Philadelphia: The Community We Serve

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Basic Premise

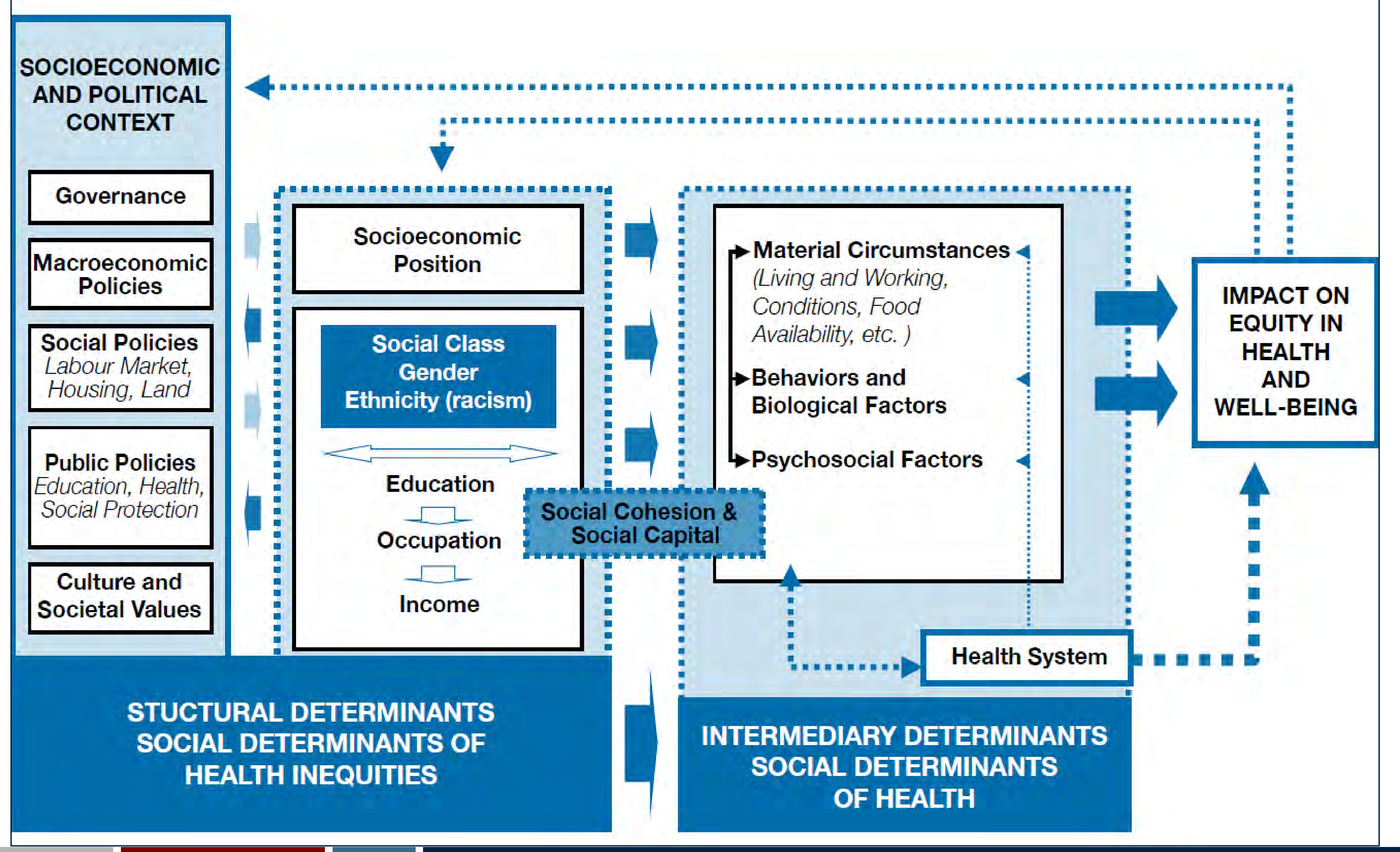
Inequality vs. Inequity

- **Health inequality** refers to differences in health or health outcomes between individuals or groups.
  - Description of an unequal distribution
  - Does not focus on whether observed differences are fair or just.

- **Health inequity** is a specific type of health inequality that denotes an unjust difference in health.
  - Systematic differences in health that could be avoided by reasonable means
  - Differences in health by social groups such as race or class are that reflect an unfair distribution of health resources and risk

- Socioeconomic inequalities experienced by communities of color in the US are the direct result of systemic and structural racism.

“Systemic and structural racism are forms of racism that are pervasively and deeply embedded in and throughout systems, laws, written or unwritten policies, entrenched practices, and established beliefs and attitudes that produce, condone, and perpetuate widespread unfair treatment of people of color………. It consists of the societal systems and structures that expose people of color to health-harming conditions and that impose and sustain barriers to opportunities that promote good health and well-being”
Braveman et al. 2020


SOCIOECONOMIC AND POLITICAL CONTEXT
Governance
Macroeconomic Policies
Social Policies
Labour Market, Housing, Land
Public Policies
Education, Health, Social Protection
Culture and Societal Values
Socioeconomic Position
Social Class
Gender
Ethnicity (racism)
Education
Occupation
Income
Social Cohesion & Social Capital
Material Circumstances
(Living and Working, Conditions, Food Availability, etc.)
Behaviors and Biological Factors
Psychosocial Factors
Health System
IMPACT ON EQUITY IN HEALTH AND WELL-BEING
STUCTURAL DETERMINANTS SOCIAL DETERMINANTS OF HEALTH INEQUITIES
INTERMEDIARY DETERMINANTS SOCIAL DETERMINANTS OF HEALTH

Health Impact Pyramid

Counseling & Education

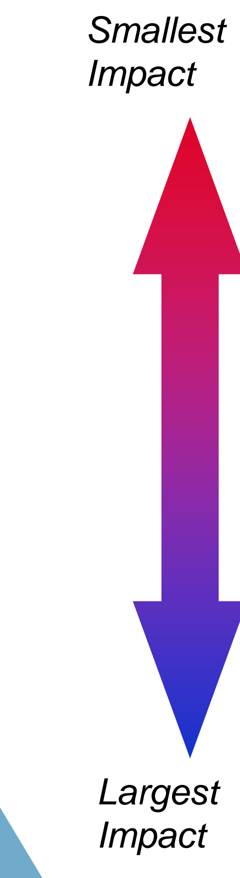
Clinical Interventions

Long-lasting protective interventions

Changing the Context to make individuals' default decisions healthy

Socioeconomic Factors

Smallest Impact



Largest Impact

Frieden T, AJPH 2009

Principles of Community Engagement (CE) for Research

Community voice: the essential, but often missing component

- Community partnered research is an essential framework for generating evidence relevant to the patients and communities for whom we strive to eliminate health disparities and achieve health equity.
- The perspective of individuals with lived experience of structural racism and barriers to health is a critical, yet often missing component of research.
- Without community perspectives driving research agendas, we risk failing to identify the critical research questions and innovative solutions to the systemic and structural factors contributing to disparities.
- While CE strategies are increasingly incorporated into research teams, they most frequently lie at the outreach and consultation end of the continuum and often fail to achieve true collaboration and shared leadership.
- These models fail to flatten traditional power hierarchies in which academic investigators hold decision-making power over community members in all aspects of study design and implementation.

Community advisory board engaged for feedback & guidance,

Eliciting community priorities to drive research agenda

Community partners as members of the research team (i.e. consultant)

Co-creation of science with bi-directional, mutually beneficial relationships

Increasing Level of Community Involvement, Impact, Trust, and Communication Flow

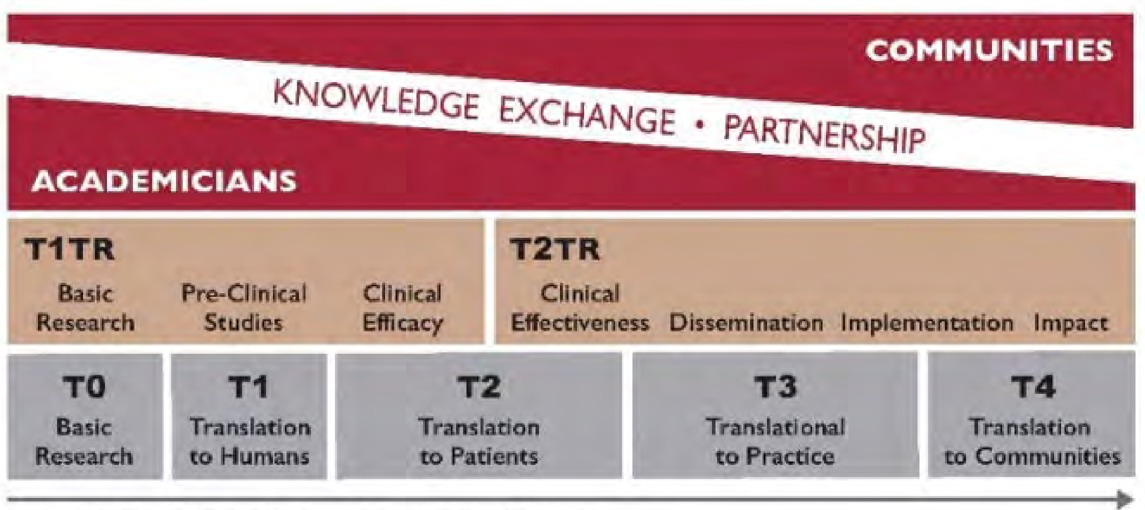
Outreach	Consult	Involve	Collaborate	Shared Leadership
Some Community Involvement *Communication flows from one to the other, to inform* Provides community with information. Entities coexist. Outcomes: Optimally, establishes communication channels and channels for outreach.	*More Community Involvement* *Communication flows to the community and then back, answer seeking* Gets information or feedback from the community. Entities share information. Outcomes: Develops connections.	*Better Community Involvement* *Communication flows both ways, participatory form of communication* Involves more participation with community on issues. Entities cooperate with each other. Outcomes: Visibility of partnership established with increased cooperation.	*Community Involvement* *Communication flow is bidirectional* Forms partnerships with community on each aspect of project from development to solution. Entities form bidirectional communication channels. Outcomes: Partnership building, trust building.	*Strong Bidirectional Relationship* Final decision making is at community level. Entities have formed strong partnership structures. Outcomes: Broader health outcomes affecting broader community. Strong bidirectional trust built.

Reference: Modified by the authors from the International Association for Public Participation.

https://www.atsdr.cdc.gov/communityengagement/index.html

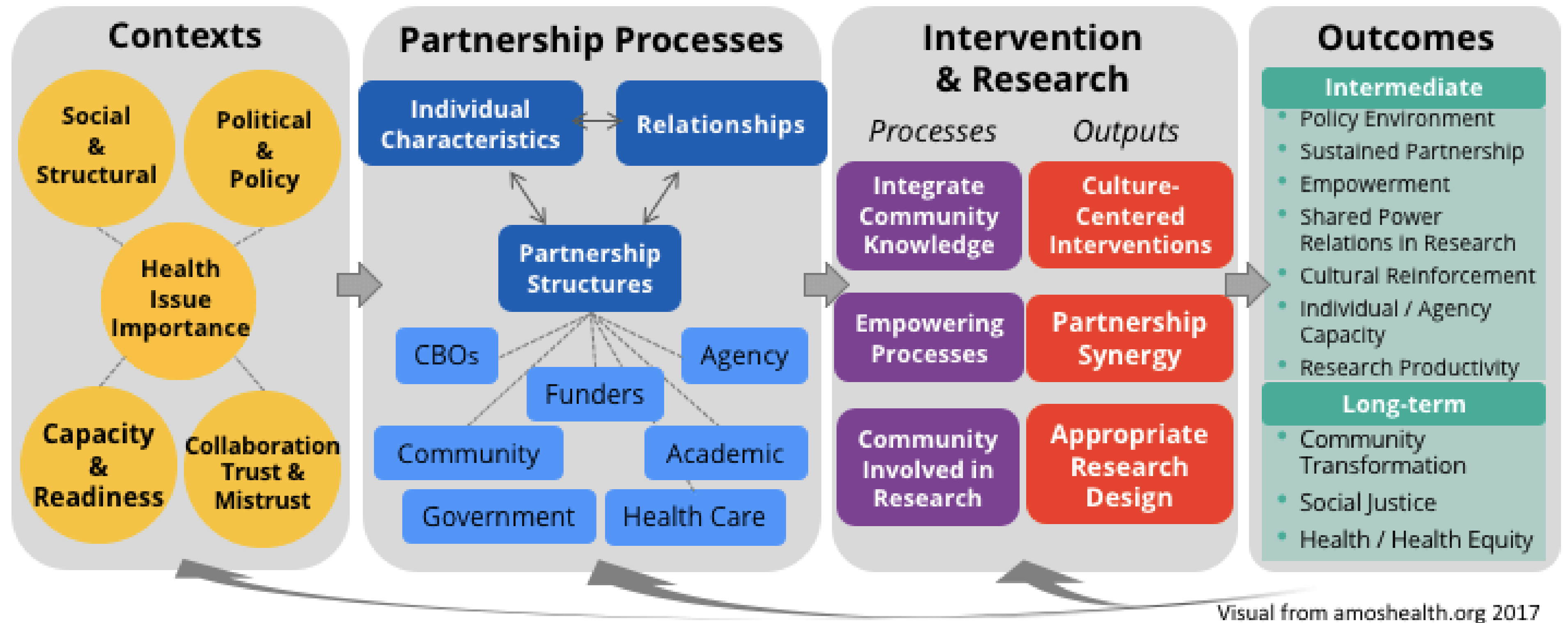
Community Based Participatory Research (CBPR)

- Combats power differentials and ensures reciprocity in community-academic research partnerships.
- Is essential to understanding racist systems and structures that create inequities and has been used to address ethical concerns in research.
- Values local or indigenous knowledge as an essential component of research teams, subscribes to collective action, promotes the co-creation of science, and engages in critical reflectivity about power and privilege in our society.
- Facilitates the translation of research into practice, particularly for dissemination, implementation, and impact that occur at the T3, dissemination & implementation research and T4, translation to community, levels of research.



CBPR Conceptual Model

Adapted from Wallerstein et al, 2008 & Wallerstein and Duran, 2010, https://cpr.unm.edu/research-projects/cbpr-project/cbpr-model.html



Contexts

- Social-Structural: Social-Economic Status, Place, History, Environment, Community Safety, Institutional Racism, Culture, Role of Education and Research Institutions
- Political & Policy: National / Local Governance/ Stewardship Approvals of Research; Policy & Funding Trends
- Health Issue: Perceived Severity by Partners
- Collaboration: Historic Trust/Mistrust between Partners
- Capacity: Community History of Organizing / Academic Capacity/ Partnership Capacity

Partnership Processes

Partnership Structures:

- Diversity: Who is involved
- Complexity
- Formal Agreements
- Control of Resources
- % Dollars to Community
- CBPR Principles
- Partnership Values
- Bridging Social Capital
- Time in Partnership

Individual Characteristics:

- Motivation to Participate
- Cultural Identities/Humility
- Personal Beliefs/Values
- Spirituality
- Reputation of P.I.

Relationships:

- Safety / Respect / Trust
- Influence / Voice
- Flexibility
- Dialogue and Listening / Mutual Learning
- Conflict Management
- Leadership
- Self & Collective Reflection/ Reflexivity
- Resource Management
- Participatory Decision-Making
- Task Roles Recognized

Commitment to Collective Empowerment

Intervention & Research

- Processes that honor community and cultural knowledge & voice, fit local settings, and use both academic & community language lead to Culture-Centered Interventions
- Empowering Co-Learning Processes lead to Partnership Synergy
- Community Members Involved in Research Activities leads to Research/Evaluation Design that Reflects Community Priorities
- Bidirectional Translation, Implementation, Dissemination

Outcomes

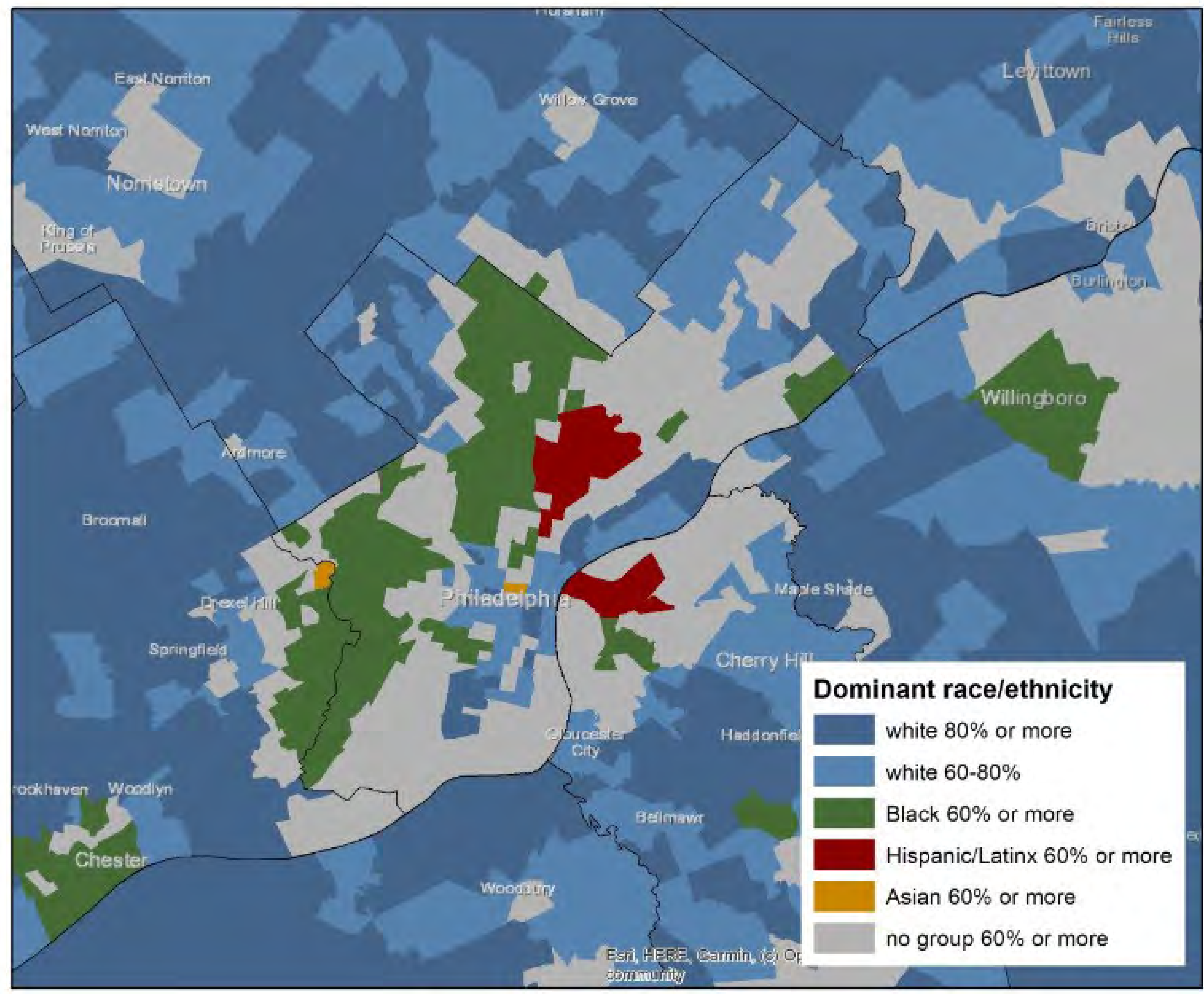
Intermediate System & Capacity Outcomes

- Policy Environment: University & Community Changes
- Sustainable Partnerships and Projects
- Empowerment – Multi-Level
- Shared Power Relations in Research /. Knowledge Democracy
- Cultural Reinforcement / Revitalization
- Growth in Individual Partner & Agency Capacities
- Research Productivity: Research Outcomes, Papers, Grant Applications & Awards

Long-Term Outcomes: Social Justice

- Community / Social Transformation: Policies & Conditions
- Improved Health / Health Equity

Philadelphia Metropolitan Area



Philadelphia is the sixth largest city in the US, with a population of nearly 1.6 million, and the eighth largest metropolitan area (MSA) with 5.7 million people.

- 3,501,200 **White** (61.2%),
- 1,156,560 **Black** (20.2%),
- 558,412 **Latinx** (9.8%),
- 358,833 **Asian** (6.3%),
- 119,758 multi-racial (2.1%)
- 6,844 **Native** residents (0.1%)

Of the 10 largest cities in the U.S., Philadelphia is the poorest

- 38% of children live in households at or below the FPL

The University of Pennsylvania & Philadelphia

Penn's relationship with its West Philadelphia neighbors has been complicated and problematic for more than a century. As a predominantly white institution (PWI) with a $20.5 billion endowment, Penn's racial composition and wealth stand in stark contrast to predominantly Black West Philadelphia neighborhoods where poverty rates often exceed 25%. The relationship is characterized today by persistent tension and conflict as well as deep engagement.

Penn's expansion during the 1950s and 1960s put the University in conflict with West Philadelphia neighbors in new ways. With the support of the City and federal Urban Renewal funding, Penn expanded westward and northward, absorbing streets, creating new housing and research facilities, and contributing to the development of University City High SchoolLinks to an external site.. This expansion led to protests among West Philadelphia residents whose homes and businesses were displaced.

- Vice Provost Valerie Swain-Cade McCoullum "Voices of Change" https://youtu.be/e_MxxTTNIbo

- Walter Palmer "Remembering Philly's Black Bottom" https://www.youtube.com/watch?v=WON0DeEFjlM

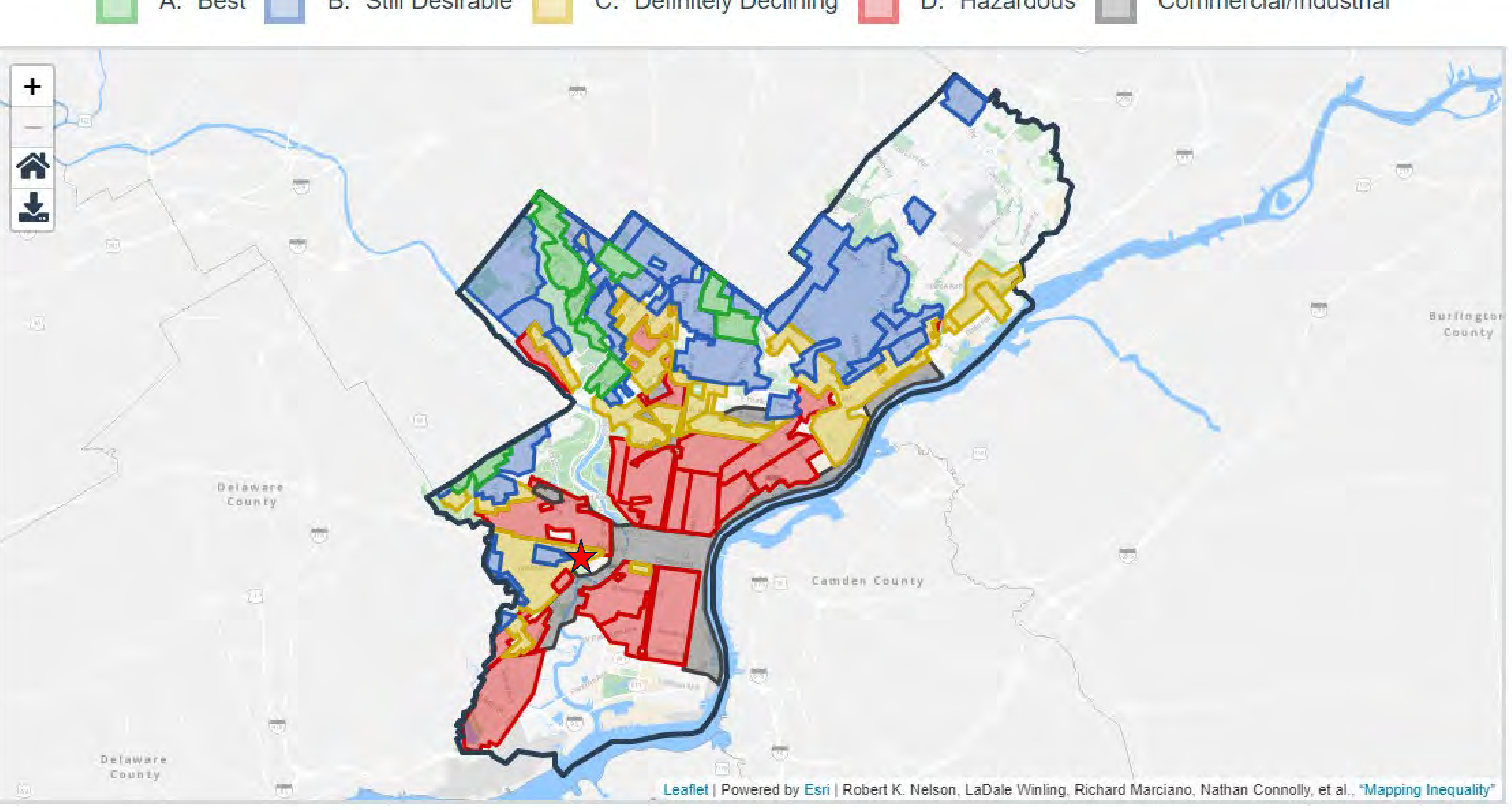
Penn Medicine

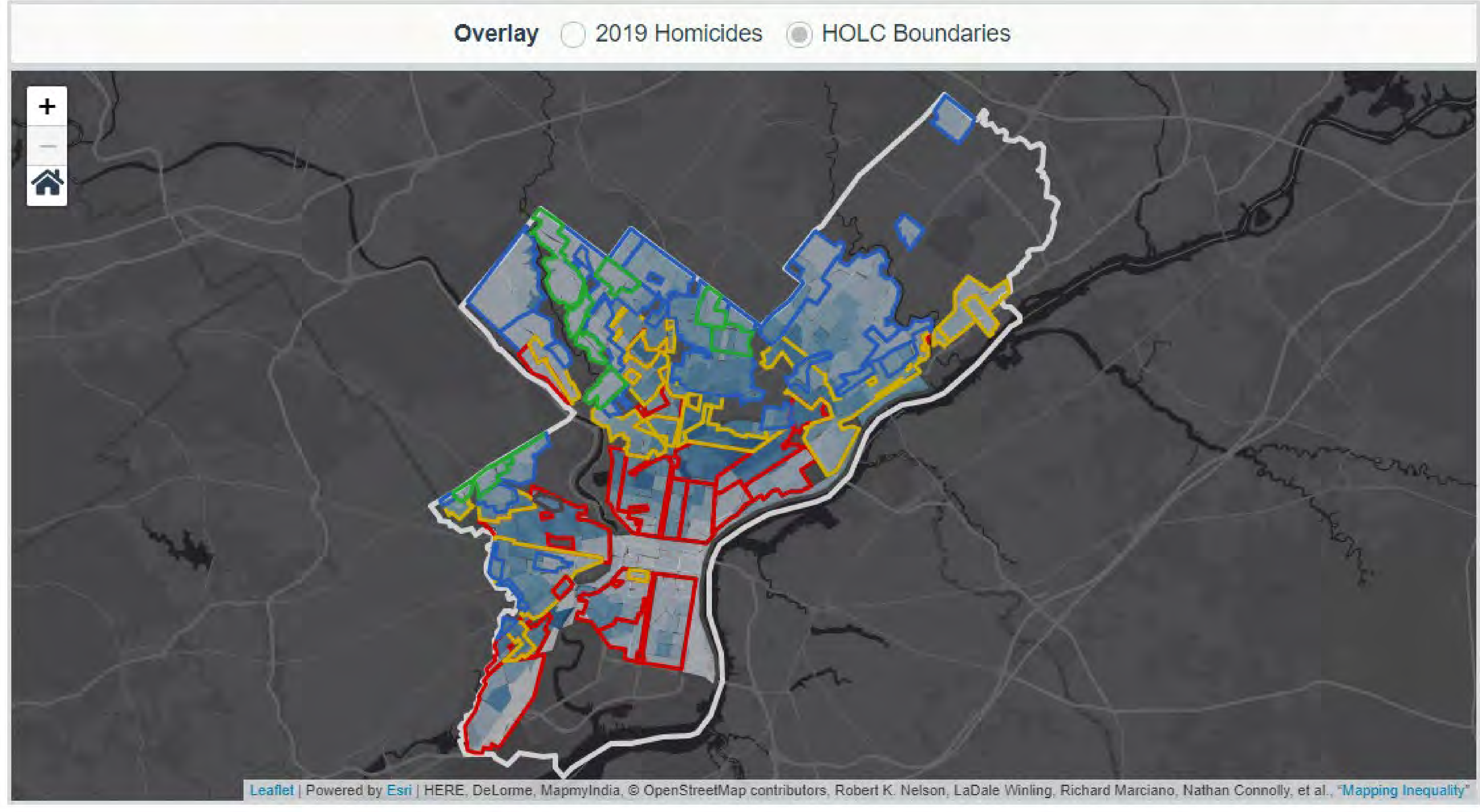
Mapping Inequality Redlining In New Deal America

- Redlining can be defined as a discriminatory practice that consists of the systematic denial of services such as mortgages, insurance loans, and other financial services to residents of certain areas, based on their race or ethnicity.
  - Redlining disregards individual's qualifications and creditworthiness to refuse such services, solely based on the residency of those individuals in minority neighborhoods; which were also quite often deemed "hazardous" or "dangerous."
  - Frederick Babcock, a central figure in early 20th-century real estate appraisal standards, wrote in his *Underwriting Manual*: "The infiltration of inharmonious racial groups ... tend to lower the levels of land values and to lessen the desirability of residential areas."
  - Use of dehumanizing language to describe "undesirable" populations

1937 Assessment Grades from the Homeowners' Loan Corporation

A: "Best" B: "Still Desirable" C: "Definitely Declining" D: "Hazardous" Commercial/Industrial





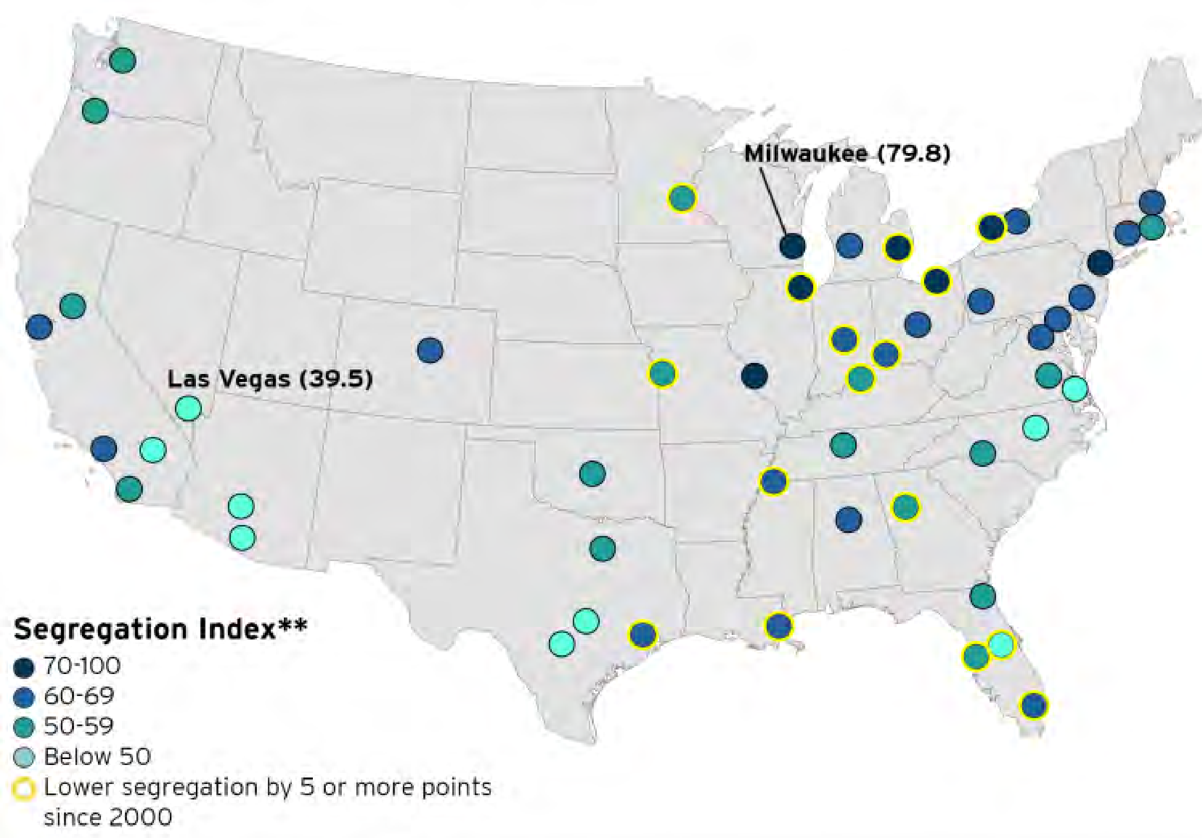
Present-day disadvantage across the city as measured from Census-based indicators, including public assistance usage, poverty rate, the number of female-headed households, and the population under 18 years old.

Segregation Index

MAP 1

Black-white segregation in US metro areas

2013-2017*



* 51 metro areas with populations exceeding one million and with black populations exceeding 3 percent of metro population (metro area names are abbreviated)

** Segregation Index is a the dissimilarity index which represents the percent of blacks that would need to relocate to be fully integrated with whites across metropolitan neighborhoods

A value of 100 indicates complete segregation; a value of 0 equals complete integration (See values for all metro areas and further details in Table A).

Source: William H Frey analysis of 2000 Census, and 2013-2017 multiyear American Community Survey (released December 6, 2018)

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TABLE 1

Metro areas with highest black-white segregation

2000 and 2013-2017*

2000			2013-2017		
		Segregation Index**			Segregation Index**
1	Detroit	85.7	1	Milwaukee	79.8
2	Milwaukee	83.3	2	New York	76.1
3	Chicago	81.2	3	Chicago	75.3
4	New York	79.7	4	Detroit	73.7
5	Cleveland	78.2	5	Cleveland	72.9
6	Buffalo	78.0	6	Buffalo	72.2
7	St. Louis	74.0	7	St. Louis	71.7
8	Cincinnati	73.6	8	Cincinnati	67.3
9	Indianapolis	71.7	9	Philadelphia	67.0
10	Philadelphia	71.0	10	Los Angeles	66.8
11	Kansas City	70.8	11	Pittsburgh	66.1
12	Los Angeles	70.0	12	Hartford	65.7

* Among 51 metro areas with populations exceeding one million and with black populations exceeding 3 percent of metro population (metro area names are abbreviated).

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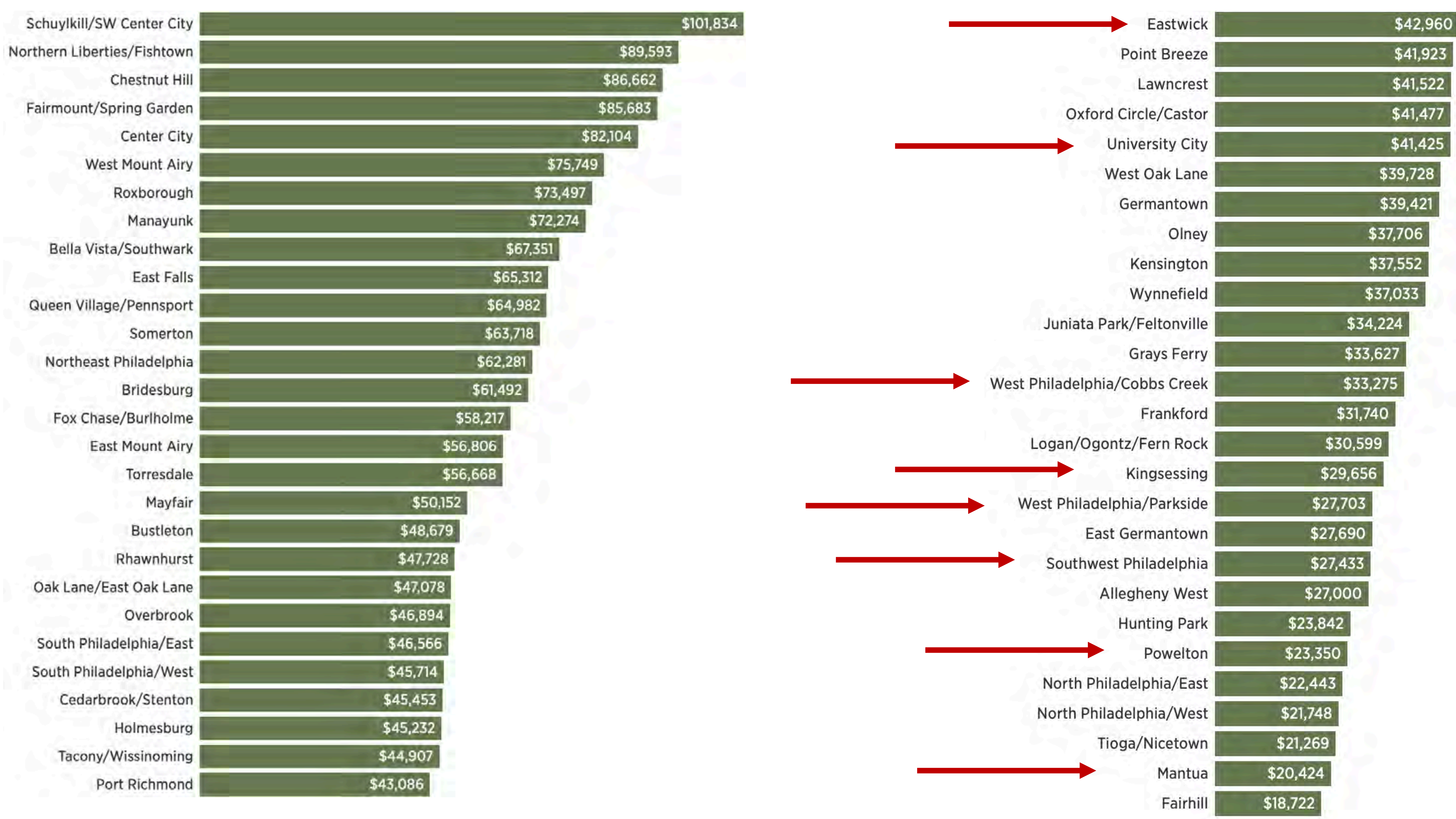
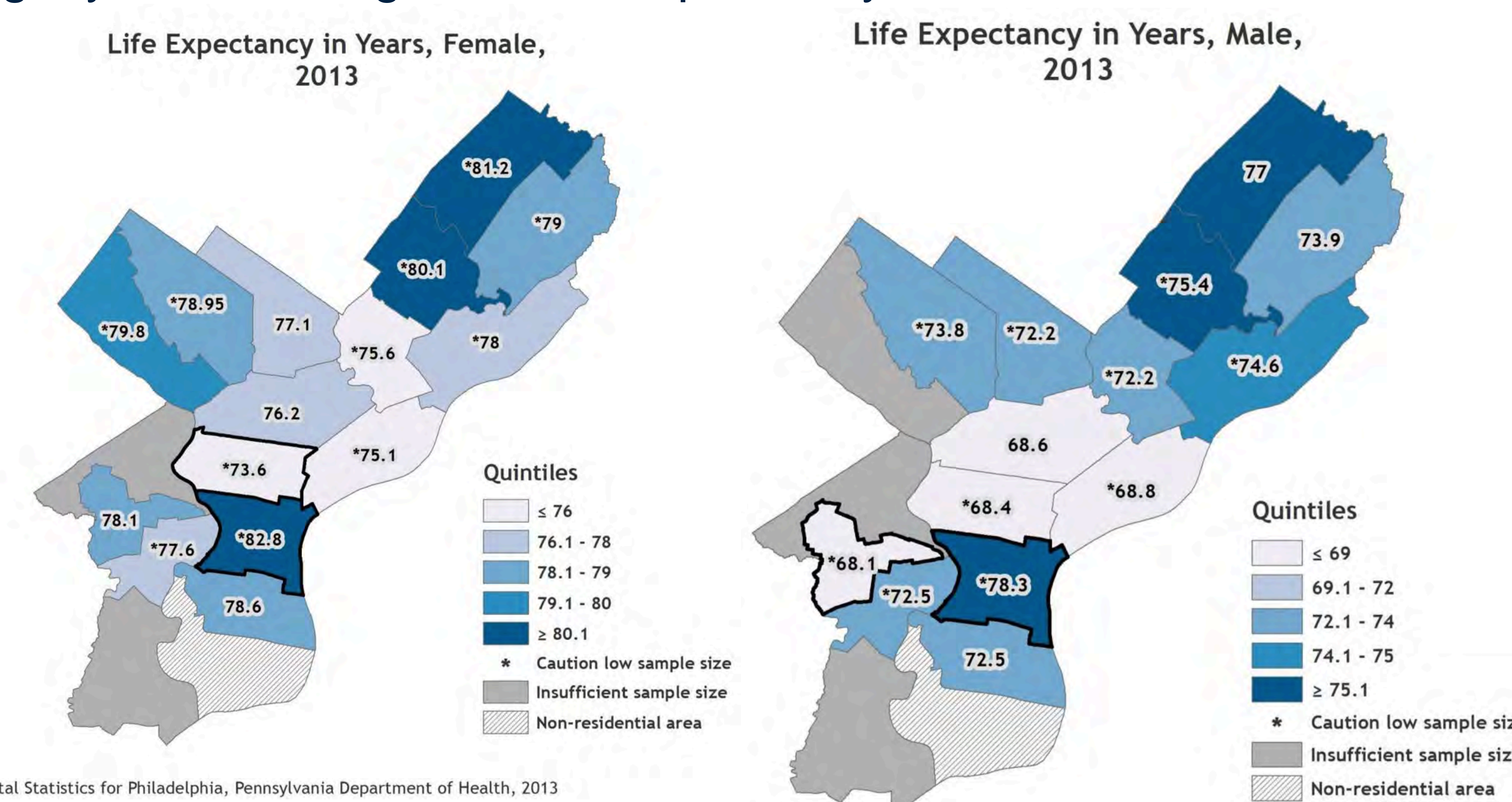
Legacy of Redlining and Neighborhood Median Income

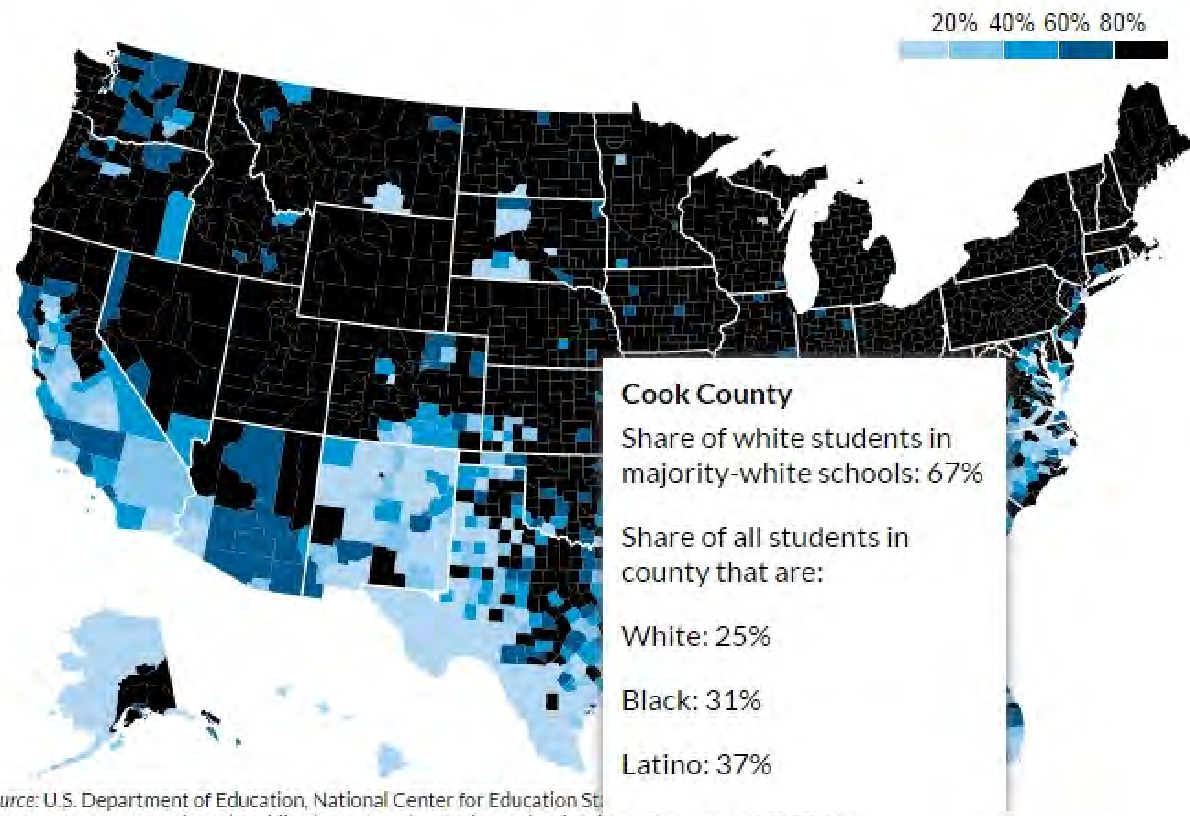


Legacy of Redlining and Life Expectancy



Residential segregation accounts for 76% of school segregation in urban areas

Share of white kids attending majority-white schools (2011-12)



Source: U.S. Department of Education, National Center for Education St[atistics,] Common Core of Data (CCD), Public Elementary/Secondary School Universe Survey Data, 2011-12.
Notes: Race shares do not add to 100%.

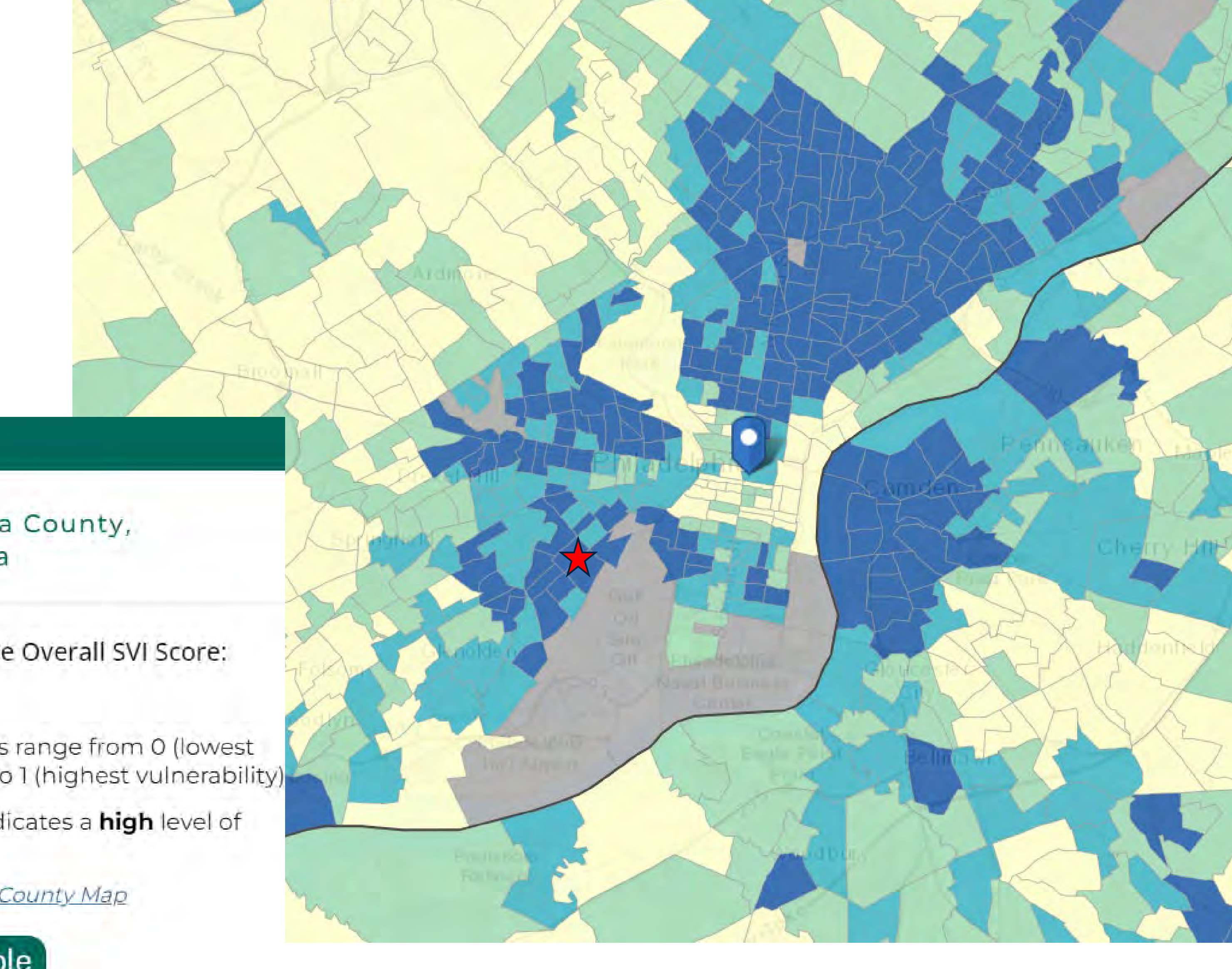
Embed this map (Click the box, Ctrl + C to Copy):

<iframe src="http://datatools.

- Evidence demonstrates that students of color and poor students benefit greatly when they attend desegregated schools.
- Schools with a majority of students of color tend to be located in distressed neighborhoods that lack the resources and supports available in middle- and upper-class neighborhoods.
- Racial and socioeconomic integration provide high-quality networks and opportunities for low-income students and students of color that are otherwise unavailable in poor, racially isolated schools.

Social Vulnerability Index

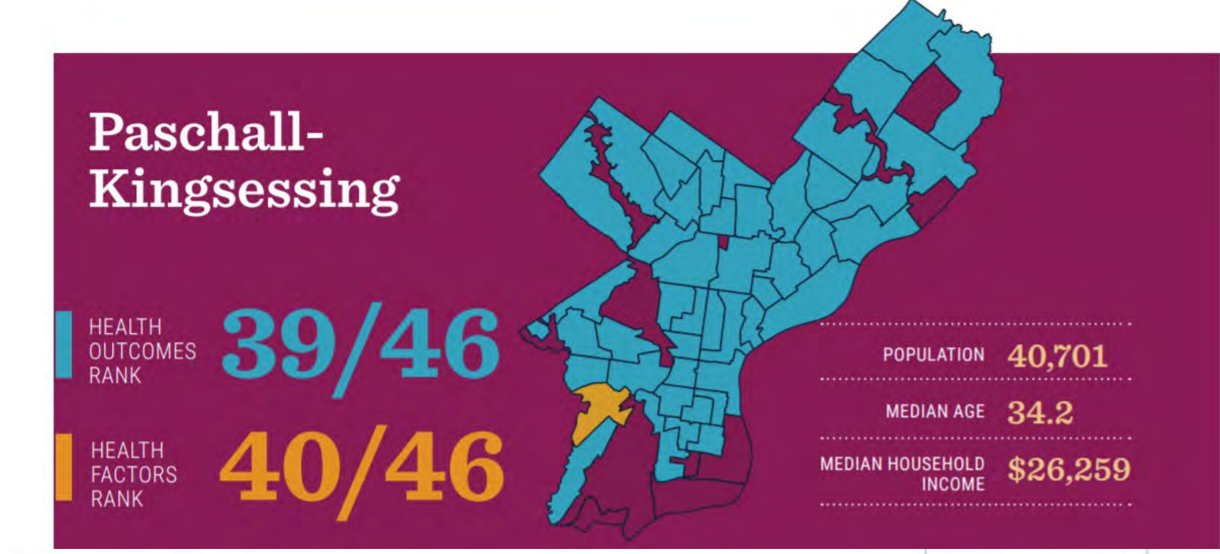
- Social vulnerability refers to the potential negative effects on communities caused by external stresses on human health.
- The CDC/ATSDR Social Vulnerability Index (CDC/ATSDR SVI) uses 16 U.S. census variables to help local officials identify communities that may need support before, during, or after disasters.



Structural Racism & Residential Impact: Community Needs in Penn's Geographic Catchment

Inequity in Penn Medicine's Geographic Catchment

- The four neighborhoods immediately adjacent to University City, Cobbs Creek, Mill Creek-Parkside, Paschall-Kingsessing, and Haddington-Overbrook rank 37th, 43rd, 39th and 38th respectively out of 46 Philadelphia neighborhoods in health outcomes.



Social & Economic Factors				
Education	Reading Proficiency (K-2)	★★★☆	52.0%	45.0%
	Completed Some College	★☆☆☆	37.3%	49.1%
Employment	Unemployment	★☆☆☆	20.2%	12.5%
Income	Children in Poverty	★☆☆☆	46.9%	36.7%
	Income Inequality	★☆☆☆	-0.27	-0.06
Family & Social Support	Single Parent Households	★★☆☆	21.6%	15.8%
Community Safety	Violent Crime (per 10,000 people)	★☆☆☆	166.3	95.7
	Injury Deaths (per 100,000 people)	★★☆☆	75.1	68.6
	Homicides (per 10,000 people)	★☆☆☆	3.9	1.7

Close to Home: The Health of Philadelphia's Neighborhoods

Southeastern PA Regional CHNA

- Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties.
  - Children's Hospital of Philadelphia
  - Doylestown Health
  - Grand View Health
  - Jefferson Health
  - Main Line Health
  - Penn Medicine
  - Redeemer Health
  - Temple University Health System
  - Trinity Health Mid-Atlantic
- Continuity of approach from the 2019 rCHNA, with expansion in scope and application of CQI principles.
- 2022 rCHNA is explicitly grounded in an approach that seeks to **advance health equity** and **authentic community engagement.**

Methodology

Quantitative

- Led by PDPH team, which included experts in epidemiological and geospatial analyses.
- Local, state, and federal data sources for indicators uniformly available at the ZIP code level across the region.
- 60+ health indicators encompassing data on community demographic characteristics, COVID-19, chronic disease and health behaviors, infant and child health, behavioral health, injuries, access to care, and social and economic conditions.

Qualitative

- Led by HCIF and a subset of Steering Committee representatives.
- 26 virtual focus group “community conversations” for geographic communities across 5 counties.
- 21 virtual focus group “spotlight” topic discussions with community organization and local government agency representatives.
  - Topics: behavioral health, chronic disease, food insecurity, housing and homelessness, older adults and care, racism and discrimination in healthcare, substance use, and violence.

Methodology

Targeted Primary Data Collection

- Goal: to better understand the needs of specific communities or populations.
- Focus areas and communities either specific to different type of facilities within participating health systems (i.e., cancer centers, rehabilitation facilities) or reflected gaps in the 2019 rCHNA:
  - Cancer
  - Disability
  - Immigrant, refugee, and heritage communities
  - Youth voice

Final Analysis

- Data synthesized by HCIF resulted in 12 community health priorities.
- Using modified Hanlon ranking method, hospitals/health system rated priorities.
- Average rating calculated and the community health priorities were organized in priority order based on:
  - Size of health problem
  - Importance to community
  - Capacity of hospitals/health systems to address
  - Alignment with mission and strategic direction
  - Availability of existing collaborative efforts

Overview of Community Health Needs

Health Issues	Access and Quality of Healthcare and Health Resources	Community Factors
• Chronic Disease Prevention and Management • Mental Health Conditions • Substance Use and Related Disorders **Maternal health outcomes**	• Access to Care (Primary and Specialty) • Food Access • Healthcare and Health Resources Navigation (Including Transportation) • Culturally and Linguistically Appropriate Services • Racism and Discrimination in Health Care	• Housing • Neighborhood Conditions (e.g., Blight, Greenspace, Air and Water Quality, etc.) • Community Violence • Socioeconomic Disadvantage (e.g., Poverty, Unemployment)

Prioritized Community Health Needs

Rank	Need
1	Mental Health Conditions
2	Access to Care (Primary and Specialty)
3	Chronic Disease Prevention and Management
4	Substance Use and Related Disorders
5	Healthcare and Health Resources Navigation
6	Racism and Discrimination in Healthcare
7	Food Access
8	Culturally and Linguistically Appropriate Care
9	Community Violence
10	Housing
11	Socioeconomic Disadvantage
12	Neighborhood Conditions

WEST PHILADELPHIA

ZIP CODES: 19104, 19131, 19139, 19151

This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Magee Rehabilitation
- Main Line Health
- Penn Medicine
- Trinity Health Mid-Atlantic

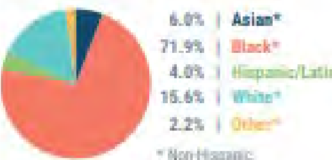
POPULATION

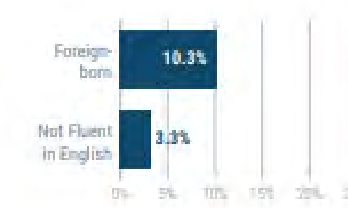
178,023

MEDIAN HOUSEHOLD INCOME

$36,186

RACE/ETHNICITY/LANGUAGE





LEADING CAUSES OF DEATH

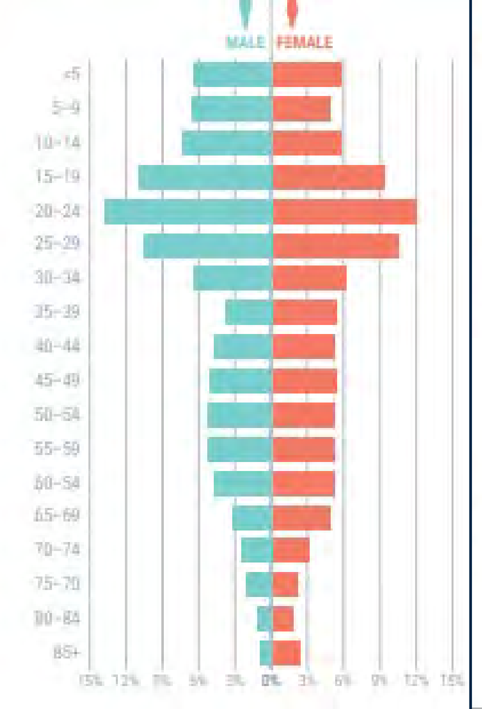
1. Heart disease
2. COVID-19
3. Cancer
4. Drug overdose
5. Cerebrovascular diseases

EDUCATIONAL ATTAINMENT

High school as highest education level **24.7%**

PEOPLE WITH DISABILITIES **16.2%**

AGE DISTRIBUTION



summary health measures

		West Philadelphia		Philadelphia County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	862.2	1,112.2	879.3	1,121.3
	Life expectancy: Female (in years)	78.6	75.8	80.0	77.5
	Life expectancy: Male (in years)	71.3	67.1	73.0	69.1
	Years of potential life lost before 75	16,417	20,100	146,900	175,443
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	1,030.2	N/A	701.4
	COVID-related hospitalization rate (per 100,000)	N/A	761.7	N/A	851.0
Chronic Disease & Health Behaviors	Adult obesity prevalence	34.5%		32.3%	
	Diabetes prevalence	14.5%		13.1%	
	Diabetes-related hospitalization rate (per 100,000)	273.6	252.2	259.6	249.7
	Hypertension prevalence	36.3%		34.1%	
	Hypertension-related hospitalization rate (per 100,000)	730.2	656.1	660.5	596.3
	Potentially preventable hospitalization rate (per 100,000)	1,648.7	1,357.1	1,521.5	1,270.8
	Premature cardiovascular disease mortality rate (per 100,000)	64.0	66.8	57.1	60.7
	Major cancer incidence rate (per 100,000)	215.1		242.5	
	Major cancer mortality rate (per 100,000)	85.4		80.3	
	Colorectal cancer screening	63.2%		63.5%	
	Mammography screening	81.1%		78.3%	
	Physical inactivity (leisure time) prevalence	28.2%		27.4%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	46.4	22.6	42.0	17.8
	Infant mortality rate (per 1,000 live births)	7.4	11.1	7.0	5.8
	Percent low birthweight births out of live births	12.7%	15.4%	11.5%	11.0%
	Percent preterm births out of live births	10.5%	11.5%	11.4%	11.1%
Behavioral Health	Adult binge drinking	18.4%		19.9%	
	Adult smoking	22.0%		22.1%	
	Drug overdose mortality rate (per 100,000)	37.6	62.4	60.4	65.9
	Opioid-related hospitalization rate (per 100,000)	85.4	84.3	106.2	99.5
	Substance-related hospitalization rate (per 100,000)	797.1	633.6	738.7	598.5
	Poor mental health for 14+ days in past 30 days	19.9%		18.5%	
	Suicide mortality rate (per 100,000)	6.2	5.1	9.9	10.3
Injuries	Fall-related hospitalization rate (per 100,000)	8,765.1	9,481.9	3,583.0	3,430.3
	Gun-related emergency department utilization (per 100,000)	54.5	92.9	25.1	44.2
	Homicide mortality rate (per 100,000)	27.5	37.1	21.9	31.0
Access to Care	Adults 19-64 years with Medicaid	26.1%		26.0%	
	Children <19 years with public insurance	68.9%		61.0%	
	Population without insurance	7.2%		8.1%	
	Children <19 years without insurance	3.9%		3.8%	
	Emergency department utilization (per 100,000)	58,476.6	42,968.1	53,146.1	40,478.1
	High emergency department utilization (per 100,000)	1,717.3	1,075.3	1,668.3	1,145.9
Social & Economic Conditions	Population in poverty	32.8%		23.1%	
	Children <18 years in poverty	42.1%		32.2%	
	Adults 19-64 years unemployed	3.4%		4.0%	
	Householders living alone who are 65+ years	26.9%		27.1%	
	Households receiving SNAP benefits	27.8%		23.4%	
	Households that are housing cost-burdened	28.7%		23.2%	
	Housing with potential lead risk	81.6%		78.2%	
	Vacant housing units	17.1%		11.9%	

Community Health Implementation Plan (CHIP)

- The CHIP is a blueprint designed to guide the implementation of strategies to address the priority health needs identified in the 2022 Regional Community Health Needs Assessment.
  - Coordinated by the Office of Government and Community Relations, the Center for Health Equity Advancement, and the Department of Family Medicine & Community Health.
- Strategies to address the priority health needs are implemented throughout the downtown hospitals and draw upon the strengths of many departments
  - Strategies are developed to address all identified priority health needs and are iteratively advanced over time.
- The CHIP can be found here: https://www.pennmedicine.org/about/serving-our-community
  - The CHNA/CHIP coordinating team is working to build an interactive, web-based version set to launch FY24

CHIP Strategic Planning Process

- Community Health Inventory
  - Annual survey of downtown entities to identify existing community health initiatives
- Domain specific work-groups
  - Stakeholders across existing programmatic initiatives, interested parties for new initiatives to respond to need
  - Review current system response to need, evaluate adequacy of current response, and recommend additional strategies as needed
- Community co-design of strategies
  - On-going & iterative process
- Develop processes for identifying and tracking metrics for programs & initiatives named in the CHIP
- Develop data-driven approach to guide future investment

Example Strategic Initiatives

Penn Medicine seeks to improve the health of the community we serve with a continued focus on our mission of dedication to discoveries that advance science, outstanding patient care, and to the education of physicians and scientists. Working together, we can improve health care across the region, and in the process create healthier, fairer, more just communities.

Priority Area #2: Access to Primary and Specialty Care

Priority #2: Access to Care (Primary and Specialty)

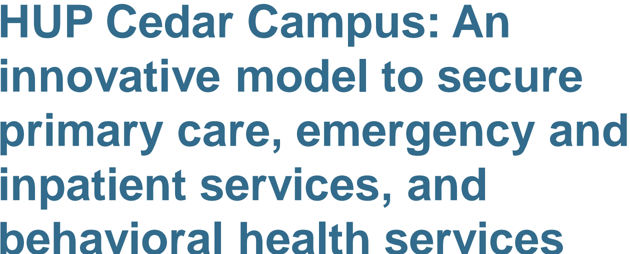
Findings

- Rate of uninsured decreasing, but challenges remain in provider acceptance of new patients with Medicaid.
- Geographic, cost, and language/cultural barriers to access.
- Limited appointment availability, significant costs, and lack of care coordination/linkage with primary care exacerbate specialty care access.
- COVID-19 impact: increased enrollment in Medicaid, increased appointment wait times, and gaps in access to preventive services.

Potential Solutions

- Establish integrated health centers with low-cost or free care options.
- Bring services to communities through health clinics in schools or mobile medical clinics.
- Embed social workers in primary care.
- Train all hospital staff and providers in the delivery of non-biased, culturally appropriate, trauma-informed care.
- Provide on-site interpreters and health education materials in diverse languages.
- Increase race, ethnicity, language diversity of staff and providers to better reflect communities served.

Strategy: Creating new access points for primary and specialty care



HUP Cedar Campus: An innovative model to secure primary care, emergency and inpatient services, and behavioral health services

Puentes de Salud: Access to primary care, dental care, and specialty care navigation for Immigrant populations

Community Health Center Partnerships: Providing community-based and continuity delivery services

LGBTQ Health Program

Equal Care

At the Penn Medicine Program for LGBTQ Health, we believe all patients have the right to high-quality, patient-centered health care that is equal and unbiased. We connect you with compassionate and skilled providers across the health system who offer culturally competent care in a judgement-free setting.

- LGBTQ Treatment Teams
- LGBTQ Patient Navigation Program
- SOGI Data Information

The Penn Medicine Program for LGBTQ Health is committed to providing the best care for the LGBTQ community in a safe and friendly environment. We are one of the only programs in the nation that's dedicated to serving the LGBTQ community by providing culturally-competent, judgement-free health care, and work in partnership and are supported by the **Office of Inclusion, Diversity and Equity** and the **Penn Medicine Center for Health Equity Advancement**.

The Penn Medicine Program for LGBTQ Health has been designated as a "Leader in LGBT Healthcare Equality" by the Human Rights Campaign Foundation, and firmly believes that LGBTQ patients deserve access to respectful, compassionate and equitable health care at all times.

About the LGBTQ Patient Navigation Program

The LGBTQ Patient Navigation Program helps connect patients anywhere along the LGBTQ spectrum to outpatient or specialty care at Penn Medicine.

Patient navigators are advocates who offer support and help navigating the health system.

This includes finding appropriate providers, making sure your records are updated to match your gender designation and pronouns, or other issues that may come up when accessing care.

For patients that are uninsured or underinsured, patient navigators can refer you to resources for assistance.

Strategy: Community Partnerships for Wellness

School Based Health: West Philadelphia High School hub & spoke model

Pre participation sports physicals program

Community based Covid & Flu vaccine program

Mobile Care with Shelter Outreach Program & DFMCH community partners

PPP Street Medicine

UCC @ AFAHO

Priority Area #4: Substance Use and Related Disorders

Priority #4: Substance Use and Related Disorders

Findings

- Drug overdose rates, driven by opioid epidemic, continue at a high rate.
- Opioid epidemic associated with increases in other health conditions including HIV, Hepatitis C, and Neonatal Abstinence Syndrome (NAS).
- Binge drinking among adults and youth, as well as cigarette, marijuana, and vape use among youth, increasingly prevalent.

Potential Solutions

- Sustain and expand prevention programs, including school-based educational programs and community drug take-back programs.
- Expand Narcan training and distribution.
- Increase medical outreach and care for individuals living with homelessness and substance use disorders.
- Engage Certified Recovery Specialists and Certified Peer Specialists across care settings.
- Develop telehealth and text-based support services to address underlying issues of substance use, provided by trained peers or qualified therapists.

Center *for* Addiction Medicine *and* Policy

Strategy: Low Barrier Connection to Care

Care Connect Warmline

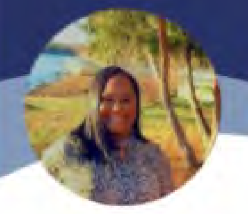
The CareConnect Warmline is a telehealth service that provides short prescriptions which will allow time for a Substance Use Navigator to connect you to resources in your area and help you to establish care

Important thing to remember: We are a telehealth-based program. In order to receive medication, it is necessary that you have a working phone that you can use to receive calls. If you do not have a reliable contact method but you have access to a phone, give us a call to discuss other options for support!

- ✓ You do not need insurance to call!
- ✓ Tele-Medicine

Important thing to remember: We are a telehealth-based program. In order to receive medication, it is necessary that you have a working phone that you can use to receive calls. If you do not have a reliable contact method but you have access to a phone, give us a call to discuss other options for support!

- ✓ You do not need insurance to call!
- ✓ Tele-Medicine



Jasmine Barnes, SUN

Gilly Gehri, SUN

Nicole O'Donnell, Lead CRS & Project Manager

Natasa Rohacs, SUN

Desiree Harris, SUN

Contact us between 9am and 9pm Monday - Sunday

Strategy: Innovative Care Models
Perinatal Resources for Opioid Use Disorder

ABOUT THE PROGRAM

PROUD (Perinatal Resources for Opioid Use Disorder) includes a team of physicians, pharmacists, and certified recovery specialists who provide pregnant patients with compassionate and non-judgmental prenatal care, post-partum care and treatment for opioid use disorder in one location.

We offer treatment with buprenorphine (Subutex) or buprenorphine/ naloxone (Suboxone) to help keep you and your pregnancy safe. We also provide other resources, such as social work, behavioral health, pediatric and primary care, lactation counseling, nutrition counseling, educational opportunities, childcare support, transportation, and more. We continue to care for you and your baby after they are born. We are here to support you wherever you are in your journey, and whatever your needs may be.

Prenatal Care

A team of physicians, pharmacists, and certified recovery specialists who provide pregnant patients with compassionate and non-judgmental prenatal and postpartum care.

Treatment Care

We offer treatment with buprenorphine (Subutex) or buprenorphine/ naloxone (Suboxone) to help keep you and your pregnancy safe.

Resources

We have access to resources, such as social work, behavioral health, lactation counseling, nutrition counseling, educational opportunities and more!

Postpartum and Pediatric Support

We continue to care for you and your baby after they are born. We are here to support you in your recovery and parenting journey.

LOCATION

Penn Family Care
3737 Market Street, 9th Floor
Philadelphia, PA 19104

For more information, please call 267-588-5314

Priority Area #7: Food Access

Priority #7: Food Access

Findings

- Challenges obtaining sufficient food of any kind, as well as issues with accessing healthy food more specifically.
- Disproportionate rate of food insecurity among Black and Hispanic/Latino communities, immigrant communities, and older adults.
- Covid-19 impact: increase in rates of food insecurity across all counties and sharply rising demand for emergency food assistance.

Potential Solutions

- Ensure more equitable access to food assistance programs/resources in region through screening and data.
- Warm handoffs to community organizations that address food insecurity.
- Increase collaboration and resource-sharing between hospitals and community groups working on healthy food access.
- Increase outreach to raise awareness and utilization of food assistance programs.
- Provide services that distribute food directly to people where they live.

Strategy: Expand and sustain resourced programs that facilitate sustainable food solutions to food-insecure patients, students, employees, and our community

PENN FOOD & WELLNESS COLLABORATIVE

A WELLNESS AT PENN & CPHI INITIATIVE

OUR MISSION

EDUCATION

The Penn Park Farm is a living laboratory with ample opportunities for hands-on learning and research. We prioritize interdisciplinary education and partner with faculty across departments.

SUSTAINABILITY

We utilize organic, regenerative, growing techniques to build healthy, soil, grow nutrient dense food, and model climate resiliency.

WELLNESS

Penn Park Farm is a vibrant wellness hub for the Penn community. We host wellness events that prioritize movement, time in nature, nutrition, and inclusive community building.

FOOD ACCESS

All of the produce at the Penn Park Farm is organically grown, locally distributed, and given free of charge to support hunger relief initiatives. on - campus and in our community.

2022 BY THE NUMBERS

>3,500 LBS

Just this year, we've grown more than 3,500 lbs. of produce on just 1/4 acre of land!

1,810 BAGS

We've distributed nearly 2,000 bags of fresh, organic produce to Penn students and HUP employees in need of support.

>300 HOURS

Students, staff, faculty, and neighbors have spent more than 300 hours collectively volunteering at the farm. Students often report that volunteering at the farm is one of their favorite ways to unwind.

815 VISITORS AND COUNTING!

The farm has seen more than 800 new faces this year! We are honored to share this beautiful space with our community for tours, workshops, classes, and events.

Priority #9 Community Violence

Priority #9: Community Violence

Findings

- Violent crime and homicide rates 8-10x higher in Philadelphia than in suburban counties.
- In 2020, Philadelphia lost 447 people to gun violence; leading cause of death for Black men 15-43 and Hispanic/Latino men15-31.
- Trauma associated with exposure to gun violence widely felt, especially among youth.
- Women, youth from immigrant communities, and LGBTQ+ communities at higher risk of intimate partner violence (IPV), sexual assault, or sex trafficking.
- Negative social media engagement, including cyberbullying, among youth a source of community violence.

Potential Solutions

- Increase awareness and availability of youth violence prevention programs
- Integrate social and mental health services into existing youth activities.
- Provide training for individuals who are trusted by and work with youth in addressing trauma and violence-related issues.
- Build youth capacity for healthy conflict resolution and create positive outlets for arguments or anger.
- Advocate for policies that prevent or reduce violence, including anti-poverty and social determinates of health initiatives.

Strategy: Working Toward a Trauma Informed Healthcare System

- From “What’s wrong with you?” to “What happened to you?”
- Ground practices in commitment to equity
- Trustworthy to patients AND employees; employees feel assured organization will support them and keep them safe

Trustworthiness
Culture of Safety
Collaboration
Patient Choice
Patient empowerment

Priority Areas #10 & #12: Housing & Neighborhood Conditions

Priority #11: Socioeconomic Disadvantage

Findings

- Poverty associated with higher rates of adverse health behaviors and outcomes; poverty resulting from structural racism is the underlying determinant for many disparities.
- Inadequate education, limited opportunities, and unemployment are key drivers of poverty.
- Impoverished communities collectively experience trauma and toxic stress, lower life expectancy, limited access to healthcare and health resources, and greater exposure to unhealthy living environments.

Potential Solutions

- Screen for socioeconomic disadvantage and establish systems for linkage to community resources to address needs.
- Partner with community-based organizations providing public benefits enrollment assistance.
- Collaborate with community colleges and universities to develop and expand programs focused on skills training and development.
- Train and employ returning citizens.
- Provide workforce development/pipeline programs with schools.

Priority #12: Neighborhood Conditions

Findings

- Neighborhood blight (e.g. abandoned homes, vacant lots, trash) associated with increased community violence.
- Access to outdoor greenspaces and recreation areas like parks and trails lower in impoverished communities.
- Communities expressed concerns about air pollution and climate change, particularly in S Philadelphia, Delaware County, and flood-prone SW Philadelphia.
- Rapid gentrification of historically low-income neighborhoods risks displacement and housing insecurity, and further racial segregation.

Potential Solutions

- Support neighborhood remediation and clean-up activities.
- Collaborate with local advocates in campaigns to improve air quality, especially in areas that have increased exposure to emissions.
- Invest in infrastructure improvements to support active transit near hospitals.
- Improve vacant lots by developing gardens and spaces for socialization and physical activity.
- Advocate for and implement responsible and equitable neighborhood development that avoids displacement and segregation.

Strategy: The Urban Health Lab @CHJ: Place-Based Interventions and Urban Nature

- "Penn Medicine and Children's Hospital of Philadelphia Launch Multi-Million Dollar Joint Initiative to Improve Health and Wellbeing in West and Southwest Philadelphia Neighborhoods with Greenspaces, Career Training, and Community Environmental Grants"

- A community-academic collaborative that uses the healing power of nature to promote health and wellbeing in Black and other minority Philadelphia neighborhoods.

- **Community Green Grants Program**
  A grant opportunity for community members, leaders, and organizations in 4 West/Southwest Philly neighborhoods – Mill Creek, Cobbs Creek, Haddington, and Kingsessing.

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