. The culminating stakeholder meetings consisted of exercises used to determine the priorities for Philadelphia's CHIP.

C | CHIP Data Sources

Philadelphia's CHA provided the overall context and data for the CHIP. CHA data came from a variety of sources, including the Philadelphia Department of Public Health, School District of Philadelphia, PHMC Household Health Survey, PA Health Care Cost Containment Council, U.S. Census, U.S. Youth Risk Behavior Surveillance System, U.S. Behavioral Risk Factor Surveillance System, RWJF County Health Rankings, and FBI Uniform Crime Report. Drawing on these sources, the CHA describes the demographics of the population and the social determinants of health. The report is divided into 12 sections, each reflecting a key public health issue, and the report concludes with an overview of public health assets. Health of the City, an executive summary of the CHA, and the full CHA is available at: <http://www.phila.gov/health/Commissioner/Reports.html>.

Stakeholder meetings served as a second key source of information (see next section for details). In addition, following each meeting emails were sent out to all relevant stakeholders, both those who attended and those who did not. The email gave a description of the CHIP process, definition of the meeting theme, and a list of discussed priority areas. The stakeholders were asked to rank the priority areas and to add any important issues that were not included.

D | Stage One: Sharing Data and Identifying Key Planning Themes

STAKEHOLDER MEETINGS

In October and November 2017, the planning team organized seven stakeholder meetings that involved 121 participants. The meetings consisted of both established groups (e.g., Philadelphia Board of Health) and stakeholders that were convened based on their expertise in 5 domains (shown below), organized using the Robert Wood Johnson County Health Rankings Framework which categorizes the major contributors to health outcomes. The size of meeting groups varied from 18-36 persons, and meeting length ranged from 90-120 minutes.

Philadelphia Community Health Improvement Plan Stakeholder Meetings

1. Health Behaviors and Chronic Disease (October 3, 2017)
2. Health Behaviors, Substance Abuse, and Infectious Disease (October 4, 2017)
3. Clinical Care (October 10, 2017)
4. Social and Economic Factors (October 11, 2017)
5. Physical Environment (October 26, 2017)

In advance of each meeting, the PDPH team tailored the Community Health Assessment (CHA) data to meet the priorities and interests of each stakeholder group. For example, the chronic disease meeting included a focused discussion of healthy food access and chronic disease like obesity, diabetes, and hypertension, while the clinical and preventive care meeting discussed adolescent health care access and centralization of care. The meetings began with a presentation of the PDPH Strategic Plan by Dr. Thomas Farley (Health Commissioner) and a presentation of the CHA data by Dr. Raynard Washington (Chief Epidemiologist), followed by a facilitated discussion led by Dr. Washington and the Drexel team.

In addition to soliciting general comments and clarifications on the data presentation, stakeholders were asked specific discussion questions:

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| » Did the CHA data offer any surprises? | » Are there more effective ways to present the data? |
| » Does the CHA data reflect what you see in your work out in the field? Do the data make sense to you? | » What do you see as aggressive but achievable public health goals for the next 3-5 years? |
| » Are there topics or data sources not currently in the CHA that should be included? | » What should we be doing collectively to address the issues highlighted today? |
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The Drexel team took detailed notes at each meeting to capture comments, themes, feedback, and questions. The Drexel team and PDPH leadership reviewed meeting notes after each meeting, and revised the agenda for future meetings as necessary. A Qualtrics electronic survey was sent out to all stakeholders following each meeting with themes from each meeting to rank and contribute any additional issues that were not addressed in the discussion.

Upon completion of all the stakeholder meetings, session notes and survey results were reviewed by the Drexel team to identify key meeting themes. The team looked to identify both specific health issues that came up repeatedly (e.g., obesity, opioid abuse), in addition to broader issues (e.g., access to care, poverty, cultural competency, food security) that were crosscutting between all stakeholder groups.

Drexel and PDPH reviewed this analysis and reached consensus on the labels and categories of themes which were organized into ten categories:

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| » Access to affordable healthcare | » Chronic disease treatment and management |
| » Air quality/pollution | » Community-based health and human services (e.g. in schools) |
| » Asthma in children | » Food access and insecurity |
| » Centralized healthcare services (e.g. co-located physical and behavioral health) | » Opioid dependence prevention and treatment |
| » Chronic disease prevention (e.g. obesity, hypertension, diabetes) | » Social determinants of health (e.g. poverty, housing, food access) |
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The themes above were presented and discussed in-depth during two subsequent priority-setting meetings held on November 6, 2017, and November 13, 2017 (see next page).

E | Stage Two: Prioritizing Health Issues

Following the stakeholder meetings, a set of priority setting meetings were held to identify the top public health priorities for Philadelphia's CHIP. All individuals who were invited to participate in stakeholder meetings were invited to attend two priority-setting meetings held in November 2017. Two meetings with identical agendas were held in order to give as many stakeholders as possible the opportunity to participate.

PRIORITY SETTING MEETINGS: NOVEMBER 6 & 13, 2017

The priority setting meetings were held on November 6th and November 13th, 2017. The goals of the priority setting meeting were to:

- Review the purpose of the CHIP planning process and resulting report;
- Present the themes identified in the 5 stakeholder meetings and solicit feedback;
- Discuss plan for prioritization; and
- Conduct an exercise to assess the priorities of participants.

Data and evaluation criteria were presented to participants during the first meeting in order to prepare them for priority setting exercises. These are summarized in the figure below.

PRIORITY SETTING TOOLS FOR DISCUSSION

Guiding principles for setting priorities

Guiding principles were extracted from stakeholder meeting notes with particular focus on those criteria that should help guide the CHIP planning process:

- » ***Making an impact*** (reducing leading causes of death):
A focus on issues that impact health very broadly (e.g., smoking cessation).
- » ***Addressing racial and ethnic health disparities***
in Philadelphia (i.e., achieving equity).
- » Addressing issues that require or would ***benefit from collective action*** (i.e., address issues that are not improving while also building on areas of momentum).

Qualitative representation of health issues

The major themes from the stakeholder meetings were presented with facilitated discussion of each theme.

VOTING ON PRIORITIES

The voting process in the priority setting meetings took place following a group discussion of the outcome of the five stakeholder meetings and the ranking of priorities through the Qualtrics electronic survey. The top ten themes were written on large pieces of paper and hung up around the room. Each participant was given the same number of colored dots to show their support of prioritizing one or more issues. For example, a participant could put all of their dots under one issue or spread them out amongst several issues depending on their preference. Participants were also invited to use markers to write specific opportunities for interventions or suggest community organization for partnership.

Following each meeting the colored dots were counted and recorded and the comments under each theme were included in the meeting notes.

Based on synthesis of the voting, stakeholder meetings, priority setting meetings, and other plans/materials reviewed, two clear priority areas were identified:

1. Social determinants of health
2. Access to affordable health care

Initial results of the final priority setting process were communicated to all participants in January 2018.

F | Stage Three: Creating the Plan

Once priority areas were identified, PDPH worked with several stakeholder groups to conceptualize and draft specific priority areas. Key stakeholder participants were engaged and recruited to participate in a CHIP Steering Committee to provide guidance during the development of the priority areas, objectives, and strategies. The steering committee included representatives from governmental and non-governmental partners listed below:

» Access Matters Melissa Weiler Gerber, JD	» Health Promotion Council Christina Miller, MS
» Center for Public Health Initiatives, University of Pennsylvania Sara Solomon, MPH, RD	» Healthy Philadelphia Carol Rogers, PA
» Center for Public Health Practice, Dornsife School of Public Health, Drexel University Jennifer Kolker, MPH	» Leonard Davis Institute, University of Pennsylvania David Grande, MD
» Community-Clinical Linkages Taskforce Kinnari Chandriani, MD	» Mayor's Office of Education Katrina Pratt-Roebuck, MBA
» Health Care Improvement Foundation Susan Choi, PhD	» Office of Community Empowerment and Opportunity Cassie Haynes, JD, MPH
» Health Federation of Philadelphia Natalie Levkovich	» PDPH Health Commissioner's Office Naomi Mirowitz, MPH Raynard Washington, PhD, MPH

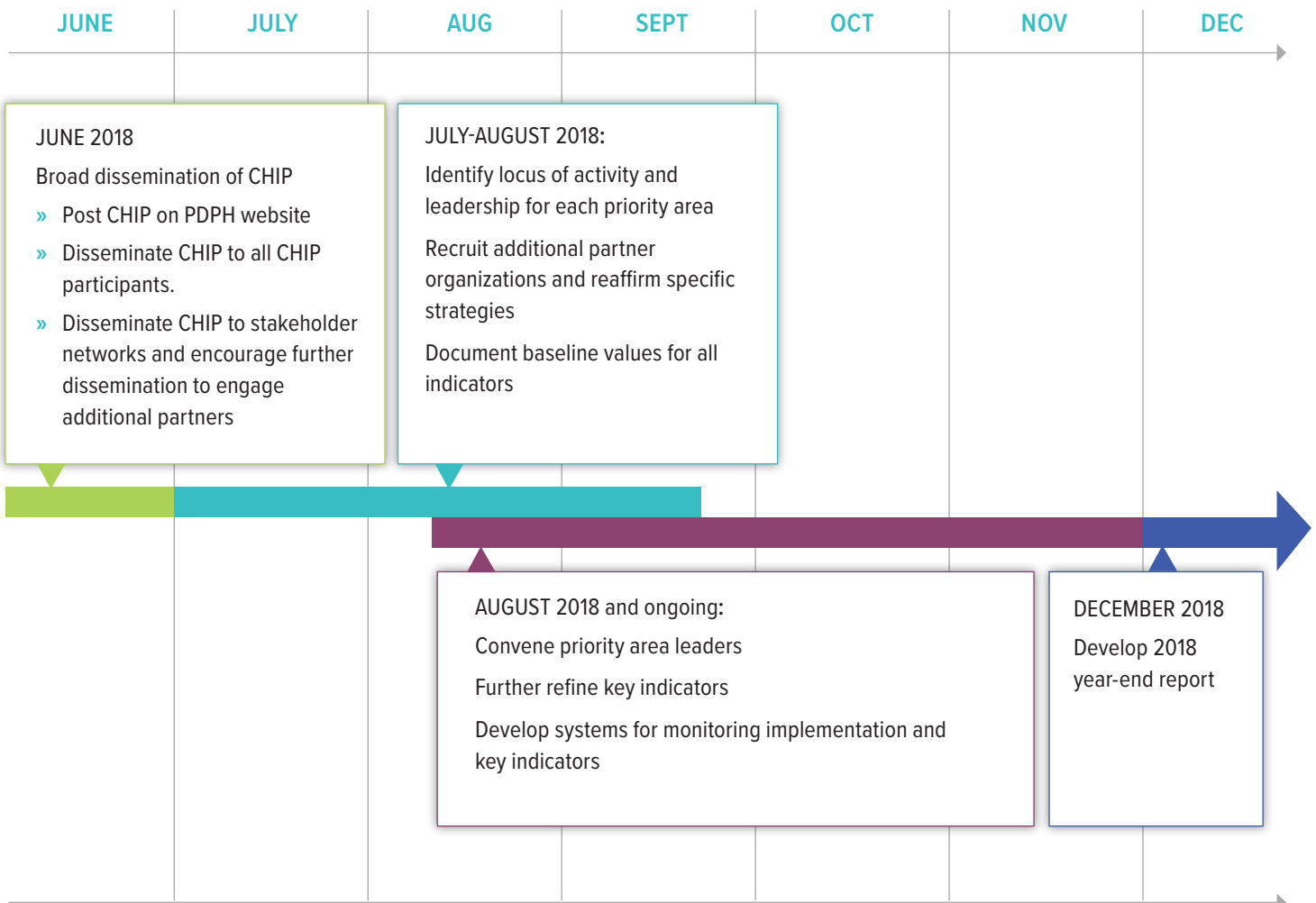
During the steering committee meeting, PDPH presented a draft of the priority areas, objectives, strategies, and potential partners. Steering committee members engaged in a robust discussion, proposed modifications to the draft plan, suggested additional partners to engage, and identified opportunities for collaboration with their own organizations. PDPH updated the draft priority areas and redistributed to the steering committee for additional feedback. A final draft was sent to the steering committee members for approval in early June 2018.

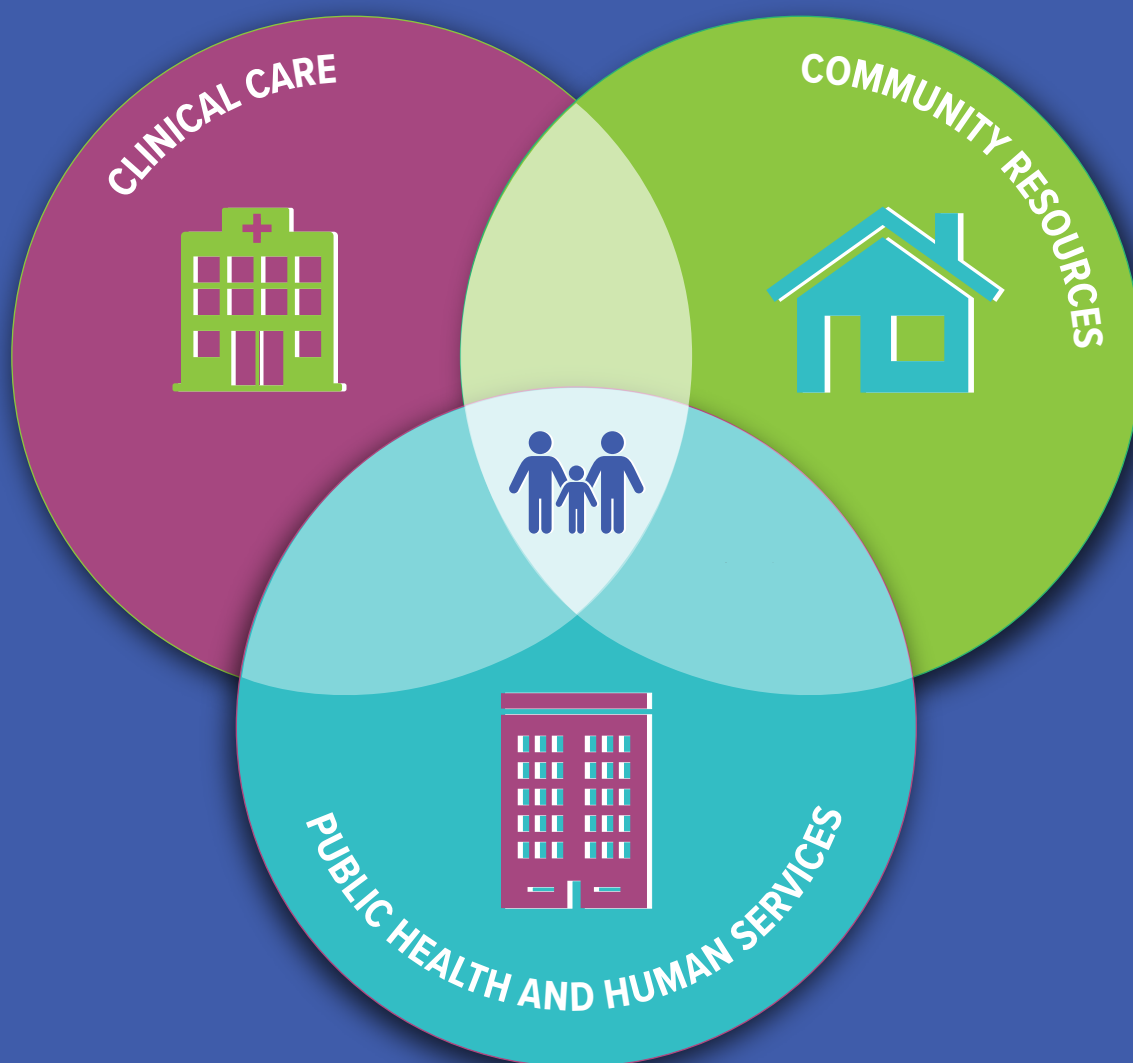
G | Stage Four: Dissemination and Implementation

The final component of the CHIP is the dissemination of the plan and implementation of the strategies.

Implementation will use existing taskforces, coalitions, partnerships, and initiatives to maximize efforts and avoid duplication within each priority area with a set schedule for monitoring and measuring progress. Implementation steps include:

CHIP IMPLEMENTATION PLAN





CLINICAL & COMMUNITY LINKAGES

The Plan:

Community-Clinical Linkages for a Healthier Philadelphia

What is Philadelphia's Community Health Improvement Plan?

The CHIP is a long-term, systematic effort to address public health priorities in Philadelphia based on the results of a comprehensive priority setting process involving stakeholders from the public and private sectors. The plan, which lasts for four years, is used by health and human service agencies and other community partners to set priorities and coordinate and target resources towards those priorities. Priorities are set based on data from the Philadelphia Department of Public Health's Community Health Assessment and input from a broad range of stakeholders. The CHIP is distinct and separate from the PDPH Strategic Plan, which outlines specific priorities and objectives that are implemented directly by PDPH and its partner organizations. The CHIP relies on the commitment of multi-sector stakeholders across the city collaborating on various initiatives to address shared priorities to improve health.

Community-Clinical Linkages

The 2018-2022 CHIP focuses on improving community-clinical linkages, including connecting people to clinical care from the community and linking people to community resources from within the clinical care setting. Building strong community-clinical linkages has been recognized as an effective approach to prevent and control chronic disease¹ and improve population health.

Philadelphia has the highest poverty rate among major U.S. cities and persistent health disparities, particularly among racial/ethnic minorities. Yet, Philadelphia has a wealth of both clinical and community resources throughout the city. Many of the most vulnerable populations find navigating these, often fragmented and siloed systems challenging and, often times, impossible.

The 2018-2022 CHIP includes two priority areas focused on improving connectivity between clinical and community sectors to ensure adequate access to health care and improve access to services that address social and economic determinants of health.

¹CDC. Community-Clinical Linkages for the Prevention and Control of Chronic Diseases: A Practitioner's Guide. Atlanta, GA: CDC, HHS; 2016

Priority Area One

IMPROVE ACCESS AND UTILIZATION OF PRIMARY CARE

It is widely known that access to health insurance is linked to overall health and well-being. Nationally, over half of uninsured adults have no regular source of health care to go to when they are sick, and they are more than twice as likely to delay or forgo needed care as the insured. The uninsured are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases.² Therefore, the Access to Care strategies all revolve around increasing access to and quality of primary care services.

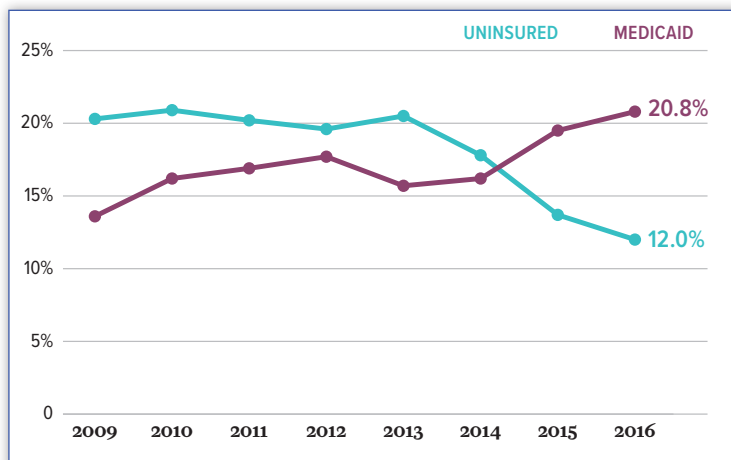
Healthy People 2020 define Access to Health Services as the timely use of personal health services to achieve the best health outcomes, which impact physical, social and mental health status, prevention of disease and disability.

In Philadelphia, approximately 12 percent of adults (ages 18-64) in Philadelphia are without health insurance. Rates of uninsured adults declined significantly as Medicaid enrollment increased as a result of ACA Medicaid expansion. Approximately 21 percent of adults (ages 18-64) are enrolled in Medicaid. Less than 4 percent of children (less than 18 years old) are without health insurance in Philadelphia. This has declined in recent years as Medicaid enrollment has also increased. Over half of Philadelphia's children are enrolled in Medicaid.

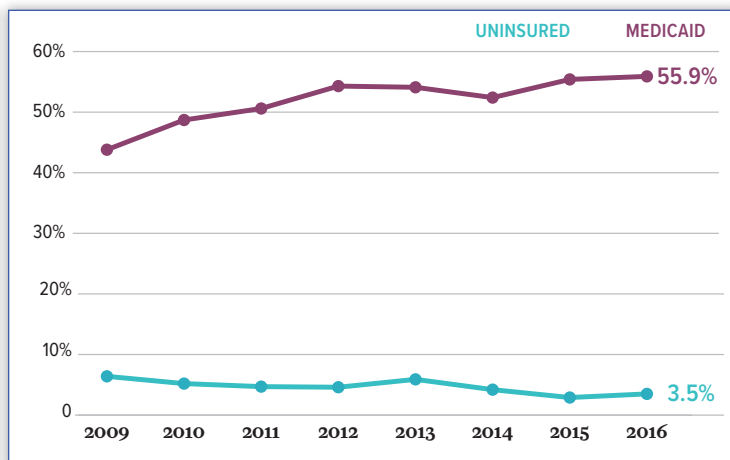
Philadelphia's health care safety net is comprised of about 38 FQHCs (eight of which are operated by the Department of Public Health), an array of free clinics, and some hospital clinics that serve the un- and underinsured. Notably, Philadelphia has no public hospital. Organizations such as the Health Federation of Philadelphia (HFP) lead networks of many of the community health centers in the region, enabling strong collaboration and coordination around systems initiatives and goals, including many of the strategies detailed in the CHIP. In addition, Philadelphia has a wealth of advocacy and nonprofit public health organizations committed to improving access to care for Philadelphians.

The CHIP includes three objectives related to access to care. These goals primarily focus on access to and improvement of the quality of primary care within the healthcare safety net, in which most of the uninsured and many of those covered by Medicaid receive their care. Within this goal is also the recognition that access to the full range of care—including reproductive health, dental, and specialty care—is critical to the health of Philadelphians.

UNINSURED/MEDICAID • ADULTS (18-64), PHILADELPHIA 2009-2016



UNINSURED/MEDICAID • CHILDREN (Ages <18), PHILADELPHIA 2009-2016



OBJECTIVES	STRATEGIES	MEASURES OF PROGRESS*
Increase Medicaid and Marketplace enrollment for eligible uninsured	<ol style="list-style-type: none"> 1. Convene health systems, community health centers, community-based organizations, health plans, and city agencies to: <ul style="list-style-type: none"> • Identify opportunities and strategies to ensure Medicaid eligibility screening and enrollment for high-risk populations • Provide ongoing support for navigation and enrollment assistance • Advocate for support and funding for safety net care and coverage • Identify and advocate for local policies changes to ensure adequate access to health care insurance 	<p>Adults without health insurance Baseline (2016): 12.0%</p> <p>Children without health insurance Baseline (2016): 3.5% Source: 1-Year Estimates, American Community Survey</p> <p>Establish and maintain Access to Primary Care Coalition</p>
Improve availability of primary care services in targeted neighborhoods and communities with inadequate access	<ol style="list-style-type: none"> 2. Establish system for routine monitoring of primary care access in Philadelphia 3. Develop a dissemination plan for the Philadelphia Department of Public Health's Access to Primary Care Report to key stakeholders to inform policy and decision making about availability, capacity, and need for primary care providers 4. Advocate for support and funding for additional safety net providers in neighborhoods and subpopulations with inadequate access 	<p>Number of census tracts designated as HSAs Baseline (2017): 48 Source: Philadelphia Department of Public Health</p> <p>Development of Access to Care Report and dissemination to stakeholders for policy/program planning</p>
Increase utilization of primary care services among targeted neighborhoods and communities with low utilization	<ol style="list-style-type: none"> 5. Establish system for routine monitoring of primary care utilization in Philadelphia 6. Develop and implement primary care awareness initiative(s) focused on population awareness of primary care as a critical gateway to (1) preventive health, (2) behavioral health and (3) human services 	<p>Children with up-to-date immunizations Baseline (2016): 76.9% Source: PhilaVac Immunization Registry, PDPH</p> <p>Adults who ever had their blood cholesterol checked Baseline (2015): 78% Source: BRFSS, Pennsylvania Department of Health</p> <p>Women age>50 with mammogram in past 2 years Baseline (2016): 80% Source: BRFSS, Pennsylvania Department of Health</p> <p>Adults age>50 with colonoscopy/sigmoidoscopy Baseline (2016): 68% Source: BRFSS, Pennsylvania Department of Health</p> <p>Childhood hospitalizations for asthma Baseline (2015): 59.5 per 10,000 children Source: Pennsylvania Health Care Cost Containment Council</p> <p>Development and implementation of primary care awareness initiative(s)</p>

**Measures of progress will be further refined during year 1 of implementation.*

Key Partners:

Healthy Philadelphia, Philadelphia Department of Public Health, Health Federation of Philadelphia, Philadelphia Office of Community Empowerment and Opportunity, Public Health Management Corporation, Health Promotion Council, Health Systems and Providers, Health Plans

Note: These partner organizations/initiatives have tentatively agreed to participate in the CHIP. Additional partner organizations will be engaged directly or through various initiatives listed here.

Priority Area Two

IMPROVE ACCESS TO COMMUNITY-BASED SERVICES THAT ADDRESS SOCIAL AND ECONOMIC DETERMINANTS OF HEALTH THROUGH THE HEALTHCARE DELIVERY SYSTEM

Philadelphia has the highest rates of poverty among major U.S. cities. As such, social and economic risks linked to poverty, particularly housing and food insecurity, poor living conditions and other social inequalities, are key drivers of poor health in Philadelphia. Approximately one-fourth of Philadelphians live in households with an income below 100 percent of the federal poverty level. While poverty rates have declined slightly in recent years, racial-ethnic minorities continue to be twice as likely to live in poverty. The CHA clearly illustrates the impact of poverty on communities. Communities with higher rates of poverty also have more single-parent households, unemployment, violent crimes, housing cost burden, housing-related illness, chronic and infectious illnesses; and lower life expectancy, access to healthy food outlets and safe outdoor spaces, and overall well-being.

Many community resources to address some of the most critical social and economic needs exist throughout the city; yet those in need often face difficulty navigating and connecting to these resources. These same individuals often have chronic and acute health conditions that are exacerbated by their social/economic conditions and require regular clinical care. Linking these individuals to community resources to address their social/economic needs while they are interacting with the healthcare system is a viable opportunity to improve individual's health outcomes and overall well-being.

Health care providers are increasingly acknowledging the importance of building strong community-clinical linkages to facilitate making these connections for their patients. Many providers are focusing efforts on standardized screening for social/economic determinants of health and successful referrals to community-based resources. As a healthcare ecosystem, ensuring coordination and collaboration of healthcare systems and community-based providers is essential to successfully connecting patients to resources.

These efforts are a central component of many health systems population health and/or community benefit initiatives—a federal requirement for non-profit health systems. A primary focus of this priority area of the CHIP is increasing coordination and collaboration across health care providers as they pursue initiatives to address social/economic determinants of health among their patient populations, including both non-profit and for-profit health systems.

Similarly, entities providing services to address social/economic needs often function independently and in silos and referral processes are fragmented. As such, another goal of the CHIP is to increase collaboration and coordination among these entities and with health care providers.

OBJECTIVES	STRATEGIES	MEASURES OF PROGRESS*
Increase routine screening for social and economic needs in healthcare settings	<ol style="list-style-type: none"> 1. Support health care providers implementation of routine, standardized screenings for social and economic risk factors in healthcare settings 2. Establish mechanisms for aggregate sharing of screening data among networks of health care providers to inform citywide population health 	<p>Number of health systems with routine screening for social and economic needs Baseline: TBD</p> <p>Number of health centers with routine screening for social and economic needs Baseline: TBD</p> <p>Number of entities reporting aggregate outcomes of routine screening for social and economic needs Baseline: TBD</p> <p>Number of individuals screened for social and economic needs at reporting institutions Baseline: TBD</p>
Increase referrals to and use of community-based services that address social and economic needs	<ol style="list-style-type: none"> 3. Convene health systems, community health centers, community-based organizations, and city agencies to: <ul style="list-style-type: none"> • Facilitate relationship-building between healthcare providers, community services, and public health and human service agencies • Identify shared opportunities and approaches to enhance and improve directories of available resources and/or investment in a shared directory • Identify shared opportunities and approaches to improve existing referral mechanisms within healthcare delivery system • Explore use of electronic health records and other technology to increase awareness of and successful referral to community services • Explore use of technology to streamline and/or coordinate intake and referral systems of community-based providers where possible • Enhance and maintain access to community-based providers through publically available resource directories/services 4. Promote integration of community services in care delivery, for example through community health workers, Patient Centered Medical Home certification, and initiatives like Room2Breathe 	<p>Establish and maintain Community-Clinical Linkages Taskforce</p> <p>Number of Health Systems and FQHCs with Community Resource Database systems Baseline: TBD</p> <p>Possible sources: BenePhilly, 2-1-1, health system reporting</p> <p>Number of health care providers with PCMH designation Baseline: TBD</p> <p>Number of referrals to community-based resources Baseline: 10,000 annually Source: UnitedWay 2-1-1 Other possible sources: BenePhilly, health system reporting</p>
Increase formal and informal partnerships among population health initiatives	<ol style="list-style-type: none"> 5. Convene local non-profit hospitals and health systems to coordinate community health needs assessment processes, specifically data collection and reporting, and implementation plans 6.. Expand use of electronic health records and other health information technology (HIT) to share data across the delivery system to inform population and public health initiatives 	<p>Number of entities participating in local health information exchange for population health via HSX and Health Federation (e.g. HSX and Health Federation PopIQ) Baseline: TBD</p>

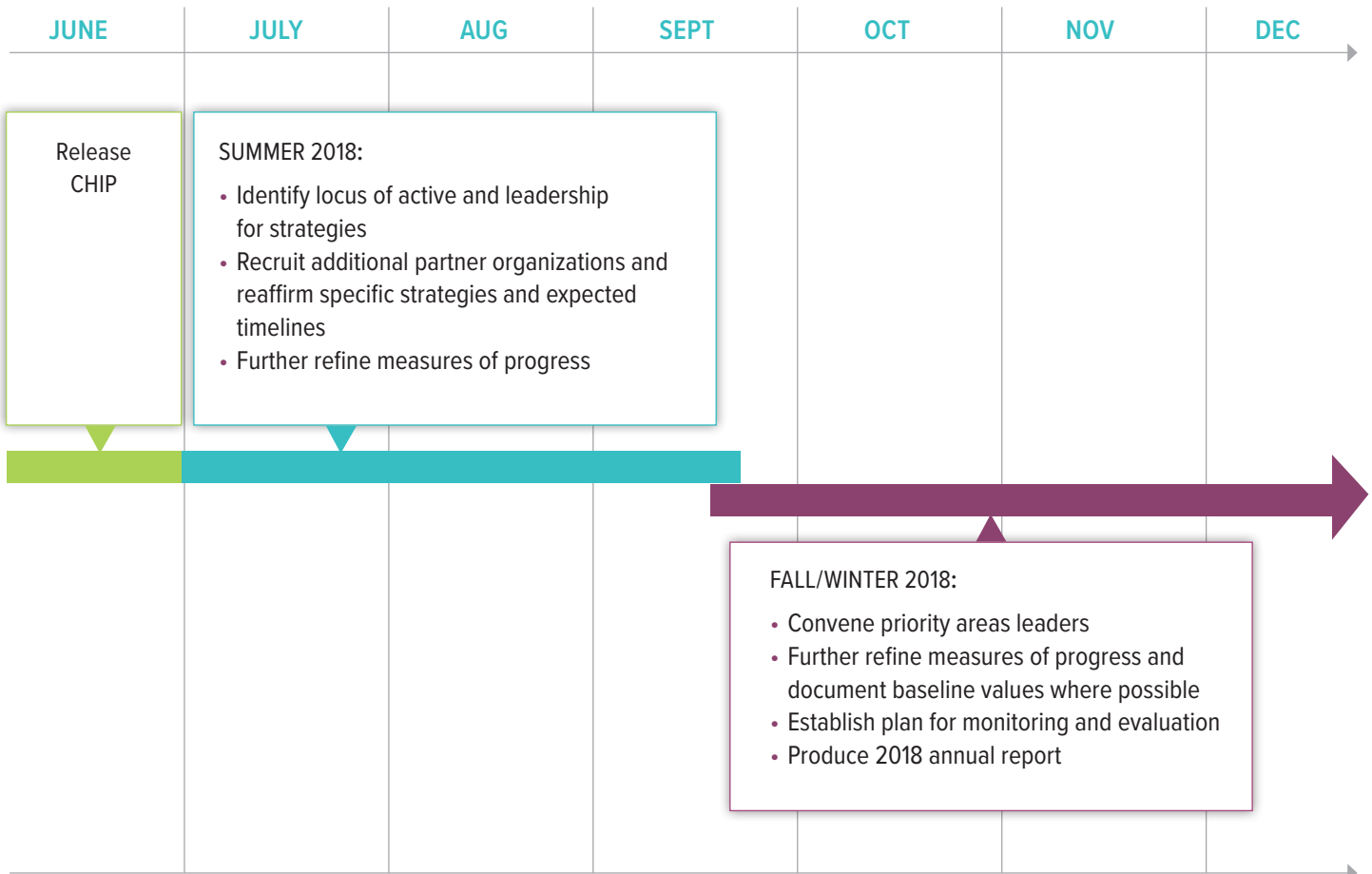
Key Partners:

Healthcare Improvement Foundation (COACH Initiative), Philadelphia Office of Community, Empowerment and Opportunity, Health Federation of PhiladelphiaHealthShare Exchange, Public Health Management Corporation, A Running Start-Health/Room2Breathe, United Way, Benefits Data Trust, PA Community Development Corporations, Health Systems and Providers, Health Plans

Note: These partner organizations/initiatives have tentatively agreed to participate in the CHIP. Additional partner organizations will be engaged directly or through various initiatives listed here.

**Measures of progress will be further refined during year 1 of implementation.*

CHIP EARLY IMPLEMENTATION AT A GLANCE 2018



MONITORING THE CHIP

PDPH will provide general oversight and monitoring of the CHIP's progress. Formal reports from key partners and initiatives will be collected at least twice each year. An annual report with updates on progress measures and progress towards the outlined objectives will be released publicly.

ACKNOWLEDGEMENTS

PDPH would like to thank all of its partners in the development of the 2018 -2022 CHIP:

AccessMatters	Health Partners Plans	Planned Parenthood of Southeastern Pennsylvania
Action Wellness	Health Promotion Council	Prevention Point
Aetna Better Health	Healthy Philadelphia	Project HOME, Stephen Kline Wellness Center
American Diabetes Association	Hepatitis B Foundation	Public Citizens for Children and Youth
American Heart Association	HIV/AIDS Regional Resource Network Program	Public Health Management Corporation
Aria Health	Intercultural Family Services, Inc.	Public Interest Law Center
Asociación Puertorriqueño en Marcha	Keystone First	Reinvestment Fund
Bebashi	Maternity Care Coalition	Safe Routes to School National Partnership
Bicycle Coalition of Greater Philadelphia	Mayor's Office of Community Empowerment and Opportunity	School District of Philadelphia
Black Women's Health Alliance	Mayor's Office of Education	SEAMACC
CDC Global Migration and Quarantine Station	Mayor's Office of LGBT Affairs	St. Christopher's Hospital for Children
Children's Hospital of Philadelphia	Mom's Clean Air Force	Street Smarts (Public Health Management Corporation)
Coalition of African Communities	National Nurse-Led Care Consortium	Temple University College of Public Health
College of Physicians	Office of HIV Planning	The Center for Returning Citizens
Delaware Valley Regional Planning Commission	Office of Homeless Services	The Consumer Satisfaction Team, Inc.
Department of Behavioral Health and Intellectual disAbility Services	Overbrook Environmental Education Center	The Food Trust
Department of Planning & Development	Pennsylvania Department of Environmental Protection	The Welcoming Center for New Pennsylvanians
Drexel University	Pennsylvania Department of Health	Thomas Jefferson University Hospital
Drexel University Dornsife School of Public Health	Philadelphia Association of Community Development Corporations	Thomas Scattergood Foundation
Einstein Healthcare Network	Philadelphia City Planning Commission	United Health
Esperanza Health Center	Philadelphia County Medical Society	United States Health and Human Services, Region III
Fairmount Park Conservancy	Philadelphia Department of Public Health	United Way
Forget Me Knot Youth Services	Philadelphia Housing Development Corporation	University of Pennsylvania, Center for Public Health Initiatives
Free Library of Philadelphia	Philadelphia Land Bank	Women Organized Against Rape
Greater Philadelphia Coalition Against Hunger	Philly Powered Ambassador	YMCA of Greater Philadelphia
Health Care Improvement Foundation		
Health Federation of Philadelphia		



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