

Strategic Plan: 2014-2018

2016 Annual Progress Report

Philadelphia Department of
Public Health

January 2017

www.phila.gov/health

twitter.com/PHLPublicHealth

www.facebook.com/phillyhealth



Table of Contents

I. Executive Summary.....	3
II. Strategic Priority 1 – Women’s and Infant’s Health	5
Objective 1 – Enhance the reproductive health of women.....	5
Objective 2 – Foster optimal infant health and development.....	7
Objective 3 – Improve immunization rates for young children	10
IV. Strategic Priority 2 – Sexual Health	12
Objective 1 - Decrease STD rates and increase condom use among youth and young adults.....	12
Objective 2 - Reduce new HIV infections and improve linkage to timely, high-quality HIV care	15
V. Strategic Priority 3 – Chronic Diseases Related to Tobacco Use and Obesity .	19
Objective 1 – Decrease rates of youth and adult smoking	19
Objective 2 – Improve nutrition and physical activity to decrease obesity.....	23
VI. Strategic Priority 4 – Environmental health.....	27
Objective 1 – Protect children from environmental health hazards	27
Objective 2 – Promote food safety through education and inspection of food establishments	31
VII. Appendix – Key Milestones Update	32

I. Executive Summary

The **mission** of the Philadelphia Department of Public Health (PDPH) is to protect and promote the health of all Philadelphians and to provide a safety net for the most vulnerable. Our **vision** is of a city in which every resident is able to:

- Live a long, healthy, and productive life;
- Be free of preventable disease and disability; and
- Live, work, learn, shop, and play in environments that promote health

After a year-long planning process, PDPH finalized a five-year Strategic Plan in May 2014. Since then, PDPH and its partners have been developing, implementing, and evaluating strategies within four focus areas: 1) Women's and Infants' Health, 2) Sexual Health, 3) Tobacco Control and Obesity Prevention, and 4) Environmental Health. This report provides a summary of those activities and our progress in achieving the Strategic Plan's core objectives.

Women's and infants' health

- The teen birth rate continued to decline, reaching 38.4 births per 1,000 teens.
- 76% of children aged 19-35 months are up-to-date on recommended vaccines.
- Approximately 45% of immunization data is now submitted to the KIDS Plus registry through electronic (HL7-format) reporting.

Sexual health

- Gonorrhea cases slightly decreased to 1,217 per 100,000 15 to 19 year olds in 2015, from 1,234 per 100,000 15 to 19 year olds in 2014.
- Chlamydia cases slightly decreased to 4,837 per 100,000 15 to 19 year olds in 2015, from 5,131 per 100,000 15 to 19 year olds in 2014.
- 91% of persons diagnosed with HIV in the previous year were linked to HIV care within 90 days following diagnosis.

Tobacco control and obesity prevention

- Youth smoking declined from 7.5% in 2013 to 7.3% in 2015.
- The prevalence of obesity among children declined from 20.3% in 2012-13 to 20.2% in 2013-2014.

Environmental health

- The number of days with good air quality increased from 132 in 2014 to 179 in 2016.
- The percentage of children, 0-5 years old, with newly identified blood lead levels (BLLs) from 10+ mcg/dL decreased from 1.5% in 2014 to 1.3% in 2015.

Further information about PDPH's Strategic Plan and its other planning and health assessment processes are available at <http://www.phila.gov/health/Commissioner/PHA.html>.

For each objective, the following information is provided:

- A Key Measures table that provides, for quantifiable measures:
 - The Strategic Plan (May 2014) (baseline) value, the description of the data source, and the year for which the baseline measure was recorded;
 - The value reported in the first annual update (January 2015) and the year for which the update measure was recorded;
 - The second annual update (January 2016) and the year for which the update measure was recorded;
 - The third annual update (January 2017) and the year for which the update measure was recorded; and
 - A graphic illustration of longer-term trends for selected measures.
- A description of Policy, Health Promotion, and Clinical Care strategies that address each objective, and an update on activities to implement these strategies.

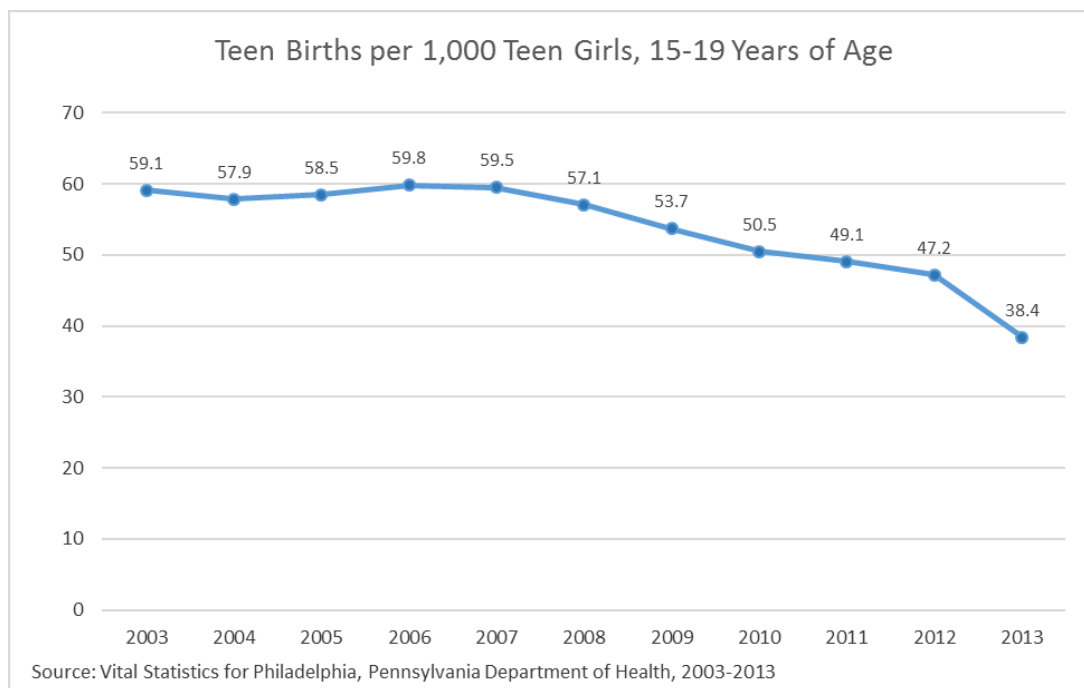
II. Strategic Priority 1 – Women’s and Infant’s Health

Objective 1 – Enhance the reproductive health of women

Key measures

	Strategic Plan May 2014	Update Report January 2015	Update Report January 2016	Update Report January 2017
1) Adolescents who report using contraception at last intercourse ¹	78.8% (2011)	79.2% (2013)	TBD	82.9% (2015)
2) Birth rate per 1,000 for women age 15 to 19 years ²	50.5 (2010)	49.1 (2011)	47.2 (2012)	38.4 (2013)
3) Births that are 5 or higher order ²	6.2% (2010)	6.1% (2011)	5.9% (2012)	6.3% (2013)

¹Youth Risk Behavior Survey, Centers for Disease Control and Prevention; ²PDPH, Philadelphia Vital Statistics



Policy strategies

1. Promote awareness of and access to long-acting reversible contraception (LARC)

- The Philadelphia Board of Health’s resolution [Increasing Access to Long-acting Reversible Contraception](#) served as a catalyst for Philadelphia reproductive health providers to unify as the Philadelphia LARC Coalition. The Coalition worked to educate PA DOH and DHS about the need to expand reimbursement for LARC.
- On December 1, 2016 the Pennsylvania Department of Human Services (PA DHS) announced that it would expand reimbursement for postpartum LARC for women who

receive health care funded by Pennsylvania Medicaid fee-for-service and increase reimbursement fees for outpatient family planning providers.

- PDPH Maternal, Child and Family Health (MCFH) with its partners, including all the city's Labor and Delivery Directors, will monitor how this expansion in reimbursement will impact access to LARC and differentially impact women who receive care through Medicaid Managed Care Organizations (MCOs). Feedback from these efforts will be provided to PA DHS to assess Medicaid MCOs' commitment to improving access to LARC.
- MCFH with its outpatient partners will monitor access to LARC for all women with a focus on those women who are exposed to Zika through their own travel or the travel of their partners and are choosing to avoid a pregnancy complicated by a congenital Zika infection.
- MCFH is working with partners to increase the capacity of Philadelphia providers to offer post-abortion, same day access to LARC.

Health promotion strategies

2. Educate the public and engage key community organizations on the importance of pre- and inter-conception health

- The Philadelphia Healthy Start Community Action Network (CAN) is comprised of 35 organizations that worked collectively in 2016 to develop a set of common goals which focus on inter-conception health including: (1) improving access to home visiting programs; (2) improving the quality of maternal mental health services; and (3) improving integration of fathers and partners in prenatal and infant care.
- The Philadelphia Healthy Start CAN has developed a governance structure and communication plan. In 2017, the Philadelphia Healthy Start CAN will develop shared measurements to monitor progress in achieving its goals and ensure sustainability.
- The MCFH Director co-chairs the Philadelphia Promise Zone's Health and Wellness Committee, which has successfully submitted several healthcare and neighborhood grants that aim to address pre-conception health by focusing on social determinants of health including the availability of trauma-informed health services.

Clinical care strategies

3. Enhance capacity to provide effective reproductive health services to adolescents in easily accessible and acceptable venues

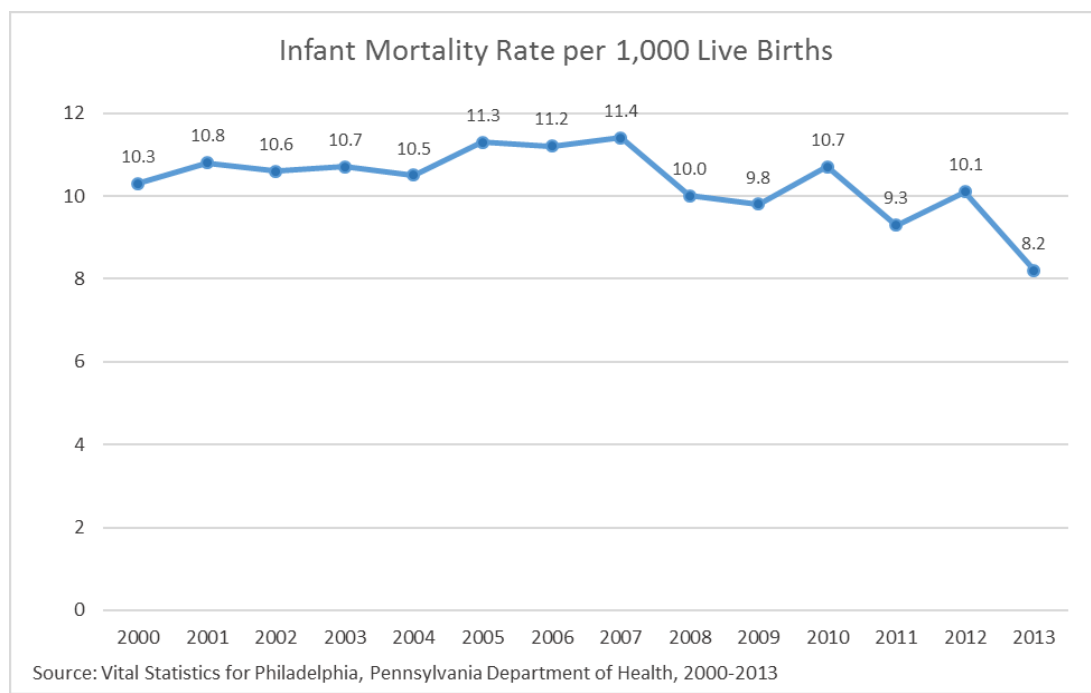
- MCFH has expanded the Youth Care Team to include a Youth Care Manager, Youth Care Coordinator, part-time MCFH Obstetrics/Gynecology Consultant, and the MCFH Director, a board certified pediatrician and adolescent medicine specialist.
- The Youth Care Coordinator has successfully expanded adolescent care coordination services to Health Centers 4 and 5. In addition, the Youth Care Coordinator is consulting with the Philadelphia School District Elect Program to better link adolescent parents to health and behavioral health services.
- The Youth Care Team is working to better understand how public health providers address the medical care (e.g., sexual and gender care) and mental health needs (e.g., risk of bullying and/or suicide) that impact LGBTQ youth and gender variant, non-conforming, and transgender youth.

Objective 2 – Foster optimal infant health and development

Key measures

	Strategic Plan May 2014	Update Report January 2015	Update Report January 2016	Update Report January 2017
1) Infant mortality rate per 1000 live births ¹	10.7 (2010)	9.3 (2011)	10.1 (2012)	8.2 (2013)
1a) Infant mortality rate per 1000 live births (white, non-Hispanic)	5.5 (2010)	5.4 (2011)	4.9 (2012)	4.9 (2013)
1b) Infant mortality rate per 1000 live births (black, non-Hispanic)	14.8 (2010)	14.1 (2011)	15.6 (2012)	11.8 (2013)
2) Pregnant women receiving late or no prenatal care ¹	15.5% (2010)	13.1% (2011)	12.2% (2012)	13.9% (2013)
3) Breastfeeding initiation ^{1*}	60.4% (2010)	62.3% (2011)	66.7% (2012)	71.7% (2013)

¹PDPH, Philadelphia Vital Statistics; *Percentage of women initiating breastfeeding before hospital discharge, out of all women for whom breastfeeding status is known



Policy strategies

1. Conduct infant fatality reviews to identify actionable policies to reduce the risk of infant death

- The Philadelphia Fetal Infant Mortality Review (FIMR) is composed of 35 members who worked together to carefully review cases in an effort to describe qualitative measures that impact sleep-related deaths in Philadelphia.

- The FIMR Team identified several explanatory variables that may impact a parent's decision to not practice safe sleep including: parental exhaustion, inadequate parental leave, displays and sale of crib bummers, inadequate support for parents who suffer from addiction, negative impact of NICU sleep practices on parental safe sleep practices after discharge, increased risk of prematurity and multiple births, early discharge of infants with immature respiratory systems, and the generational differences in knowledge of safe sleep practices.
- The Medical Examiner's Office (MEO) and MCFH are working together with the Commissioner to prepare a PDPH [CHART](#) publication on sleep-related deaths in Philadelphia.
- The MEO and MCFH are working together to complete a safe-sleep report with detailed practice and policy recommendations.
- With the Commissioner, MCFH is developing an effective safe-sleep campaign that will address safe sleep behaviors specifically among African American and Latino families whose infants are at increased risk for sleep-related infant deaths.

Health promotion strategies

2. Encourage birth hospitals to support breastfeeding initiation and achieve *BabyFriendly* status

- Three of the six Philadelphia delivery hospitals have now achieved the *BabyFriendly* designation. Two birth hospitals continue to work towards the *BabyFriendly* designation and one birth hospital is aiming to earn the PA Department of Health Keystone Ten Initiative designation. The Children's Hospital of Philadelphia, which delivers infants with complex congenital anomalies, has received the PA Department of Health Keystone Ten Initiative designation.

3. Expand a universal home visiting initiative for newborns and their caregivers

- The MOM Program will become the Philly Family Program as a way to demonstrate the program's commitment to all infant and childcare providers including fathers, grandparents, and other family members.
- The Philly Family Program will provide an in-person, in-home needs assessment with a focus on high quality referrals and effective linkages to appropriate services including housing, social services, and intensive home visiting programs.
- At risk families, including for example, parents who are adolescents, affected by behavioral health concerns, affected by substance use, experience housing insecurity, or those who have had a history of maltreatment (as a victim or perpetrator) will receive additional support to connect to beneficial services.
- The Philly Family Program will aim to continue to increase acceptance of needed referral services, reduce post-neonatal infant mortality, and increase readiness and enrollment in Philadelphia's universal Pre-K program in neighborhoods with high infant mortality and poor child health outcomes.

Clinical care strategies

4. Improve access to and use of prenatal care services

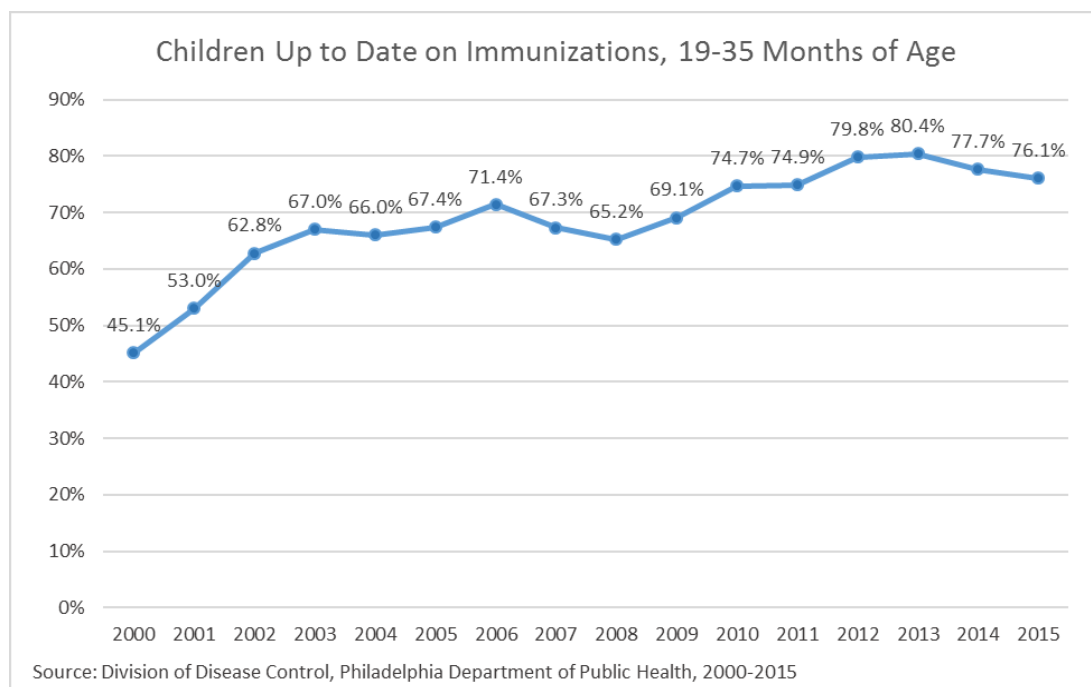
- PDPH Healthy Start staff with the PDPH Ambulatory Health Services Health Center #5 staff and the Drexel University/Hahnemann Hospital midwives launched CenteringPregnancy at Health Center #5 on 7/18/16. The CenteringPregnancy Steering Committee meets regularly to discuss expected and ongoing challenges including recruitment and retention, scheduling, and prenatal care workflows. Anecdotal reports from the CenteringPregnancy co-facilitators have noted that peer support has impacted cigarette smoking and breastfeeding behaviors.

Objective 3 – Improve immunization rates for young children

Key measures

	Strategic Plan May 2014	Update Report January 2015	Update Report January 2016	Update Report January 2017
1) Children aged 19-35 months up-to-date on recommended vaccines ^{1*}	79.8% (2012)	80.4% (2013)	77.7% (2014)	76.1% (2015)
2) Children who are immunization-delayed and then brought up-to-date through community-based outreach ¹	1,400/26% (2012)	1,600/35% (2013)	1,909/27% (2014)	2,458/35% (2015)
3) Percentage of childhood immunizations reported electronically to the KIDS registry ^{1**}	20% (2012)	28% (2013)	40% (2014)	45% (2015)

¹PDPH, Division of Disease Control; *4:3:1:3 vaccine series (DTaP, Polio, MMR, Hib); **HL7-format electronic message transmission from providers to registry



Policy strategies

1. Educate and enforce immunization requirements at childcare settings

- PDPH intends to audit immunization coverage for 19-35 month old children at a random sample of daycare centers.
- Training for daycare staff will be developed based on results of audit findings.

- 2. Assure community-wide access to vaccines and regulatory compliance of pediatric care providers through the Vaccines for Children (VFC) federal entitlement**
 - 100% of VFC Providers have transitioned to using VTrckS on-line vaccine ordering module.
 - 90% of VFC Providers received Audit and Feedback site visits (AFIX) in 2016, with >95% provider compliance.
 - CDC has revised AFIX audit requirements for 2017, shifting focus to large provider sites.

Health promotion strategies

- 3. Identify and outreach to communities and families with low rates of childhood immunization**
 - The number of children outreached and the percentage who were successfully brought up-to-date exceeded the established goal.

Clinical care strategies

- 4. Improve electronic reporting of immunizations (HL7) from provider Electronic Health Records (EHRs) into citywide Immunization Information System, known as KIDS Plus registry**
 - The percentage of immunization data transmitted to KIDS Plus registry through HL7 reporting increased to 45% by Quarter 3 of CY2016.
 - The number of providers transitioning to reporting through HL7 interconnectivity will continue to increase in 2017.
- 5. Prevent perinatal transmission of Hepatitis B Virus (HBV) by assuring complete prophylaxis and follow-up of child**
 - On target to achieve goals.

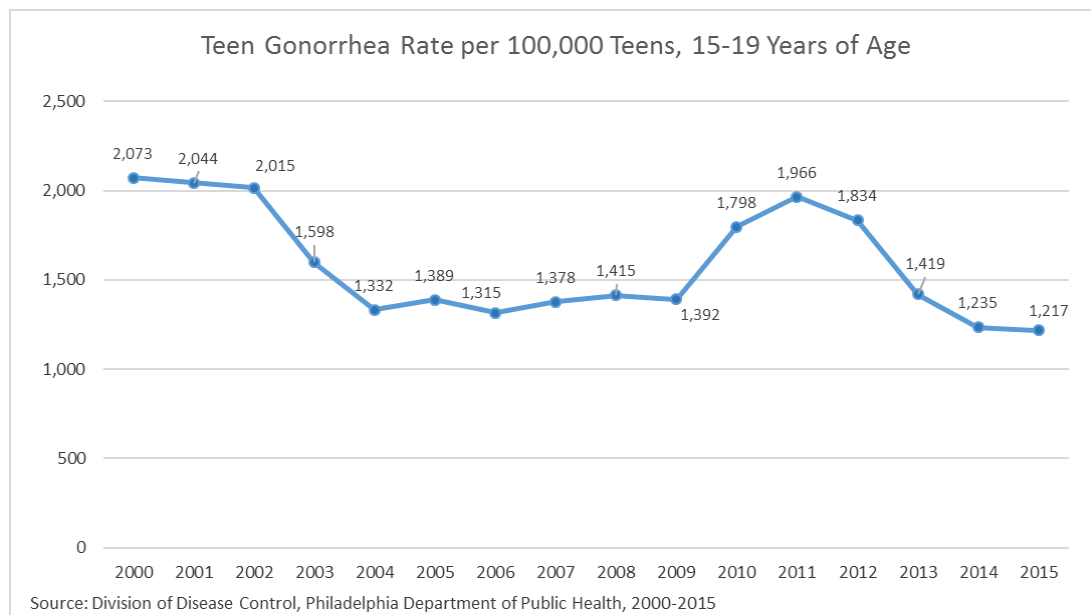
IV. Strategic Priority 2 – Sexual Health

Objective 1 - Decrease STD rates and increase condom use among youth and young adults

Key measures

	Strategic Plan May 2014	Update Report January 2015	Update Report January 2016	Update Report January 2017
1) Gonorrhea cases per 100,000 15 to 19 year-olds ¹	1,834 (2012)	1,419 (2013)	1,234 (2014)	1,217 (2015)
2) Chlamydia cases per 100,000 15 to 19 year-olds ¹	6,611 (2012)	5,916 (2013)	5,131 (2014)	4,837 (2015)
3) Condom use with last sexual encounter among 9 th to 12 th graders ²	60% (2011)	57.8% (2013)	TBD	55.9% (2015)
4) Completion of 3-dose HPV vaccination series among 13 to 17 year-old girls ¹	21% (2011)	41% (2013)	46% (2014)	58.6% (2015)

¹PDPH, Division of Disease Control; ²Youth Risk Behavior Survey, Centers for Disease Control and Prevention



Policy strategies

1. Make free condoms readily available in all public high schools

- The milestones in this strategy have been met. As of 2015, free condoms are available in all public high schools with the exception of one. The high school that exempted from making the free condoms available made the decision independent of the School District of Philadelphia recommendation.

- 2. Assist in implementing evidence-based sexual education in all public middle and high schools**
 - This strategy has been eliminated. PDPH has met with the School District of Philadelphia to implement curriculum changes, but has been unable to make headway.
- 3. Pursue expedited partner therapy (EPT) policy for teens receiving services in PDPH clinical settings**
 - Pennsylvania Department of Health has taken no action to pursue codifying EPT or enacting legislation to make EPT permissible. It is unclear at this time if PDPH can do anything to move this item forward. Discussions are ongoing.

Health promotion strategies

- 4. Utilize social media to (re)normalize condom use**
 - Active social media campaign promoting condom availability and use was continued.
 - The [Take Control Philly website](#) underwent redesign to modernize and update content.
- 5. Offer STD screening, treatment, and prevention services in all public high schools funded through public health and clinical sources**
 - In FY2016, the Philadelphia High School STD Screening Program successfully screened 10,941 adolescents through the school-based program, with more than 95% of confirmed cases receiving treatment. There were no complications or issues arising in association with the program.
 - Because the STD Program became HIPAA-covered in 2015, insurance billing resumed in CY2016. Approximately \$100,000 in revenue was collected.

Clinical care strategies

- 6. Offer timely treatment to sexual partners of those diagnosed with an STD through disease reporting and partner services interventions**
 - Partner Services capacity continued to increase in 2016. The number of staff performing services increased to 17.
 - The total number of individuals receiving Partner Services increased to 1,245.
- 7. Engage and train clinical providers—particularly family planning and primary care providers—to increase STD screening, decrease time between STD diagnosis and treatment, and enhance prevention through enhanced motivational interviewing**
 - Extragenital screening of MSM for gonorrhea and chlamydia was added as a quality measure for AIDS Activities Coordinating Office's (AACO) Ryan White provider system.
 - PDPH began receiving gonorrhea/chlamydia test volume data from commercial laboratory providers in order to assess local screening practices.

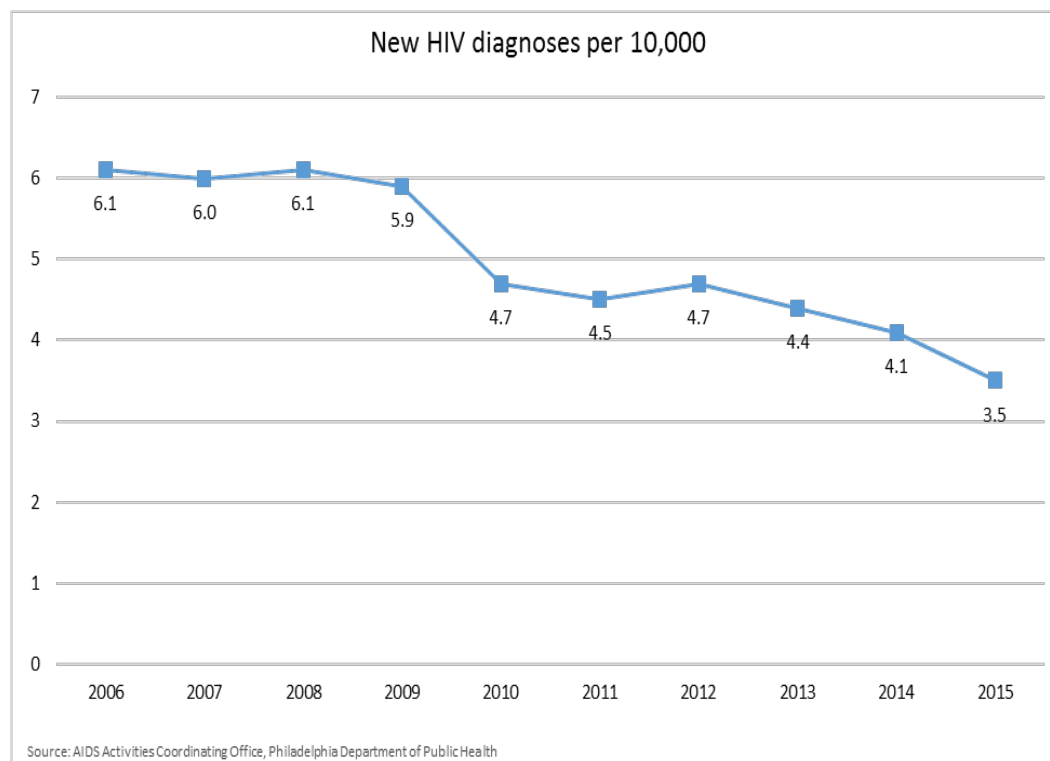
- 8. Educate parents, teens, and clinical providers on importance of initiating and completing Human papillomavirus (HPV) vaccination**
 - As of December 2015, this strategy has been completed.

Objective 2 - Reduce new HIV infections and improve linkage to timely, high-quality HIV care

Key measures

	Strategic Plan May 2014	Update Report January 2015	Update Report January 2016	Update Report January 2017
1) New HIV diagnoses per 10,000 residents ¹	4.5 (2011)	4.4 (2013)	4.1 (2014)	3.5 (2015)
2) HIV incidence in adults and adolescents ¹	872 (2011)	761 (2012)	508 (2013)	299 (2014)
3) Linkage to HIV care within 90 days ^{1*#}	82% (2011)	78% (2013)	82% (2014)	91% (2015)
4) Retention in HIV care within last year ^{1**#}	47% (2011)	52% (2013)	52% (2014)	53% (2015)
5) Viral Suppression ^{1***#}	44% (2011)	50% (2013)	53% (2014)	56% (2015)

¹PDPH, AIDS Activities Coordinating Office; *Percentage of persons diagnosed with HIV in the previous year who were linked to HIV care within 90 days following diagnosis; **Percentage of persons living with diagnosed HIV having had 2 or more CD4 or viral load test results, at least 3 months apart, during a 12 month period; ***Percentage of persons diagnosed living with HIV, who were alive at year end, and had a viral load ≤ 200 at most recent test



Policy strategies

1. Promote adoption of opt-out HIV testing among clinical providers citywide

- Provided technical assistance to providers on the integration of routine offering of HIV screening into the normal patient flow in the clinical setting and on third party billing to make HIV screening sustainable. Technical assistance was provided to 10 healthcare providers.
- Continued to transition healthcare providers to a testing coordinator model that promotes routine HIV screening. Partners include seven (7) major hospital systems throughout Philadelphia.
- Implemented electronic transfer of test-level data and/or collection of aggregate data from 9 healthcare providers. The transition from requiring a separate paper data form for each test is essential to facilitate routine screening.

Health promotion strategies

2. Offer community-based HIV screening and education, particularly among MSM, high-risk heterosexuals, and IV drug users

- HIV testing was provided at 191 non-healthcare sites in 2016 (January – June).
- Provided intensive technical assistance to providers to target testing to the highest risk populations.
- In the first half of 2016, 134 self-reported new HIV positive individuals were identified.
- PDPH staff provided intensive capacity building and technical assistance to community-based organizations to promote linkage to HIV medical care within 30 days of the positive HIV test result.
- Provided initial re-training to all funded front-line and supervisory targeted testing staff (75 persons) on the Test and Link to Care model of HIV testing which emphasizes expedited testing sessions and immediate linkage to care, an approach to HIV testing that is in line with the CDC's "Planning and Implementing HIV Testing and Linkage Programs in Non-Clinical Settings: A Guide for Program Managers."

3. Offer prison-based HIV screening and education

- There were 12,101 HIV tests performed from January 1 through June 30, 2016. The Prison Health System transitioned to using a more sensitive HIV test in the reporting period.
- The Risk Reduction and Referral (3R) program which provides one-on-one risk reduction counseling to high risk inmates and assists them access post-release referrals to bio-medical interventions and social services that address social determinants which put inmates at risk for HIV transmission provided services to 91 inmates.

4. Support syringe access services

- Expect to exceed target and provide 2.4 million syringes in 2016, up from 2.1 million in 2015.
- Services were provided to 5,500 exchangers in 2015 and will increase to 7,250 this year. Most of the new registrants are between the ages of 25-36 years of age.

Clinical care strategies

5. Improve linkage to care for HIV positive persons

- Updated the curriculum for the Test and Link to Care training to emphasize and practice skills needed for new HIV testers to successfully immediately link newly diagnosed persons to medical care.
- PDPH evaluated the most common reasons for a failure to link positive patients to HIV medical care in 2016. The two most common reasons identified were failure to attend medical appointment[s] (32%) and inability to establish contact to set up an appointment (28%). This information is being fed into a system wide quality improvement project.
- Continued to support ARTAS programs, began implementation of a CDC project that uses field staff to follow-up on HIV+ individuals who missed a first appointment after diagnosis.

6. Improve retention in care and quality of care for HIV positive persons, including achievement of viral suppression

- Outpatient-ambulatory health service (O/AHS) providers with performance below the national HIV/AIDS Strategy goal of 80% viral suppression are currently completing quality improvement projects targeting viral load suppression.
- The Eligible Metropolitan Area's (EMA) performance of 82.4% currently exceeds the National HIV/AIDS Strategy goal of 80% viral load suppression. As of August 2016, 18 out of the EMA's 24 adult O/AHS providers have a viral load suppression rate of 80% or greater—by contrast, only 4 adult HIV providers had a baseline viral suppression rate of 80% or greater in August 2014.
- PDPH has developed its Ryan White Database to facilitate analysis of long-term retention, viral load suppression and disparities in health outcomes.
- Community-based organizations funded for medical case management (MCM) are currently completing quality improvement projects targeting retention in care and viral load suppression.
- Throughout 2016, an MCM committee met to develop, implement, and analyze findings from a survey of MCM providers throughout the system, analyze care delivery models in other regions, identify best practices, streamline documentation, and make recommendations to improve MCM services in the region. The focus of this project is to improve retention in care and viral suppression.
- Brought 7 of 8 planned sites on-board for CoRECT, a CDC funded surveillance-enhanced retention in care initiative that is a randomized trial of field investigation vs. standard of care for re-engagement of persons lost to HIV medical care. Began randomization of persons lost to HIV medical care to field investigation or standard of care services for re-engagement through the CDC funded "Co-operative agreement re-engagement

controlled trial” at 7 provider sites. 600 persons have been randomized since piloting the project in 2016.

7. Offer timely screening and linkage to care for sexual partners of those diagnosed with HIV through disease reporting and partner services interventions

- AACO has begun a cross-divisional quality improvement project with the Division of Disease Control to reduce the median length of time between HIV diagnosis and partner services interview.
- In FY 2016 60% of eligible cases reported to partner services were interviewed.
- The median time to interview from diagnosis was 53 days in FY 2016.

8. Coordinate citywide provision of pre-exposure prophylaxis (PrEP)

- Technical assistance and capacity building in-services were provided to 16 clinical sites in 2016 and reached 620 individuals.
- Developed a pilot program for high risk HIV negative MSM and transgender persons of color and applies a navigation model implemented by a highly professionalized prevention workforce (MSW level) to link high risk negatives into multi-tiered systems of social care which will stabilize their ability to be PrEP adherent. Intensive navigator training was conducted in the summer and clients are being enrolled starting in October 2016.
- Conducted a survey of all front line and supervisory level HIV testing staff to determine their competency and comfort in discussing and linking high risk negative persons to PrEP.
- Developed a PrEP screening tool to assist HIV testing staff in properly identify which of their HIV negative testing clients are appropriate for referral and linkage into PrEP.
- Updated the curriculum for the Test and Link to Care training to emphasize and practice skills needed for new HIV testers to identify and link high risk HIV negative persons to PrEP.

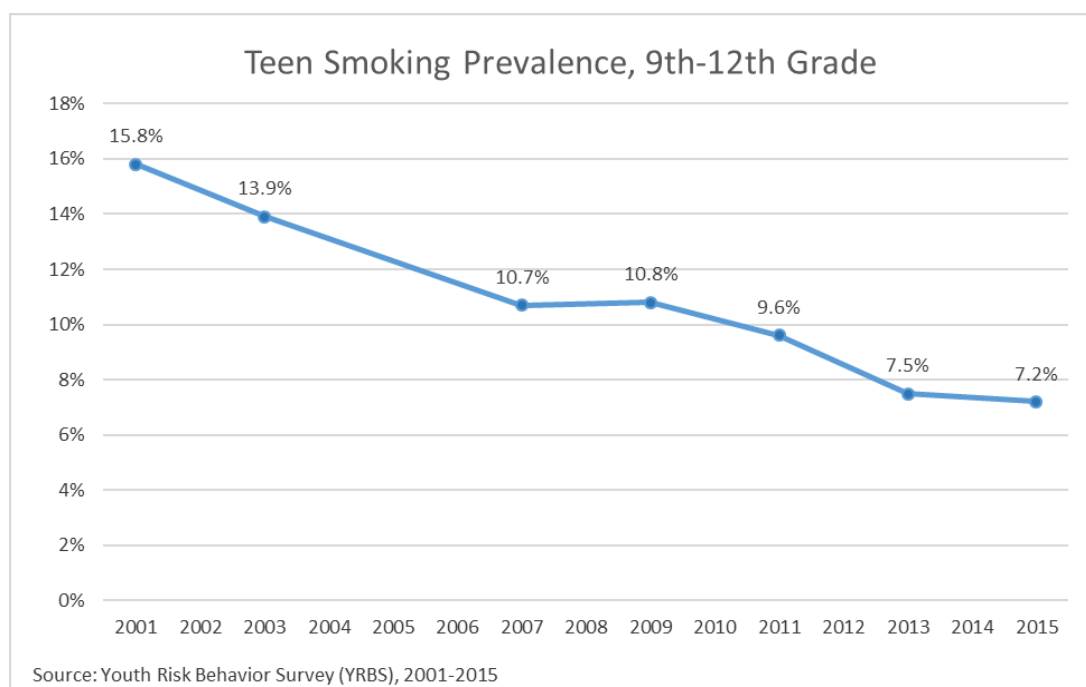
V. Strategic Priority 3 – Chronic Diseases Related to Tobacco Use and Obesity

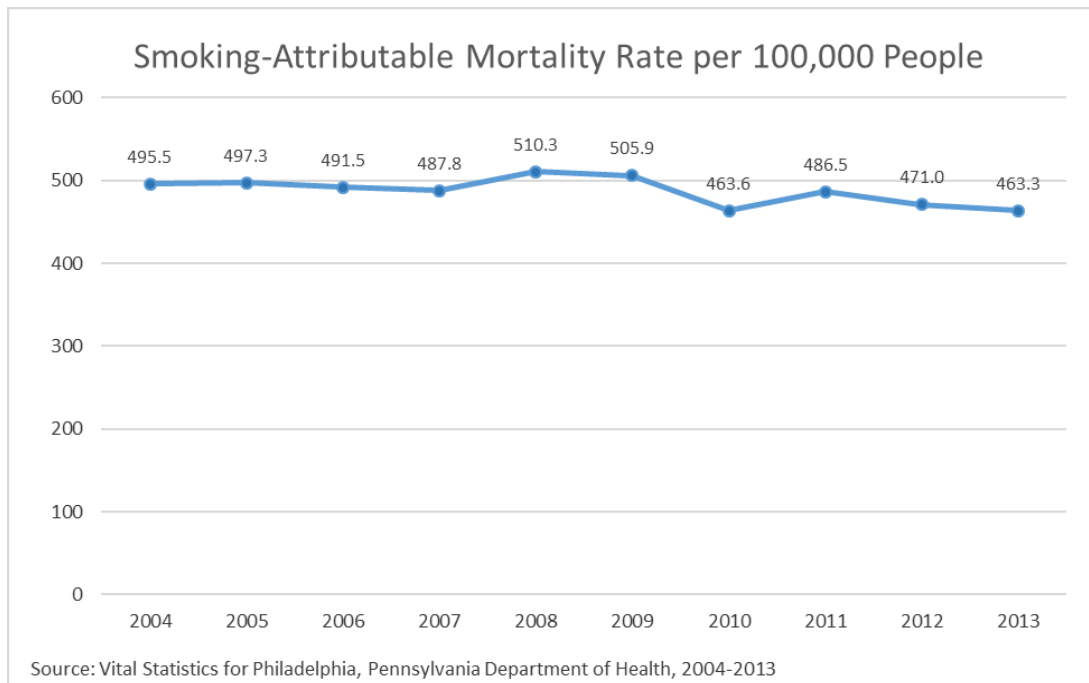
Objective 1 – Decrease rates of youth and adult smoking

Key measures

	Strategic Plan May 2014	Update Report January 2015	Update Report January 2016	Update Report January 2017
1) Adult smoking ¹	23.3% (2012)	TBD	22.4% (2014-15)	PHMC HHS data available in 2018; exploring alternative survey resources for data between PHMC HHS cycles
2) Youth smoking ²	9.6% (2011)	7.5% (2013)	TBD	7.2% (2015)
3) Smoking-attributable mortality rate per 100,000 people deaths ³	463.6 (2010)	486.5 (2011)	471.0 (2012)	463.3 (2013)

¹Public Health Management Corporation (PHMC) Southeastern Pennsylvania Household Health Survey (HHS); ²Youth Risk Behavior Survey, Centers for Disease Control and Prevention ³Philadelphia Vital Statistics; the methods for calculating premature death have been updated since prior reports, and all data years have been recalculated. This measure is based on [CDC's Smoking-Attributable Mortality, Morbidity, and Economic Costs \(SAMMEC\)](#).





Policy Strategies

1. Promote smoke-free policies for City parks, universities, and large employers

- In 2016, PDPH accelerated installation of smoke-free parks signage in city parks.
- Worked to help Hahnemann Hospital implement a smoke-free campus policy in concert with the Great American Smoke-Out on November 17, 2016.
- Currently, PDPH is offering direct technical assistance and support to 4 large colleges/universities and 2 hospitals. These institutions are also large employers within the city.
- PDPH is actively working with 10 low and middle income private housing properties to develop and implement smoke-free policies.
- PDPH is collaborating with Community Behavioral Health (CBH) and the University of Pennsylvania to transition inpatient drug and alcohol facilities that contract with CBH to tobacco-free status. After an initial planning phase, the first provider meeting was held in December 2016.

2. Partner with the Philadelphia Housing Authority to implement a smoke-free policy for all indoor spaces, including residential units

- Worked with partner at Drexel University to complete evaluation of smoke-free policy at the Philadelphia Housing Authority (PHA) that demonstrated a significant decrease in nicotine levels in the apartments of non-smokers after policy implementation.
- Paper documenting evaluation of PHA smoking policy completed, submitted, and accepted for future publication.
- Began working with low-income private housing units to promote tobacco-free policies.
- Gave testimony to Philadelphia City Council in support of bill introduced by Councilwoman Cindy Bass that requires tenant notification of tobacco policies in multi-unit housing. The bill passed into law.

3. Foster changes in the pricing, placement, and promotion of tobacco products in retail settings

- Using a data-driven process to analyze our high youth tobacco sales rate, PDPH was able to identify non-issued tickets and tickets incorrectly issued for loosies rather than cigars as problem areas and to work with the partner agency that does our compliance checks to address the problems.
- Issued a Philadelphia Board of Health regulation to address high density of tobacco retail sales in Philadelphia that are disproportionately common in low income neighborhoods, particularly around schools. The regulation:
 - Bans new tobacco permits within 500 feet of a K-12 school as of 1/1/2017.
 - Caps tobacco retailer density per planning district at 1 per 1000 commuter-adjusted daytime population as of 2/15/2017 (existing retailers grandfathered).
 - Standardizes the penalty for youth tobacco sales to a 12 month tobacco cease sales order for 3 youth sales violations within a 24 month period.
 - Raises the tobacco permit fee from \$50 to \$300 to cover the costs of our permit process and to enhance enforcement.

Health promotion strategies

4. Implement social marketing campaigns regarding quitting, the health effects of smoking and secondhand smoke, and tobacco de-normalization

- Created a new tobacco mass media campaign, *Break the Cycle*, using quotes from the tobacco industry aimed at young African-American adults and used radio, billboards, and social media for the campaign.
- Revamped our [SmokeFree Philly website](#) to update it and make it more consumer focused, resulting in its best month ever with over 30,000 hits in its first month.
- Continued to run adapted *CDC Tips from Former Smokers* mass media ads to inform Philadelphians about the impact of tobacco use.

5. Engage neighborhood organizations, community leaders, and youth to be local tobacco control champions

- In 2016, PDPH began active partnerships with over 30 young adults through the Health Promotion Council's Advocacy Institute and several local youth serving organizations. These partnerships empower Philadelphia youth to act as local tobacco control champions who contribute to efforts that reduce adult and youth tobacco use in the city.
- PDPH worked extensively with neighborhood organizations and community leaders in low-income communities on policy, media, and programmatic initiatives in 2016 that are disproportionately impacted by tobacco use. PDPH will seek to further cultivate these partnerships in the future.
- PDPH continues to train community leaders and organizations on provision of cessation resources to staff and clients.

Clinical care strategies

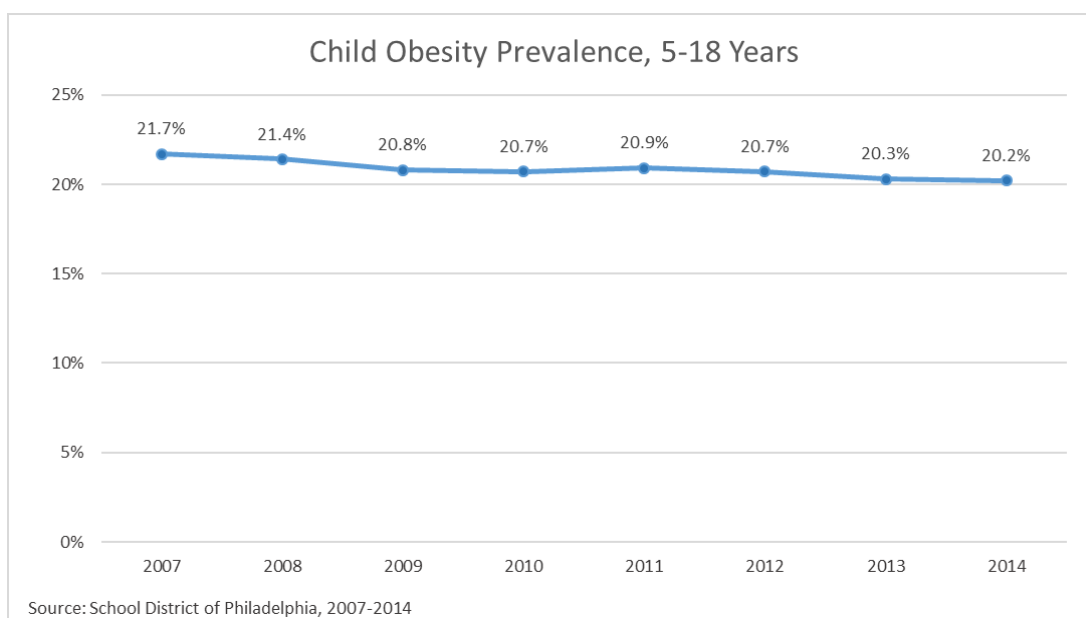
6. Support clinical providers to integrate tobacco use dependence treatment into routine care

- PDPH, Community Behavioral Health, and the University of Pennsylvania continued their collaboration through the Tobacco Recovery and Wellness Initiative in 2016 to expand the initiative from inpatient psychiatric treatment settings to residential drug and alcohol treatment facilities. This expansion will advance tobacco free-policies and evidence-based tobacco treatment for behavioral health populations to 27 individual providers at over 60 locations.
- Public health detailing, an approach to improve the quality and consistency of tobacco treatment through brief, face to face, educational encounters engaged nearly 300 clinicians in 2016. These clinicians serve a large number of vulnerable populations with exceedingly high rates of smoking.
- Staff continue to provide cessation counseling to patients at the PDPH Ambulatory Health Services Health Centers.

Objective 2 – Improve nutrition and physical activity to decrease obesity**Key measures**

	Strategic Plan May 2014	Update Report January 2015	Update Report January 2016	Update Report January 2017
1) Adult obesity ¹	31.9% (2012)	TBD	33.3% (2014-15)	PHMC HHS data available in 2018; exploring alternative survey resources for data between PHMC HHS cycles
2) Child obesity ²	20.7% (2009-10)	20.3% (2012-13)	TBD	20.2% (2013-14)
3) High blood pressure ¹	37.5% (2012)	TBD	38.2% (2014-15)	PHMC HHS data available in 2018; exploring alternative survey resources for data between PHMC HHS cycles
4) Diabetes ¹	16% (2012)	TBD	15.4% (2014-15)	PHMC HHS data available in 2018; exploring alternative survey resources for data between PHMC HHS cycles

¹Public Health Management Corporation (PHMC) Southeastern Pennsylvania Household Health Survey (HHS); ²School District of Philadelphia



Policy strategies

1. Implement nutrition standards for all food procured by City agencies and other institutional purchasers

- City Departments: Offered comprehensive nutrition training sessions to staff of city departments including all staff of the Juvenile Justice Services Center (there were a total of 6 sessions held reaching about 150 staff) and 2 combined kitchen staff trainings through Office of Homeless Services reaching 14 shelter sites.
- Developed poster to educate and promote 5 priority areas of Philadelphia Nutrition Standards to be used for kitchen staff and constituents.
- Provided class to clients (inmates) of Philadelphia Prisons System focusing on basic nutrition.
- Determined and awarded new company for city-wide vending machine contract.
- 12 hospitals have now signed Good Food, Healthy Hospitals pledge and 2 additional hospitals have expressed interest in the program. This has far exceeded the initial 4 year goal of reaching 6 hospitals.
- Integrated language to an RFP for Parks and Recreation Concessions (Aerial Adventure Park).

2. Leverage federal food programs to improve nutritional offerings in schools, afterschool settings, and childcare

- Begun working with the Mayor's Office of Education to adapt nutrition standards to include early childhood education settings and to discuss strategies for implementation in city-funded programs.
- PDPH is working with Mayor's Office of Education on Healthy Schools, a component of the new Community Schools Program. This work includes a focus on healthy, delicious food, and water access and appeal in 9 schools during the 2016-17 school year.
- Worked with the City Procurement Department on a new RFP for vending that includes the city nutrition guidelines and a new vendor has been selected to take over in 2017.

3. Advocate for minute-based PE requirements for schools

- Shared white paper on Physical Activity in Schools with leadership of the School District of Philadelphia and obtained permission to pilot a strategy for increased physical activity in 4-5 city schools in collaboration with the district.
- After approval of the Mayor's budget, which funds the Community Schools initiative, and creation of a Healthy Schools component of Community Schools in collaboration with the Mayor's Office of Education, PDPH made the decision to pilot physical activity efforts at Community Schools.
- Designed physical activity survey for implementation in public schools in Philadelphia, and have obtained provisional approval from the School District to pilot test the survey.

Health promotion strategies

4. Enhance the availability, affordability, and promotion of healthy foods in retail settings through retailer and manufacturer/distributor engagement

- Awarded a new 5 year CDC grant to expand our Sodium Reduction in Communities work to Asian buffet restaurants and efforts to decrease sodium in bread and rolls manufactured in the city.
- Worked with the Food Trust to redesign our Healthy Corner Store initiative to create a more intense intervention in 40 stores and to develop and pilot test a community engagement model around one store in North Philadelphia.
- Continued to support farmers markets and Philly Food Bucks distribution in low income neighborhoods in Philadelphia.

5. Implement social marketing campaigns to promote healthier eating and physical activity

- Continued physical activity campaign promoting free and low cost opportunities for physical activity in Philadelphia, including use of a website and database.
- Revamped [FoodFitPhilly website](#) to modernize it and make it more consumer-focused. The new site went live on November 29, 2016.
- Developed a bidirectional referral system for the YMCA's Diabetes Prevention Program and are subsidizing the full cost of this evidence-based program through a CDC grant.

6. Promote greater and safer physical activity through bicycle, pedestrian, and open space initiatives

- In partnership with Asociacion de Puertorriquenos en Marcha, Philadelphia Managing Director's Office of Transportation & Infrastructure Systems, Philadelphia Water Department, and Philadelphia City Planning Commission (PCPC), PDPH is implementing a community-led project to assess and improve neighborhood walkability in Eastern North Philadelphia.
- Continue to collaborate with the PCPC on the health aspects of district plans including walkability, bikeability, and access to open space among other built environment factors that are analyzed for their contribution to health.
- Completed collaboration with the Land Bank and the Philadelphia Horticultural Society to create easier access to vacant land for community gardens and educate city residents about safe soil practices.

- Continue to collaborate with PCPC and other city departments to make improvements to and expand the trail network.
- PDPH will work with other city departments to implement the City's Vision Zero Executive Order and help eliminate crash fatalities by serving on the Vision Zero Taskforce.
- PDPH is establishing and strengthening partnerships with organizations such as Philadelphia Parks and Recreation, the Fairmount Park Conservancy, GirlTrek, Indego, Better Bike Share Partnership through the Philly Powered physical activity media initiative to help connect Philadelphians with existing green spaces and physical activity programming.

Clinical care strategies

7. Enhance surveillance system for obesity and related chronic diseases

- Continue to work with learning collaborative of local Federally Qualified Health Centers (FQHCs) and hospitals around improving quality of care and outcomes for hypertension and diabetes using EHR related strategies.
- Utilize HealthShare Exchange of Southeastern Pennsylvania to initiate bidirectional electronic referral process for referrals from FQHCs to local Diabetes Prevention Programs.
- Continue to use aggregated data from local FQHCs on hypertension and add aggregated data on obesity and smoking to enable more frequent analysis of chronic disease trends in the city.

8. Advance health-promoting policies in hospitals

- Three of the six Philadelphia delivery hospitals have now achieved the BabyFriendly designation. Two birth hospitals continue to work towards the BabyFriendly designation and one birth hospital is aiming to earn the PA Department of Health Keystone Ten Initiative designation. The Children's Hospital of Philadelphia, which delivers infants with complex congenital anomalies, has received the PA Department of Health Keystone Ten Initiative designation.
- 12 hospitals have committed to implementing voluntary nutrition standards for hospital food service.
- The primary care collaborative facilitated by the Health Care Improvement Foundation is moving forward with home blood pressure monitoring and continuing to work to enhance detection of undiagnosed hypertension and prediabetes.
- The eight hospital systems participating in the collaboration to leverage the Community Benefit process in Philadelphia facilitated by the Health Care Improvement Foundation have decided to jointly focus on chronic disease prevention and to begin by working toward food insecurity screening and referral at all sites.

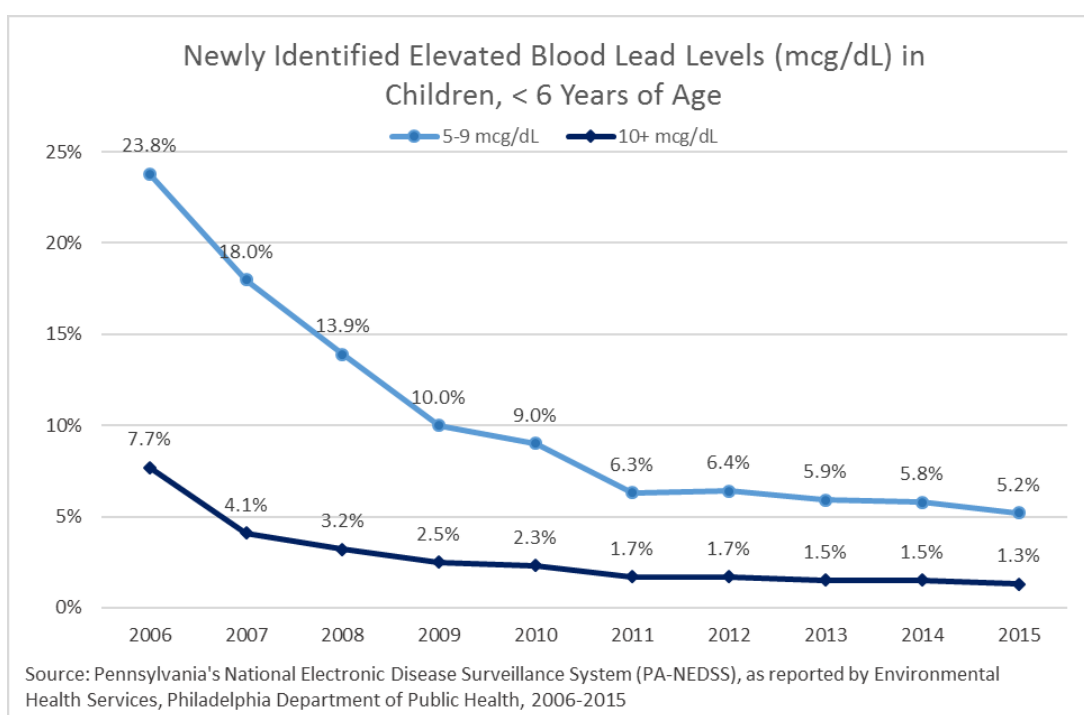
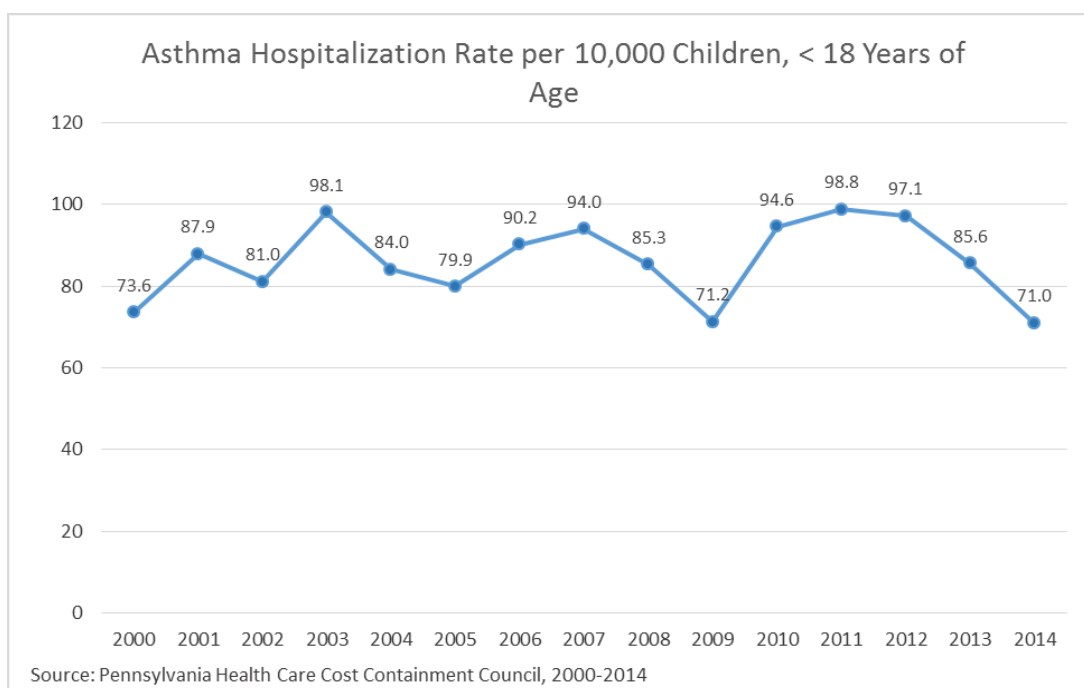
VI. Strategic Priority 4 – Environmental health

Objective 1 – Protect children from environmental health hazards

Key measures

	Strategic Plan May 2014	Update Report January 2015	Update Report January 2016	Update Report January 2017
1) Children exposed to secondhand smoke in the home ¹	17.5% (2010)	15.4% (2012)	13.7% (2014-15)	PHMC HHS data available in 2018; exploring alternative survey resources for data between PHMC HHS cycles
2) Adults exposed to secondhand smoke in the home ¹	10% (2010)	10.1% (2012)	7.9% (2014-15)	PHMC HHS data available in 2018; exploring alternative survey resources for data between PHMC HHS cycles
2) Asthma hospitalization rate per 10,000 children ²	94.6 (2010)	98.8 (2011)	97.1 (2012)	71.0 (2014)
3) Number of days with good air quality ^{3*}	135 (2012)	166 (2013)	132 (2014)	179 (2016)
4) Rat complaints per 10,000 residents ⁴	18.9 (2012)	17.2 (2013)	17.2 (2014)	25.3 (2015)
5) Elevated blood levels in children 0 to 5 years ^{5**}	1.7% (2012)	1.5% (2013)	1.5% (2014)	1.3% (2015)

¹Public Health Management Corporation (PHMC) Southeastern Pennsylvania Household Health Survey (HHS); ²Pennsylvania Health Care Cost Containment Council; ³PDPH, Air Management Services; ⁴PDPH, Environmental Health Services; ⁵PDPH, Division of Disease Control; *numbers differ from previous annual reports due to the EPA update of the air quality index (AQI) breakpoints to include the new ozone standards (Ozone Standards of 2015, 70 ppb) on June 21, 2016 and therefore AQI numbers from all years were recalculated to make yearly comparisons equivalent; **numbers differ from previous annual reports as these are incidence rates whereas prevalence rates were previously reported



Policy strategies

- 1. Meet the National Ambient Air Quality Standards (NAAQS) for particulate matter, ozone, nitrogen dioxide, sulfur dioxide, carbon monoxide, and lead, and reduce exposure to air toxics using regulatory activities**
 - The [Philadelphia Air Management Regulation II -- Air Contaminant and Particulate Matter Emissions](#) – was adopted by the Department of Records on August 11, 2016 to include a section on “Dust Control Regulations” (section IX).

- The United States Environmental Protection Agency approved revisions to the Pennsylvania's State Implementation Plan addressing the 1997 8-hour ozone Reasonably Available Control Technology (RACT) for Philadelphia, effective November 7, 2016.
- 2. Reduce health and safety hazards in low-income housing, with an emphasis on lead poisoning prevention by improving property owner awareness of compliance with the Philadelphia Property Code and Health Code**
 - PDPH Environmental Health Services (EHS) Lead and Healthy Homes Program met with the Department of Licenses & Inspections and Philadelphia Housing Authority (PHA).
 - EHS working to develop a Memorandum of Understanding (MOU) with the PHA. The MOU is in the final stages with the hope to have it signed by January 31, 2017.
 - PDPH will provide a cross training with the Department of Licenses & Inspections to the PHA in January and February 2017.
 - 3. Partner with the Philadelphia Housing Authority to implement a smoke-free policy for all indoor spaces, including residential units**
 - Follow-up air quality assessments at PHA showed a significant decrease in nicotine levels in the apartments of non-smokers from baseline.
 - Information was shared with PHA leadership and a manuscript was submitted and accepted for future publication.
 - Begun working with multi-unit private low-income housing units to promote tobacco-free policies.
 - Testified in support of a bill proposed by Cindy Bass requiring tenant notification of smoking policies that was passed into law.

Health promotion strategies

- 4. Reduce health and safety hazards, including asthma triggers, through Healthy Homes and Lead Poisoning Prevention programming**
 - Collected data on the neighborhood initiative. Implementation phase began in 2015 which will continue into 2016 and 2017.
 - Successfully transitioned to using the new integrated database for PDPH home-based environmental health programs.
- 5. Implement periodic neighborhood-focused rodent, pest, and home safety survey and educational activities**
 - As a result of receiving a CDC grant, EHS will continue to work to provide integrated home environmental health services to 105 families by 2017.

Clinical care strategies

- 6. Improve children’s clinical providers’ knowledge, counseling, and referral to reduce the risk of lead poisoning, increase lead screening, and reduce environmental triggers of asthma**
 - Engaged Philadelphia’s Medicaid managed care plans to coordinate training and resources for improved pediatric asthma care.
 - Expanded the Lead and Healthy Homes Program to PDPH Health Center #5 and Strawberry Mansion Health Center.

Objective 2 – Promote food safety through education and inspection of food establishments

	Strategic Plan May 2014	Update Report January 2015	Update Report January 2016	Update Report January 2017
1) Food establishments in compliance with food safety regulations at initial inspection ¹	39% (2012)	58.5% (FY 2013)	55.9% (FY 2014)	50% (FY 2015)

¹PDPH, Environmental Health Services

Policy strategies

- 1. Ensure routine annual inspections of food establishments, re-inspection within 30 days, and pre-court inspections of all court cases**
 - Completed the refinement of tools to track annual inspections and re-inspections.
 - Initiated the retraining of inspectional staff on tracking software.

Health promotion strategies

- 2. Develop and disseminate resources on starting various types of food businesses**
 - Based on feedback of the Special Events manual, revisions were made.
- 3. Develop and disseminate resources for food vendors on how to prepare for a successful food safety inspection**
 - In the process of finding the best industry to work with on this initiative.
- 4. Provide online availability for all food business-related applications and fees**
 - This strategy has been completed.

VII. Appendix – Key Milestones Update

Provided are updates to the PDPH Strategic Plan key milestones. Milestones may have changed due to priority changes, available resources, or project completion.

Strategic Priority 1 – Women’s and Infant’s Health

Objective 1 – Enhance the reproductive health of women

Policy strategies

1. Promote awareness of and access to long-acting reversible contraception (LARC)

Key milestones

2014	-Identify barriers to accessing and using LARC in Philadelphia
2015-16	-Implement LARC promotional strategies -Expand insurance coverage for LARC through Medicaid -Partner to create data sources for surveillance
2017-18	-Partner to create data sources for surveillance -Expand access to LARC throughout PDPH clinical sites, delivery hospitals, and family planning providers

Health promotion strategies

2. Educate the public and engage key community organizations on the importance of pre- and inter-conception health

Key milestones

2014	-Create liaisons of insurers, providers and stakeholders that agree on targeting pre-and inter-conception health issues and can coordinate to create a set of messages to address these issues
2015-16	-Develop and implement education for young women highlighting the importance of wellness and health maintenance throughout the life-course
2017-18	-Assess and modify the campaign to increase women’s awareness of and engagement with pre-conception and inter-conception health

Clinical care strategies

3. Enhance capacity to provide effective reproductive health services to adolescents in easily accessible and acceptable venues

Key milestones

2014	-Identify clinical resources that can be mobilized to support testing and counseling for specific populations
2015-16	-Increase AHS provider's ability to provide effective reproductive, sexual, and behavioral health counseling, services and referrals for all youth including LGBT youth
2017-18	-Expand case management services for teens to support optimal reproductive and sexual health care

Objective 2 – Foster optimal infant health and development

Policy strategies

1. Conduct infant fatality reviews to identify actionable policies to reduce the risk of infant death

Key milestones

2014	- Expand factors that protect against sleep-related deaths including breastfeeding initiation and reducing infant exposure to second hand smoke -Develop an approach to addressing safe sleep behaviors that is informed by and acceptable to Philadelphia stakeholders
2015-16	-Re-establish the Philadelphia FIMR with the purpose to develop interventions and policies that address infant deaths related to sleep and unintentional injury
2017-18	-Implement, assess, and modify (as needed) an intervention or set of interventions to reduce infant deaths

Health promotion strategies

2. Encourage birth hospitals to support breastfeeding initiation and achieve *Baby Friendly* status

Key milestones

2014	-100% of birth hospitals engage in Baby-Friendly process
2015-16	-50% of birth hospitals achieve Baby-Friendly designation
2017-18	-100% of birth hospitals achieve Baby-Friendly designation

3. Expand a universal home visiting initiative for newborns and their caregivers

Key milestones

2014	-Expand MOM Program to meet the needs of mothers and infants in Lower North Philadelphia.
2015-16	-Expand MOM Program to 200 additional families annually
2017-18	-Develop a model home visiting assessment and referral program that links families strategically to needed services.

Clinical care strategies

4. Improve access to and use of prenatal care services

Key milestones

2014	-Develop strategies for increasing accessibility, affordability, and participation in prenatal care
2015-16	-Assess and address issues related to wait time for appointments, access to insurance, and attendance at prenatal appointments -Establish <i>Centering Pregnancy</i> at PDPH Health Center #5
2017-18	-Modify (as needed) and expand strategies

Objective 3 – Improve immunization rates for young children

Policy strategies

1. Educate and enforce immunization requirements at childcare settings

Key milestones

2014	-Evaluate attendee vaccination status (UTD rate) in sample of childcare centers -Assess relevant regulations and policies
2015-16	-Develop and implement a performance improvement plan for childcare center compliance with vaccination requirements
2017-18	-Establish benchmarks for compliance -Monitor compliance among childcare centers

2. Assure community-wide access to vaccines and regulatory compliance of pediatric care providers through the Vaccines for Children (VFC) federal entitlement

Key milestones

2014	-Identify, enroll, and train providers in VFC, including use of online vaccine ordering system known as VTRCKS -Achieve participation by 90% of pediatric care providers in Philadelphia
2015	-Conduct annual Audit and Feedback visits to 60% of VFC provider offices -Achieve 90% VFC provider compliance
2016	-Conduct annual Audit and Feedback visits to 80% of VFC provider offices -Achieve 95% VFC provider compliance

2017-18	<ul style="list-style-type: none"> -Conduct annual Audit and Feedback site visits to at least 25% of VFC provider offices annually -Achieve 95% VFC provider compliance
---------	---

Health promotion strategies

3. Identify and outreach to communities and families with low rates of childhood immunization

Key milestones

2014	-Add geocoding to KIDS Plus immunization data that will allow for improved referral of children for immunization outreach
2015	-Improve efficiency in outreach process so that 30% of referred cases are brought up-to-date
2016-2018	-Increase number of children whose immunizations are brought up-to-date annually to 2,000

Clinical care strategies

4. Improve electronic reporting of immunizations (HL7) from provider Electronic Health Records (EHRs) into citywide Immunization Information System, known as KIDS Plus registry

Key milestones

2014-15	<ul style="list-style-type: none"> -Establish interoperability between KIDS Plus and EHRs for 90% of eligible providers -Measure #/% providers achieving Meaningful Use for this standard
2016	-Increase proportion of childhood immunizations reported to the KIDS Plus registry through HL7 to 50%
2017	-Increase proportion of childhood immunizations reported to the KIDS Plus registry through HL7 to 60%
2018	-Increase proportion of childhood immunizations reported to the KIDS Plus registry through HL7 to 80%

5. Prevent perinatal transmission of Hepatitis B Virus (HBV) by assuring complete prophylaxis and follow-up of child

Key milestones

2014	<ul style="list-style-type: none"> -Determine reasons for missing infants exposed to Hepatitis B Virus (HBV) perinatally -Evaluate missed opportunities and failures
2015-16	<ul style="list-style-type: none"> -Develop performance improvement plan to increase identification of HBV-exposed infants -Implement corrective actions
2017-18	<ul style="list-style-type: none"> -Achieve identification rate of 90% for exposed infants -Implement HBV education program in high-risk immigrant communities

Strategic Priority 2 – Sexual Health

Objective 1 - Decrease STD rates and increase condom use among youth and young adults

Policy strategies

1. Make free condoms readily available in all public high schools

Key milestones

2014	-Implement condom distribution in 25% of high schools
2015-16	-Implement condom distribution in 50% to 75% of high schools
2017-18	-Implement condom distribution in 100% of high schools

2. Assist in implementing evidence-based sexual education in all public middle and high schools

Key milestones

2014	-Review evidence and develop curriculum
2015-16	-Decision to eliminate strategy

3. Pursue expedited partner therapy (EPT) policy for teens receiving services in PDPH clinical settings

Key milestones

2014	-Review evidence and laws
2015-16	-Meet with PADOH STD Control Program to pursue legislative action to allow EPT
2017-18	-Implement legislative action to allow EPT

Health promotion strategies

4. Utilize social media to (re)normalize condom use

Key milestones

2014	-Use adolescent focus groups to define needs and preferences
2015-16	-Develop social media strategy and plan
2017-18	-Implement social media campaign; evaluate results

5. Offer STD screening, treatment, and prevention services in all public high schools funded through public health and clinical sources

Key milestones

2014	-Continue existing program in all high schools -Develop model to finance screenings through health insurance billing
2015-16	-Implement and expand health insurance billing model
2017-18	-Sustain screening and prevention program through health insurance billing

Clinical care strategies

6. Offer timely treatment to sexual partners of those diagnosed with an STD through disease reporting and partner services interventions

Key milestones

2014	-Increase partner services capacity; hire and train staff
2015-16	-Implement performance improvement activities to provide treatment within 30 days of partner diagnosis -Analyze missed opportunities and gaps in services
2017-18	-Evaluate partner services program (e.g., perform qualitative evaluation of patient perceptions of Partner Services) -Make additional program improvements

7. Engage and train clinical providers—particularly family planning and primary care providers—to increase STD screening, decrease time between STD diagnosis and treatment, and enhance prevention through enhanced motivational interviewing

Key milestones

2014	-Convene clinical providers and assess current practices -Develop training and technical assistance
2015-16	-Implement training and technical assistance -Evaluate program impact
2017-18	-Evaluate program impact -Make additional program improvements

8. Educate parents, teens, and clinical providers on importance of initiating and completing Human papillomavirus (HPV) vaccination

Key milestones

2014	-Implement reminder recall intervention for young women who have received one dose of HPV vaccine -Develop and implement media campaign for parents and teens
2015-16	-Engage clinical providers in quality improvement activities -Evaluate program impact

Objective 2 - Reduce new HIV infections and improve linkage to timely, high-quality HIV care

Policy strategies

1. Promote adoption of opt-out HIV testing among clinical providers citywide

Key milestones

2014	-Disseminate policy guidance to providers -Incorporate providers' screening policies into funding decisions -Develop metrics and reporting methods for evaluation
2015-16	-Ensure full implementation of policy in healthcare settings -Monitor implementation -Provide technical assistance as needed
2017-18	-Evaluate and modify strategies as needed

Health promotion strategies

2. Offer community-based HIV screening and education, particularly among MSM, high-risk heterosexuals, and IV drug users

Key milestones

2014	-Implement new contract service provisions and goals -Aim to identify 200 newly diagnosed HIV positive persons
2015-16	-Evaluate system performance and make changes as appropriate -Aim to identify 200 newly diagnosed HIV positive persons
2017-18	-Evaluate system performance and make changes as appropriate -Aim to identify 200 newly diagnosed HIV positive persons

3. Offer prison-based HIV screening and education

Key milestones

2014	-Maintain intake testing program at 30,000 tests per year
2015-16	-Conduct 30,000 tests per year
2017-18	-Conduct 30,000 tests per year

4. Support syringe access services

Key milestones

2014	-Provide 1.3 million syringes through exchange services at 8 sites throughout Philadelphia
2015-16	-Provide 1.3 million syringes through exchange services at 8 sites throughout Philadelphia per year
2017-18	-Provide 1.3 million syringes through exchange services at 8 sites throughout Philadelphia per year

Clinical care strategies

5. Improve linkage to care for HIV positive persons

Key milestones

2014	-Develop quality improvement projects to improve linkage to care among prevention providers -Train providers in and implement ARTAS activities -Develop strategy to utilize surveillance data to assist in linkage to care
2015-16	-Refine the quality improvement activities -Monitor and evaluate implementation of ARTAS -Implement the surveillance strategies to improve linkage to care -Enhance Partner Services to add focus on linkage to care.
2017-18	-Evaluate and modify linkage to care strategies

6. Improve retention in care and quality of care for HIV positive persons, including achievement of viral suppression

Key milestones

2014	-Continue retention and quality management activities -Develop protocols for surveillance-enhanced re-engagement programs -Seek funding for enhanced activities
2015-16	-Implement surveillance-enhanced re-engagement
2017-18	-Evaluate and modify initiatives as needed

7. Offer timely screening and linkage to care for sexual partners of those diagnosed with HIV through disease reporting and partner services interventions

Key milestones

2014	-Increase partner services capacity
2015-16	-Implement performance improvement activities to provide screening within 30 days of partner diagnosis -Evaluate partner services program
2017-18	-Evaluate partner services program -Make additional program improvements

8. Coordinate citywide provision of pre-exposure prophylaxis (PrEP)

Key milestones

2014	-Develop and implement a plan to inform the public of the availability of PrEP in coordination with local providers
2015-16	-Monitor the uptake of PrEP -Deploy prevention navigators to assist in linking high risk HIV negative persons to PrEP services
2017-18	-Evaluate and modify plan as needed

Strategic Priority 3 – Chronic Diseases Related to Tobacco Use and Obesity

Objective 1 – Decrease rates of youth and adult smoking

Policy Strategies

1. Promote smoke-free policies for City parks, universities, and large employers

Key milestones

2014	-Implement smoke-free parks policy through executive order and regulation -Complete baseline evaluation of smoke-free parks policy -Assist one university/employer to go smoke-free
2015-16	-Complete follow-up evaluation of smoke-free parks policy -Assist two universities/employers to go smoke-free and convene a city-wide smoke-free campus summit -Support the implementation of the CBH contractual requirement for smoke-free policies in inpatient psychiatric treatment facilities and to additional levels of care
2017-18	-Assist universities/employers to go smoke-free -Assist CBH in extending the contractual change to drug and alcohol treatment facilities

2. Partner with the Philadelphia Housing Authority to implement a smoke-free policy for all indoor spaces, including residential units

Key milestones

2014	-Enact and implement policy for 2 pilot sites
2015-16	-Support the Philadelphia Housing Authority (PHA) in the implement of a PHA-wide smoke-free policy -Conduct evaluation activities at select PHA sites -Continue to support PHA with outreach and education, cessation resources, content expertise, and training for PHA staff and residents following policy implementation
2017-18	-Apply lessons learned from supporting PHA efforts to promote smoke-free policies in the private housing market, focusing on low-income housing

3. Foster changes in the pricing, placement, and promotion of tobacco products in retail settings

Key milestones

2014	-Work with City Council to pass laws prohibiting e-cigarette sales to minors and indoor use of e-cigarettes -Advocate for passage of authorizing legislation from the PA General Assembly for a local \$2/pack tax on cigarettes
2015-16	-Introduce policies to reduce tobacco retailer type, density and location -Introduce policies to address tobacco coupons and multi-pack discounts
2017-18	-Introduce policies to ban flavored tobacco products

Health promotion strategies

4. Implement social marketing campaigns regarding quitting, the health effects of smoking and secondhand smoke, and tobacco de-normalization

Key milestones

2014	-Implement campaign to promote smoke-free parks and clean air
2015-16	-Implement adapted <i>Tips From Former Smokers</i> and novel media campaigns to highlight health effects of smoking and secondhand smoke exposure, and promote tobacco industry de-normalization
2017-18	-Implement adapted <i>Tips From Former Smokers</i> campaigns to highlight health effects of smoking and secondhand smoke exposure

5. Engage neighborhood organizations, community leaders, and youth to be local tobacco control champions

Key milestones

2014	-Assess experience with the inaugural year of the Get Healthy Philly Youth Council -Develop brief smoking cessation training program for community leaders/organizations -Assist 5 community organizations in implementing an <i>Ex-Smokers' Hall of Fame</i> program
2015-16	-Train 250 community leaders/organizations annually to provide brief cessation services to staff and clients -Initiate collaboration with youth at the Health Promotion Council Advocacy Institute to increase their capacity to address tobacco and to support local tobacco control policy -Enhance the capacity of several neighborhood organizations and community leaders serving vulnerable populations to address tobacco
2017-18	-Train 250 community leaders/organizations annually to provide brief cessation services to staff and clients -Maintain collaboration with youth at the Health Promotion Council Advocacy Institute to increase their capacity to address tobacco and to

	support local tobacco control policy -Enhance the capacity of several neighborhood organizations and community leaders serving vulnerable populations to address tobacco
--	---

Clinical care strategies

6. Support clinical providers to integrate tobacco use dependence treatment into routine care

Key milestones

2014	-Continue public health detailing in primary care practices -Begin public health detailing in City-funded behavioral health practices -Develop tool-kit with community cessation resources, EHR integration recommendations, and guidance for formularies, order sets, and discharge instructions -Convene nursing leaders to discuss educational and practice reforms related to cessation
2015-16	-Expand public health detailing to specialty and behavioral health providers serving high-risk groups for tobacco use -Partner with PDPH Health Centers to improve the quality and consistency of tobacco treatment through integrated staff and organizational change efforts
2017-18	-Continue public health detailing to specialty and behavioral health providers serving high-risk groups for tobacco use -Expand partnership with PDPH Health Centers to improve the quality and consistency of tobacco treatment through integrated staff and organizational change efforts

Objective 2 – Improve nutrition and physical activity to decrease obesity

Policy strategies

1. Implement nutrition standards for all food procured by City agencies and other institutional purchasers

Key milestones

2014	-Develop nutrition standards for City agencies -Enact executive order codifying nutrition standards -Begin implementation with 2 City agencies
2015-16	-Implement standards for remaining City agencies -Develop toolkit for other institutional purchasers -Partner with 2 other institutional purchasers to implement nutrition standards
2017-18	-Partner with 2-3 other institutional purchasers annually to implement nutrition standards

2. Leverage federal food programs to improve nutritional offerings in schools, afterschool settings, and childcare

Key milestones

2014	-Assist School District in choosing a new pre-plate school food vendor -Provide support to School District in meeting new federal meal standards and increasing access to water for students
2015-16	-Implement nutrition standards for City-funded afterschool programs, including vendor outreach, assistance with contracting, and menu development -Develop plan to engage childcare providers
2017-18	-Implement nutrition standards for childcare programs, including vendor outreach, assistance with contracting, and menu development

3. Advocate for minute-based PE requirements for schools

Key milestones

2014	-Develop public health and education rationale for minute-based PE requirements
2015-16	-Create timeline and workplan for changing PE requirements -Obtain funding to assist with implementation
2017-18	-Pass local rule, setting minute-based PE/Physical Activity requirements

Health promotion strategies

4. Enhance the availability, affordability, and promotion of healthy foods in retail settings through retailer and manufacturer/distributor engagement

Key milestones

2014	-Implement healthy retail certification standards for 25 corner stores -Open 2 new farmers' markets -Maintain support for 200+ healthy Chinese take-out restaurants
2015-16	-Implement healthy retail certification standards for 25 additional corner stores -Develop plan for bonus incentive programs in supermarkets -Engage 2 regional food manufacturers/distributors to make voluntary commitments to improve the nutritional quality of their products -Assess need for local regulation
2017-18	-Engage 2 regional food manufacturers/distributors annually to make voluntary commitments to improve the nutritional quality of their products -Implement local regulations

5. Implement social marketing campaigns to promote healthier eating and physical activity

Key milestones

2014	-Implement salt reduction social marketing campaign
2015-16	-Continue salt reduction social marketing campaign -Develop and implement social marketing campaign promoting physical activity
2017-18	-Develop and implement additional social marketing campaigns

6. Promote greater and safer physical activity through bicycle, pedestrian, and open space initiatives

Key milestones

2014	-With MOTU, implement low-cost safety improvements to 100 intersections -With MOTU, launch bike share program -With PCPC, complete 2 district plans
2015-16	-With MOTU, implement low-cost safety improvements to 50 intersections annually -With MOTU, expand bike share program -With PCPC, complete 2 district plans annually -With PPR, plan and implement enhancements to 2 open spaces annually
2017-18	-TBD

Clinical care strategies

7. Enhance surveillance system for obesity and related chronic diseases

Key milestones

2014	-Complete annual report on obesity among schoolchildren for data through 2012-2013 -Create phase 1 of a citywide hypertension dashboard with data on prevalence, adherence, morbidity, and mortality
2015-16	-Develop data sharing agreements with charter schools for height and weight data on schoolchildren -Augment existing electronic data sharing platforms to collect height and weight data from clinical EHRs -Create phase 2 of a citywide hypertension dashboard with data on prevalence, adherence, morbidity, and mortality
2017-18	-Augment existing electronic data sharing platforms to collect data on hypertension and diabetes from clinical EHRs

8. Advance health-promoting policies in hospitals

Key milestones

2014	-Assist 1 birthing hospital to achieve <i>Baby Friendly</i> status
2015-16	-Assist 3 birthing hospitals to achieve <i>Baby Friendly</i> status -Support 2 hospitals in implementing nutrition/procurement standards -Develop physical activity design and promotion guidelines for hospitals
2017-18	-Assist 2 birthing hospitals to achieve <i>Baby Friendly</i> status -Support 2 hospitals in implementing nutrition/procurement standards -Help 2 hospitals in implementing physical activity design and promotion guidelines

Strategic Priority 4 – Environmental health

Objective 1 – Protect children from environmental health hazards

Policy strategies

- 1. Meet the National Ambient Air Quality Standards (NAAQS) for particulate matter, ozone, nitrogen dioxide, sulfur dioxide, carbon monoxide, and lead, and reduce exposure to air toxics using regulatory activities**

Key milestones

2014	-Implement diesel retrofit construction of public works -Ensure continued compliance with the dry cleaning, emergency generators, and complex sources regulations -State submits State Implementation Plan for ozone control -Enact ordinance requiring low sulfur in fuel oil
2015-16	-Finalize dust control plan regulation -Obtain a robust emissions inventory from the Port of Philadelphia
2017-18	-Reduce transport and greenhouse gas emissions

- 2. Reduce health and safety hazards in low-income housing, with an emphasis on lead poisoning prevention by improving property owner awareness of compliance with the Philadelphia Property Code and Health Code**

Key milestones

2014	-Strengthen lead court operations
2015-16	-Convene partners -Begin PDPH Property Code enforcement -Develop educational campaign and monitoring systems
2017-18	-Continue expansion of Property Code enforcement, as feasible

- 3. Partner with the Philadelphia Housing Authority to implement a smoke-free policy for all indoor spaces, including residential units**

Key milestones

2014	-Work with PHA and Tenant Association toward enactment of smoke-free policy
2015-16	-Support the Philadelphia Housing Authority (PHA) in the implement of a PHA-wide smoke-free policy -Conduct evaluation activities at select PHA sites -Continue to support PHA with outreach and education, cessation resources, content expertise, and training for PHA staff and residents following policy implementation
2017-18	-Apply lessons learned from supporting PHA efforts to promote smoke-free policies in the private housing market, focusing on low-income housing

Health promotion strategies

4. Reduce health and safety hazards, including asthma triggers, through Healthy Homes and Lead Poisoning Prevention programming

Key milestones

2014	-Develop plan for improved infrastructure and training to integrate the lead poisoning prevention and Healthy Homes programs -Develop new database
2015-16	-Fully integrate lead poisoning prevention and Healthy Homes programs -Develop and implement neighborhood initiative -Begin using database and add epidemiologic/surveillance staff -Review collected data, evaluate the effectiveness of these services, and implement any needed changes
2017-18	-To be determined based on evaluation

5. Implement periodic neighborhood-focused rodent, pest, and home safety survey and educational activities

Key milestones

2014	-Develop a program plan, budget, and proposed revenue strategy -Convene partners
2015-16	-Implement the initiative in a targeted neighborhood -Review the data and community feedback to make changes as needed -Possibly expand to additional neighborhoods or to commercial food establishments
2017-18	-To be determined based on evaluation and available resources

Clinical care strategies

6. Improve children's clinical providers' knowledge, counseling, and referral to reduce the risk of lead poisoning, increase lead screening, and reduce environmental triggers of asthma

Key milestones

2014	-Identify and convene partners including clinicians, asthma educators, and Medicaid managed care companies to develop plan
2015-16	-Begin initiative with PDPH pediatric clinical providers -Develop and distribute written materials for clinicians and their patients; provide in-service training as needed
2017-18	-Evaluate and adapt the program

Objective 2 – Promote food safety through education and inspection of food establishments

Policy strategies

- 1. Ensure routine annual inspections of food establishments, re-inspection within 30 days, and pre-court inspections of all court cases**

Key milestones

2014	-Inventory all food establishments in the Digital Health Department database and categorize their associated inspection frequency -Provide inspection lists to all staff to ensure that all initial inspections are completed -Use the database to monitor re-inspections and provide re-inspection lists to staff
2015-16	-Continue to monitor all initial, re-inspections, and pre-court inspections to make sure they are being completed in a timely manner -Develop new strategies and implement changes as needed
2017-18	-Evaluate effectiveness of the monitoring techniques -Develop new strategies and implement changes as needed

Health promotion strategies

- 2. Develop and disseminate resources on starting various types of food businesses**

Key milestones

2014	-Continue efforts to distribute the Stationary Business manual and finalize the Mobile Vending business manual -Develop a Special Events manual
2015-16	-Receive customer feedback on the manuals and implement any needed changes
2017-18	-Converted all manuals to on-line applications

- 3. Develop and disseminate resources for food vendors on how to prepare for a successful food safety inspection**

Key milestones

2014	-Review the types of violations cited most frequently and industry feedback about the inspection process -Develop a “what to expect when inspected” handout for establishment owners -Conduct presentations and trainings for establishment owners and employees to better understand risk factors and the most common failures of inspection
2015-16	-Develop educational videos of inspections and other special processes and make these videos available through the PDPH website
2017-18	-Evaluate effectiveness of these efforts and implement changes as needed

4. Provide online availability for all food business-related applications and fees

Key milestones

2014	-Food establishments will be able to pay for their Food Safety Certificates online with EPAY
2015-16	-Expand all EHS fees available to be paid online. -Develop an online Special Events application.
2017-18	-Evaluate effectiveness and increased revenue as a result of these online payment services