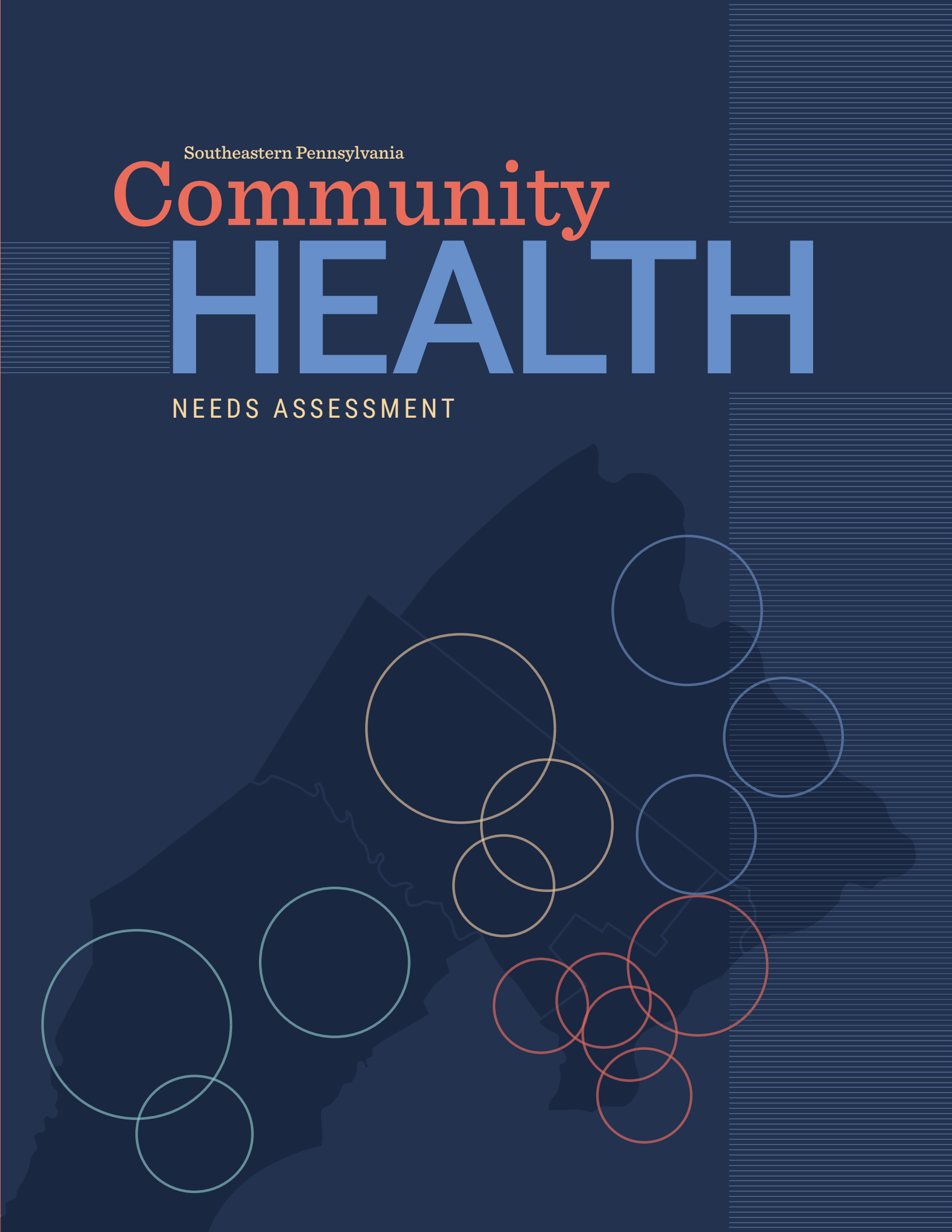Southeastern Pennsylvania

Community
HEALTH

NEEDS ASSESSMENT

Health is influenced by many factors, including social and economic conditions, the built environment, accessibility of healthy products, the behavioral choices people make, and access to and quality of the medical care system. Hospitals play a unique role addressing many of these factors both in providing medical care and investing in initiatives to improve the health and well-being of communities they serve.

The Affordable Care Act (ACA) mandates that, every three years, tax-exempt hospitals conduct a Community Health Needs Assessment (CHNA). By determining and examining the health needs and gaps in communities, these assessments drive hospitals' planning and implementation of initiatives to improve community health.

Recognizing that hospitals and health systems often mutually serve the same communities, a group of local hospitals and health systems convened to develop this first-ever Southeastern PA (SEPA) Regional CHNA, with specific focus on **Bucks, Chester, Montgomery,** and **Philadelphia** counties.
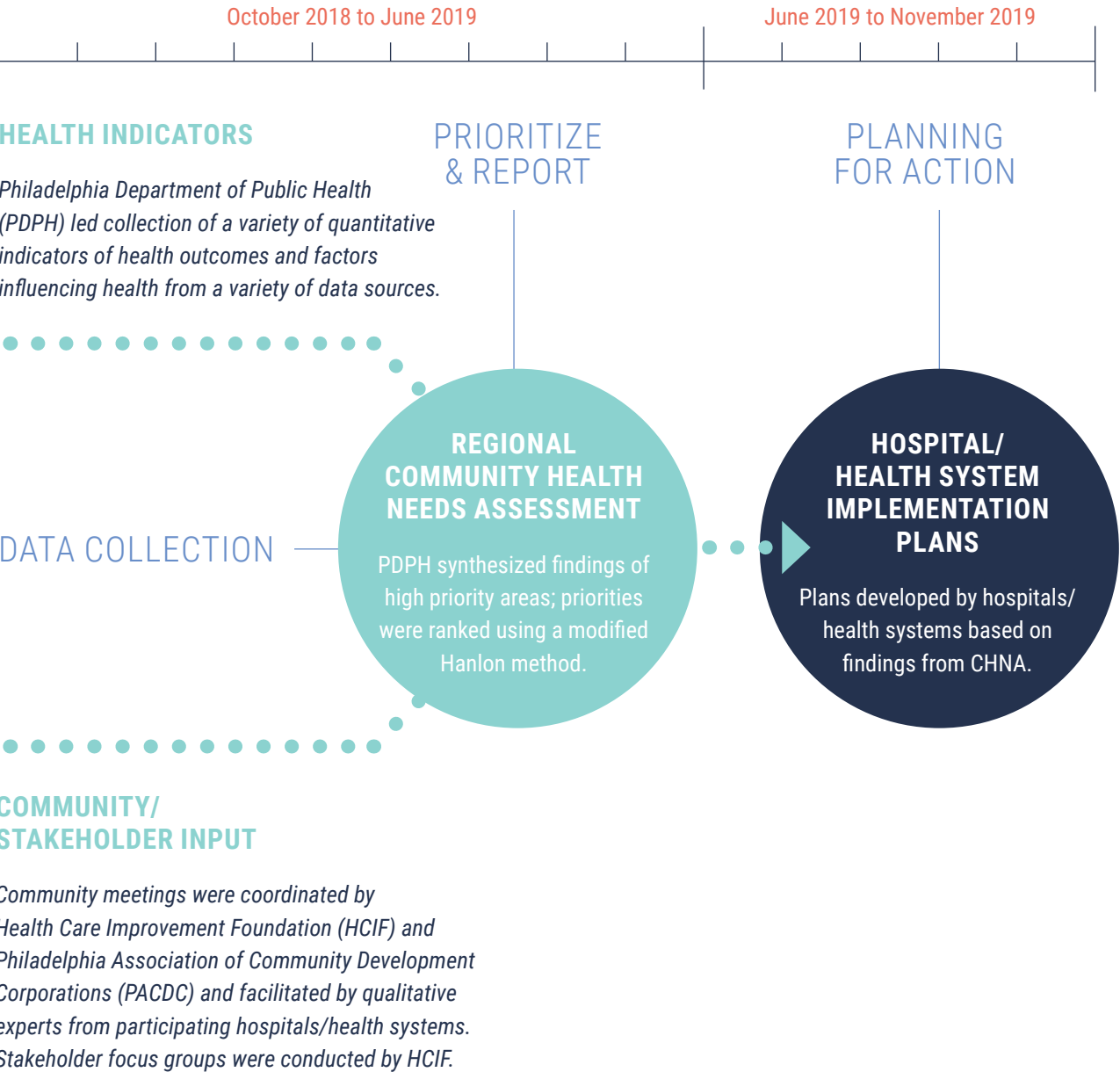
This collaborative CHNA offered:
» Increased collaboration among local hospitals/health systems serving this region
» Reduced duplication of activities and community burden from participation in multiple community meetings
» Reduced hospital/health system costs in CHNA report development
» Opportunities for shared learning
» Establishment of a strong foundation for coordinated efforts to address highest priority community needs
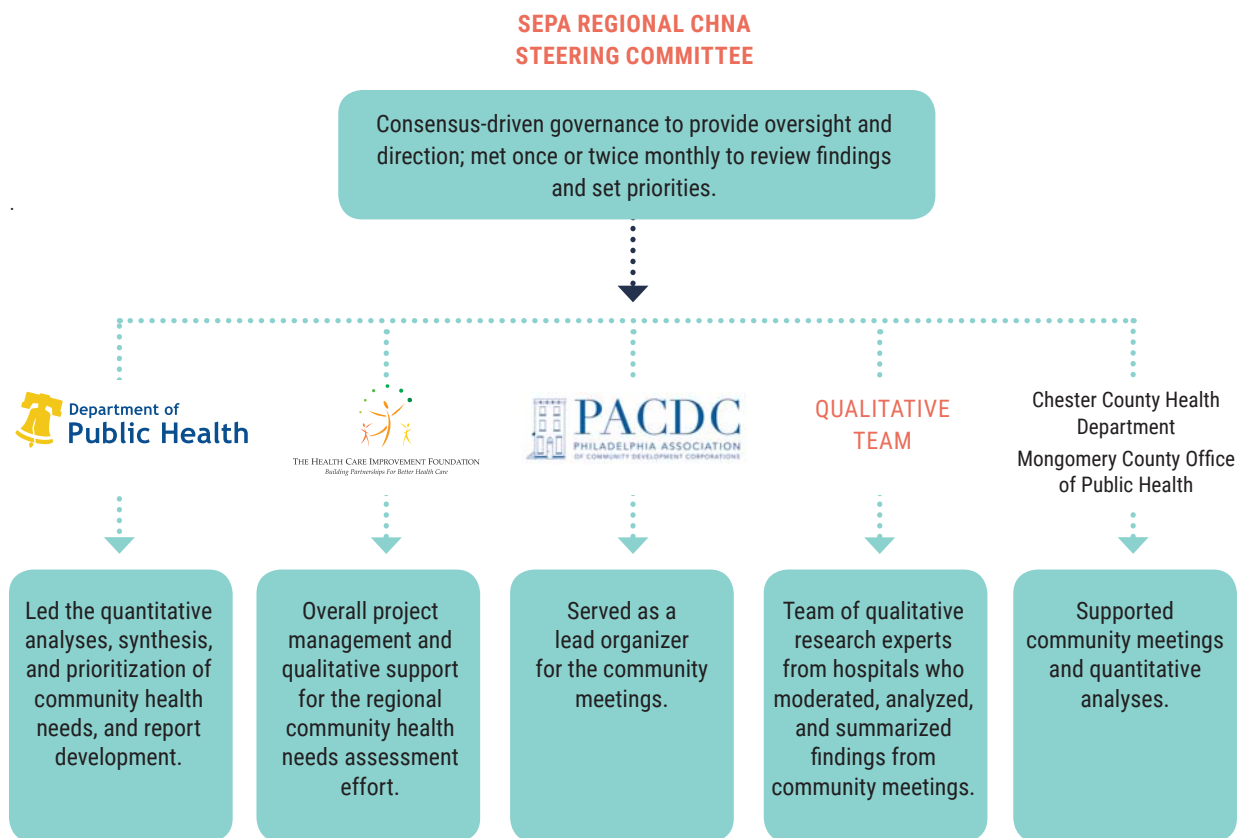
Partnering Hospitals
- Abington Hospital
- Abington Lansdale Hospital
- Chester County Hospital
- Children's Hospital of Philadelphia
- Einstein Medical Center Montgomery
- Einstein Medical Center Philadelphia
- Einstein Medical Center Elkins Park
- Grand View Hospital
- Holy Redeemer Hospital
- Jefferson Bucks Hospital
- Jefferson Frankford Hospital
- Jefferson Torresdale Hospital
- Thomas Jefferson University Hospital
- Jefferson Hospital for Neuroscience
- Jefferson Methodist Hospital
- Hospital of the University of Pennsylvania
- Pennsylvania Hospital
- Penn Presbyterian Medical Center

OUR COLLABORATIVE APPROACH

Hospitals and health systems and supporting partners collaboratively developed the CHNA that outlines health priorities for the region. The hospitals and health systems will produce implementation plans that may involve further collaboration to address shared priorities.

October 2018 to June 2019   June 2019 to November 2019

HEALTH INDICATORS

Philadelphia Department of Public Health (PDPH) led collection of a variety of quantitative indicators of health outcomes and factors influencing health from a variety of data sources.

PRIORITIZE & REPORT

PLANNING FOR ACTION

DATA COLLECTION

REGIONAL COMMUNITY HEALTH NEEDS ASSESSMENT

PDPH synthesized findings of high priority areas; priorities were ranked using a modified Hanlon method.

HOSPITAL/ HEALTH SYSTEM IMPLEMENTATION PLANS

Plans developed by hospitals/ health systems based on findings from CHNA.

COMMUNITY/ STAKEHOLDER INPUT

Community meetings were coordinated by Health Care Improvement Foundation (HCIF) and Philadelphia Association of Community Development Corporations (PACDC) and facilitated by qualitative experts from participating hospitals/health systems. Stakeholder focus groups were conducted by HCIF.

In partnership with the Steering Committee of representatives from the partnering hospitals and health systems, the Philadelphia Department of Public Health (PDPH) and Health Care Improvement Foundation (HCIF) developed a collaborative, community-engaged approach that involved collecting and analyzing quantitative and qualitative data and aggregating data from a variety of secondary sources to comprehensively assess the health status of the region. The assessment resulted in a list of priority health needs that will be used by the participating hospitals and health systems to develop "implementation plans" outlining how they will address these needs individually and in collaboration with other partners.

SEPA REGIONAL CHNA STEERING COMMITTEE

Consensus-driven governance to provide oversight and direction; met once or twice monthly to review findings and set priorities.

Department of Public Health	THE HEALTH CARE IMPROVEMENT FOUNDATION *Building Partnerships For Better Health Care*	PACDC PHILADELPHIA ASSOCIATION OF COMMUNITY DEVELOPMENT CORPORATIONS	QUALITATIVE TEAM	Chester County Health Department Mongomery County Office of Public Health
Led the quantitative analyses, synthesis, and prioritization of community health needs, and report development.	Overall project management and qualitative support for the regional community health needs assessment effort.	Served as a lead organizer for the community meetings.	Team of qualitative research experts from hospitals who moderated, analyzed, and summarized findings from community meetings.	Supported community meetings and quantitative analyses.

PDPH led the collection of quantitative indicators of health for the region, with support from the Chester County Health Department and Montgomery County Office of Public Health.

Data were acquired from local, state and federal sources and focused on indicators that were uniformly available at the ZIP code level across the region. PDPH partnered with HealthShare Exchange, the local health information exchange, to analyze key hospital-based indicators of health.

HCIF coordinated the qualitative components of the assessment which included:

» **19 Community Meetings** that were organized by PACDC and facilitated by the Qualitative Team, made up of experts from Children's Hospital of Philadelphia (CHOP), Jefferson Health, Penn Medicine, Holy Redeemer Health System, Grand View Health, and Chester County Hospital. Analysis of findings from these meetings was done by experts from CHOP, Jefferson Health, and Penn Medicine.

» **9 Key Stakeholder Focus Groups** about steering committee-selected populations of special interest, including African American and Hispanic/Latino communities; individuals experiencing homelessness; individuals experiencing housing security; prenatal and postpartum women; and individuals with behavioral/mental health conditions.

» **12 Key Informant Interviews** with leadership and staff at Federally Qualified Health Centers (FQHCs), conducted by Health Federation of Philadelphia.

» **Additional Key Informant Interviews** with hospital patient advisory groups, employees, and other stakeholders conducted by hospitals and health systems.

All data were synthesized by PDPH staff and a list of 16 community health priorities was presented to the Steering Committee. Using a modified Hanlon ranking method, each participating hospital and health system rated the priorities. An average rating was calculated, and the community health priorities were organized in priority order based on:

- Size of health problem
- Importance to community
- Capacity of hospitals/health systems to address
- Alignment with mission and strategic direction
- Availability of existing collaborative efforts

Potential solutions for each of the community health priorities, based on findings from the community meetings, stakeholder focus groups, and key informant interviews, were also included.

COMMUNITY HEALTH PRIORITIES

COMMUNITY HEALTH PRIORITIES	KEY FINDINGS	POTENTIAL SOLUTIONS
1. **SUBSTANCE/ OPIOID USE AND ABUSE**	» Drug overdose deaths have tripled and are the leading cause of death among young adults (ages 18 – 34) in the region » Increases in infectious illnesses like HIV and Hepatitis C, neonatal abstinence, and homelessness » Geographic disparities across the region	» Reduce the number of people who become addicted to opioids by reducing over-prescribing of opioids » Integrate Medication-Assisted Treatment into ambulatory care and initiate Medication-Assisted Treatment in emergency departments » Develop warm handoff projects with external organizations » Expand distribution of naloxone and other harm reduction resources » Increase school- and community-based anti-drug education and awareness » Expand medical respite for individuals with substance use disorder » Increase medical outreach and care for individuals living with homelessness and substance use disorders » Expand drug take-back safe disposal programs
2. **BEHAVIORAL HEALTH DIAGNOSIS AND TREATMENT**	» 1 in 5 adults has a depressive disorder » Undiagnosed and untreated conditions like depression, anxiety, and trauma-related conditions result in: • High utilization of emergency departments, particularly among youth, for mood and depressive disorders • Persisting rates of suicide, particularly among men • Substance use and abuse » Significant lack of community-based, integrated, and/or mobile behavioral health services » **Vulnerable populations:** individuals living in poverty, and those experiencing homelessness or housing insecurity; youth and young adults; older adults; racial and ethnic minorities, immigrants and refugees; and LGBTQ+ people	» Expand use of telemedicine and mobile care for counseling, therapy and other treatment for behavioral health conditions » Co-locate physical and behavioral health and social services » Institute trauma-informed care/counseling training for people working with youth

COMMUNITY HEALTH PRIORITIES	KEY FINDINGS	POTENTIAL SOLUTIONS

3.
 	
ACCESS TO AFFORDABLE PRIMARY/ PREVENTIVE CARE
	» High supply of primary care providers across the region, but long wait times in some areas and Medicaid acceptance variable
	
	» Low access to primary care providers for some vulnerable populations and communities due to:
	
	  • Lack of providers
	
	  • Affordability: Uninsured (no safety net providers) and low-income with high co-payments/ deductibles
	
	  • Language/cultural accessibility for immigrant/non-English speaking communities
	
	» **Vulnerable populations:** uninsured people, individuals/ families with low income, immigrants
		» Expand primary care locations in neighborhoods with low access
		
		» Support transportation assistance
		
		» Expand appointment availability and hours in low access areas
		
		» Develop health promotion campaigns and initiatives to raise awareness
		
		» Provide samples/discounts on medications and enroll patients in prescription assistance programs
		
		» Use technology/telehealth to increase access to health information

4.
 	
HEALTHCARE AND HEALTH RESOURCES NAVIGATION
	» Navigating healthcare services and other health resources, like enrollment in public benefits and programs, remains a challenge due to:
	
	  • General lack of awareness
	
	  • Fragmented systems
	
	  • Resource restraints
	
	» Financial costs and logistics associated with transportation can be a barrier to accessing healthcare and health resources
	
	» **Vulnerable populations:** individuals/families with low income, uninsured people, persons with disabilities
		» Increase access to healthcare navigators, community health workers and patient advocates
		
		» Develop community health resource directories, bulletins or newsletters
		
		» Create permanent social service hubs and resource fairs
		
		» Encourage bi-directional integration of data between health and community-based organizations
		
		» Develop school-based health and health resources navigation, like Community Schools
		
		» Provide information regarding available transportation services and facilitate the process for accessing these services
		
		» Create accessible healthcare offices and access to preventive care and health screening for persons with disabilities

COMMUNITY HEALTH PRIORITIES	KEY FINDINGS	POTENTIAL SOLUTIONS
5. **ACCESS TO AFFORDABLE SPECIALTY CARE**	» Financial and logistical barriers to specialty care for uninsured people and those with high co-pays and deductibles » Referrals from safety net providers (e.g. FQHCs) are challenging » Lack of care coordination, affordability, and appointment availability (e.g. long wait times) result in patients not seeking needed specialty care and use of emergency departments for acute needs	» Provide telehealth services » Co-locate primary and specialty care » Provide care navigation and coordination » Schedule appointments with outside providers at discharge » Provide information regarding available transportation services and facilitate the process for accessing these services » Create accessible healthcare offices for persons with disabilities
6. **CHRONIC DISEASE PREVENTION**	» Overall rates of cardiovascular disease (CVD)-related chronic disease continue to rise » Premature CVD deaths are 2-3 times higher in Philadelphia – related to higher rates of smoking, obesity, and hypertension largely driven by higher rates of poverty » Smoking rates in Philadelphia are far higher than the national average. » **Vulnerable populations:** African-Americans, Latinos, immigrants, individuals/families with low income	» Initiate health education and promotion in natural community hubs, such as beauty salons/barbershops and faith-based institutions » Support media campaigns that encourage smoking cessation » Create opportunities for physical activity like community walks, group fitness classes, or fitness vouchers » Continue expansion and marketing of wellness programs » Centralize health and social services resources information » Use technology for health education and support
7. **FOOD ACCESS AND AFFORDABILITY**	» Access to and affordability of healthy foods is a driver of poor health in many communities » Low access is largely driven by poor food environments which lack grocery stores or other sources of fresh food and produce, and are saturated with fast food outlets, convenience and corner stores, and other sources of unhealthy, often less expensive, food options » In communities where food insecurity is highest, the food environment is the poorest	» Create additional food access via farmers' markets, summer feeding programs, and food pantries » Support corner store redesign to accommodate healthier food supply » Require screening and referral for food insecurity » Provide transportation to supermarkets and other food distribution sites » Provide medical-legal partnership services

COMMUNITY HEALTH PRIORITIES	KEY FINDINGS	POTENTIAL SOLUTIONS
8. **AFFORDABLE AND HEALTHY HOUSING**	» Excessive housing cost is as high as 50% in some communities across the region » Poor housing conditions like old lead paint, asbestos, bad hygiene, infestations, lack of running water or HVAC, and damaged infrastructure, impact health: • Poor childhood health (e.g. lead poisoning, asthma hospitalizations, injuries) • Mental distress and trauma • Poor older adult health (e.g. falls, disability) » Forgoing care, food and other necessities due to financial strain » Rapid gentrification of some historically low-income neighborhoods creates risk of displacement and housing insecurity, and further segregation » **Vulnerable populations:** individuals/families with low income, persons with disabilities	» Develop new affordable housing units » Invest in cooperative young adult and senior housing » Provide home repairs and remediation for high risk youth (e.g. with asthma) and older adults » Require screening for housing insecurity » Develop medical-legal partnerships » Provide low-cost housing interventions like smoke and carbon monoxide detectors » Support rent subsidies » Provide assistance in identifying and accessing the waiting lists for accessible housing » Advocate for and implement responsible and equitable neighborhood development that avoids displacement and segregation » Raise awareness of available resources for housing repair assistance » Enforce lead abatement program policies » Invest in respite housing
9. **SEXUAL AND REPRODUCTIVE HEALTH**	» Teen births have declined substantially over the last decade, but are 2 times higher in Philadelphia and 4 times higher among Latina women » Sexually transmitted infection rates are rising among: • HIV: young Men Who Have Sex with Men (MSM) of color, People who Inject Drugs (PWID), high risk heterosexuals • Syphilis: young MSM of color in Philadelphia • Gonorrhea/Chlamydia: young females » Philadelphia's overall rate is 6 times higher compared to suburban counties » Lack of comprehensive sexual education in some public schools	» Provide free comprehensive sexual education and family planning services for youth

COMMUNITY HEALTH PRIORITIES	KEY FINDINGS	POTENTIAL SOLUTIONS
10. **LINGUISTICALLY- AND CULTURALLY- APPROPRIATE HEALTHCARE**	» About 12 percent of the population across the 4 counties was not born in the U.S. As much as 26 percent of some neighborhoods do not speak English very well. » Cultural and religious norms influence individual beliefs about health	» Implicit bias, cultural competence, and trauma-informed care competencies for healthcare providers, with focus on care for vulnerable communities like people living in poverty, LGBTQ+ people and individuals experiencing homelessness, and people living with addiction » Provide multi-lingual health care access » Recruit and retain a diverse healthcare workforce » Develop low-literacy, culturally relevant, multi-lingual health education materials
11. **MATERNAL MORBIDITY AND MORTALITY**	» Late access or inadequate access to prenatal care is 2 times higher in lower-income communities, up to 50% of pregnancies in some communities » Often related to pre-existing chronic conditions including obesity, hypertension, diabetes, and CVD » African-American mothers are 3 times more likely to die from pregnancy-related complications » Fatal drug overdoses have caused a spike in maternal deaths not related to pregnancy	» Provide prenatal, rather than postpartum, linkages to community-based services » Co-locate obstetric, primary, and pediatric care along with lab and imaging services » Raise awareness of and increase options for low-cost transportation » Create direct linkages to substance use treatment during prenatal and postpartum periods
12. **SOCIOECONOMIC DISADVANTAGE (INCOME, EDUCATION, AND EMPLOYMENT)**	» Individuals living at or near poverty levels have higher rates of adverse health behaviors and outcomes » Poverty is the underlying determinant for many racial/ethnic health disparities » Inadequate education and training and unemployment are key drivers of poverty » Poverty among children and adults tends to cluster in communities; these communities collectively experience lower life expectancy, access to healthcare and health resources, and greater exposure to unhealthy living environments	» Screen for socioeconomic disadvantage and establish systems for linkage to community resources to address needs » Provide education and training opportunities for individuals with low income » Employ and train returning citizens » Advocate for improvements to the disability system, so that people with disabilities are able to work without losing the attendant care services » Provide workforce development/pipeline programs with schools » Increase access to STEM education for youth

COMMUNITY HEALTH PRIORITIES	KEY FINDINGS	POTENTIAL SOLUTIONS
13. **COMMUNITY VIOLENCE**	» Community violence is largely driven by community disadvantage and disproportionately impacts Philadelphia » Gun violence primarily involves young Black males (>75%), many disconnected from school and employment » Women, immigrant youth, and LGBTQ+ people at higher risk for other interpersonal violence » Negative interactions and bullying are prevalent among youth	» Support and hire returning citizens » Create school and community-based mentor programs » Expand gun safety efforts like lock box distribution and provide educational materials » Provide bullying prevention programs in school and in after school programs
14. **RACISM AND DISCRIMINATION IN HEALTHCARE SETTINGS**	» Bias and discrimination experienced by individuals due to their race/ethnicity, immigration status, sexuality, adverse social experiences, and homelessness remain a challenge » Such experiences can result in further mistrust of healthcare providers and institutions and can lead to forgoing care and increased morbidity	» Create opportunities for medical professionals and communities to interact outside of the healthcare setting » Establish systems of ongoing community engagement beyond CHNA process » Offer implicit bias, cultural competence, and trauma-informed care competencies for healthcare providers, with focus on care for vulnerable communities like people living in poverty, LGBTQ+ people, individuals experience homelessness, and people living with addiction » Recruit and retain diverse healthcare workforce

COMMUNITY HEALTH PRIORITIES	KEY FINDINGS	POTENTIAL SOLUTIONS
15. **NEIGHBORHOOD CONDITIONS (E.G. BLIGHT, GREENSPACE, PARKS/ RECREATION, ETC.)**	» Access to safe outdoor and recreational spaces for physical activity and active transit (e.g. walking and biking) is a significant health priority, particularly for youth and young adults » Extreme neighborhood blight, including abandoned homes, vacant lots and extreme amounts of litter and trash, impacts communities socially and has been associated with poorer overall health and increased violence » Lack of maintenance of public spaces, like schools, libraries and recreational facilities create additional health hazards	» Develop new affordable housing units » Support neighborhood remediation and clean-up activities » Invest in infrastructure improvements to support active transit near hospitals » Improve vacant lots by developing gardens and spaces for socialization and physical activity

16.
HOMELESSNESS
	» Individuals experiencing homelessness are more likely to:
	
	  • Be racial/ethnic minorities
	
	  • Have mental health and substance use disorders
	
	  • Seek care at emergency departments/hospitals and be high-utilizers
	
	  • Experience discrimination and bias in healthcare settings
	
	» Inadequate temporary shelters, transitional housing, and affordable housing options exist for individuals experiencing homelessness throughout the region
		» Create medical respites for individuals in urgent need of transitional housing
		
		» Develop medical-legal partnerships
		
		» Develop new affordable housing units
		
		» Co-locate health and social services