Community Health Improvement Plan

2014-2018

City of Philadelphia

Annual Revision – June 2016

Compiled by the Philadelphia Department of Public Health
and the CHIP workgroups

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I. Overview

Philadelphia's Community Health Improvement Plan (CHIP) was developed through a year-long planning process led by the Philadelphia Department of Public Health (PDPH) and the Drexel University School of Public Health (Drexel). Over 160 stakeholders representing a diverse set of organizations and communities contributed to the plan. Ultimately, it was completed in May 2014 and includes three strategic priority areas and related goals, objectives, and strategies were developed.

Since May 2014, PDPH has disseminated the CHIP to local, state, and federal partners via electronic communications and presentations by the Health Commissioner and other departmental leaders. PDPH also identified chairpersons to lead implementation and monitoring workgroups for each of the three CHIP priority areas.

This document serves as the **2016 Annual Revision of the CHIP.** Revisions to this version of the CHIP include the re-framing of certain objectives and strategies, and updates to performance measures and indicators of progress. Annual CHIP Implementation and Evaluation Reports are available at: http://www.phila.gov/health/Commissioner/PHA.html.

Philadelphia CHIP Priorities and Goals

Priority 1: Access to Care	
Workgroup chairperson: Carol Rogers, Healthy Philadelphia	
Goal 1	Maximize implementation of the Affordable Care Act (ACA)
Goal 2	Maintain and grow the safety net regardless of the ACA and Medicaid expansion
Goal 3	Improve the quality of primary care services
Goal 4	Identify and take advantage of Medicaid waivers within the ACA that could improve access (e.g., health care home for chronic disease)
Priority 2: Behavioral Health	
Workgroup chairperson: Natalie Levkovich, Health Federation of Philadelphia	
Goal 1	Increase the accessibility and use of high quality behavioral health services
Goal 2	Increase the availability and use of high quality behavioral health services for at-risk children
Goal 3	Support behavioral health and primary care integration
Goal 4	Increase practical understanding of the prevalence of ACEs/trauma in the population, the impact of trauma, trauma-informed practice, resilience and availability of trauma treatment into behavioral health and medical practice
Priority 3: Chronic Disease related to Poor Diet and Physical Inactivity	
Workgroup co-chairs: Christina Miller, Health Promotion Council and Sara Solomon, University of Pennsylvania, Center for Public Health Initiatives	
Goal 1	Increase access to healthy foods
Goal 2	Increase physical activity among children and adults
Goal 3	Further the integration of nutrition and physical activity promotion with clinical practice
Goal 4	Improve knowledge of and access to evidence-based community resources

A. Community Values and Guiding Principles

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

1. Improving health requires both *programmatic* and *policy* solutions.
2. Improving health requires strong coordination between *public health* and *health care.*
3. Understanding the role of *social determinants of health* is critical to improving health outcomes.
4. All interventions to improve health in Philadelphia must address the stark *racial and ethnic health disparities* that exist.
5. Address issues that require, or would benefit from, *collective action*.
6. 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.

B. The Health of Philadelphia

The CHIP process was guided by data on the health of Philadelphians. Philadelphia is the fifth largest city in the U.S. with a population of 1.5 million. Philadelphia's population peaked in 1950 at 2.2 million and decreased steadily for the next 60 years until 2010, when the city saw a small increase. It is the poorest of the 10 largest cities with approximately 30% of all residents and nearly 40% of children living below the federal poverty level. Philadelphia is diverse: 42% of the population is Black; 37%, White; 12%, Hispanic; 6%, Asian. Nearly 1 in 5 Philadelphia births in 2011 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, child asthma hospitalizations, adult uninsurance, and adults with mental health conditions have increased consistently since 2000. The infant mortality rate is 10 deaths per 1,000 live births, and 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 18 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, rat complaints, and homicide. (Philadelphia's Community Health Assessment, September 2015)

II. The CHIP Process

A. Roles and Timeline

Following the principles and guidelines of MAPP, as well as other City and County CHIP models and processes, PDPH implemented a four-stage CHIP Development Process. The planning process was conducted as a partnership between PDPH and the Drexel University School of Public Health, Center for Public Health Practice. 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 weekly throughout the process, continuously refining and improving it as it unfolded.

CHIP Process: Roles and Timeline		
Activity	**Project Lead**	**Timeline**
Formulation of planning framework and identification of stakeholders	PDPH	April-May 2013
Stage 1: Sharing data and identifying key planning themes through 13 stakeholder meetings	Drexel/PDPH team	May-November 2013
Stage 2: Priority setting process	Drexel	December 2013-January 2014
Stage 3: Development of Goals, Objectives and Strategies	Drexel CHIP Workgroups	February-April 2014
Stage 4: Action Plan and Implementation	PDPH CHIP Workgroups	May 2014 and ongoing

B. CHIP Planning Framework

The Drexel/PDPH project team used a modified MAPP (Mobilizing for Action through Planning and Partnerships) process to create a four-stage planning process to develop Philadelphia's CHIP. Key MAPP elements that were emphasized in the process include:

- ***Organizing***: Broad community 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 priority workgroups.
- ***Action Cycle*** links three activities—Planning, Implementation, and Evaluation.

Using this modified MAPP process, the planning team convened 13 stakeholder meetings over the course of 7 months to present and get feedback on CHA data, hear themes and concerns about health in Philadelphia, and lay the groundwork to set public health priorities for the CHIP. The culminating

stakeholder meetings consisted of exercises used to determine the priorities for Philadelphia's CHIP. An electronic survey was made available for those who could not attend the priority setting meetings.

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, 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), a new ACA-mandated requirement of their non-profit status;
- **Community representation**, including community leaders and consumers of public health services (e.g., PDPH health center community boards);
- **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.

A full list of organizations and individuals engaged in the CHIP process can be found in the appendices.

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 18 sections, each reflecting a key public health issue, and the report concludes with an overview of public health assets. Slides are available at: http://www.phila.gov/health/Commissioner/pha.html.

Stakeholder meetings served as a second key source of information (see next section for details). Moreover, several strategies were used to supplement the information collected during the stakeholder meetings. First, a dedicated email account was created for the project and participants were encouraged to send comments if they thought of something after the meeting and/or wanted to contribute something they were not comfortable sharing in a large group. Second, in order to determine existing health priorities in Philadelphia, the CHIP team analyzed the annual reports and/or strategic plans of non-profit organizations, hospitals, and government agencies engaged in the CHIP process, as well as all available hospital CHNAs. Each plan was parsed for priorities relating to the interest areas highlighted in stakeholder meetings: access to care, built environment, cardiovascular disease, child health, environmental health, HIV/AIDS, maternal and infant health, obesity, teen reproductive health, tobacco and alcohol, and violence. The planning team also identified existing priorities relating to the social determinants of health and systems issues.

D. Stage One: Sharing data and identifying key planning themes

Stakeholder meetings

Between May and November 2013, the Drexel/PDPH team organized 13 stakeholder meetings that involved 180 participants. The meetings consisted of both established groups (e.g., Philadelphia Board of Health) and stakeholders that were convened based on their expertise with a particular topic (e.g., child health). The size of meeting groups varied from 5-75 persons, and meeting length ranged from 90-120 minutes. The full list of meeting topics/groups includes:

Philadelphia Community Health Improvement Plan Stakeholder Meetings
1. Smoke Free Philly (tobacco control) Coalition (May 15, 2013)
2. Medicaid Managed Care agencies (July 11, 2013)
3. Reproductive and Sexual Health (July 16, 2013)
4. Child Health (July 25, 2013)
5. Access to Care (August 5, 2013)
6. Philadelphia Board of Health (August 15, 2013)
7. HIV/STD (October 31, 2013)
8. African American Health (November 5, 2013)

9. Employers (November 7, 2013)
10. Health Center Board Members (November 14, 2013)
11. Food Fit Philly (obesity prevention) Coalition (November 15, 2013)
12. College of Physicians Section on Public Health (Nov 19, 2013)
13. Hispanic Health (November 25, 2013)

In advance of each meeting, the Drexel/PDPH team tailored the Community Health Assessment (CHA) data to meet the priorities and interests of each stakeholder group. For example, the child health meeting included a focused discussion of childhood asthma hospitalizations and infant mortality rates, while the access to care meeting discussed integration of chronic disease management and nutrition into primary care. The meetings began with a data presentation by Dr. Donald Schwarz (former Health Commissioner) and Dr. Giridhar Mallya (former PDPH Director of Policy and Planning), followed by a facilitated discussion led by Dr. Mallya and the Drexel team.

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

1. Did the CHA data offer any surprises?
2. Does the CHA data reflect what you see in your work out in the field?
3. Are there topics or data sources not currently in the CHA that should be included?
4. What do you see as aggressive but achievable public health goals for the next 3-5 years?
5. What should we be doing collectively to address the issues highlighted today?

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.

Upon completion of all the stakeholder meetings, session notes 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., tobacco), in addition to broader issues (e.g., access to care) 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 three categories: health issues, system challenges, and social determinants of health.

Themes from Stakeholder Meetings	
Health Issues	Chronic conditions related to obesity and tobacco, including adult hypertension and diabetes Infant and child health, including childhood asthma, infant mortality, and environments for children Behavioral health, including the link between mental health and physical health and the relationship between mental health and the management of chronic disease
System Challenges	Access to care at all points in the lifecycle Costs of care and insurance coverage Capacity to provide care to newly insured as well as maintaining the safety net Funding and political will for comprehensive public health actions
Social Determinants of Health	High rates of poverty in Philadelphia, often tied to race, and resulting in food insecurity, poor housing, underfunded public education, and barriers to access

The themes above were presented and discussed in-depth during the first priority-setting meeting held on December 9, 2013 (see below).

E. Stage Two: Development of Priorities

Following the stakeholder meetings, a set of priority setting meetings were held to identify three 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 December 2013. Those who were unable to attend were invited to participate in an electronic ballot.

Meeting 1- December 9, 2013

The first meeting was held on December 9, 2013, with 32 participants attending. The goals of the first priority setting meeting were to:

- Review the purpose of the CHIP planning process and resulting report
- Present the themes identified in the 13 stakeholder meetings and solicit feedback
- Discuss strategies for prioritization
- Conduct first round voting to assess the initial priorities of participants prior to formal voting on December 17, 2013. The voting forms included a comment section where participants could provide feedback on the planning process and identify elements that required clarification or improvement.

Several types of 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 table 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 (health issues/system challenges/social determinants), with facilitated discussion of each theme.
Quantitative representation of health issues (see Appendices)	A prioritization grid prepared by PDPH was presented to participants. It listed each health issue from the CHA and compared them across four categories: (1) leading cause of death ranking, (2) comparison to United States, (3) trend over time, and (4) racial/ethnic disparity. Based on CHA data, the health issues received a score for each category.

Meeting 2- December 17, 2013

The second meeting was held on December 17, 2013, with 40 participants attending. The goals of the second priority setting meeting were to:

- Review the content covered in the first meeting and highlight key feedback (described above) received during the meeting and via the comment cards;
- Discuss language and categorization challenges relevant to the list of health issues, with the goal of achieving agreement for voting;
- Complete voting process by narrowing list of health issues to top priorities that will be addressed in the CHIP.

Voting on Priorities

In-person voting. The Multi-voting Technique was utilized to narrow down a list of 10 health issues. (The tool was based on a NACCHO best practice: http://www.naccho.org/topics/infrastructure/CHAIP/upload/Final-Issue-Prioritization-Resource-Sheet.pdf). Meeting participants were asked to vote for their top 3 health issues. After two rounds of voting, the list was sufficiently reduced. The results were not announced during the meeting because they would be combined with electronic voting (for stakeholders who could not attend in person) before a priority list for the CHIP was finalized.

Electronic voting: Following the in-person meeting and voting, an electronic poll was developed and sent via email to all stakeholders. They were instructed to vote only if they were not in attendance at the priority setting meetings. The poll was open for a 2-week window, during which 40 people participated. These votes were combined with the votes cast in person at the December 17, 2013 meeting.

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

1. Access to care, particularly primary care;
2. Behavioral health;
3. Chronic diseases related to poor diet and lack of physical activity.

Results of the final priority setting process were communicated to all participants in early January 2014.

F. Stage Three: Creating the Plan

Convening the Workgroups

Once the three priorities were identified, stakeholder participants were recruited to join three workgroups (one for each priority area) to meet between early February and April 2014. The workgroups were tasked with developing goals for each priority area and objectives and strategies for each goal. Each of the workgroups followed the same operating guidelines and structure, incorporating the overarching values and guiding principles into their work. A list of the most current membership on each of the three workgroups is included in the annual implementation and evaluation reports.

Developing the CHIP: Workgroup Process and Tasks	
1. Review of workgroup charge	Develop three to five overarching goals and a set of objectives, strategies and measures, for which progress could be made in the next three to five years. Identify policy and regulatory actions to achieve goals.
2. Review and discussion of data from the CHA	Each workgroup reviewed the CHA data specific to their priority area. Since behavioral health was not covered in depth in the CHA, a special data presentation from the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) was made at the first behavioral health workgroup meeting.
3. Review and discussion of themes from the CHIP planning process and other data gathering	Workgroup members reviewed and discussed the common themes and issues from the stakeholder and priority setting meetings.
4. Overall discussion of the priority area and consensus on goals	Following robust discussion of the data and themes, each workgroup agreed upon on three to five preliminary goals for their priority area. This task proved to be less challenging than anticipated, in large part because the planning and priority

Developing the CHIP: Workgroup Process and Tasks	
	setting process and data from the CHA and other sources clearly pointed to key areas of focus.
5. Finalization of goals	Following the setting of goals, the Drexel team sent out detailed notes and asked for written feedback, which were then incorporated into a working document for each group. From there—both in meetings and via e-mail—each group finalized their three to five overarching goals.
6. Development of objectives and strategies; identification of partners	Once the goals were determined, the Drexel team created a working table of goals, strategies, and measures, which were distributed to each workgroup. Members filled in blank cells, suggested additional strategies, and finalized the priority table for each group.
7. Finalization of the CHIP	Each workgroup developed objectives, strategies, and partners for each goal. In addition, each group identified a set of policy/advocacy strategies that would help to achieve the overall goals within each priority area. Overarching measures of success and indicators of progress were determined. A draft CHIP was sent to all workgroup members for final approval in mid-April.

G. Stage Four: Implementation Plan and Next Steps

The final component of the CHIP is the development of an Action Plan and implementation of strategies. Implementation will draw upon the existing workgroups, with outreach to additional partners and organizations. The Action Plan will use existing taskforces or coalitions where possible maximize existing efforts in each priority area with a set schedule for monitoring and measuring progress. Implementation steps include:

CHIP Implementation Plan	
June 2014	Broad dissemination of CHIP • Post CHIP on PDPH website • Disseminate CHIP to all workgroup and CHIP participants • Disseminate CHIP to stakeholder networks and encourage further dissemination to engage additional partners
July 2014	Identify locus of activity and leadership for priority area: • Members of the Access to Care workgroup, as well as additional partners from Federally Qualified Health Centers (FQHCs) and other organizations have begun to meet regularly to address some of the goals in the CHIP and will determine a more formal structure for inclusion of the remainder of those strategies.

CHIP Implementation Plan	
	• The Behavioral Health workgroup and partners are already engaged in many of the activities articulated in the CHIP and their work will be formalized moving ahead. • Philadelphia's Food Fit Philly Coalition will serve as the key coordinating body related to Chronic Disease. Recruitment of additional partner organizations and reaffirm specific strategies. Document baseline values for all indicators.
August 2014 and ongoing	Convene workgroups quarterly to monitor implementation Develop systems for documenting progress and changes in indicator data.
December 2014	Develop 2014 year-end report
December 2015	Develop 2015 year-end report

III. CHIP Priorities, Goals, Objectives and Strategies

A. Summary of Goals

The table below lists the goals for each priority area. The sections that follow detail each priority area, its goals, objectives, and strategies, and identify key policy and system actions needed to achieve many of these goals. CHIP goals were aligned Healthy People 2020 goals and objectives where appropriate.

Philadelphia CHIP Priorities and Goals

Priority 1: Access to Care	
Workgroup chairperson: Carol Rogers, Healthy Philadelphia	
Goal 1	Maximize implementation of the Affordable Care Act (ACA)
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Goal 3	Further the integration of nutrition and physical activity promotion with clinical practice
Goal 4	Improve knowledge of and access to evidence-based community resources

B. Priority One: Access to Care

The CHIP planning process identified *Access to Care* as a priority for Philadelphia. Access to care was a constant theme throughout the stakeholder process, and its choice as a priority for the CHIP reflects the recognition that access to care influences each of the other priority areas, as well as the other health issues identified in the Community Health Assessment.

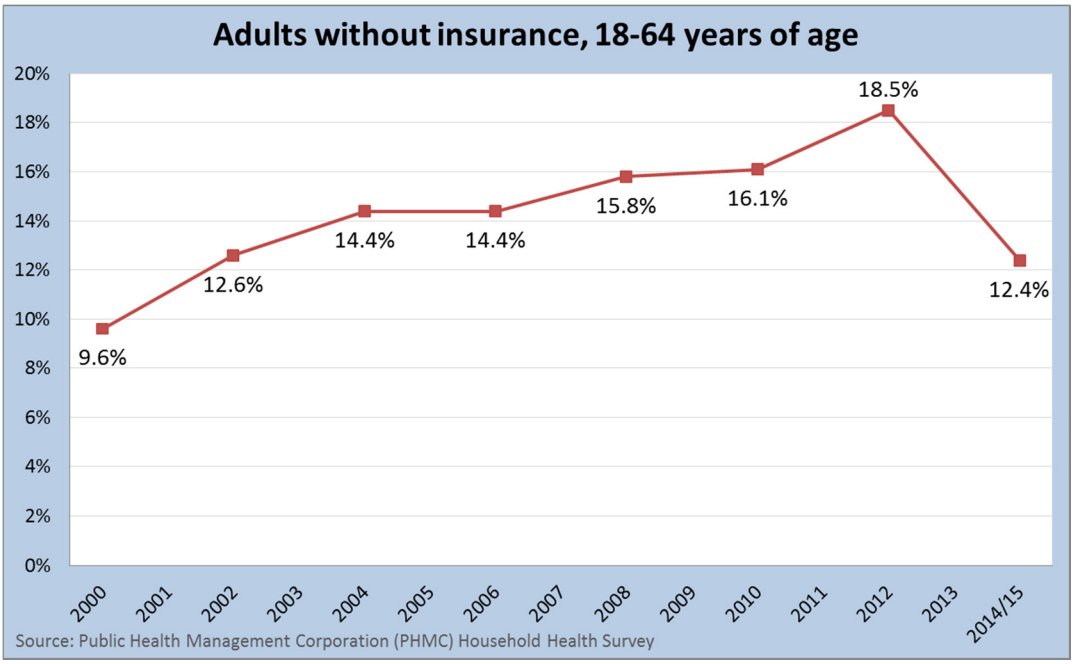
It is widely known that access to health insurance is linked to overall health and well-being. Nationally, over half of uninsured adults have no regular source of health care to go to when they are sick, and they are more than twice as likely to delay or forgo needed care as the insured. The uninsured are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases.[1] Therefore, the Access to Care strategies all revolve around increasing access to and quality of primary care services.

Healthy People 2020 defines 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. Healthy People's 2020 goal around Access to Health Services is *to improve access to comprehensive, quality health care services.* Specific Healthy People objectives that align with Philadelphia's CHIP include:

- AHS-1: Increase the proportion of persons with health insurance
- AHS-2: Increase the proportion of insured persons with coverage for clinical preventive services
- AHS-3: Increase the proportion of persons with a usual primary care provider
- AHS-4: (Developmental) Increase the number of practicing primary care providers

Philadelphia's CHA showed that the rate of adult uninsurance and the number of adults forgoing care due to cost have increased over time, with Hispanics bearing the heaviest burden in both of those indicators. While rates of children's uninsurance have improved, there are still areas of child health (e.g., asthma hospitalizations) in which improving access to care will likely improve child health.

[1] http://kff.org/health-reform/fact-sheet/the-uninsured-and-the-difference-health-insurance/


Adults without insurance, 18-64 years of age
20%
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%
9.6%
12.6%
14.4%
14.4%
15.8%
16.1%
18.5%
12.4%
2000
2001
2002
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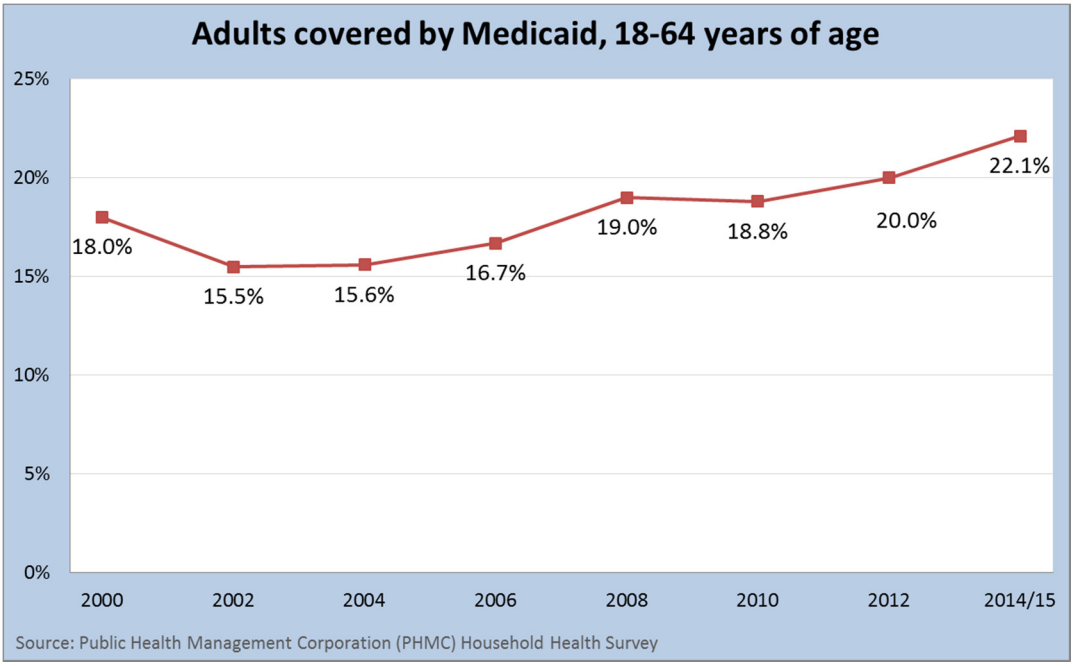
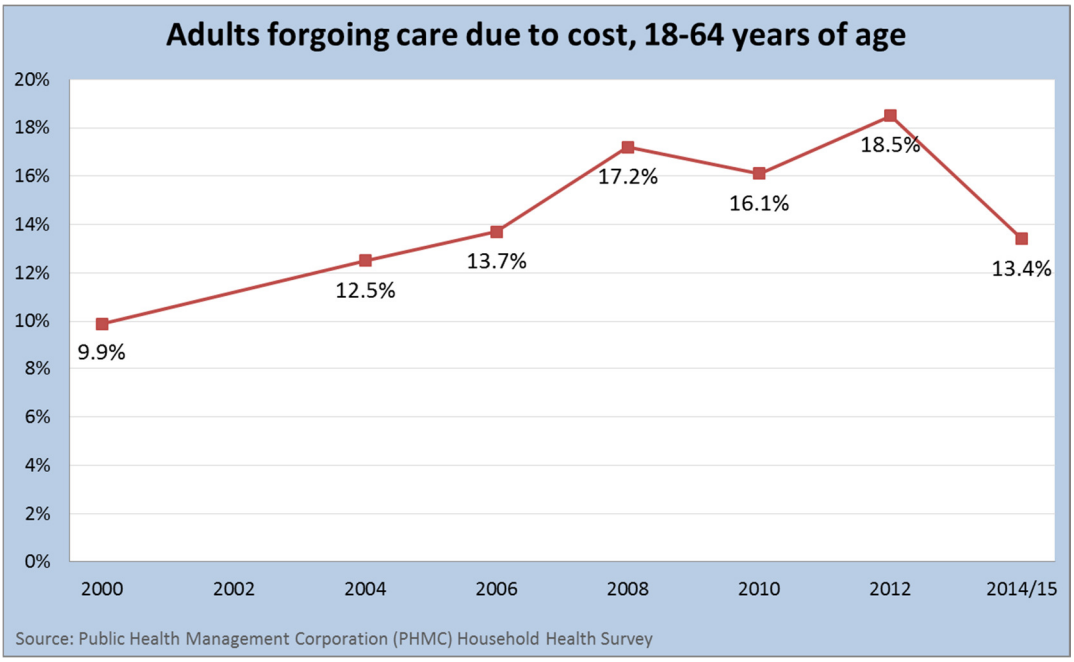
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014/15
Source: Public Health Management Corporation (PHMC) Household Health Survey


Adults covered by Medicaid, 18-64 years of age
25%
20%
15%
10%
5%
0%
18.0%
15.5%
15.6%
16.7%
19.0%
18.8%
20.0%
22.1%
2000
2002
2004
2006
2008
2010
2012
2014/15
Source: Public Health Management Corporation (PHMC) Household Health Survey



Philadelphia's health care safety net is comprised of more than 35 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) and the Public Health Management Corporation (PHMC) 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 has three goals related to Access to Care. These goals primarily focus on access to and improvement of the quality of primary care within the publicly funded setting, 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.

1. **Maximize implementation of the provisions of the Affordable Care Act (ACA) that impact access to care.** The insurance provisions within the ACA have the potential to significantly decrease the uninsurance rate for Philadelphians. However, this will only be fully realized if ACA implementation includes Medicaid expansion in Pennsylvania and efficient enrollment of all individuals who are eligible for insurance.

2. **Maintain and grow the health care safety net, regardless of the ACA and the status of Medicaid expansion**. While the ACA will increase the number of Philadelphians with insurance, there are many individuals who will remain without access to care. Reasons include: not

enrolling in insurance in a timely manner; lack of plan affordability; immigration status; and an insufficient number of providers who accept Medicaid. Therefore, maintenance of the health care safety net remains critical to ensure access to care for all Philadelphians.

3. **Improve the quality of primary care services.** The workgroup identified the improvement of quality of care in primary care settings as a priority for Philadelphia. Regardless of insurance status and primary care setting, there is room for quality improvement in primary care.

Additionally, the Access to Care group identified several areas requiring policy and advocacy action, including expansion of Medicaid in Pennsylvania and advocating for systems changes to improve quality of care in publicly funded community health centers.

Priority 1: Access to Care					
Measures of Success					
Measure		**Baseline**	**2014**	**2015**	**2018 Target**
Reduce the percentage of adults without health insurance		18.5% (CHDB, 2012)[2]	Data will be available in 2015	12.4% (CHDB, 2014-15)	13%
Reduce the percentage of adults forgoing care due to cost		18.5% in 2012 (CHDB, 2012)	Data will be available in 2015	13.4% (CHDB, 2014-15)	13%
Indicators of Progress					
Indicator	**Relevant Goal**	**Baseline**	**2014**	**2015**	**2018 Target**
Number of eligible Philadelphians enrolled in health insurance exchanges	1, 2	TBD	60,724	75,076	75.000
Percentage of uninsured with regular source of care	2	65% (CHDB, 2012)	Data will be available in 2015	64% (CHDB, 2014-15)	85%
Percentage of adults receiving preventive services and screening -Colon cancer screening (50-74 years, colonoscopy or sigmoidoscopy in lifetime) -Breast cancer screening (50-74 years, women, mammogram in last 2 years)	1, 2, 3	75% (CHDB, 2012) 83% (CHDB, 2012)	Data will be available in 2015 Data will be available in 2015	72.6% (CHDB, 2014-15) 82.5% (CHDB, 2014-15)	85% 90%

[2] CHDB=Community Health Database, FQHCs=Federally Qualified Health Centers, PDPH=Philadelphia Department of Public Health

Goals, Objectives, Strategies, and Partners		
Goal 1: Maximize implementation of the Affordable Care Act		
Objectives	**Strategies**	**Partners/Leaders**
1. Maximize enrollment of eligible Philadelphians in health insurance exchanges and ensure consumer knowledge of all exchange options.	a) Maintain and strengthen the Navigator/Assister workforce. (Year 1) b) Identify ongoing funding for Navigators. (Years 2-3) c) Train health care and social providers on enrollment and navigation of Exchanges. (Years 2-3) d) Engage tax prep organizations and attorneys to help address tax issues resulting from exchange enrollment. (Year 2-3)	Existing navigator and assister organizations, Federally Qualified Health Centers (FQHCs) and other primary care providers, hospitals, non-profit public health organizations, immigrant assistance groups, insurers
2. Ensure adequacy of health plan options	a) Monitor rates, cost-sharing, provider networks, and consumer complaints against payers. (Years 2-5) b) Create mechanism for regular engagement with insurers to negotiate issues related to the exchanges and insurance options. (Years 2-3)	Public health advocacy organizations, insurers, FQHCs, PDPH
3. Ensure/increase capacity of primary care providers	a) Develop system to monitor wait times for primary care (Years 1-2) b) Support recruiting of qualified providers for safety net settings. (Years 2-5) c) Increase provider collaboration through provider associations, ACO models, and health information exchanges. (Year 3-5)	Advocacy organizations, insurers, FQHCs, PDPH

Goal 2: Maintain and grow the safety net regardless of the ACA and Medicaid expansion		
Objectives	**Strategies**	**Partners/Leaders**
1. Ensure geographic availability and distribution of safety net health care services.	a) Engage in stakeholder driven, data-based planning process for funding new health services in areas of need. (Years 3-5)	PDPH, FQHCs, HRSA Region III leadership, Healthy Philadelphia
2. Ensure availability for underserved populations, particularly undocumented immigrants.	a) Develop a system to better distribute uninsured patients to safety net providers based on need and availability. (Years 2-3) b) Monitor safety net system for capacity and equity. (Years 3-5)	Community organizations serving undocumented immigrants, PDPH, primary care safety net providers, Healthy Philadelphia
Goal 3: Improve the quality of primary care services		
Objectives	**Strategies**	**Partners/Leaders**
1. Develop and use quality of care indicators in Philadelphia's publicly funded community-based primary care providers	a) Select key indicators from HEDIS, HP 2020, and/or Meaningful Use measures for use by primary care centers. (Years 1-2) b) Develop health center capacity and structure to increase real-time reporting of clinical quality data beyond current requirements. (Years 3-5)	FQHCs, PDPH, insurers
2. Improve rates of preventive care screening and follow-up treatment.	a) Increase knowledge among providers and patients about ACA-related preventive care coverage and copays (e.g., -colonoscopy, mammogram, etc.). (Years 2-3)	FQHCs, primary care providers, hospital providers, PDPH, non-profit public health organizations
3. Improve inter- and intra-systemic communication among agencies/organizations that serve vulnerable populations.	a) Explore data-sharing between PDPH, DBHIDS, CBH, DHS, CUAs, courts, prisons, hospitals, non-profit health and social services organizations. (Years 2-5)	PDPH, DBHIDS, CBH, DHS[3], community organizations, insurers

[3] DBHIDS-Department of Behavioral Health and Intellectual disAbility Services, CBH-Community Behavioral Health, DHS-Department of Human Services

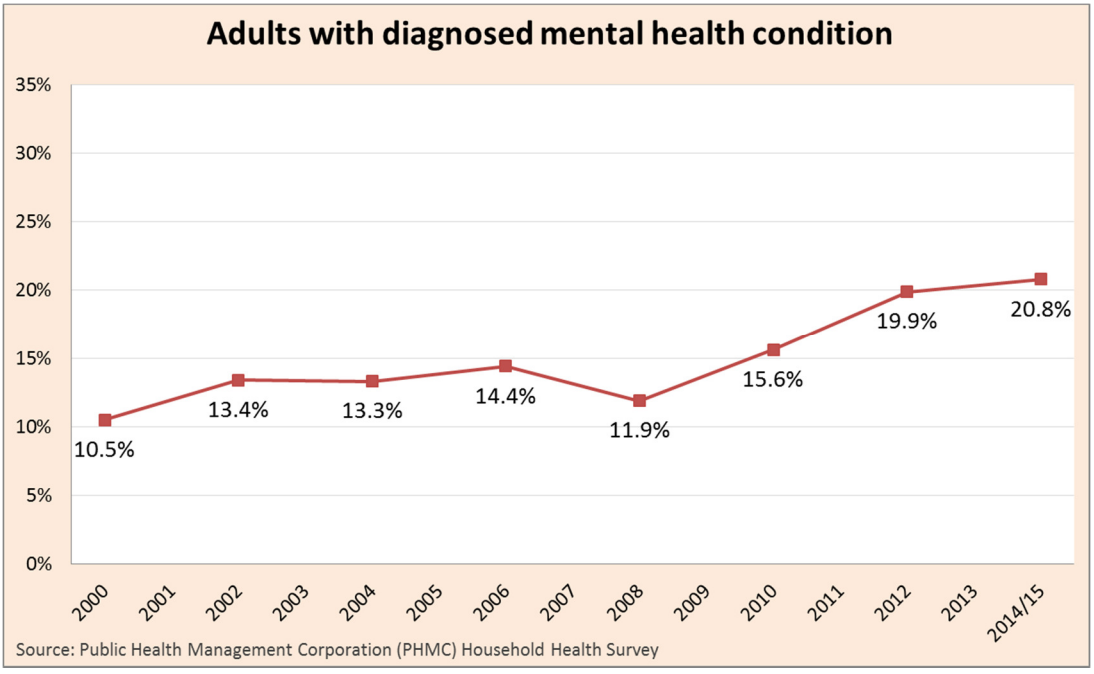
Policy, Advocacy, and Regulatory Strategies	
1. Identify and take advantage of *Medicaid waivers* within the ACA that could improve access (e.g., health care home for chronic disease). There are several Medicaid-waivers in the ACA language that have the potential to improve both access to and quality of care. Advocating that the Commonwealth pursue these waivers could have a positive impact on the health of Philadelphians.	FQHCs, primary care providers, hospital providers, PDPH, non-profit public health organizations

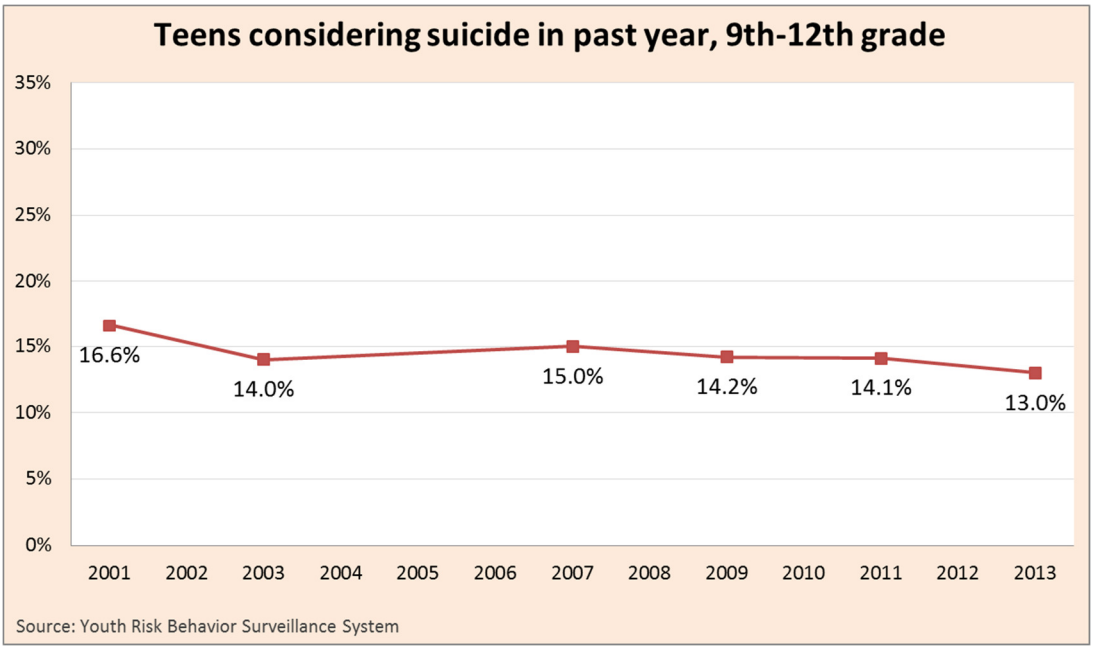
C. Priority Two: Behavioral Health

The second priority area for the CHIP is Behavioral Health—specifically, issues related to mental health and substance abuse. Healthy People 2020 defines mental health as a *state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges.* Relatedly, *substance abuse—involving drugs, alcohol, or both—is associated with a range of destructive social conditions and contributes to a number of negative health outcomes and public health problems.* Healthy People's 2020 goal for Mental Health is to *improve mental health through prevention and by ensuring access to appropriate, quality mental health services.* Healthy People objectives aligned with the CHIP include:

- MHMD-2: Reduce suicide attempts by adolescents
- MHMD-4: Reduce the proportion of persons who experience major depressive episodes
- MHMD-5: Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral
- MHMD-6: Increase the proportion of children with mental health problems who receive treatment
- MHMD-9: Increase the proportion of adults with mental health disorders who receive treatment

Philadelphia's CHA shows that adult mental health is one of the indicators that has worsened over time, with Hispanic adults and teens showing poorer mental health status than other racial/ethnic groups in the city. In addition, while showing some improvement over time, 13 percent of teenagers report considering suicide in the past year.





Mental health services in Philadelphia are organized through two overarching entities: 1) the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), the agency within City government responsible for providing services while collaborating with the Philadelphia School District, child welfare and judicial systems, and other stakeholders; and 2) Community Behavioral Health (CBH), the Philadelphia's behavioral health managed care company under Pennsylvania's HealthChoices program. Community Behavioral Health is responsible for providing behavioral health coverage for the City's 420,000 Medicaid recipients through a vast network of public and private providers.

In addition to direct service delivery, several organizations are engaged in advocacy and leadership in mental health. For example, the Health Federation of Philadelphia (HFP) has been actively engaged in the development of training and infrastructure to further the integration of behavioral health in primary care. Public Citizens for Children and Youth (PCCY), a children's advocacy organization, has dedicated staff devoted to issues of children's mental health.

The CHIP has four goals related to Behavioral Health. Like Access to Care, these are focused on those providers serving the Medicaid and uninsured populations, though lessons learned will hopefully be integrated more fully into the private sector over time:

1. **Increase the availability and use of high quality behavioral health services for all Philadelphians**. While Philadelphia has a robust delivery system of behavioral health care, the Behavioral Health workgroup identified several areas of needed improvement in the availability and use of behavioral health, particularly in those populations with a clear pattern of underuse.

2. **Increase the availability and use of high quality behavioral health services for at-risk children in Philadelphia**. While also contained in Goal 1, the workgroup identified clear areas where children's Behavioral Health required a separate set of objectives and strategies to improve children's access of services, particularly recognizing the different systems (e.g., child care, schools) that are best used to identify and treat children with behavioral health needs.

3. **Support behavioral health and primary care integration.** Several organizations in Philadelphia —largely representing FQHCs and behavioral health providers—have been at the forefront of developing protocols and structures for integration of behavioral health with primary care. The workgroup identified several strategies and objectives for furthering this work.

4. **Increase practical understanding of the prevalence of ACEs/trauma in the population, the impact of trauma, trauma-informed practice, resilience and availability of trauma treatment into behavioral health and medical practice.** Adverse Childhood Events, or ACEs/trauma have been shown to have a clear impact on future physical and behavioral health. Additionally, there has been an increase in understanding of the role that life experience plays in overall health. Furthering that knowledge and understanding, and incorporating that into primary care and behavioral health practice, is important to improving the overall behavioral health of Philadelphians.

Finally, the Behavioral Health workgroup identified necessary policy and regulatory changes to achieve these goals, particularly regarding state reimbursement for certain services and integration, and improved funding for training and infrastructure development.

The basis for many of the Behavioral Health strategies are derived from The Guide to Community Preventive Services (the Community Guide), section on Collaborative Care for Depression as well as the 2005 IOM report Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Both of these documents include goals and strategies on care collaboration, increasing capacity and workforce, and better development and use of quality data measures.

Priority 2: Behavioral Health					
Measures of Success					
Measure		**Baseline**	**2014**	**2015**	**2018 Target**
Increase the percentage of adults with a diagnosed mental health condition who are receiving care		61% (CHDB, 2012)	Data will be available in 2015	65.1% (CHDB, 2014-15)	75%
Indicators of Progress					
Indicator	**Relevant Goal**	**Baseline**	**2014**	**2015**	**2018 Target**
Number of individuals trained in Mental Health First Aid	1,2	5,000 (DBHIDS, 2014)	6,000	11,730	25,000
Percent of FQHCs that integrate behavioral health specialists into team-based care	3	~40%	TBD	83%	60%
Goals, Objectives, Strategies, and Partners					
Goal 1: Increase the availability and use of high quality behavioral health services for all Philadelphians					
Objectives	**Strategies**			**Partners/Leaders**	
1. Increase awareness of mental illness among the public and use of existing services.	a) Provide Mental Health First Aid training to individuals and organizations. (Years 1 – 5)			CBH, DBHIDS, community mental health providers, School District, mental health advocacy groups	
2. Increase awareness of how to access care.	a) Implement large scale initiatives to promote access to care. (Years 2 – 5)			CBH, DBHIDS, HFP, mental health advocacy groups	
3. Assess quality of services provided.	a) Identify quality metrics to be reported by behavioral health providers and number of providers reporting quality metrics. (Years 2-3) b) Expand number of metrics and number of providers reporting quality metrics. (Years 3 – 5) c) Track number of providers trained in Evidence-Based Practices (EBPs). (Years 1– 5) d) Track number of consumers benefiting from EBPs. (Years 2-5)			Mental health providers, FQHCs, CBH, DHBIDS, mental health advocacy groups	

	e) Track consumer satisfaction (using up to three measures). (Years 1 – 5) f) Identify neighborhoods in need of expanded access. (Years 2—5)	
Goal 2: Increase the availability and use of high quality behavioral health services for at-risk children in Philadelphia		
Objectives	**Strategies**	**Partners/Leaders**
1. a) Improve the availability and utilization of behavioral health services for very young (0-5 years) children. b) Improve availability and utilization of behavioral health services for children and youth ages 6 – 19.	a) Promote routine screening of children and youth for a full range of developmental, behavioral, and social risks/deficits in primary care. (Years 3-5) b) Provide a full range of services for prevention, treatment, and harm reduction. (Years 3-5)	DBHIDS mental health providers, pediatric practices, childcare providers, School District
2 Assure that behavioral health providers are able to meet the maximum wait time for children.	a) Track wait time for initiation of treatment. (Years 1 – 5) b) Develop mechanism for referral if not able to meet deadline and track impact. (Years 3 – 4)	CBH, insurers, DBHIDS
3. Assess and improve the quality of services provided.	a) Offer training to providers in evidence-based assessment and therapeutic treatment model(s). (Years 2-5) b) Develop shared quality metrics for public and private behavioral health providers; develop mechanism for sharing of collected data. (Years 1-3; 3-5) c) Disseminate known evidence based practices in children's behavioral health [e.g., family based, Parent Child Interaction Therapy (PCIT), Trauma Focused Cognitive Behavioral Therapy (TF-CBT) Child Parent Psychotherapy CPP]. (Years 2-5)	Mental health providers, pediatric providers, FQHCs, CBH, DHBIDS, mental health advocacy groups
4. Increase the knowledge base of mental health among child- and adolescent-serving professionals	a) Offer training to child-serving professionals to be trained in trauma informed practice and related topics.	DBHIDS, mental health providers, childcare providers, School District

(e.g., early childhood educators, teachers, counselors).	b) Offer providers coaching and technical assistance in behavioral management techniques that are empirically informed and tailored to the specific service setting. (Years 3-5)	
Goal 3: Support behavioral health and primary care integration		
Objectives	**Strategies**	**Partners/Leaders**
1. Increase the knowledge, skills and ability of behavioral health and primary care providers to coordinate care.	a) Develop and/or promote training, technical assistance and resources for providers to coordinate physical and behavioral health care. (Years 1-5)	CBH, DBHIDS, FQHCs, HFP, primary care providers, PDPH, national organizations
2. Expand Behavioral Health Consultation model for integration of behavioral health into primary care and other medical settings.	a) Review regulatory and funding mechanisms to promote implementation and sustainability. b) Explore collaboration between BH and medical payers. c) Identify and track outcome measures for utilization and impact of services on physical and behavioral health. (Years 1-5)	CBH, DBHIDS, FQHCs, HFP, primary care providers, PDPH, national organizations
Goal 4: Increase practical understanding of the prevalence of ACEs/trauma in the population, the impact of trauma, trauma-informed practice, resilience and availability of trauma treatment into behavioral health and medical practice		
Objectives	**Strategies**	**Partners/Leaders**
1. Increase the number of professionals who understand: the impact of trauma, adversity and toxic stress; intergenerational transmission of trauma (i.e., life course perspective); and integration of knowledge into clinical practice.	a) Offer conferences and trainings to share the ACEs and related research targeted to specific service systems. (Years 2-5) b) Offer conferences and trainings on promising models to mitigate harm and promote healing. (Years 2 – 5) c) Spur dissemination and adoption/adaptation of protocols for use in clinical practice. (Years 3-5) d) Identify opportunities to disseminate related information appropriate to human service providers and the general public. (Years 3 – 5)	PDPH, HFP, Drexel, children's hospitals, ACEs Task Force

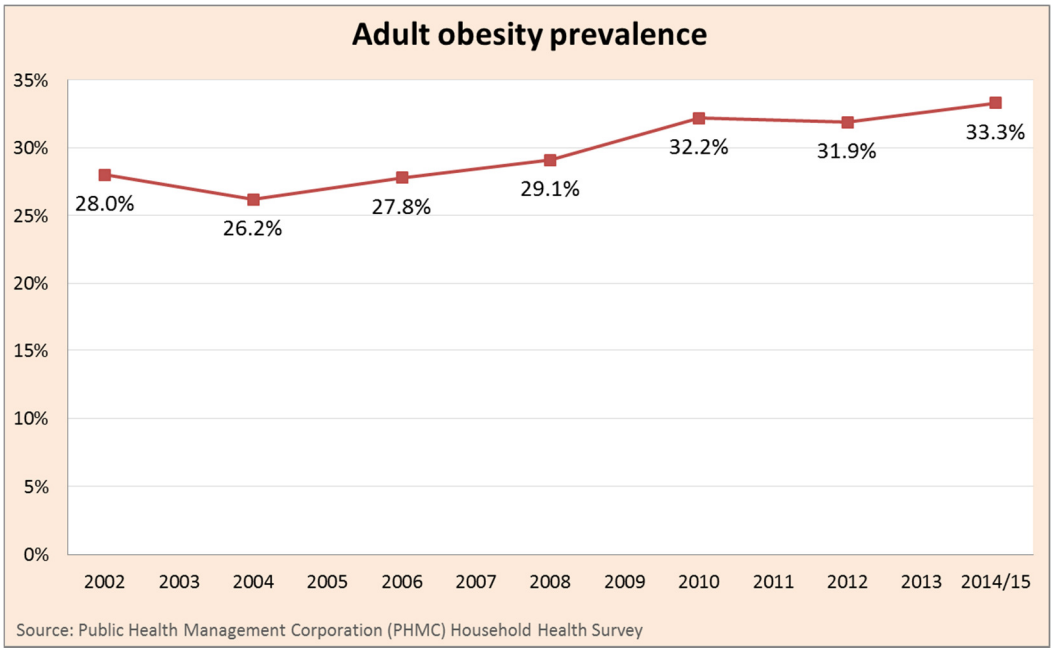
Policy, Advocacy, and Regulatory Strategies	
Strategies	**Partners/Leaders**
1. Promote collaboration among public and private partners to identify and advocate for reforms and strategies (e.g., innovations in licensing, payment and other regulatory mechanisms) that reduce barriers to integrated health care such as workforce supply, sustainability, information sharing, etc.	CBH, DBHIDS, FQHCs, HFP, primary care providers, PDPH, State

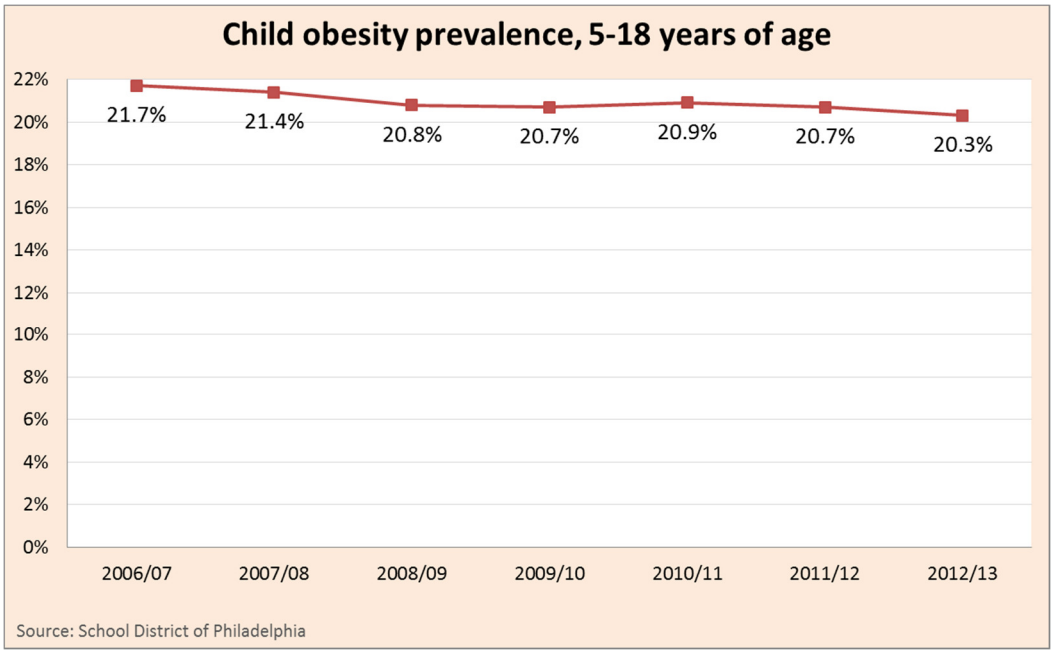
D. Priority Three: Reducing Chronic Disease Related to Poor Diet and Physical Inactivity

The third CHIP priority is reducing chronic disease related to poor diet and physical inactivity, such as obesity, diabetes, and hypertension. Healthy People 2020 prioritizes increasing the number of Americans who maintain a healthy weight, stating that…*Individuals who are at a healthy weight are less likely to develop chronic disease risk factors, such as high blood pressure and dyslipidemia… develop chronic diseases, such as type 2 diabetes, heart disease, osteoarthritis, and some cancers; experience complications during pregnancy; die at an earlier age.* An individual's ability to maintain a healthy weight is influenced by his/her level of physical activity and the nutritional quality of his/her diet. The Healthy People goal for Nutrition and Weight status is to *promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights.* The Healthy People Goal for Physical Activity is to *Improve health, fitness, and quality of life through daily physical activity.* Healthy People objectives aligned with the CHIP include:

- NWS-1: Increase the number of States with nutrition standards for foods and beverages provided to preschool-aged children in child care
- NWS-5: Increase the proportion of primary care physicians who regularly measure the body mass index of their patients
- NWS-8: Increase the proportion of adults who are at a healthy weight
- NWS-10: Reduce the proportion of children and adolescents who are considered obese
- PA-2: Increase the proportion of adults who meet current Federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity
- PA-3: Increase the proportion of adolescents who meet current Federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity
- PA-9: Increase the number of States with licensing regulations for physical activity provided in child care

Philadelphia's CHA shows high rates of obesity in both children and adults. Nearly 33 percent of adults in Philadelphia are obese. While there has been a recent decline in childhood obesity, 20.3% of children in 5-18 years old are obese.





The workgroup process focused on the need for better access to healthy foods and safe outdoor spaces, connecting residents to existing resources for healthy foods and physical activity, integrating prevention strategies into primary care, and supporting employer-based health initiatives.

Philadelphia has significant resources dedicated to healthy eating and physical activity. The Food Fit Philly Coalition serves as the key coordinating body related to obesity prevention. The Coalition was founded in 2010 and includes over 100 members representing non-profit agencies, school and

afterschool providers, universities, health care providers and payers, food retailers, youth advocates, and governmental housing, transportation, and planning agencies.

The CHIP has four goals related to reducing chronic disease associated with poor diet and lack of physical activity:

1. **Increase access to healthy food.** Through the Get Healthy Philly initiative, Philadelphia has made recent strides in the availability and accessibility of healthy foods. The workgroup recognized the need to continue this work, as well as develop strategies to engage additional locations and population groups, particularly employers and childcare settings.

2. **Increase physical activity among children and adults.** As with healthy eating, there have been several initiatives to improve physical activity in Philadelphia. Workgroup members emphasized the need to better engage employers and to further the reach of physical activity initiatives into underserved neighborhoods in Philadelphia.

3. **Further the integration of nutrition and physical activity promotion with clinical practice.** In keeping with one of the CHIP guiding principles, the workgroup discussed the need to bring together public health with clinical management of chronic disease through training, dissemination of best practices, and increasing provider knowledge of community resources.

4. **Improve knowledge of and access to evidence based community resources.** The sheer number of programs and initiatives for this priority area reinforced the need for strategies to insure that all Philadelphians—residents, clinicians, employers, educators, etc.—are aware of the wealth of community resources to improve healthy eating and increase physical activity as a means to an overall reduction in chronic disease.

Finally, this workgroup also identified policy and regulatory actions, including incentives to reduce consumption of sugar-sweetened beverages, and regulatory actions to increase physical activity in schools and licensed childcare settings.

The goals and strategies for this section are consistent with the evidence base in *The Community Guide* sections on worksite obesity programs, school-based programs (which can be adapted for child care settings), community physical activity programs and policy and environmental strategies to reduce obesity.

Priority 3: Chronic Disease Related to Poor Diet and Physical Inactivity					
Measures of Success					
Measure		**Baseline**	**2014**	**2015**	**2018 Target**
Reduce the percentage of adults who are obese		31.9% (CHDB, 2012)	Data will be available in 2015	33.3% (CHDB, 2014-15)	28%
Reduce the percentage of children <18 years old who are obese		20.7% (School District, 09-10)	20.3% (School District, 12-13)	TBD	17%
Indicators of Progress					
Indicator	**Relevant Goal**	**Baseline**	**2014**	**2015**	**2018 Target**
Adults drinking one or more sugary drinks daily	1	37.4% (CHDB, 2010)	35.4% (CHDB, 2012	31.6% (CHDB, 2014-15)	25%
Teens, 9th-12th grade, drinking one or more sugary drinks daily	1	28.0% (YRBS, 2009)	25% (YRBS, 2011)	23.7% (YRBS, 2014)	19
Number of institutions including nutrition standards in food contracts	1	0 (PDPH, 2013)	1 (PDPH, 2014)	7 (PDPH, 2015)	14
Number of schools participating in safe routes to school encouragement activities	2	8 (14 events) (PDPH, OTIS, 2013)	19 (24 events) (PDPH, OTIS, 2014)	19 (25 events) (PDPH, OTIS, 2014)	
Use of SNAP and SNAP-related incentives at farmers markets	1, 3	$117,000 (PDPH, 2013)	$129,000 (PDPH, 2014)	$98,226 (PDPH, 2015)	$200,000
Number of large businesses that adopt evidence-based nutrition and activity-related workplace changes	1, 4	~10 (PDPH, 2013)	24 (PDPH, 2014)	29 (PDPH, 2015)	50
Percentage of hospitals with *Baby Friendly* certification	1	0 (PDPH, 2013)	0 (PDPH, 2014)	2 (PDPH, 2015)	6 (100%)
Number of Indego bike share rides by cash and Access Passholders (*Indego launched in April 2015)	2	N/A	N/A	16,351 (Member and ridership data from Indego Reports to OTIS)	30,000

Goals, Objectives, Strategies, and Partners		
Goal 1: Increase access to healthy foods		
Objectives	**Strategies**	**Partners/Leaders**
1. Increase the number of businesses, and academic institutions that implement healthy food policies and programs.	a) Expand "Food Buying Club" and other produce distribution models to food retailers in low-income communities. (Years 3-5) b) Develop, expand, and sustain healthy food bonus incentive programs through SNAP and WIC, such as Philly Food Bucks. (Years 1-5) c) Examine existing food procurement contracts among food service providers to develop strategies to improve the nutritional value of foods served. (Years 3-5) d) Reduce consumption of sugar sweetened beverages through advocacy for taxes and regulation on sizing for SSBs. (Years 3-4)	Chamber of Commerce, Greater Philadelphia Business Coalition on Health, American Heart Association, colleges and universities, The Food Trust, PDPH, APM, Fair Food Philly, Health Promotion Council, Public Health Management Corporation
2. Increase the number of child care and out of school time programs that adopt best practices in nutrition and eating.	a) Develop certification program to incentivize child care and out-of-school time providers to adopt best practices in nutrition. (Years 3-5)	Child care and after school providers (United Way), Keystone STARS program, children's advocacy organizations, Maternity Care Coalition, healthy food and chronic disease organizations.
3. Increase the uptake of exclusive breastfeeding among infants 0-3 months of age.	a) Increase the number of birthing hospitals with Baby Friendly breastfeeding certification. (Years 1-5) b) Promote breastfeeding through business policy change and accommodations. (Years 1-3)	PDPH, hospitals, maternal/child health organizations, Maternity Care Coalition, WIC, family planning providers, large employers

Goal 2: Increase physical activity among children and adults		
Objectives	**Strategies**	**Partners/Leaders**
1. Improve access to safe spaces so that children and adults will feel safe exercising in their neighborhoods.	a) Increase partnerships between community facilities and trained experts to offer physical activity opportunities to children and adults(Years 2-5) b) Utilize Crime Prevention through Environmental Design (CPTED) to reduce crime in open areas so outdoor spaces can be activated for physical activity programming. (Years 3-5) c) Expand Safe Routes to School and other similar programs that promote biking and walking as fun, healthy forms of transportation in Philadelphia elementary schools. (Years 1-3) d) Expand Indego bike share system to allow for free memberships for vulnerable populations including public health residents and members of community development corporations (CDC). (Years 2-5)	Bicycle Coalition of Philadelphia, Department of Parks and Recreation, Philadelphia School District, Maternity Care Coalition, Office of Transportation & Infrastructure Systems, colleges and universities
2. Increase the number of child care and out of school time programs that adopt best practices in physical activity.	a) Develop certification program to incentivize child care and out-of-school time providers to adopt best practices in physical activity. (Years 2-5)	Child care and after school providers, children's advocacy organizations, Maternity Care Coalition, American Heart Association, United Way, Keystone STARS program

Goal 3: Further the integration of nutrition and physical activity promotion with clinical practice		
Objectives	**Strategies**	**Partners/Leaders**
1. Increase relevant resources available for providers to disseminate in their clinical practice.	a) Provide technical assistance to practices for a pilot intervention for writing healthy food prescriptions, leveraging the Philly Food Bucks program ($2 of free produce for $5 of SNAP benefits spent at farmers' markets). (Years 2-3) b) Integrate food security screenings as a standard assessment in electronic health records in primary care settings. (Years 3-4)	Providers and provider groups, FQHCs, insurers, American Heart Association, Food Trust, Fair Food Philly, Food Policy Advisory Council
2. Educate medical, osteopathy, nursing, and physician's assistant students on integrating prevention and clinical management of chronic disease.	a) Develop/adapt and integrate physical activity and nutrition assessment into health professionals' curricula. (Years 2-5)	Graduate medical education programs, providers and provider groups, FQHCs, insurers, American Heart Association
Goal 4: Improve knowledge and access of evidence based community resources		
Objectives	**Strategies**	**Partners/Leaders**
1. Continue to support the creation and dissemination of information about healthy food outlets and existing physical activity programs.	a) Develop information-sharing protocols between large existing online physical activity information portals. (Years 2-4) b) Develop/adapt and integrate nutrition and motivational interviewing modules into health professions' curricula. (Years 2-5)	Get Healthy Philly, FQHCs, children's hospitals, non-profit public health organizations, 311, 211, Food Policy Advisory Council

Appendices

1. Stakeholder Meeting Participants
2. Issue Prioritization Matrix

Philadelphia Community Health Improvement Plan
Community Stakeholder Meeting Participants

Medicaid Managed Care **July 11, 2013**	
Name	**Organization**
Y. Lily Higgins	Keystone First
Nancy Becker	Coventry
Joseph Sheridan	United Health Care
Cathy McCarron	Health Partners
Carol Wessner	Aetna
Giridhar Mallya	Philadelphia Department of Public Health (PDPH)
Donald Schwarz	PDPH
Kathy Donahue	Amerihealth
Glen Heisc	Coventry
Alice Jefferson	Aetna Better Health
Carol Johnson	PDPH

Reproductive and Sexual Health **07/16/2013**	
Name	**Organization**
Samantha Rivera	Congreso de Latinos Unidos
Karen Pollach	Maternity Care Coalition
Susan Schewel	Women's Medical Fund
Jen Horwitz	Women's Way
Melissa Weiler Gerber	Family Planning Council
Amy Lernii	CHOICE
Carol Tracy	Women's Law Project
Emily Rubin	Penn Nursing
Kara Holtz	Penn Nursing
Lauren Giardella	Penn Nursing
Giridhar Mallya	Philadelphia Department of Public Health (PDPH)
Donald Schwarz	PDPH

Child Health **July 25, 2013**	
Name	**Organization**
Suzanne Yunghans	PA Chapter American Academy of Pediatrics
Tracey Williams	School District of Philadelphia
Devin Brutan	St. Christopher's Hospital for Children
Adrienne Jackson	North Inc. Philadelphia WIC Program
Sarah Gibbons	Children's Hospital of Philadelphia
Giridhar Mallya	Philadelphia Department of Public Health (PDPH)
Donald Schwarz	PDPH

Access to Care August 5, 2013	
Name	**Organization**
Donna L. Torrisi	Family Practice and Counseling Network
Tanya Wynder	Family Practice and Counseling Network
Susan Post	Esperanza Health Center
Vince Zarro	Drexel University College of Medicine
Yolanda Watson	Sayre Health Center
Lisa Kleiner	Public Health Management Corporation
Francine Ali	Public Health Management Corporation
Phyllis Cater	Spectrum Health Services
Tom Storey	PDPH/AHS
Ann Ricksecker	Health Federation of Philadelphia
Giridhar Mallya	Philadelphia Department of Public Health (PDPH)
Donald Schwarz	PDPH

Philadelphia Board of Health August 15, 2013	
Name	**Organization**
Jose Benitez	Prevention Point Philadelphia
Scott McNeal	Delaware Valley Community Health
Donald Schwarz	Philadelphia Department of Public Health
Robert Sharrar	College of Physicians
Yolanda Slaughter	University of Pennsylvania School of Dentistry
Giridhar Mallya	Philadelphia Department of Public Health (PDPH)
Donald Schwarz	PDPH

HIV and STDs October 31, 2013	
Name	**Organization**
Kera Burns	Action AIDS
Ann Ricksecker	Health Federation
Andrew Goodman	Mazzoni Center
Giridhar Mallya	PDPH
Donald Schwartz	PDPH
Melissa Weiler Gerber	FPC
Caroline Johnson	DDC
Cherie Walker-Baban	DDC/STD
NaScyh	PDPH/HOC
Gary Bell	Bebashi
Jose Benitez	Prevention Point Philadelphia
Ellie Lippmann	DUSPH
Coleman Terrell	AACO
Jane Baker	AACO

HIV and STDs October 31, 2013	
Jane Shull	FIGHT
Melinda Salmon	DDC/STD

Health Among African Americans November 13, 2013	
Name	**Organization**
Brenda Shelton Dunston	Black Women's Health Project
Giridhar Mallya	Philadelphia Department of Public Health (PDPH)

Employers November 7, 2013	
Name	**Organization**
Ginny Peddicord	Merck
Anne Hoban	Day & Zimmerman
Donald Schwarz	PDPH
Giridhar Mallya	PDPH
Kim Eberbach	IBC
Neil Goldfarb	Greater Philadelphia Business Coalition on Health
Marnie Vaughn	Seven Trent Services
Michelle DeNault	WaWa
Franco Cognata	Novo Nordisk
Patrick Croft	Greater Philadelphia Business Coalition on Health
Donald Schwarz	PDPH

Health Center Board Meeting November 14, 2013	
Name	**Organization**
Joseph Edwards	Health Center 2
Darlene Lewis	Health Center 2
Ann Marie Draycott	Health Center 3
Linda Murray Grimes	Health Center 3
Bobbi Jaffe	Health Center 3
Lynete Lazarus	Health Center 3
Nancy Ruane	Health Center 3
Hazel Singleton	Health Center 3
Keith Walker	Health Center 3
Wayne Williams	Health Center 3
Olivia Faison	Health Center 4
Sonia Lonon	Health Center 4
Marie Blocker	Health Center 5
Brenda Jones	Health Center 5

Health Center Board Meeting November 14, 2013	
John Ray	Health Center 5
Ernestine Volcy	Health Center 5
Siomara Lopez	Health Center 6
Michael Rabb	Health Center 6
Taleah Range	Health Center 6
Martha Bernadino	Health Center 9
Kathryn Gaffney-Golden	Health Center 9
Flora Jackson	Health Center 9
Sarah Parrant	Health Center 9
Ernest Saxton	Health Center 9
Joyce Woods	Health Center 9
Marlyn Bradshaw	Health Center 10
Lorraine Brill	Health Center 10
Rhoda Gordon	Health Center 10
Elmer Money	Health Center 10
Sue Rosenthal	Health Center 10
Stanley Strez	Health Center 10
Kusema Warrakah	Strawberry Mansion Health Center
Giridhar Mallya	Philadelphia Department of Public Health (PDPH)
Donald Schwarz	PDPH

College of Physicians of Philadelphia Section on Public Health November 19, 2013	
Name	**Organization**
Sarah Ingerman	Public Health Management Corporation/Health Promotion Council
Pat West	Public Health & Preventive Medicine
George Wohlreich, MD, President & CEO	The College of Physicians
Robert G. Sharrar, MD	College of Physicians
Karim Sariammed, Philly Fellow	College of Physicians
George Downs, Pharm.D.	U. Sciences/Phila. College of Pharmacy
Carolyn Asbury, SCMPH, PhD	Section MPH & PM
Thomas M. Vernon, MD	Comcast
Paul Jay Fink, MD	Consultant
Walter Tsou	Jefferson University
Mahak Nayyar	US Department of Health and Human Services, Region III
Dalton Paxman	US Department of Health and Human Services, Region III
Jacqui Bowman	College of Physicians
Giridhar Mallya	Philadelphia Department of Public Health (PDPH)
Donald Schwarz	PDPH

Food Fit Philly November 15, 2013	
Name	**Organization**
Jonathan Kent	AHA/ASA
Janie Miller	Health Promotion Council
Julie Zaebst	Coalition Against Hunger
Robin Rifkin	Health Promotion Council
Colleen McCauley	PCCY
Samantha Driscoll	PECPA
Katja Pigur	Maternity Care Coalition
Tom Sexton	Rails-To-Trails Org
Abram Aber	Rails-To-Trails Org
Senna Gasten	PA Dept of Health
John Keith	American Lung Association
Michelle Brosbe	DUSPH
Eli Edson	YMCA of Greater Philadelphia
Aimee Smith	YMCA of Greater Philadelphia
Joshua Prasad	HHS-OASH
Jeff Knowles	DCNR-Bureau of Recreation & Conservation
Michele Holloway	NU Sigma Youth Service
Staci Stills	PDPH/PPR
Jessica Robbins	PDPH/AHS
Rickie Brawer	Jefferson Hospital & University
Linda Samost	Sunday Suppers SHARE Food Program
Barb Hadley	Maternity Care Coalition
Mercelyne Latorre	Sunday Suppers SHARE Food Program
Donald Price	APM
Donna Clarke	HUD
Michelle Davis	HHS
Lauren Puzen	Alliance for a Healthier Generation OSTRC/PYSC
Gabriella Mora	The Food Trust
Stephanie Weiss	The Food Trust
Amy Vires	School District of Philadelphia
Devon Sundberg	School District of Philadelphia
Nikki Lee	Division of Maternal Child & Family Health/PDPH
Tracey Williams	School District of Philadelphia
Giridhar Mallya	Philadelphia Department of Public Health (PDPH)
Donald Schwarz	PDPH

Health Among Hispanic Populations November 25, 2013	
Name	**Organization**
Donald Price	Asociación Puertorriqueños en Marcha
Nilda Ruiz	Asociación Puertorriqueños en Marcha
Giridhar Mallya	Philadelphia Department of Public Health (PDPH)
Donald Schwarz	PDPH

CHIP Prioritization Rankings December 2013							
		Leading cause of death	**Comparison to U.S.**	**Trend over time**	**Racial/ethnic disparity**	**Total**	**Notes**
1	**Teen sexual health**	3	2	4	4	**13**	
2	**HIV**	3	4	1	4	**12**	
3	**Maternal and infant health**	1	4	3	3	**11**	
4	**Violence and mental health**	3	2	3	2	**10**	Includes alcohol; patterns for violence and mental health are different
5	**Obesity**	5	1	2	2	**10**	Includes cardiovascular disease, diabetes, htn, built envt
6	**Tobacco**	5	1	2	2	**10**	Includes cardiovascular disease, htn
7	**Child health**	1	2	3	3	**9**	Indicators in this category are highly varied
8	**Cancer screening and prevention**	5	0	2	1	**8**	Leading cause of death reflects cancer deaths; other comparisons reflect cancer screening
9	**Access to care**	1	0	4	3	**8**	
10	**Environmental health**	1	*	2	*	**3**	Hard to compare to U.S. and to judge disparities with our current indicators

CHIP Prioritization Rankings December 2013							
		Leading cause of death	**Comparison to U.S.**	**Trend over time**	**Racial/ethnic disparity**	**Total**	**Notes**

NOTES

Leading cause of death- disease	Average difference for Philly vs. U.S.	% of indicators improving	Average disparity for non-white vs. white	
1- not top 10 cause of death, 3- top 6-10, 5- top 5	0= Philly better than U.S.; 1 = Philly 0-19% worse than U.S.; 2 = 20-39% worse; 3 = 40-59% worse; 4=60%+ worse	1 = 100% of indicators improving; 2 = 66% to 99.9% improving; 3 = 33% to 65.9% improving; 4 = 0% to 32.9% improving or 33%+ not improving	1 = Non-white group 0-24% worse than white group; 2 = 25-49% worse; 3 = 50-74% worse; 4=75%+ worse	
2010 Philadelphia Vital Statistics **2000 U.S. Actual Causes of Death, Mokdad et al 2004**	**2013 CHA**	**2013 CHA**	**2013 CHA**	