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
“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
Health Impact Pyramid

- Counseling & Education
- Clinical Interventions
- Long-lasting protective interventions
- Changing the Context to make individuals’ default decisions healthy
- Socioeconomic Factors

Largest Impact

Smallest 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.
### Increasing Level of Community Involvement, Impact, Trust, and Communication Flow

<table>
<thead>
<tr>
<th>Outreach</th>
<th>Consult</th>
<th>Involve</th>
<th>Collaborate</th>
<th>Shared Leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some Community Involvement</td>
<td>More Community Involvement</td>
<td>Better Community Involvement</td>
<td>Community Involvement</td>
<td>Strong Bidirectional Relationship</td>
</tr>
<tr>
<td>Communication flows from one to the other, to inform</td>
<td>Communication flows to the community and then back, answer seeking</td>
<td>Communication flows both ways, participatory form of communication</td>
<td>Communication flow is bidirectional</td>
<td>Final decision making is at community level.</td>
</tr>
<tr>
<td>Provides community with information.</td>
<td>Gets information or feedback from the community.</td>
<td>Involves more participation with community on issues.</td>
<td>Forms partnerships with community on each aspect of project from development to solution.</td>
<td>Entities have formed strong partnership structures.</td>
</tr>
<tr>
<td>Entities coexist.</td>
<td>Entities share information.</td>
<td>Entities cooperate with each other.</td>
<td>Entities form bidirectional communication channels.</td>
<td>Outcomes: Broader health outcomes affecting broader community.</td>
</tr>
</tbody>
</table>

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

https://www.atstdr.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.
Our Philadelphia: Residential Segregation and its impact on SDOH
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 School. 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_MxxTTNlbo](https://youtu.be/e_MxxTTNlbo)

- **Walter Palmer “Remembering Philly’s Black Bottom”**
  [https://www.youtube.com/watch?v=WON0DeEFjIM](https://www.youtube.com/watch?v=WON0DeEFjIM)
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
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

Black-white segregation in US metro areas
2013-2017*

TABLE 1
Metro areas with highest black-white segregation
2000 and 2013-2017*

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2013-2017</th>
<th>Segregation Index**</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Detroit</td>
<td>Milwaukee</td>
<td>79.8</td>
</tr>
<tr>
<td>2</td>
<td>Milwaukee</td>
<td>2 New York</td>
<td>76.1</td>
</tr>
<tr>
<td>3</td>
<td>Chicago</td>
<td>3 Chicago</td>
<td>75.3</td>
</tr>
<tr>
<td>4</td>
<td>New York</td>
<td>4 Detroit</td>
<td>73.7</td>
</tr>
<tr>
<td>5</td>
<td>Cleveland</td>
<td>5 Cleveland</td>
<td>72.9</td>
</tr>
<tr>
<td>6</td>
<td>Buffalo</td>
<td>6 Buffalo</td>
<td>72.2</td>
</tr>
<tr>
<td>7</td>
<td>St. Louis</td>
<td>7 St. Louis</td>
<td>71.7</td>
</tr>
<tr>
<td>8</td>
<td>Cincinnati</td>
<td>8 Cincinnati</td>
<td>67.3</td>
</tr>
<tr>
<td>9</td>
<td>Indianapolis</td>
<td>9 Philadelphia</td>
<td>67.0</td>
</tr>
<tr>
<td>10</td>
<td>Philadelphia</td>
<td>10 Los Angeles</td>
<td>66.8</td>
</tr>
</tbody>
</table>
| 11     | Kansas City | 11 Pittsburgh | 66.1
| 12     | Los Angeles | 12 Hartford | 65.7                |

*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 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).

### Legacy of Redlining and Neighborhood Median Income

<table>
<thead>
<tr>
<th>Neighborhood</th>
<th>Median Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastwick</td>
<td>$42,960</td>
</tr>
<tr>
<td>Point Breeze</td>
<td>$41,923</td>
</tr>
<tr>
<td>Lawncrest</td>
<td>$41,522</td>
</tr>
<tr>
<td>Oxford Circle/Castor</td>
<td>$41,477</td>
</tr>
<tr>
<td>University City</td>
<td>$41,425</td>
</tr>
<tr>
<td>West Oak Lane</td>
<td>$39,728</td>
</tr>
<tr>
<td>Germantown</td>
<td>$39,421</td>
</tr>
<tr>
<td>Olney</td>
<td>$37,706</td>
</tr>
<tr>
<td>Kensington</td>
<td>$37,552</td>
</tr>
<tr>
<td>Wynnewfield</td>
<td>$37,033</td>
</tr>
<tr>
<td>Juniata Park/Feltonville</td>
<td>$34,224</td>
</tr>
<tr>
<td>Grays Ferry</td>
<td>$33,627</td>
</tr>
<tr>
<td>West Philadelphia/Cobbs Creek</td>
<td>$33,275</td>
</tr>
<tr>
<td>Frankford</td>
<td>$31,740</td>
</tr>
<tr>
<td>Logan/Ogontz/Fern Rock</td>
<td>$30,599</td>
</tr>
<tr>
<td>Kingsessing</td>
<td>$29,656</td>
</tr>
<tr>
<td>West Philadelphia/Parkside</td>
<td>$27,703</td>
</tr>
<tr>
<td>East Germantown</td>
<td>$27,690</td>
</tr>
<tr>
<td>Southwest Philadelphia</td>
<td>$27,433</td>
</tr>
<tr>
<td>Allegheny West</td>
<td>$27,000</td>
</tr>
<tr>
<td>Hunting Park</td>
<td>$23,842</td>
</tr>
<tr>
<td>Powelton</td>
<td>$23,350</td>
</tr>
<tr>
<td>North Philadelphia/East</td>
<td>$22,443</td>
</tr>
<tr>
<td>North Philadelphia/West</td>
<td>$21,748</td>
</tr>
<tr>
<td>Tioga/Nicetown</td>
<td>$21,269</td>
</tr>
<tr>
<td>Mantua</td>
<td>$20,424</td>
</tr>
<tr>
<td>Fairhill</td>
<td>$18,722</td>
</tr>
</tbody>
</table>

*The table above lists neighborhoods in Philadelphia and their respective median incomes.*
Legacy of Redlining and Life Expectancy

Life Expectancy in Years, Female, 2013

Life Expectancy in Years, Male, 2013

Quintiles

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

- 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.
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.
Goal: to better understand the needs of specific communities or populations.

Focus areas and communities either specific to different types 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

<table>
<thead>
<tr>
<th>Health Issues</th>
<th>Access and Quality of Healthcare and Health Resources</th>
<th>Community Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Disease Prevention and Management</td>
<td>Access to Care (Primary and Specialty)</td>
<td>Housing</td>
</tr>
<tr>
<td>Mental Health Conditions</td>
<td>Food Access</td>
<td>Neighborhood Conditions (e.g., Blight, Greenspace, Air and Water Quality, etc.)</td>
</tr>
<tr>
<td>Substance Use and Related Disorders</td>
<td>Healthcare and Health Resources Navigation (Including Transportation)</td>
<td>Community Violence</td>
</tr>
<tr>
<td>Maternal health outcomes</td>
<td>Culturally and Linguistically Appropriate Services</td>
<td>Socioeconomic Disadvantage (e.g., Poverty, Unemployment)</td>
</tr>
<tr>
<td></td>
<td>Prioritized Community Health Needs</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>1</td>
<td>Mental Health Conditions</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Access to Care (Primary and Specialty)</td>
<td></td>
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<tr>
<td>3</td>
<td>Chronic Disease Prevention and Management</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Substance Use and Related Disorders</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Healthcare and Health Resources Navigation</td>
<td></td>
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<tr>
<td>6</td>
<td>Racism and Discrimination in Healthcare</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Food Access</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Culturally and Linguistically Appropriate Care</td>
<td></td>
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<tr>
<td>9</td>
<td>Community Violence</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Housing</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Socioeconomic Disadvantage</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Neighborhood Conditions</td>
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</tr>
</tbody>
</table>
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**
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
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 judgment-free setting.

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 is dedicated to serving the LGBTQ community by providing culturally-competent, judgment-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.
- Develop telehealth and text-based support services to address underlying issues of substance use, provided by trained peers or qualified therapists.
**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.

**484-278-1679**

**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

**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.

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.

- HUP Harvest
- Penn Food and Wellness Collaborative
- CHEA Food Access Support Technology
- 4th Trimester Produce Prescription Program
- Good Food, Healthy Hospitals
- Local Procurement

Good · Fresh · Local
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!

1810 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.


‣ 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
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.
“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.
References


