TEMPLE UNIVERSITY HOSPITAL

2019 COMMUNITY HEALTH NEEDS ASSESSMENT
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Thank you for your continued support of Temple University Hospital and your interest in our 2019 Community Health Needs Assessment.

Temple University Hospital, the flagship institution of Temple University Health System, has served our community for more than 125 years. We’re proud of our legacy and dedicated to our mission to advance the health and well-being of residents from North Philadelphia and beyond.

The Community Health Needs Assessment provides the information we need to make important decisions about programs, services, and community partnerships to meet the needs of the community we serve. This assessment provides insights into health-related issues and reveals opportunities to create partnerships across our service area. It is also critical in helping us pinpoint the resources we need to provide high-quality care to all of our patients, including our underserved neighbors.

We can’t solve every problem alone. But with the support of our partners and community, we can align resources and make thoughtful decisions to improve the health of those who depend on us.

We appreciate the opportunity to make a positive impact on the lives of our patients, their families, and our neighbors as we share this report with you.

Sincerely,

Michael A. Young, MHA, FACHE
President and CEO
Temple University Hospital
INTRODUCTION TO THE COMMUNITY HEALTH NEEDS ASSESSMENT

THANK YOU FOR BEING PART OF OUR COMMUNITY.

Temple University Hospital (TUH) is proud to present its 2019 Community Health Needs Assessment (CHNA). This report summarizes a comprehensive review and analysis of public health, socioeconomic, and other demographic data relevant to the communities we serve. All data was reviewed and analyzed to determine the top health issues facing our surrounding neighborhoods.

This CHNA will assist our hospital, as well as local and community organizations and social agencies to identify community health priorities, develop interventions and determine how to effectively commit resources to improve the health of the neighborhoods we serve.

We offer special thanks to the many community-based organizations and over 200 citizens and stakeholders that participated in this assessment. We appreciate their time and valuable input throughout the CHNA process. We also thank our patients, their families and communities without which this assessment would not have been possible.

Thank You!

PARTICIPATING ORGANIZATIONS

City of Philadelphia
Hero Community Center
Hunger Coalition
Lewis Katz School of Medicine at Temple University
Miriam Medical Clinics, Inc.
New Bethany Holiness Church
Nueva Esperanza, Inc.
School District of Philadelphia
Shriners Hospital for Children - Philadelphia
Temple Center for Population Health
Temple Physicians, Inc.
Temple University Institute for Survey Research
Temple University Physicians Faculty Practice Plan
Tioga United
Well Done Community Resources
Zion Baptist Church

STEERING COMMITTEE MEMBERS

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Barron, Kathleen
Carson, Steven R
Craig, Elizabeth
Donnelly, Lisa
Gonzalez, Evelyn
Helstrom, James
Kunka, Andrew F
Levins, Katherine
Mazer, Sherry
McBee, Dwight W
Rasi, Luciano P
Rastogi, Abhinav
Reed, Tony S
Whyte, Veronica D
Zambon, Allison
ABOUT

TEMPLE UNIVERSITY HOSPITAL

Temple University Hospital (TUH) was founded in 1892 as “Samaritan Hospital,” with the mission of providing care to low-income residents of its surrounding North Philadelphia neighborhood. Today, as the chief academic teaching hospital of the Lewis Katz School of Medicine at Temple University, TUH is a 732-bed non-profit acute care hospital that provides a comprehensive range of medical services to its low-income communities, and a broad spectrum of secondary, tertiary, and quaternary care to patients throughout Southeastern Pennsylvania and beyond. TUH is accredited as an Adult Level 1 Trauma Center by the Pennsylvania Trauma Systems Foundation.

In addition to its main campus in North Philadelphia, TUH includes its Episcopal and Northeastern campuses, both of which are in economically distressed areas within three miles of the TUH main and medical school campus. The Episcopal Campus (Episcopal) is home to Temple Hospital’s behavioral health services, including a Crisis Response Center that handles over 11,000 psychiatric emergency visits each year. In addition, Episcopal provides a wide range of long and short-term adult psychiatric services as well as a full-service emergency room and various outpatient services. Episcopal is a key provider of psychiatric care within Philadelphia County.

The Northeastern Campus provides outpatient services in a setting convenient to the community it serves. Services include Endoscopy, Oncology, Radiology, Cardiology, Orthopedics, Women’s Health Services and Ready Care, which is open 7 days a week.

TUH is staffed by physicians of Temple University Physicians, our faculty-based practice plan, as well as physician scientists from our affiliated Fox Chase Cancer Center and our community-based Temple Physicians, Inc. Temple physicians represent 17 academic departments including subspecialties in Emergency Medicine, Oncology, Gastroenterology, Obstetrics, Gynecology, Orthopedics, Neurology, general and specialty Surgery and Psychiatry.

TUH physicians also staff important clinics that address major public health concerns, such as the Comprehensive NeurAIDS Center at Temple University, which is dedicated to improving the public health impact of bench-to-clinic research associated with HIV-induced neurological diseases and cognitive disorders.

Among our recent distinctions is the achievement of Magnet status from the American Nurses Credentialing Center, a prestigious recognition of quality nursing care, community commitment and staff dedication bestowed upon only 8% of U.S. healthcare organizations.

TUH works in close partnership with the Temple Center for Population Health (TCPH), which promotes and supports our population health efforts. The TCPH aligns its efforts with the goals of the United States Department of Health and Human Services’ three-part aim of achieving better care for patients, better health for our communities, and lower costs through health care system improvement. Its mission is to attain a sustainable model of health care delivery through clinical and business integration, community engagement, and academic distinction to promote healthy populations.
The TCPH includes an extensive network of:
- Patient Centered Medical Homes
- Chronic disease management programs for high risk populations utilizing nurse navigators
- Comprehensive inpatient and outpatient community health worker program
- Peer coaching
- A central access center for appointment scheduling and acute care follow-up

The TCPH ambulatory performance improvement platform provides the infrastructure on which outpatient clinics can continue to achieve better care, smarter spending and healthier communities.

All TUH physicians, whether faculty or community based, care for patients covered by Medicaid in both the inpatient and outpatient setting. About 85% of TUH’s inpatients are covered by government programs: 40% by Medicare and 45% by Medicaid. Patients dually eligible for both Medicare and Medicaid comprise about 52% of our Medicare inpatient base. Approximately 41% of our total inpatient cases include a behavioral health diagnosis.
A Community Health Needs Assessment (CHNA) helps gauge the health status of a community and guides the development and implementation of strategies to improve a community’s health. The CHNA process also promotes collaboration among local agencies and provides data to evaluate outcomes and the impact of population health efforts. The purpose of the needs assessment is to identify and prioritize community health needs so that the hospital can develop strategies and implementation plans that benefit the public as well as satisfy the requirements of the Affordable Care Act.

The 2019 TUH CHNA process was facilitated by Strategy Solutions, Inc., a planning and research firm with a mission to create healthy communities. The CHNA process followed best practices outlined by the Association for Community Health Improvement and meets all Internal Revenue Service (IRS) requirements for nonprofit hospitals.

The process was conducted to identify the primary health issues, current health status, and health needs of residents living within the Hospital’s community, defined as its immediate service area (service area). The results enable our Hospital and community partners to establish priorities, develop interventions, and direct resources to improve the health of those living in the neighborhoods we serve. This CHNA includes the components that are outlined in Figure 1 below.

**Figure 1: CHNA Components**

![CHNA Components Diagram](image-url)
To support this assessment, numerous qualitative and quantitative data sources were used to validate findings using the triangulation method outlined in Figure 2. All sources are cited throughout the report and are listed in Appendix A.

Figure 2: Data Triangulation

The CHNA used City, County, and State Departments of Health data compiled from the most up-to-date, publicly available resources along with Healthy People 2020 benchmarks and The Robert Wood Johnson Foundation’s County Health Rankings. This information provided a framework for this CHNA as well as primary research conducted to collect input from community residents, providers and stakeholders. Zip code level demographic and socio-economic data for Temple University Hospital’s service area was collected from the U.S. Census Bureau (obtained through Environics Analytics and IBM Market Expert), the American Community Survey as well as the U.S. Bureau of Labor Statistics.
In compliance with patient privacy laws, aggregate TUH utilization data was included from patient records. The indicators reported on for TUH’s 2019 CHNA can be found in Appendix B of this report.

TUH collected a total of 41 Key Informant Surveys and 181 Resident Surveys and conducted three (3) Focus Groups that included a total of 31 participants.

The TUH Steering Committee met to review primary and secondary data collected and discussed health needs and issues present across the Hospital’s service area. During this meeting, 42 needs and issues were identified based on health, social, economic and other health disparities found in the data (differences in sub-populations, comparison to State, National or Healthy People 2020 goals, negative trends, or growing incidence). Thereafter, the Steering Committee completed a prioritization exercise using an online survey tool to rate all identified needs and issues on a 1 to 10 scale for each of the selected criteria below:

- **Magnitude of the Problem** - The degree to which the problem leads to death, disability, or impaired quality of life and/or could be an epidemic based on the rate or percentage of the population that is impacted by the issue.
- **Impact on Other Health Outcomes** - The extent to which the issue impacts health outcomes and/or is a driver of other conditions.
- **Capacity** - The extent to which systems and resources are in place or available to implement evidence-based solutions.

Following the Steering Committee’s completion of the prioritization exercise, the consulting team analyzed all response scores and ranked results based on the overall composite score (highest to lowest) calculated by summing scores for each of the three criteria described above.

In developing our priorities, Steering Committee members and Hospital leadership used a consensus building approach to identify health priorities. In addition to the prioritization exercise, TUH considered whether an issue is the root cause of other problems, the internal resources available to address the issue, the external resources in the community, the academic resources of Temple University, the community’s ability to respond to the issue, and the public health consequences of not responding to an identified need. Through this process, TUH identified the following priorities:

1. Chronic disease;
2. Access to health care;
3. Mental health access and education
4. Substance abuse treatment integration;
5. Violence prevention and intervention; and
6. Programs for moms and newborns.

These priority areas are in-line with the priority areas identified and addressed in our 2016 CHNA. TUH will continue to focus on these health needs through its programs and services offered to the community.

**REVIEW AND APPROVAL**

The TUH Board of Governors approved the Hospital’s CHNA on May 20, 2019.
COMMUNITY DEFINITION

In compliance with the IRS guidelines at the time of data collection for this assessment, TUH defined its immediate service area (service area) as 11 zip codes: 19120; 19121; 19122; 19124; 19125; 19129; 19132; 19133; 19134; 19140; and, 19144. These are the zip codes in which about 70% of TUH’s patients reside as illustrated in Figure 3. These zip codes also largely overlay with the City of Philadelphia’s Lower North, North and River Wards Planning Districts as set forth in the City of Philadelphia Department of Public Health’s 2017 Community Health Assessment for Philadelphia, PA.

Figure 3: TUH Service Area

Source: Esri, HERE, USGS, Intermap, INCREMENT, PNR
METHODOLOGY

TUH contracted the services of Strategy Solutions Inc., (SSI) to assist the Hospital with the 2019 CHNA. SSI facilitated the CHNA process following best practices outlined by the Association for Community Health Improvement, an affiliate of the American Hospital Association. This CHNA’s methodology complies with the Internal Revenue Service’s (IRS) guidelines (IRS Notice 2011-52) for charitable 501(c)(3) tax-exempt hospitals published in December 2014, and reflects input from individuals representing the broad interests of the communities served by Temple University Hospital (TUH), including those with direct knowledge on the needs of medically underserved, and populations with chronic disease.

Throughout the nine (9) months beginning in August 2018, SSI worked closely with TUH to identify and collect primary and secondary data, analyze the results and create the Hospital’s needs assessment. Figure 4 is a summary of the methodology used to create the 2019 TUH CHNA report.

Figure 4: TUH 2018-2019 CHNA Methodology Summary

Source: Strategy Solutions, Inc., 2019
DATA COLLECTION

In an effort to examine the health-related needs of the residents of the TUH service area and to meet current IRS requirements, our methodology employed both qualitative and quantitative data collection and analysis methods. The Hospital and its consulting team made significant efforts to ensure the entire service area, all socio-demographic groups and all potential needs, issues and underrepresented populations were considered to the extent possible. This was accomplished by organizing Focus Groups and identifying key stakeholders that represented various subgroups in the community described in detail below. In addition, the process included extensive use of data from the Philadelphia Public Department of Health, Pennsylvania Department of Health and U.S. Centers for Disease Control and Prevention.

To guide this assessment, the Hospital formed a Steering Committee consisting of 16 Hospital leaders with experience serving the surrounding community. These included representatives who understood the needs and issues faced by underrepresented groups within the Hospital’s service area, including medically underserved populations and low-income individuals, minority groups and those with chronic disease needs and issues. The TUH Steering Committee met bi-weekly between August 2018 and April 2019, with two of these meetings held in person on September 21, 2018 and March 8, 2019. The remaining meetings were held via teleconference. These Steering Committee meetings were conducted to provide guidance on the various components of the CHNA.

The secondary quantitative data collection process included:

- Disease incidence and prevalence data obtained from the Pennsylvania Departments of Health and Vital Statistics as well as the City of Philadelphia Department of Health;
- Behavioral Risk Factor Surveillance Survey (BRFSS) data collected by the Centers for Disease Control and Prevention;
- American Community Survey; and
- Healthy People 2020 goals from HealthyPeople.gov.

In addition, various health and health related data from the following sources were utilized:

- Pennsylvania Department of Education;
- County Health Rankings and Roadmaps;
- Philadelphia County 2017 PA Youth Survey and the National Survey Results on Drug Abuse – 1975-2013;
- Emergency Department and inpatient utilization data from the Hospital was also included; and
- Economic data was obtained through the United States Census Bureau.
The City of Philadelphia Department of Public Health's 2017 Philadelphia Health Needs Assessment provides public health data for 18 different planning districts across the City. These districts represent distinct neighborhoods facing different health, economic, social and other challenges. Throughout this CHNA, where available, public health data is reported for the districts that largely overlay with TUH's service area, which include the City's North, Lower North and River Wards Districts. These districts are outlined below in red in Figure 5.

**Figure 5: Philadelphia Department of Health Planning Districts**

Data presented throughout the CHNA is the most recent published by the source at the time of the data collection. Significant differences are noted for data only where the source published differences based on statistical significance testing.
HOSPITAL UTILIZATION DATA

In accordance with patient privacy laws, aggregate TUH utilization data was included from patient records. This utilization data was reported by age (adults age 18 years and older and youth under 18 years of age) and was based on:

- Emergency department discharges for ambulatory care sensitive conditions;
- Emergency department and inpatient psychiatric admissions; and
- Preventable hospitalizations.

FOCUS GROUPS

The Steering Committee identified numerous community stakeholders that represent target populations served by the Hospital within its immediate service area. TUH staff and SSI developed a Focus Group facilitation guide to capture community input and feedback on community health status and health needs, access to services and potential solutions. Steering Committee members scheduled the Focus Group sessions and invited identified community stakeholders. SSI facilitated the Focus Groups and recorded feedback. For the 2019 CHNA, Focus Groups were conducted with three (3) groups in November and December 2018 representing the TUH campuses as shown in Table 1. See Appendices C and D for the Focus Group guides used for this assessment.

Table 1: Focus Groups Conducted

<table>
<thead>
<tr>
<th>Date Conducted</th>
<th>Group</th>
<th>Number of Participants</th>
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<tbody>
<tr>
<td>November 29, 2018</td>
<td>TUH- Episcopal Campus</td>
<td>5</td>
</tr>
<tr>
<td>November 29, 2018</td>
<td>Temple University Hospital, Main Campus</td>
<td>21</td>
</tr>
<tr>
<td>December 19, 2018</td>
<td>TUH-Episcopal Campus</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td><strong>Total Participants</strong></td>
<td><strong>31</strong></td>
</tr>
</tbody>
</table>

Source: 2018 Focus Groups, Strategy Solutions, Inc.

KEY INFORMANT SURVEY

The Steering Committee identified key stakeholders in the community to receive a Key Informant Survey. SSI and TUH staff developed the Key Informant Survey. This survey was used to obtain vital information about community from the social and health services providers serving them. SSI created an electronic survey and link, which TUH sent out to the identified Key Informants. The survey was active from December 11, 2018 to January 24, 2019. A total of 41 Key Informants completed the survey: 24 for Temple University Hospital’s main campus and 17 for the Episcopal Campus. See Appendices E and F for the Key Informant Surveys used for this assessment.
RESIDENT SURVEY

Temple University’s Institute for Survey Research (ISR) conducted the Resident Survey using contact information (phone and email) from a sample of over 2,000 Philadelphia residents within their survey database living in the 11 zip codes representing 70% of where TUH’s inpatients reside.¹

From this sample, ISR successfully surveyed 181 residents through online and direct telephone outreach throughout December 2018. The Key Informant Survey was also used for the Resident Survey and is provided in Appendix G. A total of five ISR staff worked on the Resident Survey, including three phone room staff, one systems engineer that did programming, testing and electronic deployment of the survey, and two research analysts who summarized survey results.

DATA LIMITATIONS

The primary and secondary data collected for this assessment includes several limitations. Much of the secondary data is from the County level and is not specific to the Hospital’s service area due to geographic limitations of currently available data. In addition, researchers were limited to the collection of the most recent publicly available data sources of which many are two (2) or more years old. All primary data is also qualitative and does not necessarily reflect a representative sample of the service area since it was collected through convenience sampling.

FEEDBACK FROM PREVIOUS TUH CHNA REPORT

Through its Office of Patient Experience, TUH established two Patient Family Advisory Groups comprised of community members who provide regular feedback on community healthcare needs. TUH also welcomes questions and comments on its CHNAs through a link provided on its Community Health webpage under contact us (click here). No substantive comments have been received through this site since the 2016 CHNA report was published.
DEMOGRAPHICS

Residents of TUH’s immediate service area experience many social and economic challenges as demonstrated by the demographic data described below in Figure 6.

Figure 6: TUH Service Area Demographic Profile

Sources:
Gender: Claritas - Pop-Facts Premier 2018, Environics Analytics
Inpatient Payor Mix: IBM Market Expert, State Inpatients Area Based Analysis, (CY2017)
Over the next 5-year period, TUH’s community as defined in this report is expected to grow by about 1.6%, from 462,455 to 469,720, which is slightly above the City of Philadelphia’s expected growth rate (1.5%). The community has slightly more Females (52.9%) than Males (47.1%). Having an inverse ratio of White to Black when compared to other areas, the community is predominantly Black (46.1%) and has a larger Hispanic population (29.8%) than the City of Philadelphia, Pennsylvania and Nation. Throughout the report, indicators that identify Non-Hispanic White, Non-Hispanic Black and/or Non-Hispanic Asian rates or percentages will be referred to as White, Black and Asian respectively.

The median age in 2018 was 31.9 and is expected to grow slightly older to 33.0 by 2023. The percentage of residents living in our community with an education beyond high school (36.3%) is substantially lower than the City of Philadelphia (49.4%), Pennsylvania (53.6%), and Nation (59.4%). The average household income is $47,672, with 25.8% of the individuals having incomes below the federal poverty level and 67.6% of households having incomes under $50,000.

For the TUH service area, Table 2 lists the poverty percentage, unemployment rate, and average life expectancy by zip code. Over half of the population in zip code 19133 (54.8%) lives in poverty with a 19.0% unemployment rate and an average life expectancy of 73.8 years. Zip code 19121 has the lowest average life expectancy at 69.3 years, almost 10 years less than the U.S. average.

Table 2: Temple University Hospital Poverty, Unemployment and Average Life Expectancy Demographics

<table>
<thead>
<tr>
<th>City</th>
<th>Zip Code</th>
<th>Unemployment Rate</th>
<th>Poverty Percentage</th>
<th>Average Life Expectancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philadelphia</td>
<td>19133</td>
<td>19.0%</td>
<td>54.8%</td>
<td>73.8 Years</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>19121</td>
<td>15.2%</td>
<td>44.7%</td>
<td>69.3 Years</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>19140</td>
<td>19.0%</td>
<td>41.9%</td>
<td>74.5 Years</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>19132</td>
<td>17.1%</td>
<td>40.3%</td>
<td>75.9 Years</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>19134</td>
<td>19.1%</td>
<td>39.1%</td>
<td>75.9 Years</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>19122</td>
<td>12.1%</td>
<td>35.9%</td>
<td>74.4 Years</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>19144</td>
<td>12.8%</td>
<td>32.5%</td>
<td>76.7 Years</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>19120</td>
<td>15.4%</td>
<td>30.7%</td>
<td>74.6 Years</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>19124</td>
<td>16.0%</td>
<td>30.0%</td>
<td>73.1 Years</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>19129</td>
<td>8.5%</td>
<td>20.9%</td>
<td>77.1 Years</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>19125</td>
<td>10.9%</td>
<td>18.3%</td>
<td>71.6 Years</td>
</tr>
</tbody>
</table>

Sources:
Poverty Rate as of 11/15/18: 2012-2016 American Community Survey
Unemployment Rate as of 11/15/18: U.S. Census Bureau, Census 2010 Summary File 1
Average Life Expectancy: Robert Wood Johnson Foundation, 2019
COMMUNITY & HOSPITAL RESOURCES

Existing health and social services in the service area, and for Southeastern Pennsylvania as a whole, were collected for this report. Information on social services was obtained through the United Way 2-1-1 in Southeastern Pennsylvania and from the Yellow Pages internet search. Existing Hospital and Health System resources can be found in Appendix H, Hospital Resource Listing. The community-based health care and social service resources can be found in Appendix I, Community Resource Listing.
SUMMARY OF PROGRESS ON 2016 CHNA IMPLEMENTATION STRATEGY

Figure 7 below lists the major health priorities that the Hospital identified in their 2016 CHNA and decided to concentrate on over three (3) years ending June 30, 2019.

Figure 7: TUH 2016 CHNA Identified Health Priorities

Figures 8, 9, 10 and 11 below highlights the major accomplishments that the Hospital made in each of the seven health priorities that were outlined in their 2016 CHNA Implementation Strategy Action Plan. TUH has created annual implementation strategy updates on the progress made in each of the health priority areas. Please visit https://www.templehealth.org/locations/temple-university-hospital/about/community-health/implementation-strategy-updates to access these updates.

Figure 8: 3-Year Evaluation of 2016 CHNA Summary, 1 of 4

Source: Temple University Hospital, 2019
Figure 9: 3-Year Evaluation of 2016 CHNA Summary, 2 of 4

| Address Diabetes | • Secured grant funding to add additional program sites offering TUH’s Diabetes Prevention Program; total sites increased by six and were chosen based on zip codes of underserved, uninsured or Medicaid populations; program is free to participants.  
• In response to an increase in need, TUH launched 20 additional diabetes education classes utilizing faith-based organizations for class locations.  
• TUH’s Diabetes Prevention Program received CDC recognition in June 2018.  
• TUH entered into Letters of Agreements with Health Partners Plan and Keystone First to provide the Diabetes Prevention Program to their Medicare and Medicaid patients. |

| Reduce Gun Violence | • Offered Cradle to Grave Program – presentations to community and at-risk youth, including those in the juvenile justice system.  
• TUH offered Project Fighting Chance – first aid training in neighborhoods with high gun violence rates.  
• In collaboration with SEPTA police, TUH continued its Safe Bet Program – a free gun lock program. To-date, the hospital has given away approximately 2,000 gun locks through this program.  
• In November 2017, TUH launched a new program - the Victim Support Collaboration, whose goal is to support victims (all ages) of crime. |

Source: Temple University Hospital Evaluation of 2016 CHNA

Figure 10: 3-Year Evaluation of 2016 CHNA Summary, 3 of 4

| Address Women and Infants Health | • Achieved Baby Friendly Designation in 2018, which is an international program signifying the hospital’s commitment to breastfeeding.  
• Advanced the Infant Safe Sleep Program through a distribution of baby sleep boxes.  
• Offered smoking cessation awareness and education program.  
• As a key strategy in improving compliance with prenatal care, the hospital implemented a comprehensive coordinated approach to prenatal care & education through cost-effective prenatal education materials in all prenatal practices and inpatient settings.  
• Continued support of the City of Philadelphia MOM program, which connects mothers and babies from birth through age 5 with social, educational and healthcare support. |

| Address Obesity and Overweight | • Implemented Farm to Families program in 2017 – a program that provides food boxes of fruits and vegetables to hospital staff and community members; some patients received prescriptions to access these boxes.  
• Expanded Farm to Families program in 2018 to be available every Thursday; since 2017, TUH sold 439 boxes – 191 to hospital staff and 248 to community members.  
• Hosted Multi-Disciplinary Poverty Simulation in Collaboration with Coalition Against Hunger; more than 40 TUH department leaders, physicians and employees participated in a poverty simulation to improve awareness of the complexities of social programs and the pros and cons of how they address learning experience to allow members of the healthcare community to understand a variety of needs and programs to address social determinants of health. |

Source: Temple University Hospital Evaluation of 2016 CHNA
### Address Access to Mental Health Resources

- Received approval from Community Behavioral Health to expand TUH’s Crisis Response Center beds from six (6) 23-hour chairs to ten (10) 23-hour chairs; largest use of the Crisis Response Center beds was for opioid-related issues.
- In 2018, a collaboration was formed with PROACT to provide Warm Hand-Off Program for those patients with substance use disorder issues.
- Formed an agreement with Merakey to provide onsite outpatient and intensive inpatient services for those patients with co-occurring substance use disorder and mental health issues.

Source: Temple University Hospital Evaluation of 2016 CHNA
Ambulatory care sensitive conditions are health conditions for which Hospital admission could be prevented by interventions in primary care. Reducing avoidable hospitalizations provides opportunities for reducing health care spending and improving quality of care and quality of life. Avoidable hospitalizations are associated with high and rising costs, and they disrupt elective health care planning and affect patients’ daily life.\(^9\) Hospitalizations for ambulatory care sensitive conditions are potentially avoidable by preventing the onset of disease, controlling an acute episodic illness, or managing a chronic condition effectively.\(^{10}\) Since data is available only for half of the most recent year (2018), changes in utilization are calculated for years 2016 to 2017.

This utilization data was analyzed based on emergency room and inpatient visits, broken out by Adults age 18 years and older and Youth under 18 years by the following areas:
- Ambulatory care sensitive conditions – emergency room only;
- Emergency room and inpatient psychiatric admissions; and
- Mental health and substance abuse conditions.

The main takeaways from each of these areas are described below. Detailed tables are located in Appendix J.

The largest increases for ambulatory care sensitive conditions – ER only include:
- Kidney/Urinary Infections (TUH 116.7% Adults and Episcopal Campus 223.6% Adults);
- Pneumonia, Bacterial (Episcopal Campus 53.5% Adults);
- Angina (TUH 75.0% Adults, Episcopal Campus 120.0% Adults);
- Congestive Heart Failure (Episcopal Campus 150.0% Adults);
- Diabetes Mellitus with Coma and Ketoacidosis (Episcopal Campus 500.0% Adults); and
- Diabetes Mellitus with Complications (Episcopal Campus 77.8% Adults).

The following psychiatric diagnoses for Adults (age 18 and older) had a substantial increase from 2016 to 2017:
- Substance related issues (TUH Main Inpatient 87.2%, Episcopal Campus ER 86.1%, Episcopal Campus Inpatient Medical/Surgical 96.9% and Episcopal Campus Inpatient – Behavioral Health Services 68.9%);
- Suicide (Episcopal Campus Inpatient – Behavioral Health Services 1,753.1%);
- Screening and history of mental health and substance abuse codes (Episcopal Campus Inpatient – Behavioral Health Services 82.8%);
- Developmental disorders (Episcopal Campus Inpatient – Behavioral Health Services 50.7%);
- Attention-deficit conduct and disruptive behavior disorders (Episcopal Campus ER 483.3%); and
- Adjustment disorders (Episcopal Campus ER 235.9%).

For the three years ending 2018, the following diagnoses have increased at TUH for Adults 18 years and older:
- Acute myocardial infarction discharged alive – 78.4%;
- Other circulatory system diagnosis – 32.1%;
- Other respiratory system or procedures – 55.7%; and
- Cirrhosis/alcoholic hepatitis – 64.4%.

For the three years ending 2018, the following diagnoses have increased at TUH for Youth 18 years and younger:
- Full term neonate w/ major problems – 36.7%.

For the three years ending 2018, the following diagnoses have increased at the Episcopal Campus for Adults 18 years and older:
- Heart failure/shock – 40.7%;
- Poison/toxic effects drugs – 34.8%;
- Nutrition/miscellaneous metabolic disorders – 50.0%;
- Pneumonia/pleurisy – 67.9%; and
- Kidney/urinary tract infections – 40.0%.
Based on an analysis of primary and secondary data, the following community health needs and issues were identified:

- Chronic disease;
- Access to quality health care and barriers to healthcare;
- Substance use disorders;
- Healthy environment;
- Mental health;
- Healthy mothers, babies & children;
- Physical activity & nutrition; and
- Infectious disease.

Each of the above topics are discussed in more detail on the pages that follow. Each topic is broken down into the following sections:

- **What the Community is Saying**, which reflects input from participants in the primary data collection;
- **Opportunities for Improvement**, which were determined based on the identification of negative trends over time and/or through a comparison of local secondary data to State and national data as well as the Healthy People 2020 benchmarks and/or where significant disparities exist even if data has improved in recent years; and
- **Areas of Improvement**, which were included based on the identification of positive trends over time and/or through a comparison of local secondary data to the State and national data as well as the Healthy People 2020 benchmarks.¹¹

*A full listing of all secondary indicators can be found in Appendix B.*
**CHRONIC DISEASE**

Conditions that are long-lasting, in remission, relapse and have continued persistence are categorized as chronic diseases. Public health data, Key Informant Survey and Resident Survey respondents identified the following as needs and issues related to chronic disease:

- Cancer;
- Cardiovascular disease and stroke;
- Diabetes;
- Overweight/obesity; and
- Dental health.

**WHAT THE COMMUNITY IS SAYING**

Resident and Key Informant Survey respondents identified the following as the overall top community health needs and issues:

- Overweight/obesity;
- Diabetes;
- Cancer;
- Heart disease;
- Dental health; and
- Stroke.

Focus Group participants identified lack of post care planning and lack of knowledge about medications and how to use them as issues related to Chronic Disease.

Barriers to care related to Chronic Diseases identified by primary research respondents include:

- Navigating the system long term;
- Lack of income;
- High co-pays; and
- Lack of insurance coverage.

**Figure 12: Focus Group Participants, Key Informant and Resident Survey Respondents: Top Four Needed Services Related to Chronic Disease**

Sources:
2018 Temple University Hospital Focus Groups, Strategy Solutions, Inc.
2019 Key Informant Survey, Strategy Solutions, Inc.
2018 TUH Resident Survey, Temple University Institute for Survey Research (ISR)
OPPORTUNITIES FOR IMPROVEMENT

HEART

While the percentage of Adults age 35 and older Who Have Ever Been Told They Had a Heart Attack in Philadelphia County has remained fairly consistent and in 2015-2017 (7.0%) was comparable to the State (7.0%), the percentage was almost double that of the Nation (4.4%).

Although the Heart Disease mortality rate per 100,000 has decreased in Philadelphia County in 2016 (215.8), it remains significantly higher than the State (175.8).

Despite decreasing from 2011 (155.2) to 2016 (146.3), the Coronary Heart Disease mortality rate per 100,000 in Philadelphia County in 2016 was also significantly higher than the State (107.6), and the Nation (126.2). It was also well above the Healthy People 2020 Goal (103.4).

The Cardiovascular mortality rate per 100,000 in Philadelphia County also decreased from 2011 (289.7) to 2016 (274.1) but remains significantly higher than the State (225.8). The Heart Disease (215.8) and Cardiovascular (274.1) mortality rates in Philadelphia County are also significantly higher than the State rates (175.8 and 225.8 respectively).

The overall Premature (under age 65) Cardiovascular Disease mortality rate for the City of Philadelphia was 60.6, while the rate among Black residents was higher at 78.5 (2014). The City’s North District (88.6), Lower North District (94.6) and River Wards District (70.5) are all higher than the City of Philadelphia rate overall for premature (under age 65) Cardiovascular Disease mortality.

The percentage of Adults Who Have Ever Been Told They Have Hypertension has been increasing over the past fifteen years from 31.3% in 2000 to 38.2% in 2014/15 for the City of Philadelphia. The percentage was higher for Black residents (48.0%), the City’s North District (41.7%) and Lower North District (41.4%), while the River Wards District (30.6%) was lower than the City overall.

STROKE

The Cerebrovascular mortality rate in 2016 for Philadelphia County (42.1) was significantly higher than the State (36.8) even though the rate has decreased since 2011 (49.1).

CANCER

The incidence rate for All Cancers in Philadelphia County has increased from 492.3 in 2011 to 542.7 in 2016. The County rate is significantly higher than the State rate (474.1). The mortality rate for All Cancers in Philadelphia County has decreased from 215.7 in 2011 to 192.8 in 2016 but is still significantly higher than the State (158.7). The rate is also higher than both the US rate (158.7) and the Healthy People 2020 goal (161.4).

The incidence rate for All Cancers in the City of Philadelphia in 2016 was 492.3, significantly higher than the State (474.1). For the City, the rate for Cancer mortality (All Causes) was significantly higher (192.8) for All Races than the State (164.0). The rate among the Black population (214.5) was also significantly higher than the State (198.7).

The Cancer mortality rate per 100,000 people in the City’s North District (250.3), Lower North District (246.8) and River Wards District (240.9) were higher when compared to the City of Philadelphia overall (199.9). The Cancer mortality rates for Black (216.3) and White (201.5) residents are higher than the City as well.
Although the percentage of Adults in Philadelphia County reporting being a current smoker decreased from 25.0% in 2011-2013, to 22.0% in 2015-2017, the percentage was still significantly higher than the State (18.0%).

The Cancer mortality rate per 100,000 people in the City’s North District (250.3), Lower North District (246.8) and River Wards District (240.9) were higher when compared to the City of Philadelphia overall (199.9). The Cancer mortality rates for Black (216.3) and White (201.5) residents are higher than the City as well.

Although the percentage of Adults in Philadelphia County reporting being a current smoker decreased from 25.0% in 2011-2013, to 22.0% in 2015-2017, the percentage was still significantly higher than the State (18.0%).

While the Bronchus and Lung Cancer incidence rate per 100,000 in Philadelphia County has decreased from 2011 (81.5) to 2015 (75.8) the rate in 2015 was significantly higher when compared to the State (63.2). The available US rate in 2014 was 50.8 and for that year, Philadelphia County (77.2) was higher than the Nation. The Bronchus and Lung Cancer mortality rate for 2016 (50.9), although decreasing since 2011 (58.3), was still significantly higher than the State (40.9) as well.

The Colorectal Cancer incidence rate per 100,000 in 2015 in Philadelphia County (45.3) was significantly higher when compared to the State (41.9) and the Healthy People 2020 Goal (39.9), even though the rate has decreased since 2011 (51.3). The Colorectal Cancer mortality rate in 2016 (19.4) was also significantly higher than the State (14.7) and the Healthy People 2020 Goal (14.5). The rate for Women (17.0) was significantly higher than the State rate (12.2).

The Prostate Cancer incidence rate for Philadelphia County in 2015 (136.3) was significantly higher than the State (104.4), although it has been decreasing since 2011 (179.8). The Prostate Cancer mortality rate in Philadelphia County was also decreasing from 36.1 in 2011 to 30.7 in 2016. However, the rate was still significantly higher than the State (19.2).

The Cancer of the Liver and Bile Ducts mortality rate for All Races in Philadelphia County (11.5) was significantly higher than the State (6.5). The County also has significantly higher rates than the State for Males (18.1 vs. 9.8), Females (6.6 vs. 3.6) and the White population (8.3 vs. 5.7).

DIABETES

The 2012-2015 three-year percentage for Diabetes prevalence in the City’s North District (18.6%) and River Wards District (16.5%) is higher than the City of Philadelphia (15.4%) overall. The Black (18.8%) Diabetes prevalence is also higher than the City overall for the same time period.

ASTHMA

The age-adjusted rate of hospital discharges with a primary diagnosis of Asthma per 10,000 children 18 years and under for the three Districts in TUH’s service area is available by zip code. For zip code 19140 in the City’s North District for 2013-2015, the rate was 128.1, more than double the rate for the City of Philadelphia overall (59.5). For zip codes 19132 (152.6) and 19133 (121.0) in the Lower North District, the rates were triple and double (respectively) the City rate. Zip code 19134 (114.1) in the River Wards District was also double the City rate.
AREAS OF IMPROVEMENT

BREAST CANCER

In 2011, the Breast Cancer mortality rate in Philadelphia County was 30.5 and was significantly higher than the State rate that year and for the next three years. In 2016, the rate had dropped to 23.8, and was comparable to the State rate of 21.4.\textsuperscript{46}

DIABETES

The Diabetes mortality rate in Philadelphia County in 2011 was 26.9 and was significantly higher than the State. By 2016, the rate had dropped to 21.4 and was comparable to the State (20.2).\textsuperscript{47}

ASTHMA

In 2011, the percentage of students with Asthma conditions was 17.9% and by 2016 had dropped to 12.1\%.\textsuperscript{48} The age-adjusted rate of hospital discharges with a primary diagnosis of Asthma per 10,000 children 18 years old and under for the City of Philadelphia overall in 2015 (59.5) shows a decreasing trend since 2011 (98.8).\textsuperscript{47}
ACCESS TO QUALITY HEALTH CARE

Access to comprehensive, quality health care is important for the achievement of health equity and for increasing the quality of life for everyone in the community. In the TUH service area, as in many other communities in the United States, there are individuals who cannot access health care. Secondary data, Focus Groups, Key Informant Survey and Resident Survey data show the following needs and issues related to access:

- Health insurance issues of high deductibles/copays/affordability of health care plans;
- Uninsured and underinsured;
- Health care costs;
- Transportation;
- Availability of providers (number of providers, convenient hours, wait times to schedule an appointment);
- Knowing what services are available and how to access these services, including navigation;
- Financial resources;
- Safe and affordable housing;
- Homelessness;
- Lack of trust in the health system; and
- Language and cultural accessibility.

WHAT THE COMMUNITY IS SAYING

When asked to rate the health status of the community, 69.0% of Focus Group participants rated the health status of the community as Fair or Poor as shown in Figure 13.

Figure 13: Focus Group Rating of Community Health Status

Source: 2018 Temple University Hospital Focus Groups, Strategy Solutions, Inc.
When asked to explain the rating, participants noted the following:

- There are higher rates of asthma and other chronic conditions including diabetes and hypertension;
- The Geriatric community is underserved, and they don’t know what is available to them;
- Gun violence is a tremendous problem;
- Drug use;
- Lack of medication compliance because they either can’t get or can’t afford their prescriptions; and
- Poor housing conditions.

More than three quarters of the Resident Survey respondents (77.8%) indicated that Inability to Pay Out of Pocket Expenses is a barrier to health care as illustrated in Figure 14. Almost two thirds (65.9%) identified Lack of Health Insurance Coverage as a barrier and Inability to Navigate the Health Care System was identified as a barrier by over half (52.7%). More than a quarter (27.0%) stated that Basic Needs Not Met was a barrier.

**Figure 14: Resident Survey Participants: Most Frequent Barriers Identified N=144**

Source: 2018 Resident Survey, Temple University Hospital’s Institute for Survey Research
Other barriers identified included:

- Lack of trust;
- Language/cultural barriers;
- Availability of providers/appointments; and
- Lack of child care.

Four (4) residents also discussed the lack of Medicaid providers and long wait times, limited appointment availability and other issues associated with Medicaid providers as their reason for selecting the top 3 factors preventing their community from accessing health care. Healthcare cost and access issues for those that do not qualify for Medicaid were also raised.

As shown in Figure 15, almost half (41.2%) of the Key Informant Survey respondents ranked Inability to Pay Out of Pocket Expenses and Inability to Navigate the Health Care System as top Barriers to Care in the community.

**Figure 15: Key Informant Survey Participants: Most Frequent Barriers to Care in Community, N=41**

Needed services related to access to care identified by primary research participants included:

- Education on the resources available;
- Increase in the number and range of providers, particularly in primary care;
- Mobile urgent care units;
- Access to free/low cost medical care including dental care;
- Health education; and
- Outreach and assistance with navigating the system.
According to respondents of the Resident and Key Informant Surveys, the top five (5) underserved populations include:

- Uninsured/underinsured;
- Low income/poor;
- Black/African American;
- Homeless; and
- Seniors/aging/elderly.

**OPPORTUNITIES FOR IMPROVEMENT**

**HEALTH AS FAIR OR POOR**

When looking at the access indicators from the 2015-2017 Pennsylvania Behavioral Risk Factor Surveillance Survey (BRFSS), a significantly higher percentage of Philadelphia County residents rated their health as Fair or Poor (21.0%) when compared to the State (17.0%).

Almost a third of the residents of the City's North (32.5%), Lower North (32.4%) and the River Ward Districts (28.2%) rated their health as Fair or Poor, compared to the City of Philadelphia overall (23.6%).

**IMPACT OF POOR HEALTH**

For 2015-2017, a significantly higher percentage of Philadelphia County residents reported Poor Physical or Mental Health Prevented Usual Activities in the Past Month (29.0%) versus the State (24.0%).

**YEARS OF POTENTIAL LIFE LOST**

Years of Potential Life Lost Before Age 75 is an age-adjusted rate per 100,000 population. It is based on the average years a person would have lived if he or she had not died before age 75. In the City of Philadelphia, the North (12,861), Lower North (14,588) and River Wards (12,506) Districts have some of the highest rates of Years of Potential Life Lost in Philadelphia County.

**HEALTH INSURANCE/AFFORDABILITY**

Affordability of health care services is a problem for many City of Philadelphia residents. For 2014/15, Adults age 18-64 Who Did Not Seek Care Due to Cost in the River Wards District (25.7%) was almost double the City of Philadelphia (13.4%) overall, and was higher than the North District (19.8%) and the Lower North District (11.4%).

Looking at the breakdown of ethnicity/race and affordability of care on the City level, Hispanic (18.3%), Black (14.1%) and Asian (13.7%) residents who Did Not Seek Care Due to Cost are all higher than the City of Philadelphia overall (13.4%).

A significantly higher percentage of Adults ages 18-64 for Philadelphia County report that they have No Health Insurance (14.0%), compared to the statewide percentage of 9.0%. A substantial percentage of Philadelphia County residents reported Need[ing] to See a Doctor But Could Not Due To Cost in the Past Year (15.0%); the percentage was significantly higher than the State (11.0%).

“Quality of care is limited when Medicaid is the only option. There are many places that are sliding scale fees, but that is too expensive for many people. Navigating systems, finding who or how to pay, what is covered are all issues facing health care in Philadelphia”

~ Resident Survey Respondent
HEALTH INSURANCE AND MEDICAID

For the years 2014/15, Adults age 18-64 with No Health Insurance for the City’s North District (16.6%) and Hispanics (24.6%) within the City of Philadelphia are higher than the City overall (12.4%). For the same time period, Adults age 18-64 who are covered by Medicaid in the City’s North District (40.9%) is almost double the Adult percentage in the City overall (22.1%). Black (32.4%) and Hispanic (23.5) Adults who have Medicaid have percentages that are also higher than the City overall.

PERSONAL CARE PROVIDER

Almost one in five (18.0%) Philadelphia County residents indicated that they have No Personal Health Care Provider, which was significantly higher than the State overall (14.0%).

SCREENINGS

Although overall, the percentage of Women age 50-74 in the City of Philadelphia receiving Mammograms in the past two years (2014/15) was 82.5%, the percentage of White Women receiving a Mammogram was only 76.2%.

DIAGNOSIS

The rates of new HIV diagnoses per 100,000 of the population for the City's North District (40.6) and Lower North District (49.1) are higher than the City overall (31.5). The City trend has been decreasing since 2012 (47.8). When looking at new HIV diagnoses in relation to ethnicity and race, Hispanic (49.0) and Black (48.0) rates are higher than the City overall as well.

AREAS OF IMPROVEMENT

SCREENINGS

The percentage of Adults in Philadelphia County reporting that they had a Routine Checkup in the Past Year for latest reportable year of 2015-2017 (87.0%) has increased from 2011-2013 (85.0%). This was slightly higher than the State percentage of 85.0.

Since 2011, the percentage of Women in Philadelphia County appropriately receiving Mammograms has increased from 54.1% to 62.2%, although the percentage was lower than the overall State percentage of 64.8.

The percentage of residents in Philadelphia County Ever Tested for HIV, ages 18-64 (65.0%) has increased since 2011 (63.0%) and was significantly higher than the State (41.0%).

For the City of Philadelphia overall, the percentage of Adults age 50-74 reporting ever having had a Colonoscopy or Sigmoidoscopy has increased from 54.6% in 2002 to 72.6% in 2014/15.

MENTAL HEALTH PROVIDERS

The number of Mental Health Providers has increased in Philadelphia County, as evidenced by the decrease in the provider/population ratio. The ratio was 524 people for each provider in 2015 and dropped to 436 people for each provider in 2018.

INSURANCE

Adults age 18-64 with No Health Insurance in the River Wards District (9.9%) was lower than the City overall (12.4%) for the time period 2014/15. For the City overall, the trend has been decreasing since 2012 (18.5%).
Social Determinants of Health (SDoH) is a new term in health care. According to the World Health Organization (WHO), SDoH are “the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels” and often determine the access to and quality of medical care that individuals receive.

For the 2019 CHNA, the Hospital leaders and Steering Committee members were interested in the barriers related to the social determinants of health that the community is facing that are preventing them from obtaining medical services.

Specific barriers related to each of the topical areas of the report are listed in those sections.

Focus Group participants and Resident Survey and Key Informant Survey respondents identified the following barriers to care:

- Inability to pay out of pocket expenses;
- Lack of insurance;
- Pipeline for assisting those coming out of incarceration;
- Entry level and sustainable employment opportunities;
- Stable housing;
- Lack of multi-lingual providers, especially Spanish speaking
- Transitional services coming out of treatment or jail; and Young children who have aged out of Department of Human Services who are coming back to the area – there is a need for reintegration into the community.

Resources needed to improve access to care identified by primary research respondents and participants include:

- Financial assistance with utilities;
- Education on the resources that are available in the community;
- Social workers who can assist with connecting services with the needs of patients/help people navigate the system;
- Job education and training;
- Lowering the cost of healthcare;
- Education to promote healthy lifestyles;
- Free/low cost medical and dental care;
- Prescription assistance;
- Health screenings;
- Transportation;
- Medical specialists; and
- Bi-lingual services.

“The biggest problem is not being able to afford healthcare unless you qualify for Medicaid or other government funded insurance. There aren’t enough doctors. There is no question about that. Appointments are few and far between. The health centers where they offer free care are packed. It’s likely that you will spend the entire day just waiting. The emergency rooms are too. So even if you have insurance it’s just a big waiting game.”

~ Resident Survey Respondent

“Many people do not have health insurance or if they have Medicaid/Medicare, their options are severely limited. I work at a Spanish/English bilingual clinic and many of our patients have difficulty getting an appointment with us due to high demand and lack of available appointments. Many of our patients are also severely limited when sent to specialty appointments due to a lack of Spanish speaking providers.”

~ Resident Survey Respondent
SUBSTANCE USE

Public health data, Focus Group participants, Key Informant Survey and Resident Survey respondents identified the following identified needs and issues related to substance use disorders:

- Substance abuse – Adults and children;
- Alcohol abuse/deaths – Adults and children;
- Smoking/vaping – Adults and children; and
- Inability to navigate the system.

“We have a very bad epidemic of drug use in our area which is prefaced by mental health/suicide. We must try and help them, we need access to health care.”

~ Resident Survey Respondent

WHAT THE COMMUNITY IS SAYING

Figure 16 shows that almost a quarter (22%) of Philadelphia County adults current smoke. Almost three fourths of Key Informant Survey respondents (73.7%) indicated that Substance Abuse/Alcohol Abuse was the top health issue related to substance use disorder. More than three quarters (76%) of Philadelphia County high school seniors reported having used alcohol in their lifetime.

Figure 16: TUH Focus Group Participants and Resident Survey Respondents: Substance Use Disorder, 2018

Sources:
- 2015-2017 PA Department of Health BRFSS Data
- 2018 Temple University Hospital Key Informant Surveys, Strategy Solutions, Inc.
- 2017 PA Youth Survey, Philadelphia County
Almost half (42.9%) of Focus Group participants indicated that Drug and Alcohol treatment that is both trauma-informed and gender specific is a top community need. More than three-quarters of the Resident Survey respondents (76.3%) indicated that Substance Abuse/Alcohol Abuse was one of the top three issues related to Substance Use Disorder. Tobacco was identified as a top issue by 11.3% of the Resident Survey participants.

Other needs and issues identified by participants in the primary research included:

- Lack of detox beds available in the community;
- Inability to navigate the system;
- Increase in the number and the range of services available; and
- Early intervention education and services.

Barriers identified by participants in the primary research include:

- Stigma;
- ID requirements in the Philadelphia area; and
- Inability to navigate the system.

Needed services for mental health and substance abuse identified by the Key Informant and Resident survey respondents and Focus Group participants include early intervention and education services.

**OPPORTUNITIES FOR IMPROVEMENT**

**TOBACCO**

Although the percentage of Adults in Philadelphia County reporting being a Current Smoker decreased from 25.0% in 2011-2013, to 22.0% in 2015-2017, the percentage was still significantly higher than the State (18.0%).

The prevalence of Adults Smoking in the City of Philadelphia overall has been on a decline from 27.3% in 2008 to 22.4% in 2014/15, although Black Adults (25.8%) were higher than the City overall, while Asian Adults (9.1%) were two times lower than the City. Adults living in the City’s North District (28.3%), Lower North District (25.3%) and the River Wards District (38.8%) were higher than the City’s overall percentage.

The Smoking-Attributable mortality rate for the River Wards District (766.2) was the worst in the City of Philadelphia.

Although the percentage of Teen Tobacco Use and Cigarette Smoking prevalence, 9th-12th Grade, in the City of overall Philadelphia has been on a steady decline between 2001 (15.8%) and 2015 (7.2%), the percentages for White (34.8%) and Hispanic Teens (31.0%) are higher than the City overall.

“We have too many individuals with substance use/opioid use disorder that need help, counseling, access to treatment and integrated care.”

~ Resident Survey Respondent
DRUG-INDUCED MORTALITY

The Drug-Induced mortality rate in Philadelphia County (47.2) in 2016 was significantly higher than the State (38.5). The rate has almost doubled over the past six years from 28.3 in 2011 to 47.2 in 2016.

Opioid-Related mortality rate in the City of Philadelphia overall has more than tripled since 2003 (14.0) to 40.3 in 2016. The rate among White residents (65.3) was significantly higher than the State, while the Hispanic rate (43.7) was slightly higher. The rate for Black residents was significantly lower than the State (24.8) as was the Asian rate (7.0).

The City’s River Wards District Opioid Related mortality rate for 2016 (105.1) was more than double the City (40.3) overall, and is the highest rate in the City. Both the North District (44.1) and Lower North District (61.5) were also higher than the City overall.

EXCESSIVE DRINKING

The percentage of Adults who reported Excessive Drinking has increased in Philadelphia County from 18.0% in 2011 to 22.1% in 2018. This was slightly higher than the State percentage of 20.5%. The percentage of Adults who reported Excessive Drinking for the City of Philadelphia overall remained constant between 2014 (19.2%) and 2015 (19.5%), although the percentages for White (25.8%) and Hispanic Adults (22.1%) were higher than the City (18.7%) overall for 2012.

PRESCRIPTION PAIN RELIEVER USE

The percentage of students in Philadelphia County reporting Prescription Narcotics Use has increased from 5.6% in 2013 to 7.3% in 2017. The percentage was highest among high school seniors (9.9%), although the percentage among those in 10th grade has increased from 5.6% in 2013 to 7.1% in 2017.

AREAS OF IMPROVEMENT

ALCOHOL IMPAIRED DRIVING MORTALITY

Alcohol Impaired Driving Deaths in Philadelphia County have decreased from 27.4% in 2014 to 22.5% in 2018. This was lower than the State percentage of 30.1%.

YOUTH ALCOHOL USE

The percentage of students in Philadelphia County who report Lifetime Alcohol Use has decreased from 56.2% in 2013 to 49.3% in 2017. In 2017, over three-fourths of high school seniors (76.0%) report some Lifetime Alcohol Use.

YOUTH TOBACCO USE

The percentage of students reporting Lifetime Cigarette Use has decreased in Philadelphia County between 2013 (19.1%) to 14.5% in 17. The percentage of students reporting using cigarettes in the past 30 days has also decreased from 8.9% in 2013 to 2.4% in 2017.

VAPING/E-CIGARETTE USE

Almost one in five (18.3%) Philadelphia County students in 2017 reported Vaping/E-Cigarette Use in the past 30 days.

“Addressing the needs of IV drug and opioid users is a top community need. Nine times out of ten, they don’t have stable housing and have difficulty accessing medical services in the community.”

-- Resident Survey Respondent
Environmental quality is a general term which refers to varied characteristics that relate to the natural environment such as air and water quality, pollution and noise, weather as well as the potential effects these characteristics have on physical and mental health. In addition, environmental quality also refers to the socio-economic characteristics of a given community or area, including economic status, education, crime and geographic information. Public health data, Focus Group participants, Key Informant Survey and Resident Survey respondents mentioned the following needs and issues related to healthy environment:

- Gun violence/mortality;
- Children living in poverty/poverty in general; and
- Lack of safe and affordable housing.

WHAT THE COMMUNITY IS SAYING

As shown in Figure 17, almost three fourths of Focus Group participants (71.4%) indicated that preventative services for gun violence and education for young people is a top need related to a healthy environment. Almost two thirds of Focus Group participants (61.9%) rated Stable Housing as a top community need.

Figure 17: TUH Focus Group Participants and Resident Survey Respondents: Healthy Environment, 2018

Sources:
2018 Temple University Hospital Focus Groups, Strategy Solutions, Inc.
FBI Uniform Crime Reports 2000-2015
Overall, Focus Group participants and Survey respondents (both Key Informant and Resident) indicated the top needs and issues related to a healthy environment included:

- Safe gun education;
- Housing conditions;
- Lack of sustainable employment; and
- Addressing homelessness and low-income.

Barriers identified by primary research participants related to a healthy environment included:

- Lack of trust in the community;
- Lack of money/income;
- Low graduation rates; and
- Limited educational attainment.

Needed services related to a healthy environment included:

- Awareness and education on gun violence;
- A pipeline to assist those coming out of incarceration;
- Affordable childcare;
- Safe housing; and
- Job training.

OPPORTUNITIES FOR IMPROVEMENT

POVERTY

The percentage of Children Living in Poverty in Philadelphia County in 2018 (37.2%) has increased from 2011 (31.7%). The percentage of Children Living in Single Parent Homes (59.8%) has also increased from 2011 (57.8%).

The percentage of Children Living in Poverty in the City of Philadelphia in 2015 (38.3%) has slightly increased from 2000 (31.6%). The percentage of Children Living in Poverty who are Hispanic (50.3%) and Black (45.9%) are higher than the City overall.

The percentage of Children Living in Single Parent Homes in the City of Philadelphia in 2015 (60.2%), which has increased from 2013 (58.2%). Children Living in Single Parent Homes for the City’s North District (77.6%), Lower North District (79.2%) and the River Wards District (62.5%) are all higher than the City’s overall percentage in 2015.

EMPLOYMENT

The Unemployment rate for those 16 years old and older in 2015 for the City’s North (23.4%), Lower North (18.3%) and River Wards Districts (18.0%) are all above the City of Philadelphia overall (10.9%). The Unemployment rate for those 16 years old and older in 2015 who are Black (15.2%) and Hispanic (14.5%) were also higher than the City overall.

HOUSING

The percentage of Philadelphia County residents with Severe Housing Problems in 2018 was 24.3%, much higher than the State (15.5%). For 2016, the Philadelphia Building Construction and Occupancy Code Violations per 1,000 Occupied Housing Units for the City of Philadelphia was 193.4, and violations have been slowly increasing since 2009 (164.7). When comparing the City to the planning districts, the City’s North (282.7), Lower North (480.5) and River Wards (240.2) Districts are all higher than the City overall.
VIOLENCE

The Violent Crime rate for Philadelphia County in 2018 was 1094.2 per 100,000 population. This was three times the State rate of 332.7.

FIREARM MORTALITY

The Firearm mortality rate in Philadelphia County for 2016 (17.9) was significantly higher than the State (11.9) and was almost twice the Healthy People 2020 Goal of 9.3. The rate among Black Males in Philadelphia County was 62.7, also significantly higher than the State rate for Black Males (49.4).

HOMICIDE

The Homicide mortality rate in the City of Philadelphia overall has fluctuated over the past thirteen years, but overall has decreased from 22.0 in 2003 to 17.8 in 2016. The rate was significantly higher for Black residents (31.6). The City’s North (46.4) District has the highest Homicide rate in the City and one of the highest rates in the Nation. The Lower North District (39.0) is also higher than the City overall, while the River Wards District (12.7) is lower.

The Firearm Homicide rate for the City of Philadelphia has also fluctuated over the past thirteen years, but overall has decreased from 17.3 in 2003 to 14.9 in 2016. This rate was also significantly higher among Black residents (27.3). Both the City’s North District (37.5) and the Lower North District (35.6) rates are more than double the City overall rate in 2016. The North District also has the highest rate in the City.

AREAS OF IMPROVEMENT

VIOLENCE

The Violent Crime rate for the City of Philadelphia in 2015 was 1,029 per 100,000 population; the trend shows a consistent decrease since 2008 (1,441).

YOUTH AND ADULT ASTHMA

In 2011, the percentage of students in Philadelphia County with Asthma conditions was 17.9%, and by 2016 has increased to 18.6%. Since 2011 (17.0%), the percentage of Adults Who Have Ever Been Told They Have Asthma dropped slightly to 16.0% in 2015-2017, and the percentage was no longer significantly higher than the State (15.0%). The percentage of Adults Who Currently Have Asthma in 2015-2017 (12.0%) was also lower than 2011-2013 (13.0%) and was also no longer significantly higher than the State (10.0%).

AIR POLLUTION

The average number of days per month with Air Pollution – Particulate Matter has decreased in Philadelphia County from 16.0 in 2011 to 11.2 in 2018. In the City of Philadelphia, the number of Days with Good Air Quality in 2016 (178) has fluctuated over time but has been increasing since 2000 (137), and the number of Days with Unhealthy Air Quality has been decreasing from 29 in 2000 to 9 in 2016.

Employment
EMPLOYMENT

The Unemployment rate in Philadelphia County has been decreasing over the past few years to 6.8% in 2018, although the rate was higher than the State rate of 5.4%. The City of Philadelphia Unemployment rate has also been decreasing from 10.9% in 2012 to 6.8% in 2016. Additional detail on the unemployment rates within the service area are included by zip code in Table 2 in the Demographics section of this report.

HIGH SCHOOL GRADUATION RATES

The percentage of students Graduating High School has increased in Philadelphia County from 59.0% in 2014 to 69.8% in 2018. While the local percentage has increased in recent years, the percentage was still lower than the State (85.4%) and U.S. (84.0%). The On-Time High School Graduation rate for the City of Philadelphia increased from 55.2% in 2011 to 64.8% in 2015. The rate for Hispanic Students in 2014/15 was much lower at 53.3%.
MENTAL HEALTH

Secondary health data, Focus Group participants, Key Informant Survey and Resident Survey respondents indicated the following needs and issues related to mental health:

- Lack of mental health providers;
- High suicide rate;
- Mental/behavioral health issues; and
- Inability to navigate the system.

WHAT THE COMMUNITY IS SAYING

Figure 18 illustrates that over half of the Resident Survey respondents (59.7%) indicated mental health care was one of the top needed services. Almost all (90.5%) of the Focus Group participants indicated that Early Intervention for Mental Health is a top priority and just under half (46.0%) of Philadelphia County residents indicated their mental health was not good one or more days in the past month.125

Focus Group participants, Key Informant, and Resident Survey respondents also mentioned that there is a limited range of providers with accommodating hours.

Figure 18: TUH Focus Group Participants and Resident Survey Respondents: Mental Health, 2018

Sources:
2015-2017 PA Department of Health BRFSS Data
2018 Temple University Hospital, Strategy Solutions, Inc.
2018 Resident Survey, Temple University Hospital’s Institute for Survey Research
Twenty-two (22) out of 181 residents commented on the need for more mental health services, especially among vulnerable populations that lack access to healthcare and other resources as their reason for selecting Mental Health as one of the top three health issues facing their community. The intersection between mental health and substance abuse services was also raised by 14 residents, as well as the need for integrated behavioral healthcare (1 resident).

Barriers identified by primary research participants related to mental health services included:
- Language and cultural barriers accessing services;
- Stigma;
- ID requirements to access services in Philadelphia;
- Difficulty navigating the system;
- Health insurance costs and coverage (co-pays, deductibles, prescriptions, etc.);
- Time limitations (long wait times, limited office hours); and
- Lack of resources for co-occurring conditions of mental health and addiction.

OPPORTUNITIES FOR IMPROVEMENT

MENTAL HEALTH NOT GOOD

The percentage of Adults in Philadelphia County who reported that their Mental Health Was Not Good 1+ Days in the Past Month (46.0%) was significantly higher than the State (38.0%).126 The percentage has also increased slightly since 2011 (44.0%).127

MENTAL HEALTH CONDITIONS

For the City of Philadelphia overall, the percentage of Adults Diagnosed with a Mental Health Condition has increased from 10.5% in 2000 to 20.8% in 2014/15.128 The City’s Hispanic percentage (29.6%) was almost fifty percent higher than the overall percentage (20.8%). The White percentage was comparable to the City of Philadelphia (23.0%), while the Black percentage was slightly lower (18.5%).129

About one in four Adults in the City’s North (26.4%), and Lower North (28.9%) Districts and about one in three Adults in the River Wards District (36.7%) were Diagnosed with a Mental Health Condition for the time period 2012-2015; all three districts are higher than the City of Philadelphia overall (20.8%).130

“There are rampant addiction issues, and I ranked mental health a close second, because it is so closely related to the underlying causes of addiction. We desperately need better community support systems and mental health services for people struggling with addiction and their families and friends.”

~ Resident Survey Respondent

“A large number of people don’t have access to care. Even those with access to care struggle with mental health and a huge number of our most vulnerable (homeless, unemployed, etc.) are where they are because of mental health issues”

~ Resident Survey Respondent
AREAS OF IMPROVEMENT

SUICIDE

The Suicide mortality rate per 100,000 in Philadelphia County in 2016 (9.1) was significantly lower than the overall State rate of 14.6.1 The rate has also decreased slightly since 2011 (10.2).12

The City of Philadelphia rate for 2016 was 9.1, which has been decreasing slightly since 2012 (11.4).13 The rate for Whites (14.7) in the City was significantly higher than the State, while the Black rate (5.5) in the City was significantly lower than the City overall.14

The Suicide mortality rate for residents in the City’s North District (5.2) and Lower North District (7.6) were lower than the City of Philadelphia overall (9.1).15

TEENS CONSIDERING SUICIDE

Over the past 13 years, the percentage of students in 9th-12th grade in Philadelphia County Who Have Seriously Considered Attempting Suicide in the past 12 months has decreased from 16.6% in 2000 to 14.0% in 2015. The percentage among Hispanic students was higher (16.2%) than the County overall (14.0%) and was lower among Black (11.9%) and Asian (9.8%) students.16
HEALTHY WOMEN, MOTHERS, BABIES & CHILDREN

The well-being of children determines the health of the next generation and can help predict future public health challenges for families, communities, and the health care system. The healthy mothers, babies and children topic area addresses a wide range of conditions, health behaviors, and health systems indicators that affect the health, wellness, and quality of life for the entire community. Public health data and Focus Group participants identified the following needs and issues related to healthy women, mothers, babies and children in the Hospital’s community and service area including:

- Affordable childcare;
- Medicaid assistance;
- WIC assistance;
- Low birth rate;
- Non-smoking during pregnancy;
- No prenatal care;
- Teen pregnancy; and
- Infant mortality.

WHAT THE COMMUNITY IS SAYING

Figure 19 shows that just over half (57.1%) of Focus Group participants identified affordable childcare as a top community need as well as the rise in Teen Pregnancy, especially for second-time teen parents. Resident Survey respondents ranked maternal/infant health as one of the least pressing health issues. A little more than one in ten (11%) of Key Informant survey respondents identified Children/Youth as underserved in the community. In response, needed services identified by Focus Group participants include a holistic program for teen pregnancy that includes education on the role of a midwife, parenting classes and affordable childcare.

Barriers identified by Focus Group participants related to maternal child health included:

- Lack of money/income; and
- Lack of insurance.
Figure 19: TUH Focus Group Participants and Resident Survey Respondents: Women, Infant and Children Health, 2018

OPPORTUNITIES FOR IMPROVEMENT

PRENATAL CARE

While the percentage of Mothers Receiving Prenatal Care in the First Trimester in Philadelphia County has increased from 2011 (54.3%) to 2016 (61.9%), the percentage has remained significantly lower when compared to the State (73.8% in 2016). Also, the percentage of Women Receiving No Prenatal Care (5.2%) was significantly higher than the State (1.6%).

The percentage of Black Women Receiving Late or No Pre-Natal Care (2014: 16.4%) in the City was slightly higher, while Hispanic (13.8%), Asian (10.9%) and White (8.3%) percentages were slightly lower than the City overall (13.3%).

In 2014, the percentages of Women Who Received Prenatal Care either in the third trimester or not at all for the City’s North District (14.4%) and the Lower North District (16.2%) were higher than the City of Philadelphia overall (13.3%).
MATERNAL SMOKING

The percentage of Non-Smoking Mothers During Pregnancy in Philadelphia County has been significantly higher than the State (88.5% in 2016) over the past five years. The percentage has increased from 89.4% in 2011 to 93.5% in 2016. This percentage has also been significantly higher when compared to the State (84.3% in 2016). This percentage has also increased from 85.6% in 2011 to 90.9% in 2016.

LOW BIRTH WEIGHT BABIES

The percentage of Low Birth Weight Babies in Philadelphia County has been significantly higher than the State (8.2% in 2016) for the past five years, although the percentage has decreased from 11.3% in 2011 to 10.8% in 2016. For the City of Philadelphia, the percentage for Black babies was 13.6% (higher than the City), Hispanic was 9.5%, White was 7.2% and Asian was only 6.5%, while the City of Philadelphia percentage overall was 10.7%. For 2014, the City’s North District (11.1%) and the Lower North District (14.7%) were both higher than the City for Low Birth Weight Babies, although the River Wards District (8.6%) was slightly lower than the City overall.

INFANT MORTALITY

The Infant mortality rate per 1,000 live-born infants under one year of age in the City’s Lower North District (14.6) in 2014 is double the City of Philadelphia overall rate of 7.8 while the North District (9.3) and River Wards District (8.4) are slightly higher than the City. The City’s Lower North District rate is the highest in the City.

BREASTFEEDING

The percentage of Women Initiating Breastfeeding before Hospital Discharge, in 2014 for the City’s North (67.1%), Lower North (69.5%) and the River Wards Districts (70.5%) were all lower than the City of Philadelphia’s overall percentage of 77.3%.

WIC ASSISTANCE

The percentage of Mothers Reporting WIC assistance in Philadelphia County was significantly higher when compared to the State (35.0% in 2016) for the past five years, although the percentage has been decreasing from 61.2% in 2011 to 52.9% in 2016. The percentages for Black, (63.6%), Hispanic (74.0%), and Asian (47.0%) Women within Philadelphia County was significantly higher than the State percentages for these groups (61.7%, 68.4%, and 29.2% respectively).

CHILDHOOD OBESITY

The percentage of students in grades K-6 who are considered Obese in Philadelphia County has remained fairly consistent since 2011 and in 2016 (18.7%) was higher than the State (16.7%) and the Healthy People 2020 Goal (15.7%). The percentage of students in grades 7-12 considered Obese in Philadelphia County has fluctuated slightly from 2011 (20.1%) to 2016 (20.0%) and continues to be higher than the State (19.1%) and the Healthy People 2020 Goal (16.1%).

Although the Child Obesity Prevalence, 5-18 Years of Age for the City of Philadelphia for the year 2014/15 has remained somewhat constant from 2001 (21.7%) to 2015 (20.6%), Black Females (22.8%), White Males (21.2%), and Hispanic Females (22.0%) and Males overall (25.7%) have higher percentages than the City overall.
For the school year 2014/15, the percentage of children, age 5 to 18 years with Child Obesity Prevalence for the planning districts has been reported by zip code. Therefore, looking at the City’s North District, zip code 19140 (23.7%) is higher than the City of Philadelphia percentage of 20.6%. The Lower North District zip codes 19132 (23.2%), 19133 (26.7%), 19121 (22.5%), and 19122 (21.5%) are all slightly higher than the City overall. In the River Wards District, zip codes 19137 (25.6%), 19134 (21.2%) and 19125 (24.6%) are all slightly higher than the City overall as well.

AREAS OF IMPROVEMENT

INFANT MORTALITY

Over the past seven years in the City of Philadelphia, the Infant mortality rate per 1,000 live births has decreased from 11.4 in 2007 to 7.8 in 2014. However, the rate among Blacks residents was 12.2, significantly higher than the overall rate, while the White (3.8) and Hispanic (5.6) rates were lower than the City overall.

BREASTFEEDING

After being significantly lower than the State percentage for several years, the percentage of Breastfeeding Mothers in Philadelphia County has increased over the past five years from 62.3% in 2011 to 80.9% in 2016. The percentage was comparable to the State (81.1%). The percentage was lower for Black and Hispanic Women (74.4% and 74.8% respectively) and higher for White (81.8%) and Asian (85.3%) Women when compared to the City overall (77.3%).

TEEN PREGNANCY

The Teen Pregnancy rate per 1,000 Females ages 15-17 in Philadelphia County has been decreasing from 55.7 in 2011 to 26.6 in 2016, although it was still significantly higher than the State (10.6 in 2016). The rate for ages 18-19 has been decreasing as well from 116.7 in 2011 to 69.8 in 2016. However, the rate remained above the State (38.1).

The Teen Birth rate per 1,000, 15-19 Years of age in the City of Philadelphia has been steadily decreasing over the past 7 years, from 59.5 in 2007 to 34.9 in 2014. Teen Births in 2014 in the City’s North District (56.4) and the River Wards District (36.7) are higher than the City overall (34.9). The Lower North District (24.2) has a lower rate than the City overall. Births for Hispanic (58.9) and Black (43.1) Teens are both higher than the City rate overall.
PHYSICAL ACTIVITY & NUTRITION

Good nutrition, physical activity, and a healthy body weight are essential parts of a person's overall health and well-being. Together, these can help decrease a person's risk of developing serious health conditions, such as high blood pressure, high cholesterol, diabetes, heart disease, stroke, and cancer. Secondary data and Focus Group participants identified the following needs and issues related to physical activity and nutrition:

- Food insecurity/access to healthy foods/nutrition; and
- Lack of physical activity/leisure time/green space.

WHAT THE COMMUNITY IS SAYING

As illustrated in Figure 20, the majority of Focus Group participants (72.6%) indicated Food Insecurity as a top community need. They also stressed that access to healthy food upon discharge from the Hospital is an important priority, along with Safe exercise spaces and more green space (57.1%).

Figure 20: TUH Focus Group Participants and Resident Survey Respondents: Food Insecurity and Physical Activity Responses, 2018

Primary research participants identified additional needs and issues related to physical activity and nutrition including:

- The lack of healthy food options within walking distance of everyone in the city;
- Lack of food resources in areas of the community; and
- The presence of food deserts.

Barriers identified by primary research participants included that SNAP is inadequate alone and that many people rely on food banks to supplement their food.

Needed Services identified by primary research participants included:

- Nutritional education;
- Development of safe exercise and recreation spaces; and
- Increased access to affordable, healthy food.
OPPORTUNITIES FOR IMPROVEMENT

PHYSICAL ACTIVITY

Over a quarter (27.0%) of Philadelphia County Adults report that they had No Leisure Time Physical Activity in the Past Month.\textsuperscript{168}

FOOD INSECURITY

More than one in five (21.0%) of the Philadelphia County population has food insecurity which was much higher than the State percentage of 13.1%.\textsuperscript{169} Since 2014, the percentage of Philadelphia County students qualifying for Free or Reduced-Price Lunch has increased from 74.9% to 95.4%, almost double the State (48.2%).\textsuperscript{170}

The percentage of the City of Philadelphia population Living in High-Poverty Areas with Low to No Walkable Access to Healthy Foods has decreased slightly from 24.1% in 2010 to 22.4% in 2014, although the percentage has increased slightly since 2012 (20.1%).\textsuperscript{171} The percentages in the planning districts within the Hospital’s service area were all higher than the City overall (22.4%) – North District (34.4%), Lower North District (38.8%), and River Wards District (26.4%).\textsuperscript{172}

The percentage of City of Philadelphia residents reporting that it was Difficult or Very Difficult to Find Fruit and Vegetables in their neighborhoods for 2014/15 overall was 7.9%, although the percentage among Hispanics was 12.4% and Blacks was 10.7%.\textsuperscript{173}

PHYSICAL ACTIVITY

The percentage of Adults in the City of Philadelphia who said they had Access to Nearby Parks or Outdoor Space has remained consistent between 2012 (72.1%) and 2014/15 (73.1%), although Hispanic Adults (69.6%) were less likely to indicate they had access to Nearby Parks or Outdoor Space.\textsuperscript{174} Those Adults living in the City’s North District (60.7%) and Lower North District (66.0%) had lower percentages than the City overall (73.1%) while the River Wards District (74.7%) was slightly higher.\textsuperscript{175}

OBESITY

Since 2000, the prevalence of Obesity (percentage of Adults with Body Mass Index greater than or equal to 30kg/m\textsuperscript{2} based on self-reported height and weight) in the City of Philadelphia has increased from 25.2% to 33.3% in 2014-15.\textsuperscript{176} The percentage for Blacks (40.1%) was substantially higher, while the percentage for Asians was much lower (9.8%) when compared to the City overall.\textsuperscript{177} The prevalence of Obesity in the North District (33.2%) is comparable to the City overall and is lower in the River Wards District (32.3%), while Adults in the Lower North District (39.5%) have a higher prevalence.\textsuperscript{178}

AREAS OF IMPROVEMENT

None of the selected indicators met the criteria for inclusion in this section. See Appendix A for additional

"Unhealthy food is cheaper than eating healthy. For example, the dollar menu at a fast food restaurant is also cheaper than getting food at Whole Foods, etc."

- Resident Survey Respondent

"There are no affordable exercise classes. At all. I've been looking into joining a gym or dance studio or karate studio for years and even with a decent income they are unaffordable. Eating healthy is super expensive. I can buy a can of soup or a burger for a dollar. A salad or fruit or anything nutritious is so much more expensive. These factors make staying healthy or managing conditions nearly impossible to anyone on a limited income."

- Resident Survey Respondent
INFECTIONOUS DISEASE

Pathogenic microorganisms, such as bacteria, viruses, parasites or fungi, cause infectious diseases; these diseases can be spread, directly or indirectly, from one person to another. These diseases can be grouped in three categories: diseases which cause high levels of mortality; diseases which place heavy burdens of disability on populations; and diseases, which owing to the rapid and unexpected nature of their spread, can have serious global repercussions.  

WHAT THE COMMUNITY IS SAYING

Although not discussed at length by those participating in the primary research, 38.1% of Focus Group participants rated Hepatitis C treatment and screening as an important community need. Access to HIV screening was also identified by 14.3% as important.

OPPORTUNITIES FOR IMPROVEMENT

CHLAMYDIA

For the past six years, the Chlamydia rate per 100,000 population in Philadelphia County has been significantly higher than the State (445.4), although the rate has been decreasing from 2011 (1,332.3) to 1,275.7 in 2016.

The current county rate was almost triple the State. The Chlamydia rate for Teens, 15-19 Years of Age for the City of Philadelphia has increased from 4,837 in 2015 to 5,050 in 2016. The City’s North District (7,157.3) and the Lower North District (4,922), both had rates higher than the City overall (4,837 in 2015)

GONORRHEA

The Gonorrhea rate in Philadelphia County has been increasing from 440.0 in 2011 to 444.7 in 2016. This was three times higher than the State rate of 114.3.

NEW HIV CASES

The rate of newly diagnosed HIV cases in the City’s North District (40.6) and the Lower North District (49.1) were higher than the City of Philadelphia overall (31.5) for 2016. The rates for Hispanics (49.0) and Blacks (48.0) were also higher than the City overall for 2016. The trend for the City has been decreasing (47.8 in 2012).

NEVER TESTED FOR HIV

For the City of Philadelphia, the percentage of Adults Never Tested for HIV, 18-39 Years of Age, has increased slightly between 2012 (23.2% and 2014/15 (25.6%). Asian Adults Never Tested for HIV, 18-39 Years of Age, 2015 was 52.5%, double the City’s overall percentage.

AREAS OF IMPROVEMENT

GONORRHEA

The Gonorrhea rate per 100,000 for Teens, 15-19 Years of Age in the City of Philadelphia has been steadily decreasing since 2011 (1,966) to 1,168 in 2016. The rate in the River Wards District (626.0) was lower than the City overall rate of 1,217 for 2015.
EVER TESTED FOR HIV

The percentage of Adults ages 18-64 in Philadelphia County Who Have Ever Been Tested for HIV has increased from 2011 (63.0%) to 65.0% in 2016.190 This was significantly higher than the State percentage (41.0%).191

PNEUMONIA VACCINE

From 2011-2013 to 2015-2017, the percentage of Adults age 65 or older Who Have Ever Had a Pneumonia Vaccine was significantly lower than the State.192 Since 2011-2013 (66.0%), the percentage increased to 70.0% (2015-2017) and was no longer significantly lower than the State (74.0%).193
Following the meeting, the Steering Committee completed a prioritization exercise using an online survey tool to rate all identified needs on a 1 to 10 scale for each of the selected criteria listed in Table 3.

Table 3: Prioritization Criteria

<table>
<thead>
<tr>
<th>Item</th>
<th>Definition</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Low (1)</td>
</tr>
<tr>
<td>Magnitude of the Problem</td>
<td>The degree to which the problem leads to death, disability, or impaired quality of life and/or could be an epidemic based on the rate or % of population that is impacted by the issue</td>
<td>Low numbers of people affected; no risk for an epidemic</td>
</tr>
<tr>
<td>Impact on Other Health Outcomes</td>
<td>The extent to which the issue impacts health outcomes or is a driver of other conditions</td>
<td>Little impact on health outcomes or other conditions</td>
</tr>
<tr>
<td>Capacity (systems and resources to implement evidence-based solutions)</td>
<td>This would include the capacity to and ease of implementing evidence-based solutions</td>
<td>There is little or no capacity (systems and resources) to implement evidence-based solutions</td>
</tr>
</tbody>
</table>

Source: Temple University Hospital Prioritization Exercise, 2019, Strategy Solutions, Inc.
Following the Steering Committee’s completion of the prioritization exercise, the consulting team analyzed all response scores and ranked results based on the overall composite score (highest to lowest) calculated by summing scores for each of the three criteria described above. The top ten identified needs based on the overall composite score are listed in Table 4. See Appendix K for the list of categorized needs and issues along with the entire prioritization results.

### Table 4: Top 10 Identified Needs of the Service Area as Ranked by the TUH Steering Committee

<table>
<thead>
<tr>
<th>Identified Need</th>
<th>Magnitude (M)</th>
<th>Impact (I)</th>
<th>Capacity (C)</th>
<th>TOTAL M+I+C</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Disease: Diabetes</td>
<td>9.00</td>
<td>9.13</td>
<td>7.93</td>
<td>26.06</td>
<td>1</td>
</tr>
<tr>
<td>Chronic Disease: Overweight/Obesity</td>
<td>9.06</td>
<td>9.13</td>
<td>7.53</td>
<td>25.72</td>
<td>2</td>
</tr>
<tr>
<td>Access to Quality Health Services: Know What is Available and How to Access/Navigate the Services</td>
<td>8.88</td>
<td>8.87</td>
<td>7.20</td>
<td>24.95</td>
<td>3</td>
</tr>
<tr>
<td>Substance Use Disorder: Substance Abuse/Alcohol Abuse and Deaths - Adults and Youth</td>
<td>8.75</td>
<td>8.64</td>
<td>6.80</td>
<td>24.19</td>
<td>4</td>
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<tr>
<td>Healthy Environment: Gun Violence/Mortality</td>
<td>8.67</td>
<td>8.43</td>
<td>6.79</td>
<td>23.89</td>
<td>5</td>
</tr>
<tr>
<td>Healthy Environment: Those Living in Poverty/Poverty in General</td>
<td>9.06</td>
<td>9.43</td>
<td>5.40</td>
<td>23.89</td>
<td>6</td>
</tr>
<tr>
<td>Chronic Disease: Asthma/COPD (youth/young adults and those presenting in the ER)</td>
<td>8.38</td>
<td>7.80</td>
<td>7.53</td>
<td>23.71</td>
<td>7</td>
</tr>
<tr>
<td>Chronic Disease: Cardiovascular Disease (heart disease, cholesterol, etc.)</td>
<td>8.13</td>
<td>7.36</td>
<td>8.00</td>
<td>23.49</td>
<td>8</td>
</tr>
<tr>
<td>Physical Activity/Nutrition: Food Insecurity/Access to Healthy Foods/Nutrition/More Healthy Options at Food Banks</td>
<td>8.60</td>
<td>8.64</td>
<td>6.13</td>
<td>23.37</td>
<td>9</td>
</tr>
<tr>
<td>Access to Quality Health Services: Availability of Providers - Number of Providers, Convenient Hours, Wait Times</td>
<td>7.75</td>
<td>8.20</td>
<td>6.73</td>
<td>22.68</td>
<td>10</td>
</tr>
</tbody>
</table>

Source: TUH Prioritization Exercise, 2019, Strategy Solutions, Inc.
In developing their priorities, Steering Committee members and Hospital leadership used a consensus building approach to identify health priorities. In addition to the prioritization exercise, TUH considered whether an issue is the root cause of other problems, the internal resources available to address the issue, the external resources in the community, the academic resources of Temple University, the community’s ability to respond to the issue, and the public health consequences of not responding to an identified need. Through this process, TUH identified the following priorities:

- Chronic disease;
- Access to health care;
- Mental health access and education;
- Substance abuse treatment integration;
- Violence prevention and intervention; and
- Programs for moms and newborns.

These priority areas are in-line with the priority areas identified and addressed in our 2016 CHNA. Through use of the City’s data and educational resources, our Hospital will continue to work with the City of Philadelphia toward the achievement of mutual goals. Furthermore, we will align our efforts with the Temple Center for Population Health, to help achieve the goals of the United States Department of Health and Human Services’ three-part aim of achieving better care for patients, better health for our communities, and lower costs through health care system improvement.

REVIEW AND APPROVAL

The 2019 CHNA was presented and approved by the TUH Board of Governors on May 20, 2019. The TUH 2019 CHNA is posted on the TUH website (https://www.templehealth.org/locations/temple-university-hospital/about/community-health). To request a printed copy contact: communityhealth@spprd.templehealth.org.