

**ADDRESS: 4641 E ROOSEVELT BLVD**

Proposal: Remove building, construct health center

Review Requested: Review In Concept

Owner: Thomas Scattergood Foundation

Applicant: Joseph Pyle, Thomas Scattergood Foundation

History: 1813; Friends Hospital

Individual Designation: 1/14/1975

District Designation: None

Staff Contact: Laura DiPasquale, [laura.dipasquale@phila.gov](mailto:laura.dipasquale@phila.gov)

**BACKGROUND:**

This in-concept application proposes to demolish a historic building and construct a new municipal health center on the grounds of the historic Friends Hospital in the Frankford section of Philadelphia. Established by the Quakers in 1813 as the first private psychiatric hospital in the United States, the Friends Hospital complex is composed of numerous historic and modern buildings set on 99 acres. The local designation of Friends Hospital is largely undocumented and the buildings on the site were not classified as contributing or non-contributing. It appears that the hospital was designated in the early 1970s in response to the proposed Pulaski Expressway, a highway that would have connected the Betsy Ross Bridge to Route 309, cutting across the hospital grounds. In addition to its local designation, Friends Hospital is a National Historic Landmark. The building proposed for demolition, known as Lawnside, was constructed in 1859 as the superintendent's house and is classified as contributing in the National Register designation. Any state or federal funding or other involvement in the health center project may trigger a Section 106 review, a federal preservation review, which may preclude demolition.

The Department of Licenses and Inspections is prohibited by Section 14-1005(6)(d) of the preservation ordinance from issuing a demolition permit for a locally designated building except in two cases. The section stipulates that "No building permit shall be issued for the demolition of a historic building ... unless the Historical Commission finds that issuance of the building permit is necessary in the public interest, or unless the Historical Commission finds that the building ... cannot be used for any purpose for which it is or may be reasonably adapted." The demolition of Lawnside is prohibited unless the Historical Commission finds that the demolition is necessary in the public interest and/or the building cannot be feasibly reused, the hardship exception.

The application documents the analyses the City's Department of Public Health has undertaken to select a site for Northeast Philadelphia Health Center. The City considered 44 sites and selected the Friends Hospital site. The application also includes analyses that the City, Scattergood Foundation, VSBA, and other consultants have undertaken to identify a site on the grounds of Friends Hospital that can accommodate the new health center. The project has very strict requirements for the new building and parking that involve security, ease of access by foot, mass transit, and car, drop off and pick up, parking, and flow through the building. The impact of the building on the historic site, especially potential impacts on view sheds, were also considered. The application presents three options for siting the new building, the preferred Option A as well as Options B and C. In order to accommodate a new 98 foot by 287 foot building and parking lot, the application proposes to demolish Lawnside. All three options include the demolition of Lawnside. The application claims that the project is necessary in the public interest; the area needs a new health center and this location and configuration is the best for that center.

The Historical Commission has been confronted with similar questions recently related to a church complex at 4<sup>th</sup> and Race Streets in Old City and the Lutheran Seminary in Mt. Airy. Both cases involve non-profit organizations seeking to construct new facilities. The church sought to construct a homeless shelter, but had an eighteen-century building standing within the construction zone. The Historical Commission ultimately approved a plan to move the historic building to create a space for the new facility. The seminary project is not as far along in the planning, but the Historical Commission did reject the seminary's suggestion when designating that the Commission list a house on the site as non-contributing so that it could be demolished for new construction. The Commission did conceptually support the plans for new construction, but suggested that the house could be integrated into the new project or relocated elsewhere on the large, open site.

**SCOPE OF WORK:**

- Demolish 1859 building known as "Lawnside"
- Construct health center

**STANDARDS FOR REVIEW:**

- *Standard 9: New additions, exterior alterations, or related new construction shall not destroy historic materials that characterize the property. The new work shall be differentiated from the old and shall be compatible with the massing, size, scale, and architectural features to protect the historic integrity of the property and its environment.*
  - The application proposes to demolish a historic structure, thereby failing to satisfy this Standard.
  - Without the demolition of Lawnside, the application would meet this Standard.
- *Section 14-1005(6)(d) of the preservation ordinance: No building permit shall be issued for the demolition of a historic building ... unless the Historical Commission finds that issuance of the building permit is necessary in the public interest, or unless the Historical Commission finds that the building ... cannot be used for any purpose for which it is or may be reasonably adapted.*
  - This application has demonstrated that the demolition of Lawnside for the construction of the health center is in the public interest, but it has not demonstrated that it is necessary in the public interest. It has likewise contended but has not demonstrated that Lawnside cannot be reasonably adapted for a new use. The feasibility of integrating Lawnside into the new construction or moving and rehabilitating Lawnside should be considered.

**STAFF RECOMMENDATION:** The staff recommends that additional analyses should be undertaken to determine whether it is feasible to reuse Lawnside in its current location or at a nearby, new location on the large site.

Presentation to the  
**PHILADELPHIA HISTORICAL COMMISSION**  
Architectural Review Committee

City of Philadelphia  
**HEALTH CENTER 11**  
On the Grounds of Friends Hospital 4641 Roosevelt Boulevard

**Site Development Plan and Removal of Lawnside**

**IN-CONCEPT SUBMISSION**  
August 11, 2020

**THE SCATTERGOOD FOUNDATION**  
VSBA ARCHITECTS & PLANNERS

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# SCATTERGOOD

THINK|DO|SUPPORT

August 11, 2020

Jonathan E. Farnham, Ph.D.  
Executive Director  
Philadelphia Historical Commission  
1515 Arch St., 13th Floor  
Philadelphia, PA 19102

**RE: Historical Commission Conceptual Approval  
Health Center 11 at Friends Campus  
4641 Roosevelt Blvd, Philadelphia, PA 19124**

Dr. Farnham,

Please accept this submission on behalf of The Thomas Scattergood Behavioral Health Foundation ("Scattergood Foundation"), respectfully requesting the Conceptual Approval of the site location for Health Center 11 outlined below.

The Scattergood Foundation and the City of Philadelphia's Department of Public Health are collaborating to develop a much-needed Health Center – known as Health Center 11 – to serve lower Northeast Philadelphia and which will be strategically located on Friends Campus (the "Campus"). Scattergood Foundation would develop the new facility on a build-to-suit, turnkey basis and the City would purchase the new Health Center upon its completion.

The new Health Center will provide primary care health and wellness services to an area that has experienced substantial population growth and shifting demographics and that has significant areas of need. After careful analysis of various sites, the Departments of Public Health and Public Property have identified the Campus as the proposed location for the new Health Center. Not only is it the best fit for the Health Center, but it also furthers Scattergood Foundation's vision to build a campus dedicated to health and wellness.

As demonstrated herein, the specific site location on the Campus proposed for the Health Center is ideal for an intensively used facility and provides easy access from main entry drive for visitors arriving by car, public transportation, or on foot and limits the incursion of vehicles into the Campus. Furthermore, the view corridor to the hospital from Roosevelt Boulevard will be maintained.

To achieve the goals above and further described within this submission, the placement of the new Health Center will necessitate the removal of an existing 2,196 square foot, two-story building referenced herein as the "Lawnside building". The Lawnside building was constructed as the hospital superintendent's house but is in poor condition and has been unoccupied for over fifteen years. The Lawnside building currently does not support the hospital's mission and the existing limitations of the building preclude any modern, code-compliant uses associated with medical and health center needs. In addition, retaining the Lawnside building would

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scattergoodfoundation.org

necessitate constructing the Health Center closer towards the hospital, compromising the proposed arrival/drop off and entry sequence and encroaching on the view of the hospital.

As additional background, please find the following information on the mission of the Scattergood Foundation and a summary of the community benefits and services associated with the proposed Health Center 11 at the Campus:

The Scattergood Foundation believes major disruption is needed to build a stronger, more effective, compassionate, and inclusive society where behavioral health is central. The Scattergood Foundation approaches their work with humility and strives to share power responsibly while being unrelenting advocates for practices that advance equity for all. At the Foundation, they THINK, DO, and SUPPORT in order to shift the paradigm and practice for behavioral health, and recognize the unique spark and basic dignity in every human. The Scattergood Foundation is the owner the Campus, which consists of 99-acres in the lower Northeast neighborhood of Philadelphia, has a 20% ownership stake in Friends Hospital and provides approximately \$1,000,000 of grants to community organizations each year.

The Board of Managers and leadership at the Scattergood Foundation are committed to the Campus to improve the health and wellbeing for all Philadelphians. The Scattergood Foundation's commitment to the community dates back to 1813 with the opening of Friends Hospital, the nation's first private psychiatric facility. It is the Scattergood Foundation's goal to develop the Campus into a comprehensive health campus with strategically positioned, complementary services. The placement of Health Center 11 on the Campus furthers this goal by integrating traditional physical medicine, behavioral health services, green space, and local community-based programming to address the social determinants of health. Locating these services together on one campus significantly increases ease of access and reinforces holistic health approaches, thereby decreasing population health disparities in the neighborhood and beyond.

Based on the enclosed submission, the Scattergood Foundation is requesting the Commission's Conceptual Approval of the proposed site as well as the approval to remove the Lawnside building as a matter of the public interest to allow for the construction of this significant and important civic project.

On behalf of the Scattergood Foundation, we thank you for your consideration and look forward to meeting with the Architectural Committee to discuss this request further.

Respectfully Submitted,



Joseph Pyle, President  
Scattergood Foundation

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## CITY OF PHILADELPHIA

DEPARTMENT OF PUBLIC HEALTH  
1101 Market Street, 13th Floor, Suite 1320  
Philadelphia, Pennsylvania 19107  
Tel: (215) 686-5200 · [www.phila.gov/health](http://www.phila.gov/health)

THOMAS FARLEY, MD, MPH  
Health Commissioner

August 7, 2020

Jonathan E. Farnham, Ph.D.  
Executive Director  
Philadelphia Historical Commission  
1515 Arch St., 13th Floor  
Philadelphia, PA 19102

RE: Health Center at Friends Campus – Conceptual Approval  
4641 Roosevelt Blvd, Philadelphia, PA 19124

Dear Dr. Farnham:

Please accept this letter of support confirming the City of Philadelphia's goal to develop a new City health center at Friends Campus, located at the address above. The development will require authorization from Philadelphia City Council, members of which have indicated support for this important project.

The proposed center, the City's ninth, will serve significant areas of need in lower northeast Philadelphia, as highlighted in the Philadelphia Department of Public Health's report, *Staying Healthy: Access to Primary Care in Philadelphia* (enclosed). After a thorough evaluation of potential sites in the region, the Department of Public Health determined that the Friends Campus is an ideal fit for the City's programmatic needs and fills an important gap in our city's primary care access. Furthermore, we have determined that the proposed location of the new Center on Friends Campus meets the needs of future clients.

On behalf of the Department of Public Health, I support this project and request that the Commission grant the Conceptual Approval of the proposed location of the health center on site.

Respectfully,

Thomas Farley, MD, MPH  
Health Commissioner

Enclosure

## SUBMISSION SUMMARY

### I. INTRODUCTION

Friends Hospital, under the auspices of the Scattergood Foundation, provides an array of mental health services to the community and region, continuing the mission begun in 1817 with the construction of the original hospital building. The Scattergood Foundation is embarking on a plan to broaden the range of services it provides by developing its campus with new health and wellness facilities (see pages 1 and 2). A master plan, prepared in 2013 (see page 5), identified potential sites and broad options for locating new facilities.

The campus, including the hospital and eleven supporting structures, is nationally and locally designated an historic landmark (see pages 8 and 9). An important element of the plan is to generate revenue necessary to renovate, maintain, and operate the historic buildings and grounds.

The Philadelphia Health Department requires a new City health center in Northeast Philadelphia to provide primary care health and wellness services to an area that has experienced substantial population growth and shifting demographics (see page 6). Key criteria for selecting a new site included proximity to population served, access by public transportation, pedestrian access, and parking for visitors and staff (see page 7). After careful consideration of several sites, the Friends Hospital site was selected; not only is it the best fit for the health center, it furthers Scattergood's vision to build a campus dedicated to health and wellness. The City of Philadelphia and the Scattergood Foundation are collaborating to develop the health center.

### II. HEALTH CENTER CONCEPTUAL DESIGN

#### A. Site Selection

The campus site selected for the health center is ideal for the intensively used public facility. It is immediately visible to visitors entering the campus and provides easy access from the main entry drive for those arriving by car, SEPTA bus, or on foot. The center will generate significant

vehicular traffic, including cars, paratransit and other patient drop-off vans, and service trucks. The site limits their incursion into the campus.

The proposed building sits between the entry drive and the existing parking lot and does not encroach on views of the front façade of the historic Friends Hospital from the Boulevard. It sets back from the drive, enabling restoration of the trees that once lined it. The setback also helps preserve oblique views towards the hospital as visitors round the curve in the entry drive. The view corridor to the hospital from Roosevelt Boulevard is maintained and the site wall, grading, and vegetation obscure views of the proposed building from the Boulevard sidewalk (see pages 10, 11, and 15).

#### C. Building Design Concept

The proposed 2-story building is 30' tall and will include a screened mechanical penthouse. In massing, it is lower than the 4-story hospital, and its long elevation, set back from the tree-lined entry drive, would be designed as a background building with a subtle brick pattern. The preferred concept locates drop-off and entrance at the west end of the building, enabling the desired linear patient flow within the health center. The entry area and large, more public activities above would be clad in more transparent materials to provide views towards the hospital building (see pages 11, 13, and 15).

Visitors arriving by car can drop off and proceed to parking; those arriving via SEPTA or on foot can enter from the sidewalk along the entry drive. Paratransit and other vehicles dropping off visitors can circle back to the entry drive and depart without intruding further into campus. The entry is visible to visitors arriving by car or on foot. A generous landscaped zone buffers the building from the proposed parking.

#### B. Parking

Another benefit of the site is the opportunity to share parking and access lanes with the hospital, using excess capacity in the existing lot to partially offset the significant parking needs of the health center. The lot in its current configuration has 236 spaces, of which approximately 136 are used by the hospital. The proposed health center requires a total of 225 spaces; by using the 100 available spaces, 125 new spaces will be needed. While these could be accommodated by adding another bay of parking to the existing lot, it is not efficiently laid out and could benefit from being upgraded.

The proposed redesigned lot is much more efficient, accommodating needed spaces with less paving and includes landscaped drainage swales between parking bays. The parking access points are moved away from the front of the hospital, reducing the impact of vehicles. An axial path through the parking links the hospital to the path network and landscaped area adjacent to the Boulevard while providing visitors a pedestrian-friendly way to the hospital entrance. A 35' landscaped arc extends the full length of the hospital, buffering it from the parking.

#### D. Other Options Considered

Other two story options considered included midpoint drop-offs / entrances, either from the entry drive or the parking access drive (see pages 12 and 14). In both cases, entries would be needed on each side for pedestrian access, creating a central entry zone extending through the building. This does not allow the desired patient flow, creates confusing cross traffic, and requires two security points. From a functionality perspective, the health center does not consider these viable options.

Placing the drop-off along the entry drive would compromise the tree-lined landscape and create possible vehicle stacking problems at the campus entrance. Visitors dropping off would need to re-enter the drive and proceed around the building to find the parking. If the drop-off is on the parking side, visitors must drive around the building and enter the parking to find the entrance.

A 3-story option that would reduce the footprint was considered but ruled out by the health center. All current health centers are 1-story buildings that depend on a carefully organized sequence of services for effective and efficient operation. In this case, a 2-story building was feasible due to the inclusion of particular program elements, including physical therapy services and a teaching kitchen. Program elements on the ground floor are highly interdependent and necessary to achieve the desired patient flow.

Another concern about a 3-story health center would be its height and massing relative to the hospital building. With necessarily high floor-to-floor dimensions and a mechanical penthouse, a 3-story building would be significantly larger than the hospital. This would upset the hierarchy of campus buildings in which the hospital is clearly the main building and others play supporting roles.

### III. LAWNSIDE

To achieve the desired site circulation and interior programmatic relationships, the 2,200 square foot residential building called Lawnside would need to be removed. Lawnside was constructed in 1859 on the hospital grounds and is one of twelve structures included in the historical designation. Constructed as the superintendent's house, it fronted what is now Roosevelt Boulevard and was a considerable distance from the core of historic buildings. It was expanded in 1890 and again in 1920. Further modifications were made in 1950 (see pages 16 through 19).

Lawnside ceased to function as the superintendent's house long ago and was converted for general residential use. The building currently does not support the hospital's mission and has been unoccupied for over 15 years, except by squatters and trespassers who persistently circumvent security and safety measures implemented by the Scattergood Foundation.

Its particularly small rooms, tight circulation, proximity to Roosevelt Boulevard and remoteness from the hospital make it difficult to repurpose for uses associated with medical and health center needs, consistent with the overall plan for the campus. It is structurally sound but with many elements in poor condition. A significant investment would be needed to restore the envelope and make the interior habitable and code compliant for continued residential use (see pages 20 and 21). Such an investment would diminish funds for needed improvements to the hospital and other core historic buildings that support the Foundation's mission. Moreover, the costs associated with maintaining and securing Lawnside diverts much needed resources from the Scattergood Foundation that could otherwise go towards programming and additional supportive services.

Retaining Lawnside would necessitate shifting the health center towards the hospital, thereby compromising the proposed arrival / drop-off, entry sequence, and linear patient flow required by the program (see pages 23 through 26). The building would also encroach on views of the hospital, revealed as visitors round the curve of the entry drive. The service area would still infringe on Lawnside and its context would be significantly altered.

Due to the site wall / fence and vegetation along the Boulevard, Lawnside's primary facade is visible only where there is a break in the trees. The side elevation is set back 145' from the entry drive and is obscured by vegetation.

Given the important public health services provided by the City Health Center, and the Scattergood Foundation's commitment to health and wellness and the preservation of its mission supporting structures, we respectfully request conceptual approval to remove Lawnside.



## Site Development Options

In keeping with the Scattergood Foundation's goal for compatible uses for new development on the site, we worked with a basic medical office building footprint and the possibility of one smaller building designated for daycare. The office building footprint recommended by Jones Lang LaSalle is as follows:

Footprints should be between 15,000 SF and 30,000 SF. Wings of up to 30,000 SF can be connected via a central atrium. Footprints smaller than 15,000 SF are inefficient for multi-tenant use and are difficult to lease. Depth of footprint is generally 110' to 120' so that there is a single, double loaded corridor in the public area, with each side accommodating double-loaded corridor suites in a racetrack format.

The recommended building footprints are large in comparison to the existing buildings on site. All of the site development options considered methods to reduce the apparent sizes of the buildings, primarily through using "L" shaped buildings. All proposed new buildings are two-stories tall, with pitched roofs. Overall building heights are below the cornice line of the Scattergood Building. Bays, porches, dormers, and roof monitors are proposed to further articulate the structures and enhance their compatibility with the human scale of existing buildings on the campus.

New buildings are clustered in three areas: Unit 10, to the west of the main parking lot; Units 5 and 6, to the east of the main parking lot; and Unit 7, to the east of Greystone. A primary consideration for all of the new development was to maintain the existing tree buffer along Roosevelt Boulevard. All three areas are deemed suitable for new construction and each offers different pros and cons.

Unit 10 is relatively level and has ample space for new buildings and surface parking. Although not required for development, it would be prudent to relocate the entry drive at Unit 10 to improve safety as part of developing this parcel. Existing electrical and gas service to the campus runs under this parcel and will require locating new buildings to avoid conflict with these utilities.

Developing Units 5 and 6 would likely require the demolition or relocation of Lawnside, an 1859 residential building currently listed as contributing within the historic district on the National Register Nomination. The site of Lawnside, at the intersection of Roosevelt Boulevard and Langdon Avenue, provides maximum visibility for new tenants.

Unit 7 has the opportunity for a cluster of buildings a short distance from the heart of the campus. Various configurations of buildings were studied for this parcel in order to provide vehicular access, visibility, and a new exterior courtyard. Access to this parcel remains somewhat problematic due to the need to keep Greystone in its current location.

Multiple site development options were studied (Schemes A through G) prior to selecting Schemes H.0 and H.2.

Scheme A



Scheme D



Scheme B



Scheme E



Scheme C



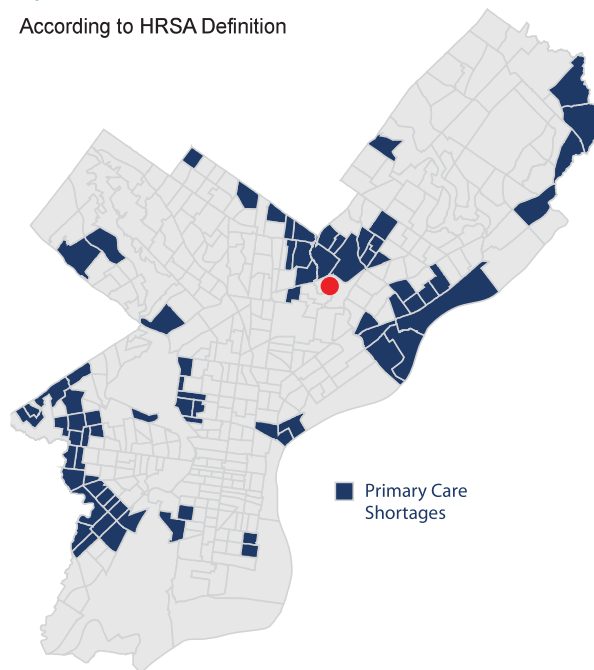
# SUPPLY AND AVAILABILITY OF PRIMARY CARE PROVIDERS

KEY

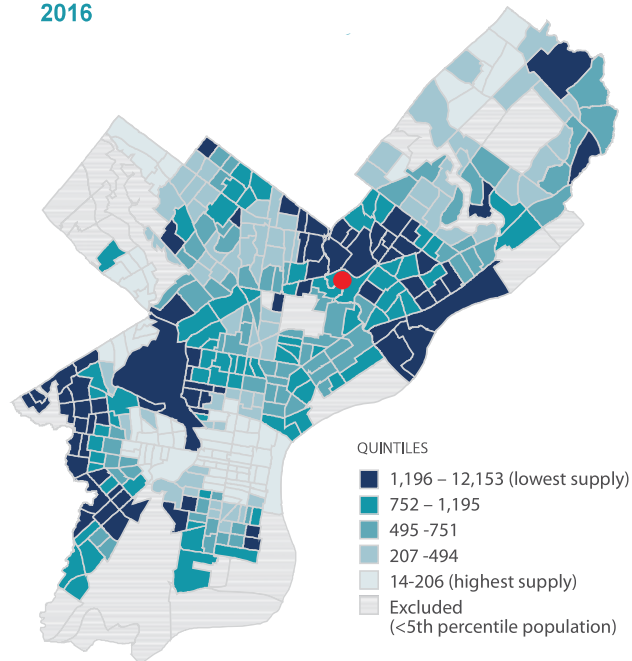
● FRIENDS HOSPITAL

## Primary Care Shortage Areas by Census Tract

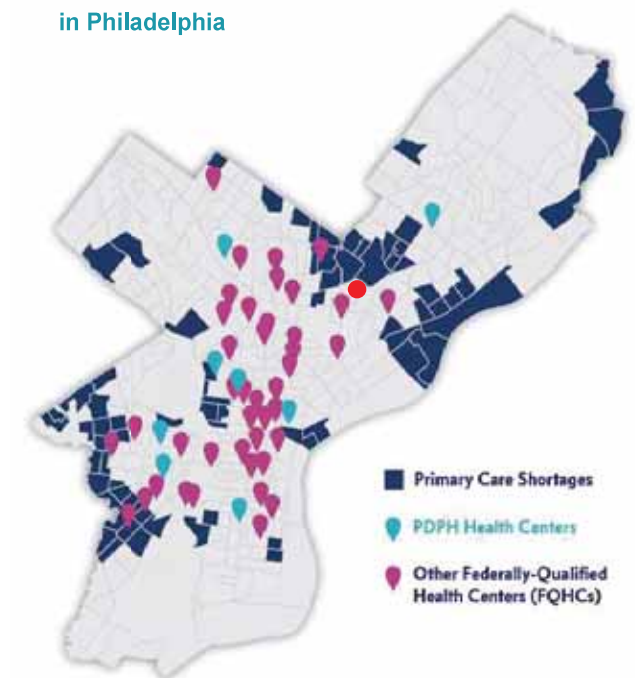
According to HRSA Definition



## Medicaid PCP to Medicaid Population Ratios by Census Tract, 2016

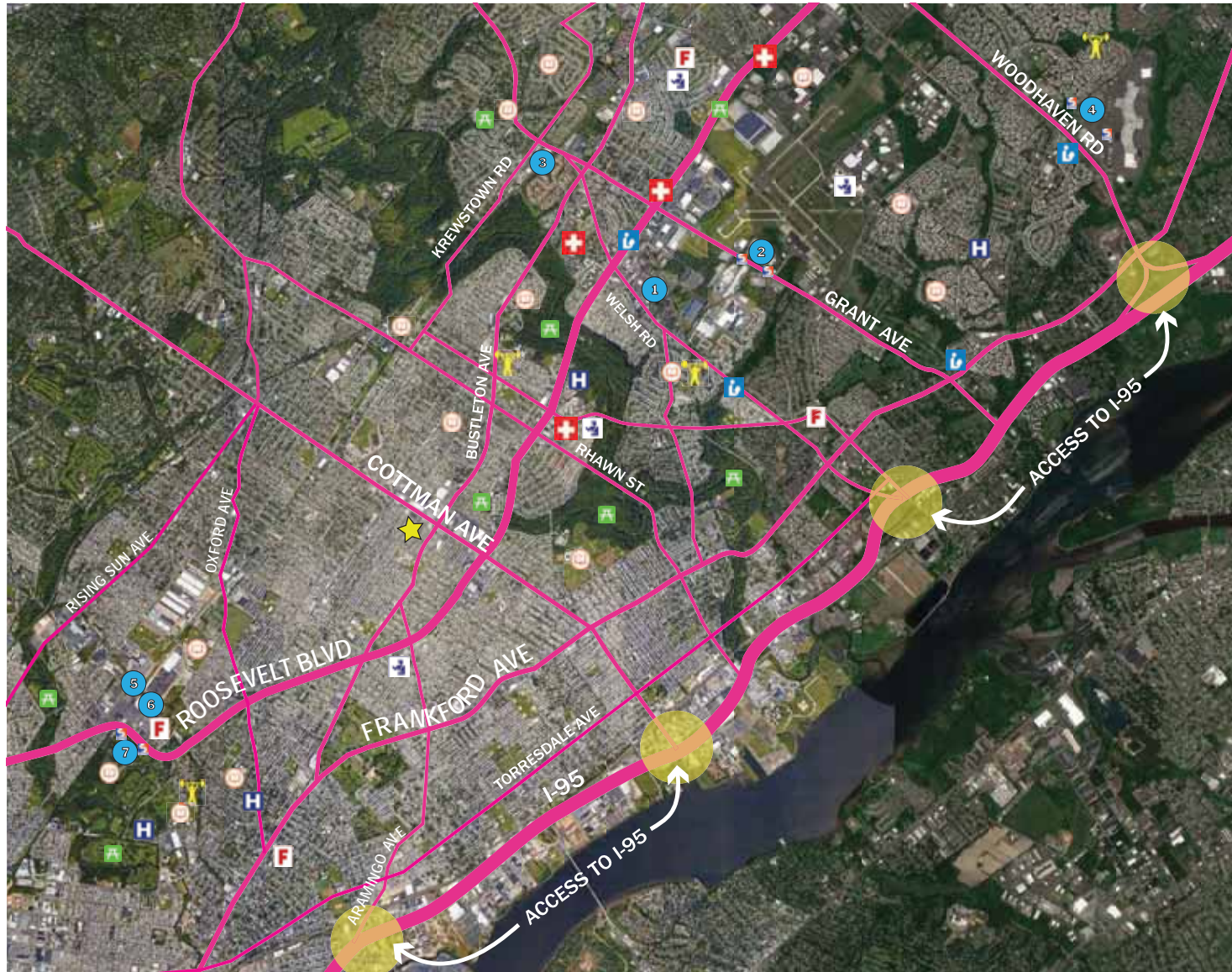


## Primary Care Shortages and Health Center Locations in Philadelphia



Source: Leonard Davis Institute of Health Economics,  
University of Pennsylvania





## SITE OPTIONS

To develop a new Northeast Philadelphia Health Center (NPHC), the City of Philadelphia considered 44 sites throughout the target area and conducted site visits for approximately a dozen sites. Among the sites considered, the City's Department of Public Health requested VSBA to investigate five potential sites that were identified as the most promising for meeting the size and program needs for a new health center in this part of Philadelphia. In addition, the City's Department of Public Property added two additional sites for consideration at the 3/6/2019. This report analyzes seven sites in detail.

This overall plan indicates each site's proximity to major roads, public transportation, schools, libraries and other significant facilities.

### KEY

- HEALTH CENTER 10
- 2361-2375 WELSH ROAD SITE
- 2901 GRANT AVENUE SITE
- KREWSTOWN & GRANT SITE
- 20 FRANKLIN MILLS BLVD SITE
- NE TOWER CENTER: TRIANGLE
- NE TOWER CENTER: POWER PLANT
- FRIENDS HOSPITAL SITE
- SCHOOLS
- PARKS
- SEPTA BUS STOP
- HOSPITAL
- URGENT CARE
- LIBRARY
- POLICE STATION
- FIRE DEPARTMENT
- CITY REC CENTER





1843 PHILADELPHIA ATLAS, CHARLES ELLET

IMAGE: LIBRARY OF CONGRESS.



1849 MAP OF OXFORD TOWNSHIP, M. DRIPPS

IMAGE: FREE LIBRARY PHILA.



1895 PHILADELPHIA ATLAS, BROMLEY

IMAGE: FREE LIBRARY OF PHILA.



1910 PHILADELPHIA ATLAS, BROMLEY

IMAGE: FREE LIBRARY OF PHILA.



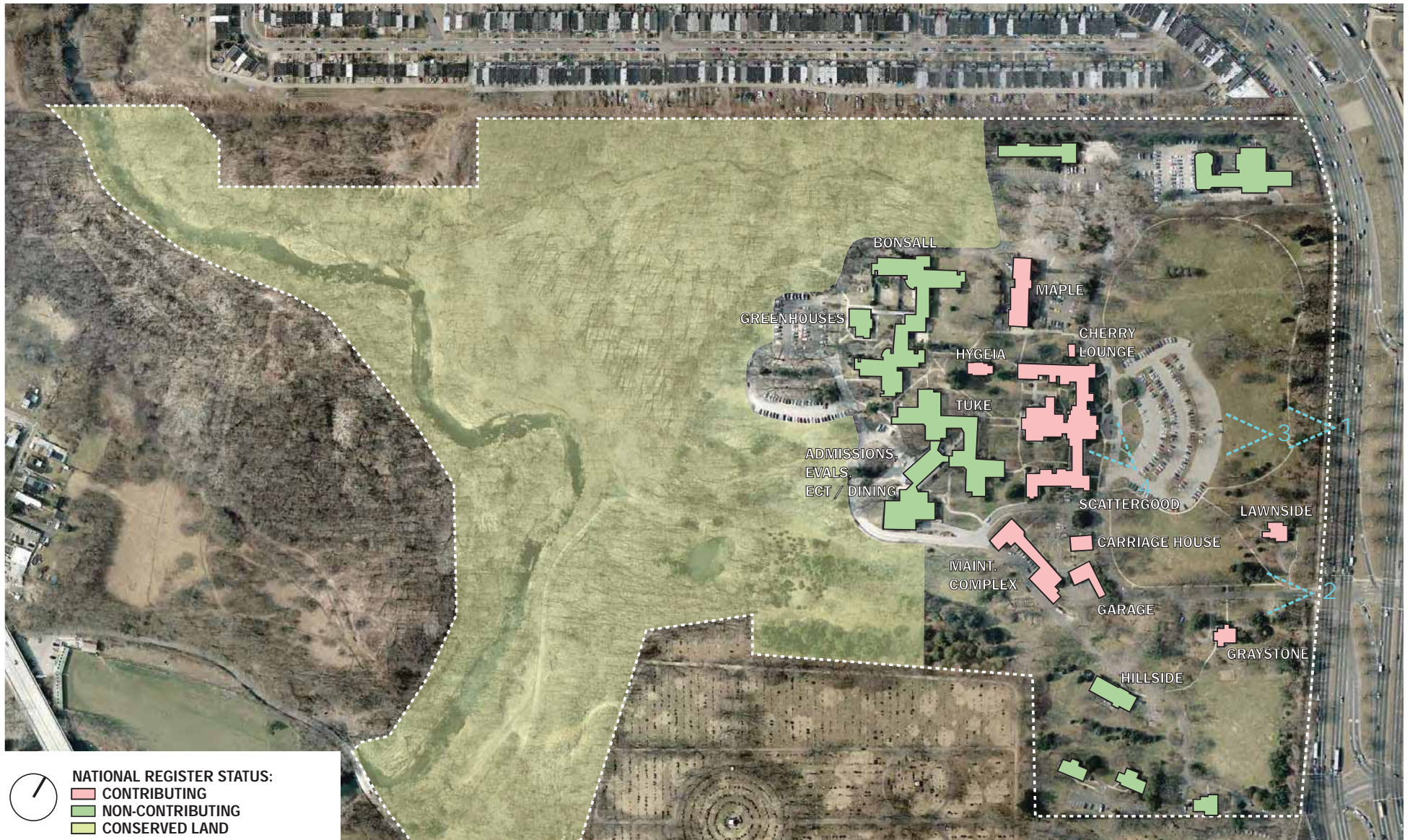


IMAGE SOURCE: SCATTERGOOD FOUNDATION





**VIEW 1: VIEW FROM ROOSEVELT BOULEVARD**



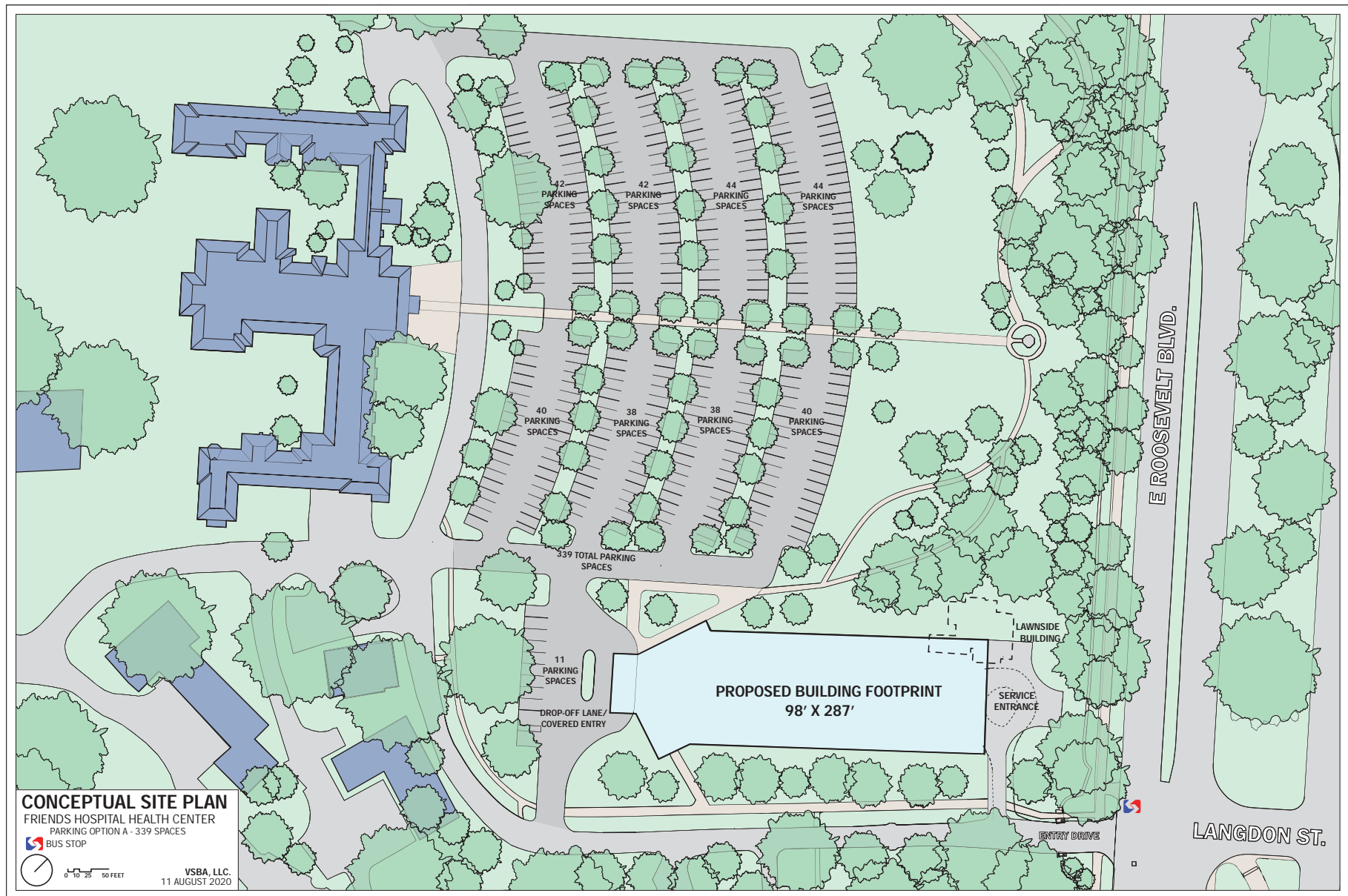
**VIEW 2: APPROACH AT GATE**



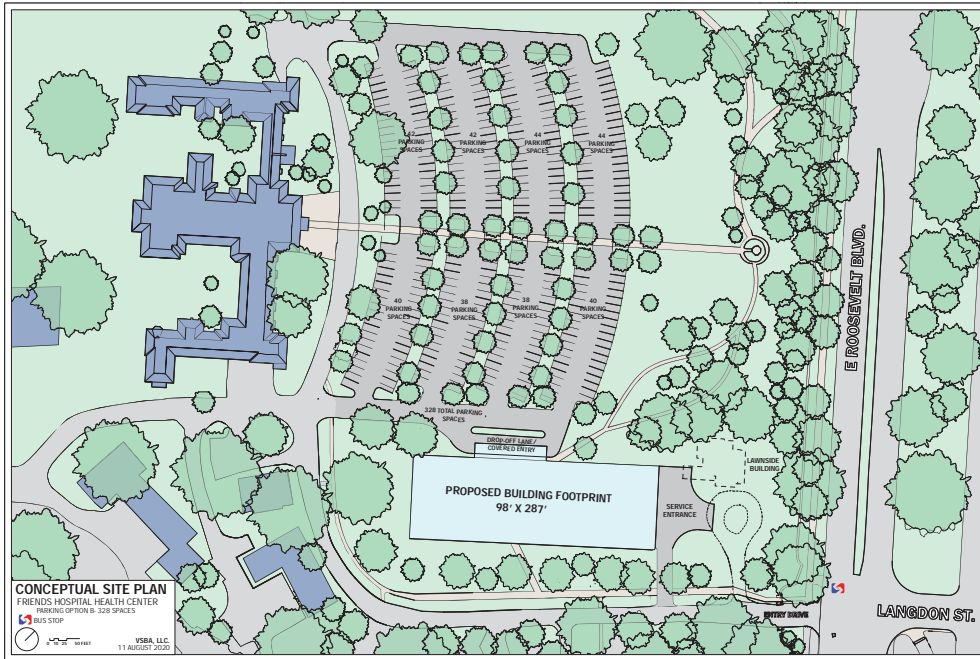
**VIEW 3: VIEW OF HOSPITAL FROM LAWN**



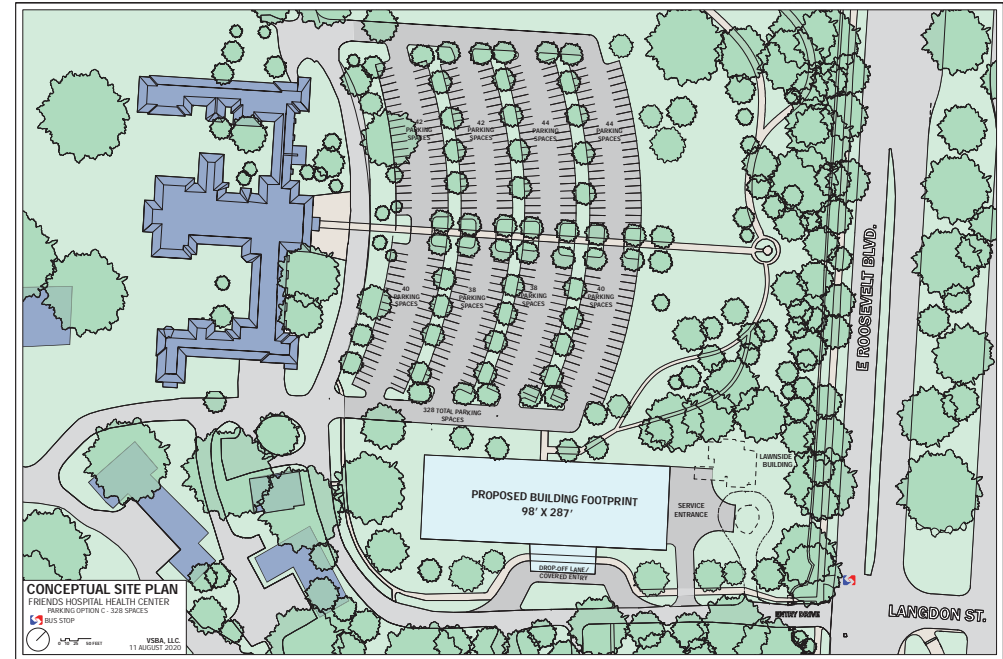
**VIEW 4: VIEW OF HOSPITAL FROM DRIVE**





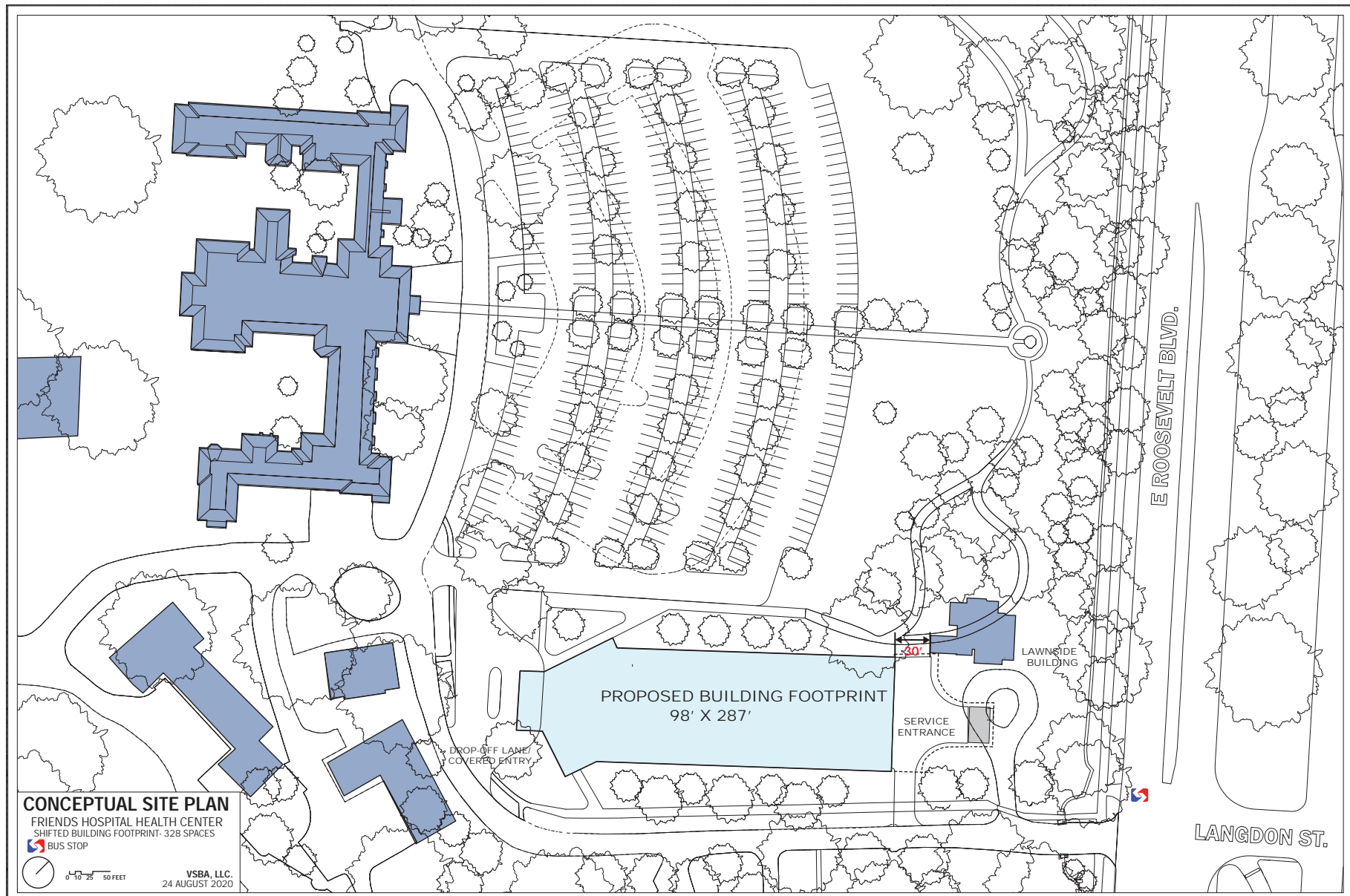


OPTION B

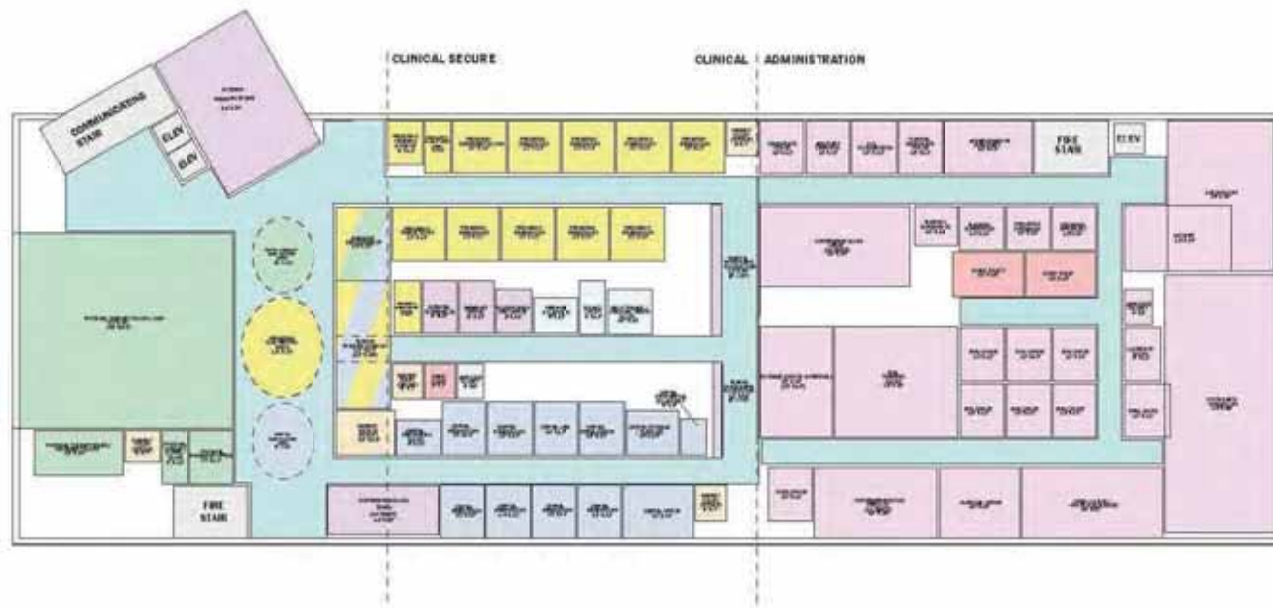


OPTION C

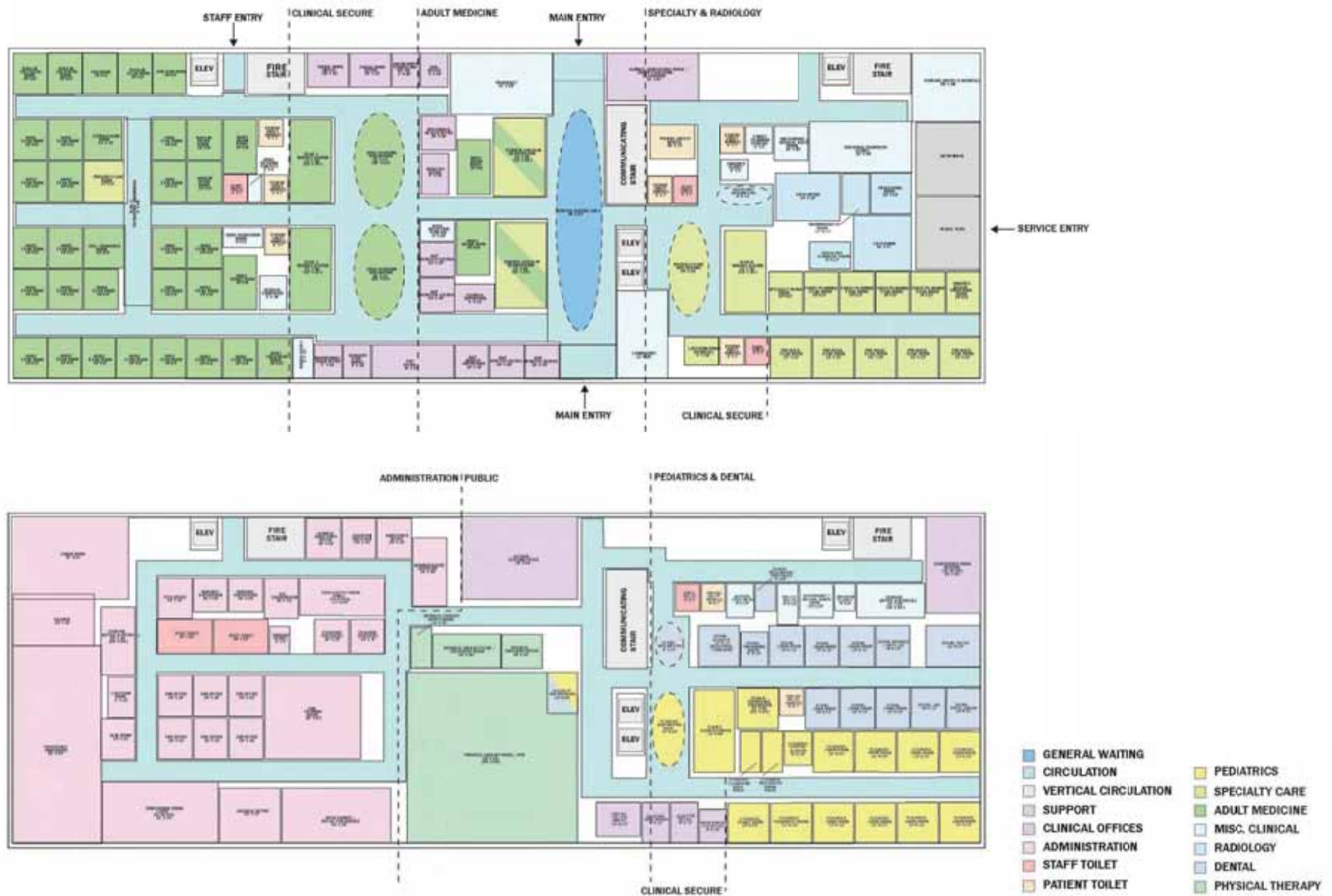








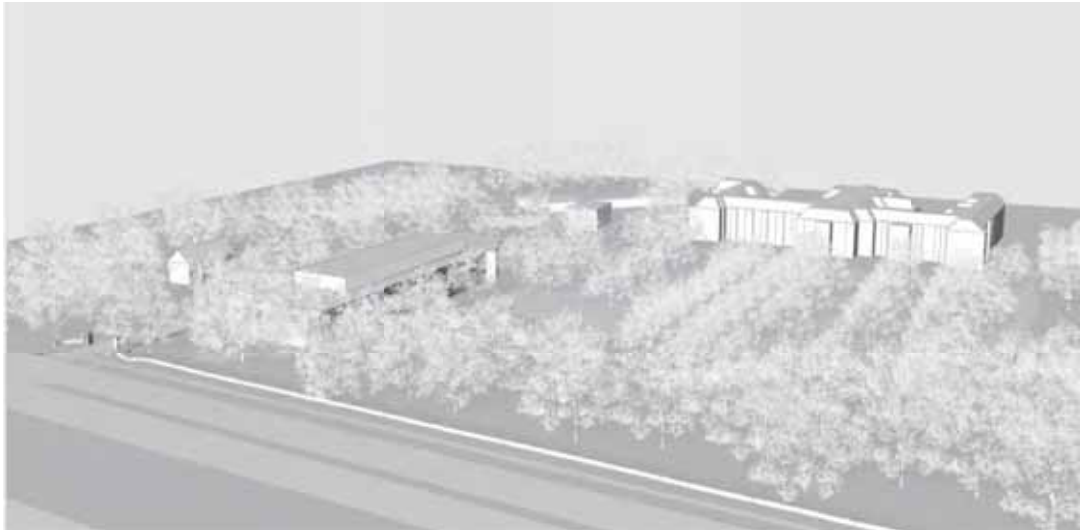
- |                      |                  |
|----------------------|------------------|
| GENERAL WAITING      | PEDIATRICS       |
| CIRCULATION          | SPECIALTY CARE   |
| VERTICAL CIRCULATION | ADULT MEDICINE   |
| SUPPORT              | MISC. CLINICAL   |
| CLINICAL OFFICES     | RADIOLOGY        |
| ADMINISTRATION       | DENTAL           |
| STAFF TOILET         | PHYSICAL THERAPY |
| PATIENT TOILET       |                  |







**VIEW 1: AERIAL VIEW OF SITE, LOOKING WEST**



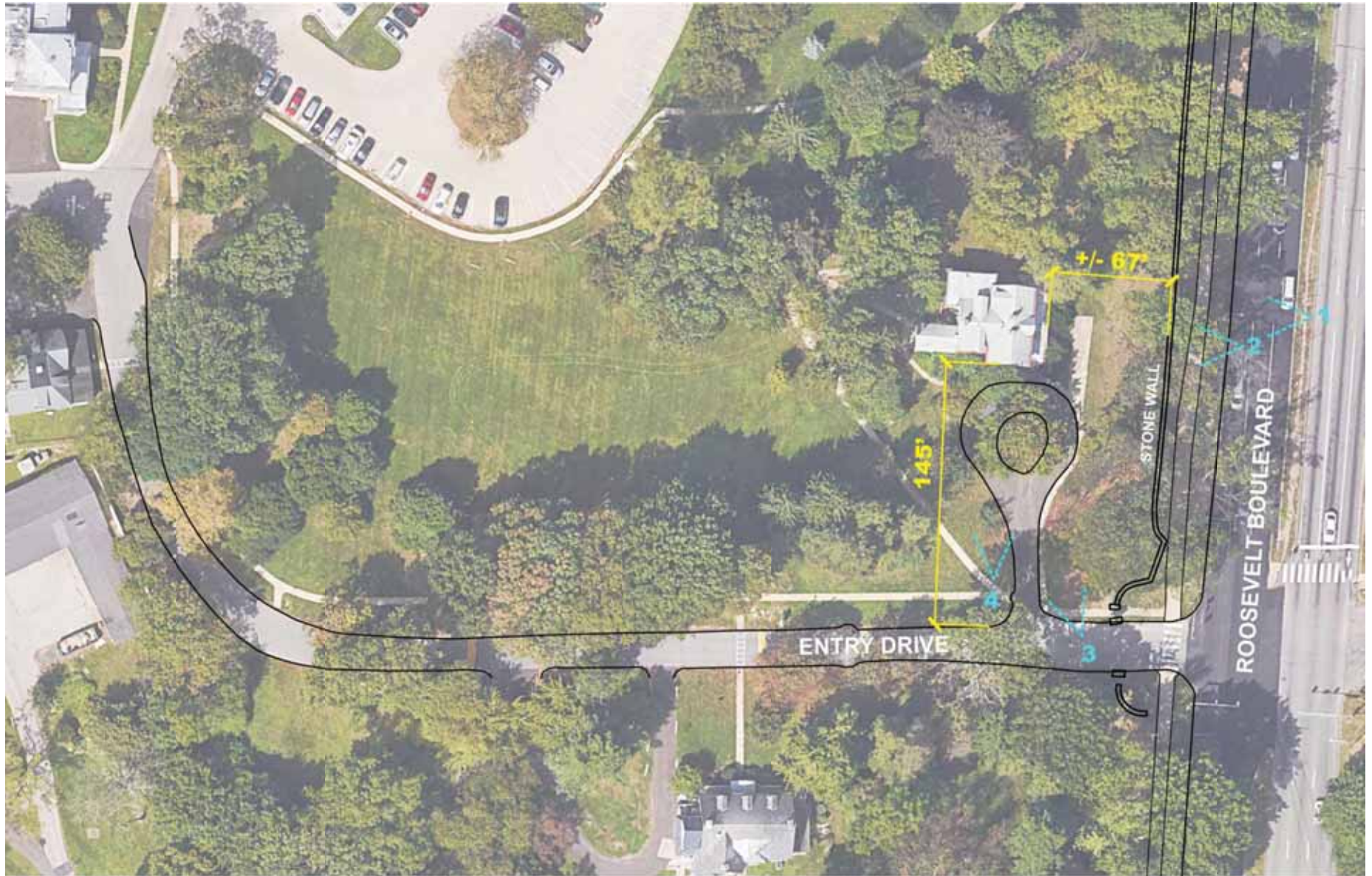
**VIEW 2: AERIAL VIEW OF SITE, LOOKING SOUTH**



**VIEW 3: APPROACH AT GATE**



**VIEW 4: APPROACH AT DROP OFF LANE**







**VIEW 1: VIEW FROM CENTER OF ROOSEVELT BOULEVARD**



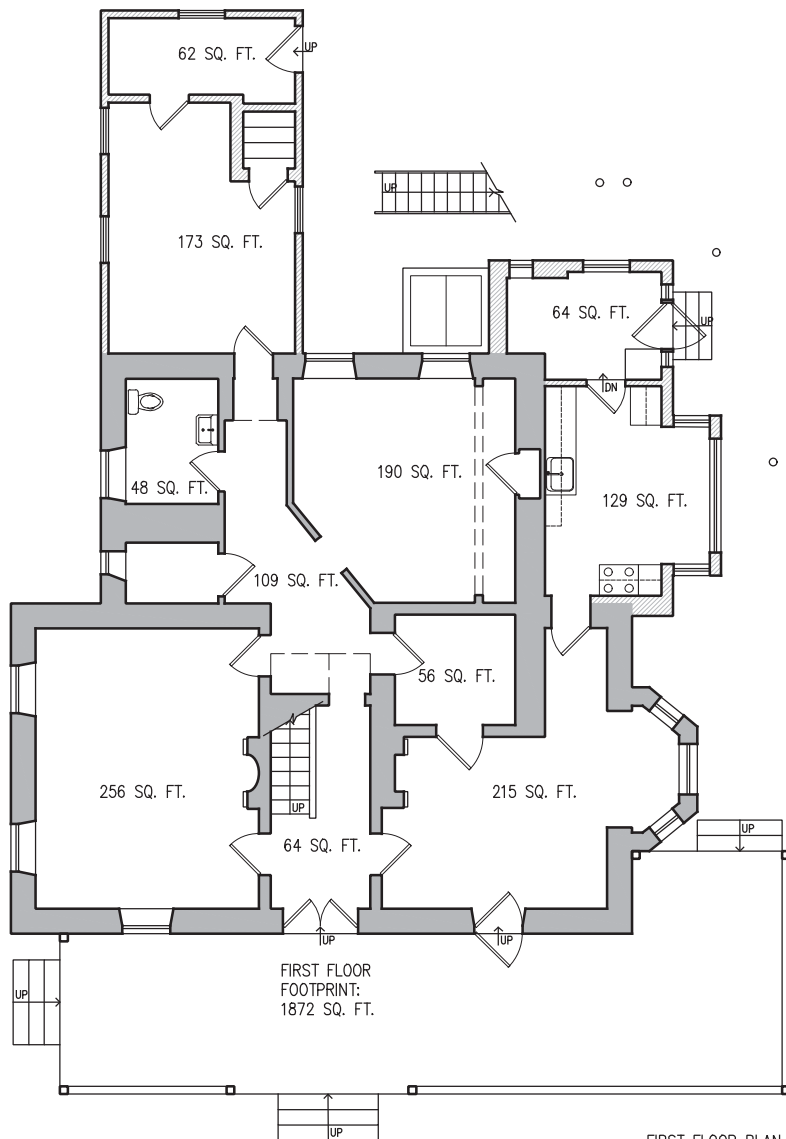
**VIEW 2: VIEW FROM ROOSEVELT BOULEVARD CURB**



**VIEW 3: VIEW FROM ENTRY DRIVE**



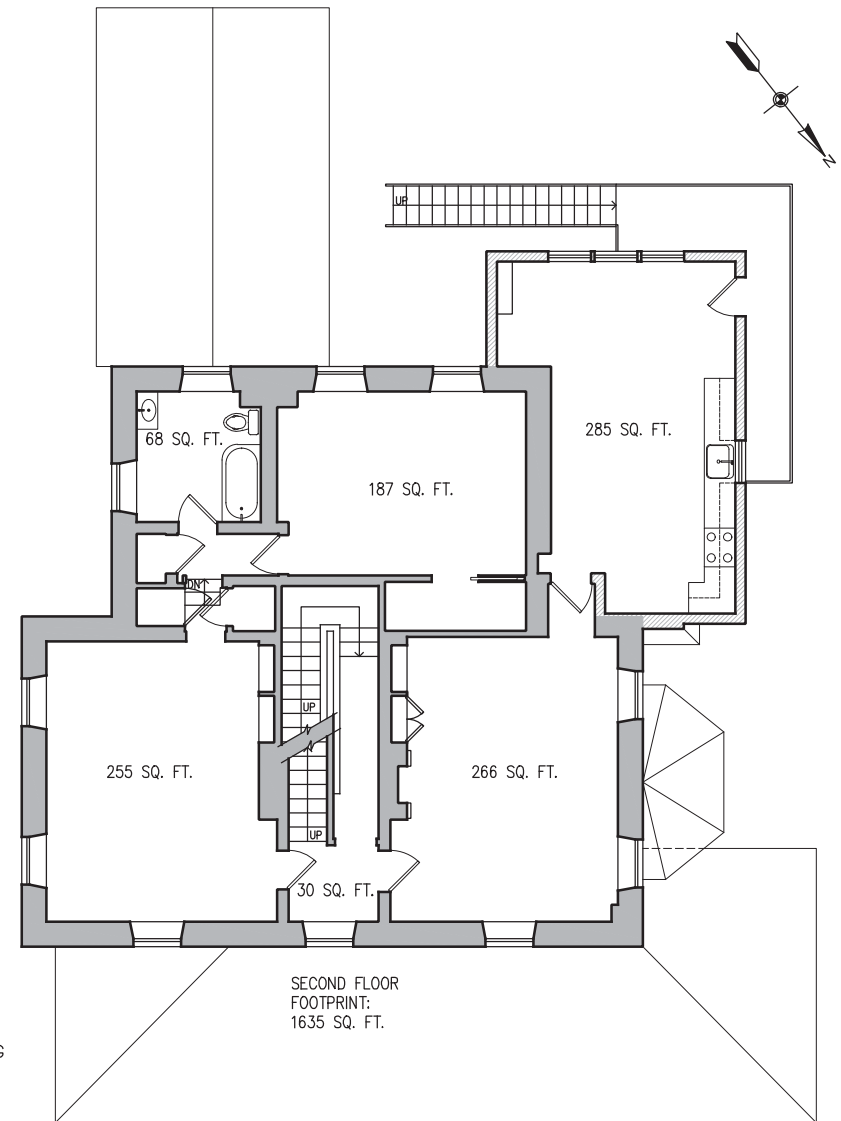
**VIEW 4: VIEW FROM PATH ADJACENT TO ENTRY DRIVE**



FIRST FLOOR  
FOOTPRINT:  
1872 SQ. FT.

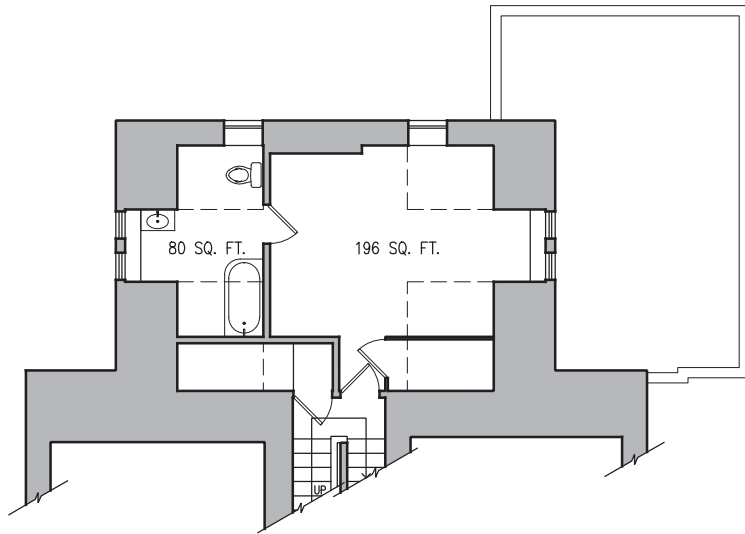
FIRST FLOOR PLAN  
1/8" = 1'-0"

■ ORIGINAL BUILDING  
▨ LATER ADDITION

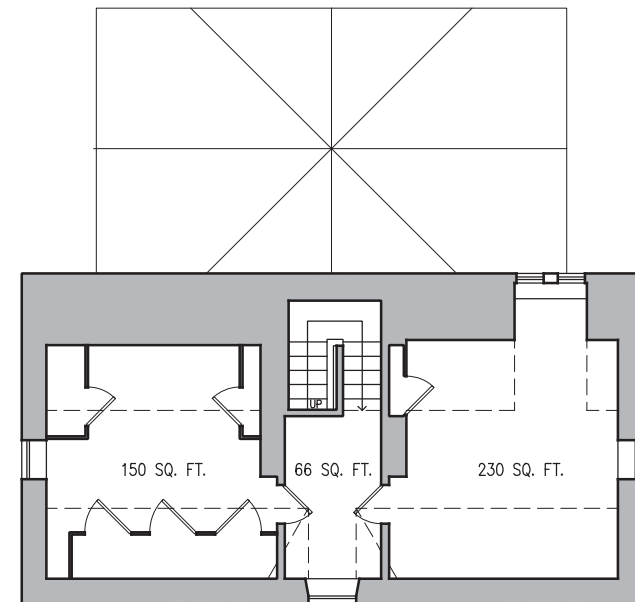


SECOND FLOOR  
FOOTPRINT:  
1635 SQ. FT.

SECOND FLOOR PLAN  
1/8" = 1'-0"



THIRD FLOOR PLAN (LOWER)  
1/8" = 1'-0"



THIRD FLOOR  
FOOTPRINT (COMBINED):  
1306 SQ. FT.

THIRD FLOOR PLAN (UPPER)  
1/8" = 1'-0"







# APPENDIX



# VSBA ARCHITECTS & PLANNERS

116 SHURS LANE PHILADELPHIA PA 19127 (215) 487-0400 VSBA.COM

DRAFT

## NEW NORTHEAST PHILADELPHIA HEALTH CENTER

Revised: July 7, 2020 PROGRAM WORKSHEET

			Min # Occ	# Req'd	Size (feet)	Area (NSF)	Total Area (NSF)	VSBA questions / remarks
<b>CLINICAL SPACE REQUIRED</b>								
		<b>ADULT MEDICINE</b>		<b>36</b>	<b>Exam Rooms</b>			Work flow assumption: 2-3 exam rooms per provider. 1 Provider/.075 Nurse or 3 Providers/ 2 Nurses
	1	Adult Exam Room	2-3	22	10 x 12	120	2,640	Included: behavioral health, nutritionist services and suboxone room.
	1	Adult Triage Room	2-3	4	10 x 16	160	640	quantity of pediatric touchdown stations w/ counter height w/ stools
	1	Adult Treatment Room	2-3	1	10 x 12	120	120	
	1	Walk-In Triage Room	2-3	1	10 x 12	120	120	
	1	Walk-In Treatment Room	2-3	2	10 x 12	120	240	
	1	Walk-In Exam Room	2-3	2	10 x 12	120	240	
	1	EKG Room	2-3	1	10 x 12	120	120	
	1	Isolation Room	2-3	1	10 x 12	120	120	Negative pressure room
	1	ADA / Bariatric Room	2-3	1	12 x 12	144	144	
		Podiatry Exam Room	2-3	1	12 x 12	144	144	To be located in/adjacent to adult medicine
	1	Adult Medication Room	2-4	1	6 x 12	72	72	1 vaccine refrigerator, counter space, cabinets and storage
		<b>SPECIALTY MEDICINE</b>		<b>11</b>	<b>Exam Rooms</b>			
	1	Family Planning Exam Room	2-3	4	10 x 12	120	480	
	1	Pre-Natal Exam Room	2	5	12 x 12	144	720	patient restroom adjacent to pre-natal exam rooms
	1	Women's Health Procedure Room	2	1	10 x 12	120	120	
	1	Specialty Triage Room	2-3	1	10 x 12	120	120	
		<b>PEDIATRICS</b>		<b>10</b>	<b>Exam Rooms</b>			quantity of pediatric touchdown stations w/ counter height w/ stools
	2	Pediatric Exam Room	2-4	8	12 x 12	144	1,152	
	2	Pediatric Triage Room	2-4	1	12 x 12	144	144	
	2	Pediatric Treatment Room	2-4	1	12 x 12	144	144	
	2	Pediatric Phlebotomy Area	2-4	1	6 x 12	72	72	1 phlebotomy chair, sink, counter space, storage, 2 guest chairs (size TBD)
	2	Pediatric Medication Room	2-4	1	6 x 12	72	72	1 vaccine refrigerator, 1 vaccine freezer, counter space, cabinets and storage
	2	Pediatric Hearing and Vision	2	1	8 x 10	80	80	
		<b>RADIOLOGY</b>						
	1*	X-Ray Office	2-3	1	14 x 19	266	266	3 workstations
	1*	X-Ray	2	1	16 x 17	272	272	
	1*	Processing Room	1	1	12 x 12	144	144	
	1*	Radiology Changing Room	1	1	8 x 12	96	96	
	1*	Mammography	2	1	17 x 11	187	187	
	2	Dental Exam Room	2	6	10 x 12	120	720	
	2	Dental Lab	1	1	10 x 12	120	120	
	2	Dental Office	4	1	12 x 16	192	192	
	2	Dental Mechanical Equipment		1	6 x 8	48	48	
	2	Dental Storage / Supplies		1	10 x 12	120	120	possible reduce size of room based on storage requirements
	2	Dental Sterilization	1	1	10 x 12	120	120	

			Min # Occ	# Req'd	Size (feet)	Area (NSF)	Total Area (NSF)	VSBA questions / remarks
	2	Dental Panoramic Room	2	1	8 x 10	80	80	
	1	Pharmacy	6	1	30 x 18	540	540	(2) pharmacists, (3) tech workstations = (5) workstations + (2) service windows
	1	Laboratory	4	1	13 x 30	390	390	(2) phlebotomy chairs.
	2*	Physical Therapy Room/ Gym		1	50 x 50	2500	2,500	(3) PT providers
	2*	Physical Therapy Exam/Treatment Room	2	1	10 x 20	200	200	Include vision panel in upper half of door
	2*	Physical Therapist Office	3	1	10 x 12	120	120	(1) workstation w/ 2 guest chairs; with glass wall to observe PT Room.
	2*	Physical Therapy Supply Room		1	6 x 12	72	72	size TBD based on storage requirements
	1	Clinical Conference Room / Group Education Classroom	18-35	1	14 x 27	378	378	(18) seats at the table or (35) theater style seats.
	1	Managed Care Nurse	2	1	8 x 10	80	80	(1) workstation; located between lobby and adult medicine
	1&2	Benefits Office	2	2	8 x 12	96	192	(1) office for adult medicine on first floor; (1) office for Peds on second floor
	1	PAP Office	4	1	10 x 24	240	240	(2) workstations; Same as HC2 (or consider 2 offices w/ shared med storage); located between lobby and adult medicine
	2	Nutritionist - Ped Office	2	1	8 x 10	80	80	(1) workstation (ask cheryl about registered dietitian exam room and health promotion council nutritionist in conference room)
	1	Nutritionist - Adult Office	2	1	8 x 10	80	80	(1) workstation
	1	Clerical Supervisor	3	2	8 x 12	96	192	(1) workstation
	1	Social Work Office	3	2	10 x 12	120	240	(1) workstation; include sink, counter & storage for in office rapid HIV testing (increase room size from 8x10); confirm 10x12 is adequate; adjacent to adult/ specialty
	1	Ameri Corps Counseling Office	2	1	8 x 10	80	80	(1) workstation
	1	EHR Office	2	1	8 x 10	80	80	(1) workstation
	1	NAP Benefits Clerks	2	4	10 x 10	100	400	(1) workstation per office
	1	NAP Benefits Supervisor	1	1	10 x 10	100	100	(1) workstation
	1	Behavioral Health Office	2	1	10 x 10	100	100	(1) provider, (1) patient ; Cheryl to confirm this space is not already included in adult exam room count
	1	General Waiting Area	96	1	20 x 62	1,240	1,240	(96) seats. Includes waiting for pharmacy and lab. Cash kiosks and optional check-in kiosks.
	1	Central Check-In / Registration	15	1	15 x 50	750	750	Counter space to allow for credit / debit card terminals; 12 stations on 1st fl, 3 stations on 2nd fl
	1	Adult Medicine Sub-Waiting		1	25 x 44	1,100	1,100	(118) seats
	2	Dental Sub-Waiting		1	8 x 12	96	96	(10) seats; w/ dental triage station
	1	Specialty Care Sub-Waiting		1	20 x 25	500	500	(52) seats
	1	Radiology Sub-Waiting		1	5 x 12	60	60	(6) seats
	2	Pediatric Sub-Waiting Area		1	15 x 20	300	300	(30-40) seats [confirm requirement]; old # (27) seats
	1	Benefits Sub-Waiting Area		1	x	0	0	Incorporated within other waiting areas.
	1	Lactation Room (clinical)		1	8 x 10	80	80	
	1	Team A Physicians Touchdown	4	1	12 x 40	480	480	
	1	Team A Nurses Station	5	1	12 x 50	600	600	
	2	Team B Nurses Station	5	1	12 x 50	600	600	
	2	Team B Physicians Touchdown	4	1	12 x 40	480	480	
	2	Kitchen - Teaching Space	15-20	1	34 x 24	816	816	Adjacent to Group Education Classroom /Conference Room.

			Min # Occ	# Req'd	Size (feet)	Area (NSF)	Total Area (NSF)	VSBA questions / remarks
	1&2	Soiled Utility		2	6 x 12	72	144	
	1	Family Planning Storage		1	8 x 8	64	64	
	1	Bio Storage/ Medical Waste Room		1	10 x 10	100	100	
	1&2	Medical Equipment		2	8 x 10	80	160	
	1	Adult Medicine Samples		1	4 x 8	32	32	
	1	Sterilization Room		1	11 x 12	132	132	
	1&2	Staff Toilet (Single Stall)		2	8 x 7	56	112	Sizes and quantity to be adjusted per IBC and Plumbing Codes
	1&2	Patient Toilets (Single Stall)	1	7	8 x 7	56	392	Sizes and quantity to be adjusted per IBC and Plumbing Codes
	1&2	Patient Toilets (Multi Stall)		2	10 x 13	130	260	(2) fixtures each, near General Waiting Area
		<b>Clinical Subtotal (NSF)</b>					<b>24,631</b>	
		<b>ADMIN &amp; SUPPORT SPACE REQUIRED</b>						
	2	Director's Office	1	1	10 x 12	120	120	
	2	Clinical Director's Office	1	1	10 x 12	120	120	
	2	Administrative Assistant	3	1	10 x 20	200	200	(1) workstation
	2	Clerical Office	8	1	16 x 18	288	288	same as per existing HC10
	2	Assistant Director	3	1	10 x 12	120	120	(1) workstation
	2	H.C. Coordinator	3	1	10 x 12	120	120	(1) workstation
	2	Pediatric Specialist	3	1	10 x 10	100	100	(1) workstation
	2	Open Flex Office	2	1	10 x 12	120	120	(2) workstations
	2	Nursing Supervisor	3	2	10 x 10	100	200	(1) workstation
	2	Open Lounge/Office for Nurses	16	1	16 x 32	512	512	w/ adjacent lockers in corridor
	2	Physician's Workroom	27	1	26 x 58	1,508	1,508	53 exam rms, 2 exam rms per provider. Confirm # of providers to # of rooms (2 or 3)
	2	EHR - offices	1	12	10 x 10	100	1,200	EHR staff office
	2	EHR Training Room	31	1	26 x 28	728	728	(30) dedicated training workstations
	2	Conference Room - Small (10 seats)	10	1	11 x 25	275	275	
	2	Conference Room - Medium (12 seats)	12	1	16 x 28	448	448	
	2	Conference Rooms - Large (18 seats)	18	1	18 x 34	612	612	
	2	Medical Legal Partnership Office	3	1	10 x 12	120	120	(1) workstation; 1 task, 2 guest chairs
	2	Lunch Room		1	24 x 34	816	816	(9) tables, (54) seats
	2	Kitchen		1	15 x 24	360	360	Size of a commercial kitchen for cooking class.
	2	Misc Reception Storage		1	6 x 10	60	60	
	2	Mailroom		1	10 x 12	120	120	Size reduced by 20% compared to HC2 mailroom. Confirmed
	1&2	Storage (Office and Medical)			x		1600	Storage for office and medical supplies, comparable to HC2 storage total area. Confirmed
	2	Lactation Room (admin)		1	8 x 12	96	96	This room to include wi-fi.

			Min # Occ	# Req'd	Size (feet)	Area (NSF)	Total Area (NSF)	VSBA questions / remarks
	2	Staff toilet (Multi Stall)		2	10 x 16	160	320	(3) fixtures each.
	1	Custodial Equipment Closet		1	15 x 30	450	450	Storage for floor buffer, carts, etc. Include elec outlets for charging equipment
	1&2	Janitor's Closet		2	6 x 8	48	96	
		<b>Admin &amp; Support Subtotal (NSF)</b>					<b>10,709</b>	
		<b>Total Building Net Assignable Area (NSF)</b>					<b>35,340</b>	
		OTHER AREAS						
		Corridors						
		Mechanical Rooms						
		IT Rooms						See Tel/ Comm/ IT Room notes below
		Tel/Com Closets						See Tel/ Comm/ IT Room notes below
		Stairs						
		Misc Closets						
		Electrical Closets						
		Exterior Walking Track						
		Exercise Room						Part of Physical Therapy Room, if required.
		Trash / Recycling						
		Elevators						
		<b>Space Factor (1.55)</b>					<b>19,437</b>	
		<b>Total Gross Square Feet Area (GSF)</b>					<b>54,777</b>	

## Tel/ Comm/ IT Room Notes:

The IT Room should be at least 12'x6' or 72 sq.ft.  
 It should fit a racking system w/cable and overhead tray management to support a patch panel servicing at least 250 network terminations, a stack of 6 Juniper switches, fiber connections and telephone equipment to handle 200 (IP) phones, UPS w/temperature monitoring, audio/video surveillance equipment, wireless control, fire suppression equipment and analog termination for 12 fax lines.

# of staff (FT and PT) is 123

# of electronically connected devices should be 213.

# of physical phones is 153. This includes phones and language lines.

# of fax lines is 12.

# STAYING healthy



## ACCESS TO PRIMARY CARE IN PHILADELPHIA



### EXECUTIVE SUMMARY

Primary care providers serve as the front line of the city's health care system, helping people stay healthy and preventing hospitalizations. Yet, some Philadelphians lack adequate access to primary care services. Access to care largely depends on having health insurance coverage, being able to afford healthcare costs, and having adequate availability and accessibility of healthcare providers and facilities.



## INTRODUCTION

This report summarizes recent data on primary care access in Philadelphia. Key findings include:

- **Overall supply of primary care providers (PCPs) continues to rise** — there is approximately one primary care provider for every 1,243 residents. While the total number of PCPs continues to rise, the percent of PCPs accepting Medicaid has declined in recent years.
- **There is significant variation in supply of PCPs** across the city. Communities with the lowest supply of PCPs are more commonly low-income and have high proportions of racial/ethnic minorities.
- **Clusters of neighborhoods in the Northeast and Southwest regions had significantly lower supply of PCPs** — some areas even reaching the threshold for designation as a primary care shortage area. In these same areas, availability for primary care appointments was lowest.
- **Availability of primary care appointments is lower and wait times are longer for people with Medicaid** compared to those who are privately insured.
- Philadelphia has 46 community health centers — only one is in the Northeastern region.
- **Rates of uninsured adults and children have declined significantly after the implementation of the Medicaid expansion.** Overall, 12 percent of adults are uninsured, yet, in some communities — particularly in the Northeast and Southwest regions — rates of uninsured adults are nearly 40 percent.
- **Uninsured rates are highest among younger adults, men, racial ethnic minorities, those just above the federal poverty line, and the unemployed.**
- **Nearly 40 percent of non-citizen immigrants are uninsured** — over four times the rate of the general population.
- **Approximately 1 in 6 adults reported not having a primary care provider** — they were more likely to be younger, men, low-income, and uninsured.
- **The number of hospitalizations that are potentially preventable with timely access to primary care continues to decline;** however, rates are more than twice as high among non-Hispanic blacks and Hispanics.

The findings of this report highlight several opportunities for organizations — particularly health care providers, payers, and government — and people to improve primary care access throughout Philadelphia. Notably, addressing the gaps in access in communities in Northeast and Southwest Philadelphia should be a high priority for stakeholders.



Many of the leading causes of premature death in Philadelphia can be prevented or delayed with high-quality primary care. Done well, primary care helps people maintain healthy lifestyles, identifies disease early, helps patients manage chronic conditions, coordinates care for patients with more than one problem, and avoids costly complications and hospitalizations. Adequate access to primary care has been shown to improve health outcomes and reduce overall health care costs. It is an essential building block of a high functioning health care system and population health.

The Affordable Care Act included several provisions to improve access to primary care through provision of comprehensive health insurance. In Philadelphia, this resulted in expanded access to Medicaid for many low-income families and affordable comprehensive insurance through the exchanges for many others. Concerns about the capacity of the primary care workforce to handle increases in healthcare coverage have been noted nationally. Because of higher reimbursement rates for Medicare and private insurance, some providers limit their practices to only those patients. As such, primary care access concerns are even greater for those covered by Medicaid and the uninsured.

Although primary care is largely delivered by private providers, it plays such an essential role in health that monitoring access to primary care is an important function of public health departments. In 2014, the Philadelphia Department of Public Health, in collaboration with the Leonard Davis Institute at the University of Pennsylvania began developing methods for routinely monitoring access to primary care in Philadelphia. This new report provides comprehensive information on access to primary care and can be used to inform decisions on where to direct additional primary care services.

Access to primary care is a complex issue to measure, involving not just enrollment in health insurance, but also structural factors, like availability of quality providers within a reasonable distance of a patient's home, and a host of social, economic and behavioral patient factors.

This report focuses on four important areas of access to care in Philadelphia:

1. Availability and capacity of primary care providers
2. Health insurance coverage
3. Utilization of preventive healthcare services
4. Adverse outcomes from inadequate primary care

Definitions of the measures in this report are included in the Appendix.

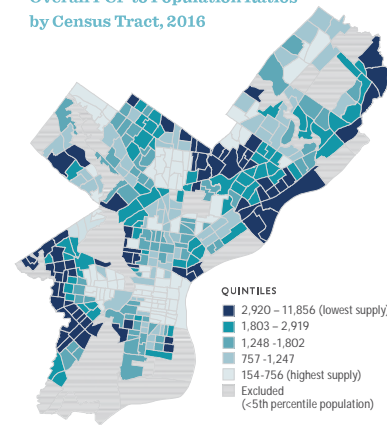
# 1.

## Supply and Availability of Primary Care Providers

### Supply of Primary Care Providers (PCPs)

One important measure of primary care access is the supply of primary care providers. Overall, Philadelphia has a large supply of primary care providers — *approximately one primary care provider for every 1,243 residents* — similar to the national average of one primary care provider for every 1,320 people. The Health Services and Resources Administration (HRSA) designates geographic areas with more than 3,500 residents for every primary care provider as a primary care health professional shortage area (HPSA). Overall, Philadelphia fares well against this threshold, but there is significant variation across the city and some areas meet the criteria as primary care HPSA.

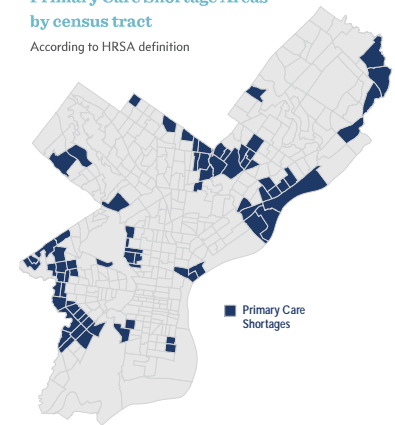
FIGURE 1  
Overall PCP to Population Ratios by Census Tract, 2016



Source: Leonard Davis Institute of Health Economics, University of Pennsylvania

Several clusters of areas have lower access to primary care, as measured by provider to population ratios. As shown in Figure 1, there are large clusters of census tracts with significantly lower provider to population ratios in the Northeast, Southwest, and parts of South Philadelphia.

FIGURE 2  
Primary Care Shortage Areas by census tract  
According to HRSA definition



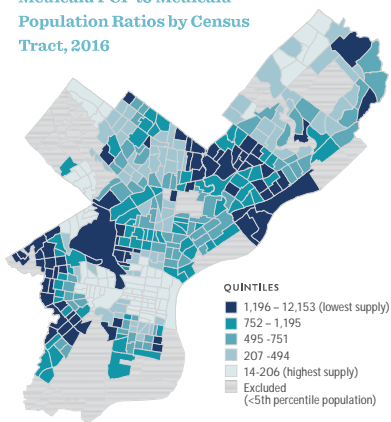
Source: Leonard Davis Institute of Health Economics, University of Pennsylvania

The census tracts highlighted in Figure 2 have a provider to population ratio greater than 3,500 above the HRSA threshold for primary care shortage areas.





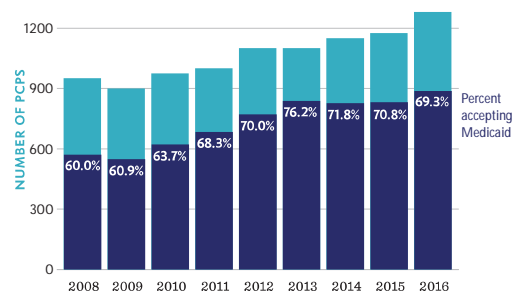
**FIGURE 3**  
Medicaid PCP to Medicaid  
Population Ratios by Census  
Tract, 2016



Source: Leonard Davis Institute of Health Economics,  
University of Pennsylvania

Not all primary care providers accept patients with Medicaid. Figure 3 presents ratios of Medicaid-accepting providers to the number of residents enrolled in Medicaid by census tract. Similarly, there is significant variation in provider supply across the city and some clusters of lower access are apparent, including areas in west, southwest, and northeast.

**FIGURE 4**  
Supply and Medicaid Acceptance of PCPs in Philadelphia,  
2008–2016



Source: Leonard Davis Institute of Health Economics, University of Pennsylvania

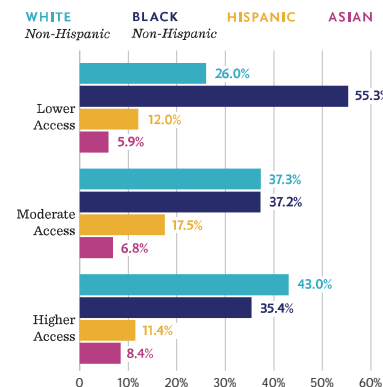
Overall the supply of primary care providers in Philadelphia has been increasing in the past decade. However, the proportion of primary care providers that accept patients with Medicaid has declined over the past few years.

For additional information on Supply of Primary Care Providers in Philadelphia see Molly Candon, Elena Andreyeva, Rebecka Rosenquist, and David Grande. Supply of Primary Care Providers and Appointment Availability for Philadelphia's Medicaid Population. Penn LDI Issue Brief. 2018. <https://ldi.upenn.edu/brief/supply-primary-care-providers-and-appointment-availability-philadelphia-s-medicaid-population>

## Characteristics of Areas with Lower Supply of PCPs

Areas with lower supply of PCPs did not differ by age or percent of adults without insurance from areas with higher supply. However, areas with lower access to primary care had higher concentrations of non-Hispanic blacks and a lower median household income, compared to areas of higher access to primary care.

**FIGURE 5**  
Race/Ethnicity of Lower Access Areas

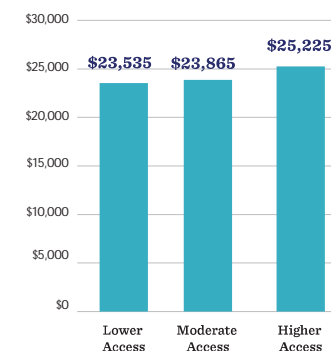


Source: Race/Ethnicity—American Community Survey,  
U.S. Census Bureau

## Availability of Primary Care Providers

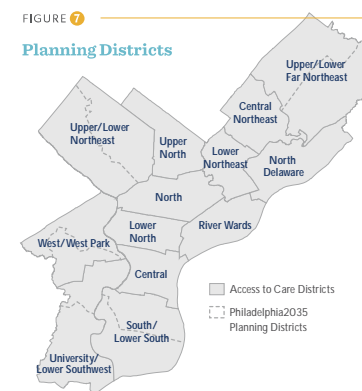
While provider-to-population ratio is an important measure of supply, it does not fully represent availability of primary care providers to provide care. Based on a survey conducted of over 400 primary care providers in Philadelphia during 2014–2016 period, availability of existing primary care providers for non-urgent health care appointments varies throughout Philadelphia. Citywide, of the providers surveyed, 85 percent had an appointment available for a patient with private insurance and 66 percent had an appointment available for a patient with Medicaid—a notable difference. Appointment availability also varied by planning district differently for private insurance and Medicaid patients (Figures 8 and 9).

**FIGURE 6**  
Relationship between median income  
and supply of PCPs



Source: Average Median Income - American Community Survey,  
U.S. Census Bureau

**FIGURE 7**  
Planning Districts

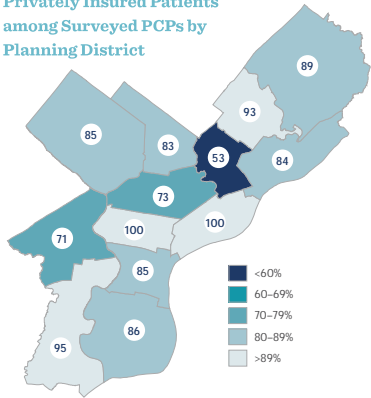


Despite the large sample of primary care providers surveyed, some planning districts had too few providers to produce reliable estimates. Some planning districts were merged as shown here to account for this difference.



Availability of  
Primary Care  
Providers  
(continued)

FIGURE 8  
Appointment Availability for  
Privately Insured Patients  
among Surveyed PCPs by  
Planning District



Source: Leonard Davis Institute of Health Economics, University of Pennsylvania

Primary care appointment availability for the privately insured was significantly lower in the Lower Northeast than in other planning districts. In many planning districts, nearly all providers had appointments available for patients with private insurance.

FIGURE 10  
Non-urgent appointment  
availability for Medicaid  
and private insurance:  
Philadelphia and  
select major cities

Private insurance and Medicaid appointment availability in Philadelphia was similar and in many cases better than other major U.S. cities. Of note, some cities, like Pittsburgh, PA and Atlanta, GA, did not have as great a disparity in overall availability between private insurance and Medicaid.

Source: Primary Care Access in Philadelphia, Leonard Davis Institute of Health Economics, University of Pennsylvania

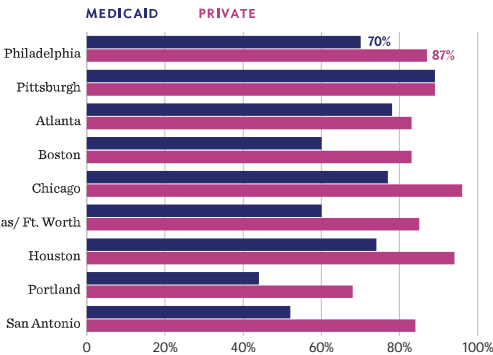
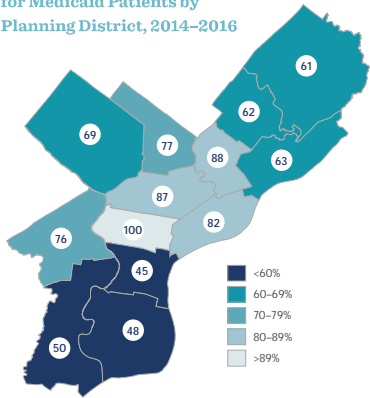


FIGURE 9  
Appointment availability  
for Medicaid Patients by  
Planning District, 2014–2016



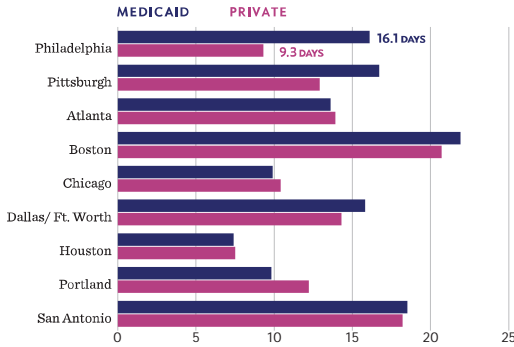
Source: Leonard Davis Institute of Health Economics, University of Pennsylvania

Primary care appointment availability for patients with Medicaid coverage was lowest in the central planning district. This suggests while supply of providers who receive Medicaid reimbursement may be high in this area, fewer providers have real-time availability to accept new patients on Medicaid. Medicaid appointment availability was also low in the South/Lower South region.

Wait  
Times

Another important component of availability of primary care providers is the amount of time a patient has to wait for an appointment. Based on the same study, of providers surveyed, average wait times for a new patient appointment in Philadelphia were approximately 9 and 16 days for privately insured and Medicaid patients, respectively. Wait times varied across major U.S. cities.

FIGURE 11  
Wait time in days for Medicaid  
and Privately-insured:  
Philadelphia and  
select major cities

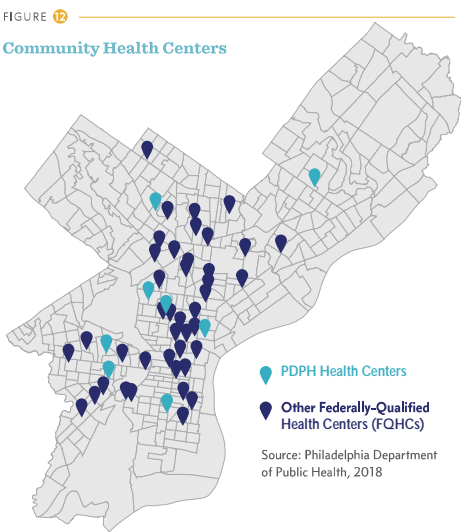


Source: Primary Care Access in Philadelphia, Leonard Davis Institute of Health Economics, University of Pennsylvania

For additional information on Supply of Primary Care Providers in Philadelphia see Molly Candon, Elena Andreyeva, Rebecka Rosenquist, and David Grande. Supply of Primary Care Providers and Appointment Availability for Philadelphia's Medicaid Population. Penn LDI Issue Brief. 2018. <https://ldi.upenn.edu/brief/supply-primary-care-providers-and-appointment-availability-philadelphia-s-medicaid-population>

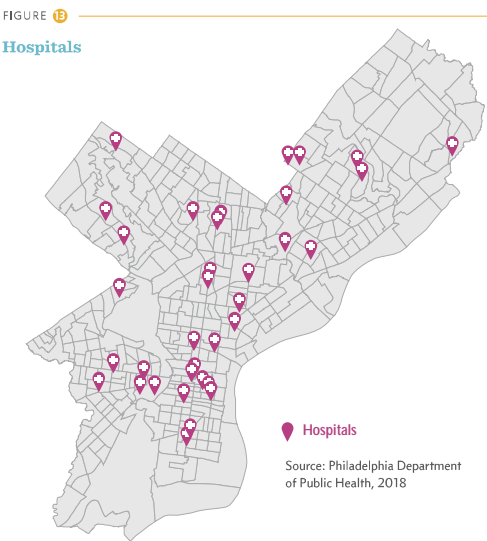
Community Health Centers

Community health centers are an essential component of the health care safety net in Philadelphia. Community health centers provide health care service to the most vulnerable populations, particularly individuals without insurance or U.S. citizenship. These centers are often located in areas of the city with high proportions of these at-risk populations and lack of access to other affordable options. Figure 14 shows the location of the eight city-operated community health centers and the other 46 community health centers. These centers tend to be clustered in the central parts of Philadelphia. Of note, areas in the Northeast have low access and only one community health center.



Acute Care Hospitals

Philadelphia has 37 hospitals that provide acute and long-term acute care. Many of these hospitals are part of health systems that provide primary care in co-located outpatient practices.



2.

Health Insurance Coverage in Philadelphia

Uninsured in Philadelphia

Individuals are more likely to avoid primary care if they do not have health insurance. Approximately 12 percent of adults ages 18-64 in Philadelphia are without health insurance.

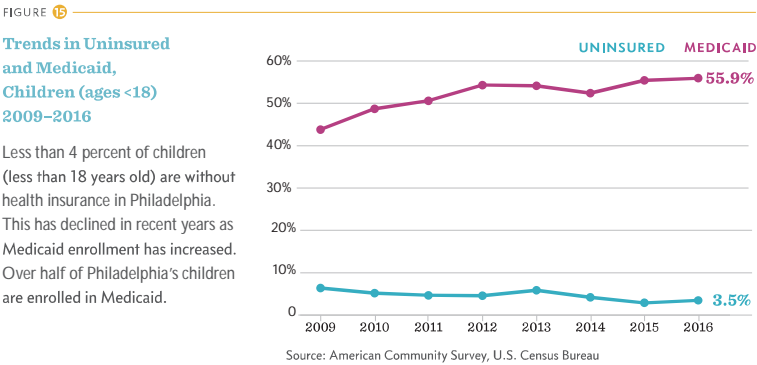
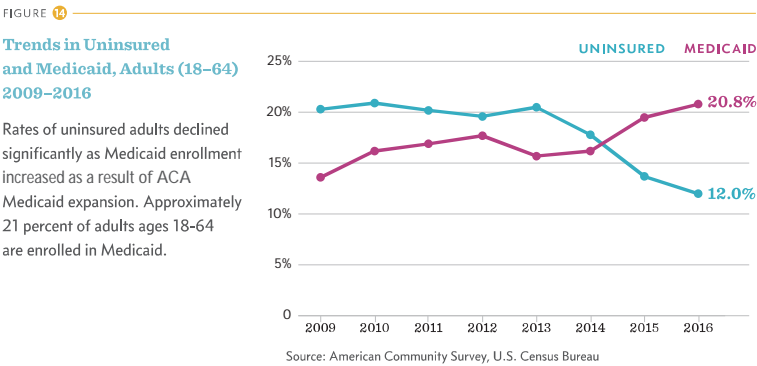


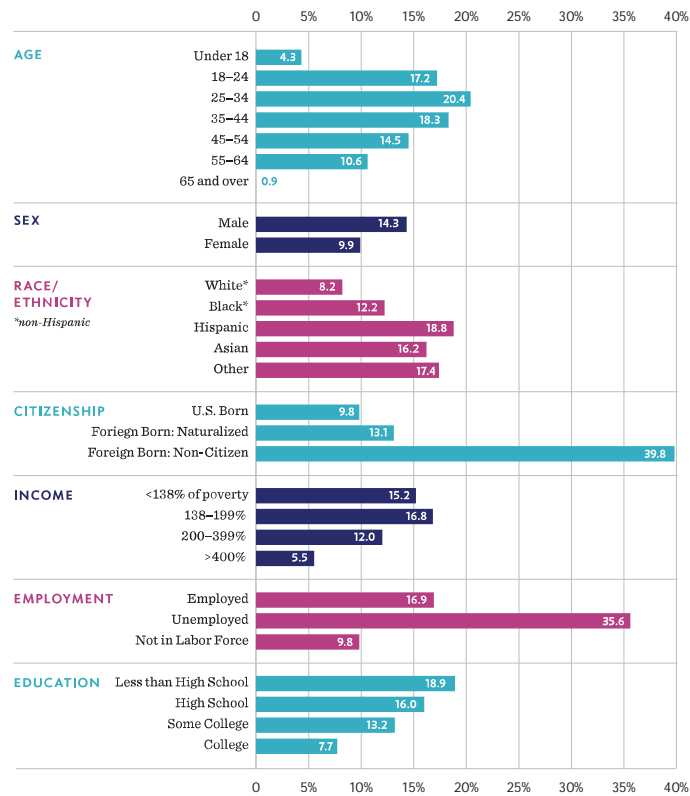


FIGURE 16  
Uninsurance Rates  
in Subpopulations  
2016

Uninsured rates vary by demographics and geography. Some notable trends are highlighted below. Uninsured rates are higher among:

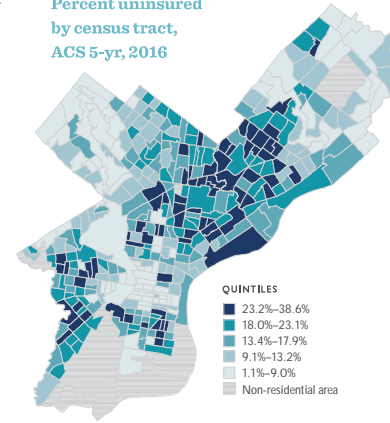
- Younger adults (ages 18–44)
- Males
- Racial/ethnic minorities
- Foreign-born non-citizens
- Individuals just above 138 percent of federal poverty threshold
- The unemployed
- Individuals with less than a high school diploma

Source: American Community Survey, U.S. Census Bureau



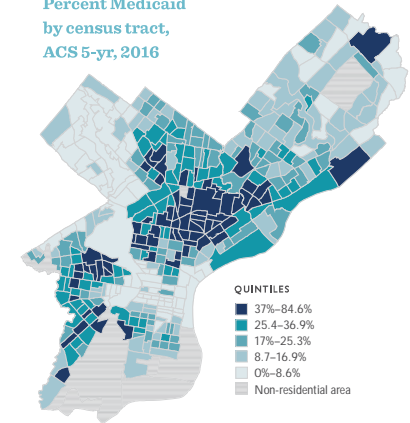
## Uninsured in Philadelphia (continued)

FIGURE 17  
Percent uninsured  
by census tract,  
ACS 5-yr, 2016



Source: American Community Survey, U.S. Census Bureau

FIGURE 18  
Percent Medicaid  
by census tract,  
ACS 5-yr, 2016

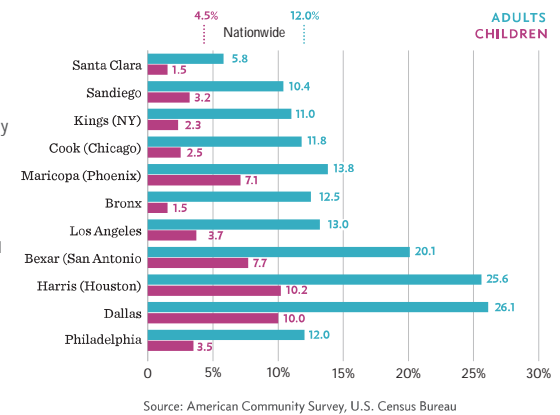


Source: American Community Survey, U.S. Census Bureau

Several areas within North, Northeast, West and South Philadelphia have significantly higher uninsured populations. Many of these same areas have high rates of Medicaid enrollment. Many of these are the same areas that have shortages of primary care providers.

FIGURE 19  
Percent uninsured adults  
(18–24) and children (<18)  
in major U.S. cities

Rates of uninsured adults and children in Philadelphia are mostly comparable but in some cases significantly lower than other major U.S. cities. U.S. cities with the highest uninsured rates also have high rates of undocumented immigrants and are in states that did not expand Medicaid.



# 3.

## Utilization of Preventive Healthcare Services



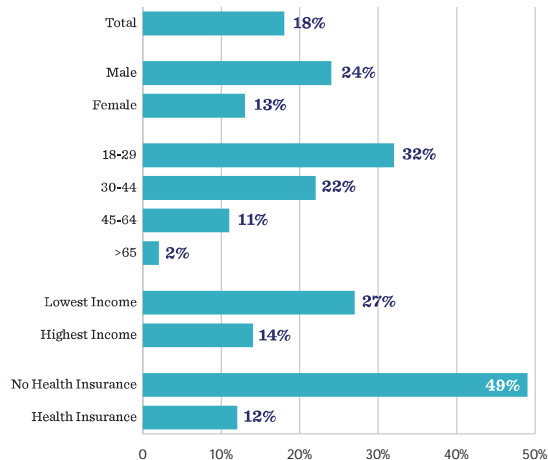
### Utilization of Primary Care Services

Beyond availability of primary care providers and health insurance coverage, individuals must actually use primary care services regularly. Determining use of primary care services at the population level can be challenging as distinguishing between preventive and urgent/acute visits to primary care providers is complex. Population-based surveys provide some insight into utilization of preventive services.

FIGURE 20

#### Characteristics of Adults without a Primary Healthcare Provider, Philadelphia 2016

In 2016, 18 percent of adults reported not having a primary care provider. Adults without a primary care provider were more likely to be men, younger, low-income and without health insurance.



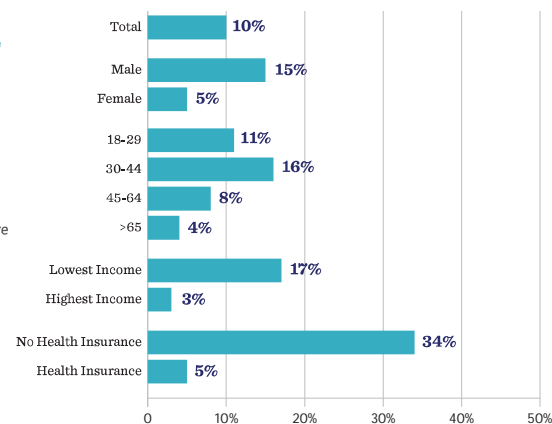
Source: PA BRFSS, PA Department of Health

### Utilization of Primary Care Services

FIGURE 21

#### Characteristics of Adults Who Usually Receive Care at an Emergency Room, Philadelphia 2014

Approximately 10 percent of adults reported the emergency room as their usual source of care. Adults who usually receive care in the emergency room were more likely to be men, younger, low-income and without health insurance.

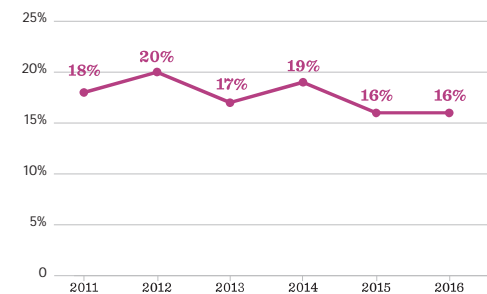


Source: PA BRFSS, PA Department of Health

FIGURE 22

#### Adults Avoiding Needed Care Due to Cost in Philadelphia, 2011-2016

There are several potential barriers to accessing preventive and other health care. For uninsured and low-income, cost is commonly the primary driver. In 2016, approximately 16 percent of adults reported not accessing care due to cost, a slight decrease from previous years. Among adults without health insurance, 48 percent reported avoiding care due to cost, compared to only 13 percent among adults with health insurance.



Source: PA BRFSS, PA Department of Health

### Preventive Screenings

Based on 2016 results from the Pennsylvania Behavioral Risk Factor Surveillance System (PA BRFSS), in Philadelphia:

- 80 percent of women ages 50 to 74 reported having a mammogram within the previous 2 years
- 75 percent of men over the age of 50 reported ever having a prostate cancer screening
- 68 percent of adults over the age of 50 reported ever having a colon cancer screening



# 4.

## Adverse Outcomes from Inadequate Primary Care



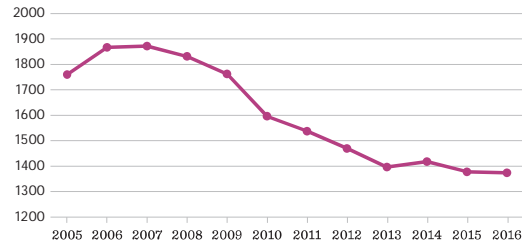
When chronic health conditions like asthma, diabetes, and hypertension are managed adequately in primary care settings, patients can avoid many hospitalizations for complications. For this reason, rates of hospitalizations for these “ambulatory care-sensitive conditions” (ACSCs), are used as an indicator for access to and quality of primary care.

### Adverse Outcomes

FIGURE 23

#### Hospitalizations for Ambulatory Care Sensitive Conditions, 2005–2016

In Philadelphia, rates of hospitalizations due to ACSCs have declined steadily over the last decade.



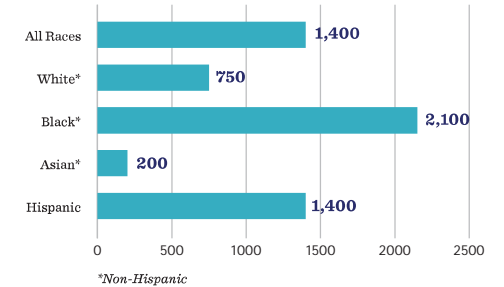
Source: Hospital Inpatient File, Pennsylvania Health Care Cost Containment Council, 2005–2016

### Adverse Outcomes

FIGURE 24

#### Hospitalizations for Ambulatory Care Sensitive Conditions by Race/Ethnicity, 2005–2016

However, rates are nearly 2.5 times higher among non-Hispanic blacks and 2 times higher among Hispanics than non-Hispanic whites.

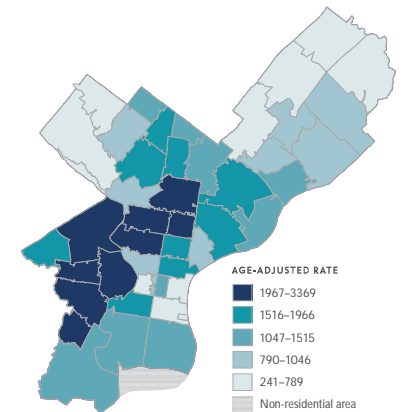


Source: Hospital Inpatient File, Pennsylvania Health Care Cost Containment Council, 2005–2016

FIGURE 25

#### Ambulatory Care Sensitive Hospitalization Rates per 100,000 by zip code, 2016

Rates are also higher among residents from North and West Philadelphia.



Source: Hospital Inpatient File, Pennsylvania Health Care Cost Containment Council, 2005–2016

# What Can Be Done

Primary care can be improved in ways to benefit the health of people in Philadelphia if organizations and individuals take these steps:

## The Department of Public Health will:

- Continue to provide primary care to all patients, including those who are uninsured, through eight health centers
- Expand services in Northeast Philadelphia where the need for primary care is high and the number of primary care providers is inadequate
- Encourage health systems and other providers to locate primary care facilities in underserved areas, particularly in Northeast and West/Southwest Philadelphia
- Continue to convert its health centers from Federally Qualified Health Center (FQHC) “look-alike” status to Section 330 FQHCs as funding becomes available to permit expansion of services to underserved parts of Philadelphia

## Health systems can:

- Expand primary care services to underserved areas, particularly in Northeast and West/Southwest Philadelphia
- Accept patients who are on Medicaid Managed Care Plans or are uninsured as part of community benefit services and assure that appointments are available for these patients
- Develop or expand collaborative relationships with primary care providers to reduce hospitalizations by improving the utilization and quality of primary care for chronic conditions such as diabetes, hypertension, asthma, and chronic heart or lung disease

## Federally-qualified health centers and other outpatient primary care providers can:

- Expand primary care services to underserved areas, particularly in Northeast and Southwest Philadelphia
- Accept not only patients who are on Medicaid, but also patients who are uninsured, and assure that appointments are available to these patients
- Develop or expand collaborative relationships with health systems to reduce hospitalizations by improving the utilization and quality of primary care for chronic conditions such as diabetes, hypertension, asthma, and chronic heart or lung disease

## Managed Care Organizations can:

- Negotiate with health systems so that members can easily access primary care
- Encourage members with chronic conditions to use consistent primary care providers to prevent complications
- Require provider networks to provide full access to any Medicaid patient seeking to receive primary care from one of their provider practices
- Develop value-based reimbursement strategies with outpatient practices that reward successful management of chronic health conditions in the outpatient setting

## People can:

- Use primary care providers consistently to improve management of chronic conditions and prevent complications

## Measures and Definitions

### Supply of Primary Care Providers (PCP)

**Number of PCPs** - The number of primary care providers are estimated using a combination of data sources, including a proprietary list of providers from SK&A™, local provider network directories, and the PDPH directory of community health centers. The directories are filtered to the following specialties: certified registered nurse practitioner (CRNP); family practice (FP); general practice (GP); pediatrics (PED); internal medicine (IM); nurse practitioner (NP); osteopathic medicine (DOP); and geriatrics (GER).

**Percent of PCPs Accepting Medicaid** – Medicaid acceptance was based on reports to SK&A™ or via telephone survey. As most providers do not exclusively serve Medicaid patients, an adjustment factor was applied to reflect only a portion of the provider’s time serving Medicaid patients.

**Overall PCP to Population Ratio** – Ratio of primary care provider to number of individuals living in the census tract, based on American Community Survey 5-year population estimates.

**Medicaid PCP to Medicaid Population Ratio** - Ratio of primary care providers that accept Medicaid, to adults (age 18-64) with public/means-tested insurance living in the census tract, based on American Community Survey 5-year population estimates.

**Primary Care Shortage Area** – A census tract with an overall PCP to population ratio greater than 1:3,500.

### Characteristic of Lower PCP Supply Areas

**Low, Medium and High Supply Areas** – Designations assigned based on tertiles of overall PCP to population ratios.

**Area Characteristics** (e.g. Race/Ethnicity and Median Income) – Demographic and socio-economic data were obtained from the American Community Survey 5-year estimates.

### Availability of PCPs

**Appointment Availability** – Appointment availability was obtained from a survey of a large sample of PCP practices in the Philadelphia region. This study was conducted in coordination with a larger effort to produce similar estimates for other major U.S. cities, hence allowing for the city-to-city comparison. PCPs were surveyed via telephone and asked about availability of an appointment at that time for a non-urgent patient with private and Medicaid insurance separately.

**Appointment Wait Time** - Appointment wait time was obtained from a survey of a large sample of PCP practices in the Philadelphia region. This study was conducted in coordination with a larger effort to produce similar estimates for other major U.S. cities, hence allowing for the city-to-city comparison. PCPs were surveyed via telephone and asked for the date of the next available appointment for a non-urgent patient with private and Medicaid insurance separately.

### Health Insurance Coverage

**Uninsured Adults and Children** – Insurance status was obtained from American Community Survey 1-year estimates.

**Adults without a PCP** – Self-reported by Philadelphia residents surveyed as a part of the PA Department of Health Behavioral Risk Factor Surveillance System.

**Adults with Emergency Room as Usual Source of Care** - Self-reported by Philadelphia residents surveyed as a part of the PA Department of Health Behavioral Risk Factor Surveillance System.

**Adults Avoiding Care Due to Cost** - Self-reported by Philadelphia residents surveyed as a part of the PA Department of Health Behavioral Risk Factor Surveillance System.

### Adverse Outcomes from Inadequate Primary Care

**Hospitalizations for Ambulatory Care Sensitive Conditions** – Age-adjusted rate of hospitalizations for conditions where ambulatory care prevents or reduces the need for admission to the hospital for adults under 75 years of age, based on the Agency for Healthcare Research and Quality Prevention Quality Indicators composite acute and chronic condition measures.

## Acknowledgements



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