SOUTHEASTERN PENNSYLVANIA

COMMUNITY HEALTH NEEDS ASSESSMENT 2022

Table of Contents

Identifying and addressing unmet health needs of local communities is a core aspect of the care provided by hospitals and health systems across the U.S. The Affordable Care Act (ACA) formalized this role by mandating that tax-exempt hospitals conduct a Community Health Needs Assessment (CHNA) every three years and implement strategies focused on emergent priorities from the assessment. This assessment is central to not-for-profit hospitals and health systems' community benefit and social accountability planning. By better understanding the service needs and gaps in a community, an organization can develop implementation plans—also mandated by the ACA—that more effectively respond to high priority needs.

Recognizing that hospitals and health systems often mutually serve the same communities, a group of local hospitals and health systems have again collaborated on a Southeastern Pennsylvania (SEPA) Regional CHNA (rCHNA), with specific focus on Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties. This continued collaboration enables continuity of approach, while also providing opportunities to expand and improve upon the last assessment process. Participants recognize that the CHNA is an important part of how health systems, multi-sector partners, and communities work together to achieve meaningful and positive community change. In addition to the shared learning, increased efficiencies, and reduced community burden offered by the collaborative approach, participants have derived particular benefit from mutual support in the face of the COVID-19 pandemic and its cascading impacts. In response to the crises of the past several years, the 2022 rCHNA is explicitly grounded in an approach that seeks to advance health equity and authentic community engagement.

Partnering Health Systems and Hospitals

Children's Hospital of Philadelphia
- Children's Hospital of Philadelphia
- Middleman Family Pavilion at CHOP, King of Prussia

Doylestown Health: Doylestown Hospital

Grand View Health: Grand View Hospital

Jefferson Health
- Einstein Medical Center Elkins Park
- Einstein Medical Center Montgomery
- Einstein Medical Center Philadelphia
- Jefferson Abington Hospital
- Jefferson Bucks Hospital
- Jefferson Frankford Hospital
- Jefferson Hospital for Neuroscience
- Jefferson Lansdale Hospital
- Jefferson Methodist Hospital
- Jefferson Torresdale Hospital
- Magee Rehabilitation Hospital
- MossRehab
- Rothman Orthopedic Specialty Hospital
- Thomas Jefferson University Hospital

Main Line Health
- Bryn Mawr Hospital
- Bryn Mawr Rehabilitation Hospital
- Lankenau Medical Center
- Paoli Hospital
- Riddle Hospital

Penn Medicine
- Chester County Hospital
- Hospital of the University of Pennsylvania
- Hospital of the University of Pennsylvania – Cedar Avenue
- Penn Presbyterian Medical Center
- Pennsylvania Hospital

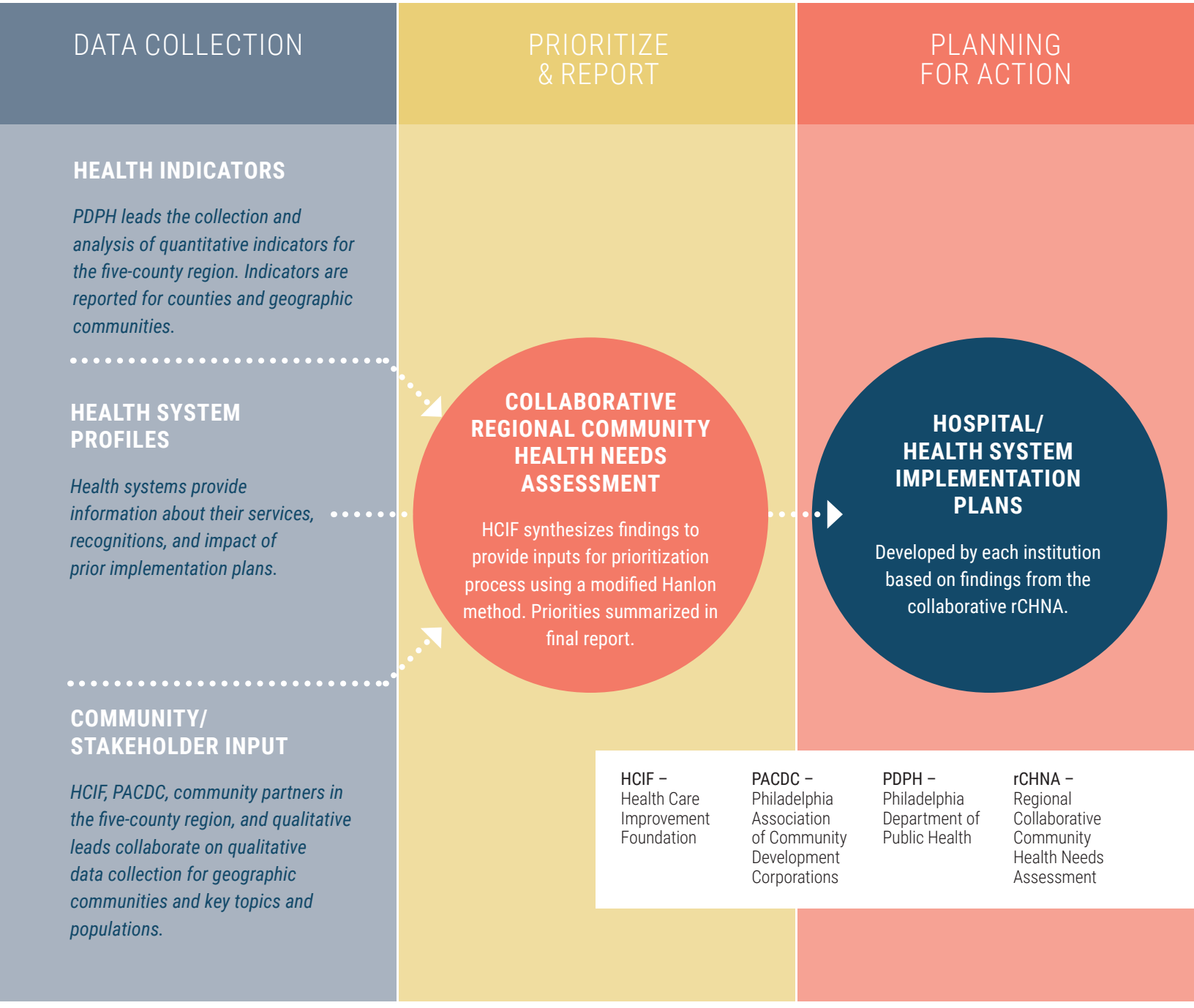
Redeemer Health: Holy Redeemer Hospital

Temple University Health System
- Fox Chase Cancer Center
- Temple University Hospital
- Temple University Hospital – Episcopal Campus
- Temple University Hospital – Jeanes Campus
- Temple University Hospital – Northeastern Campus

Trinity Health Mid-Atlantic
- Mercy Catholic Medical Center, Mercy Fitzgerald Hospital Campus
- Nazareth Hospital
- St. Mary Medical Center and St. Mary Rehabilitation Hospital

OUR COLLABORATIVE APPROACH

Hospitals/health systems and supporting partners collaboratively developed the community health needs assessment process and report to identify regional health priorities and issues specific to each participating institution's service area. Based on these priorities, hospitals/health systems produce implementation plans to respond to unmet health needs. These plans may involve further collaboration or coordination to address shared priorities.



HCIF – Health Care Improvement Foundation

PACDC – Philadelphia Association of Community Development Corporations

PDPH – Philadelphia Department of Public Health

rCHNA – Regional Collaborative Community Health Needs Assessment

EXECUTIVE SUMMARY

In partnership with the Steering Committee of representatives from the partnering hospitals and health systems, the project team—composed of staff from Health Care Improvement Foundation (HCIF), Philadelphia Department of Public Health (PDPH), and Philadelphia Association of Community Development Corporations (PACDC)—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.

Quantitative 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. The PDPH team, which included experts in epidemiological and geospatial analyses, compiled, analyzed, and aggregated over 60 health indicators encompassing data on community demographic characteristics, COVID-19, chronic disease and health behaviors, infant and child health, behavioral health, injuries, access to care, and social and economic conditions.

HCIF, guided by a Qualitative Team composed of a subset of Steering Committee representatives, coordinated the qualitative components of the assessment, which included:

- 26 virtual focus group-style "community conversations" held to gather input from residents of geographic communities across all five counties.
- 21 virtual focus group discussions centered on "spotlight" topics conducted with community organization and local government agency representatives. Topics covered included behavioral health, chronic disease, food insecurity, housing and homelessness, older adults and care, racism and discrimination in health care, substance use, and violence.

Two experts in qualitative data collection and analysis engaged as Qualitative Lead consultants facilitated all of these discussions, analyzed the qualitative data, and summarized key findings.

In addition, the project team either undertook directly or supported partners with targeted primary data collection to better understand the needs of particular communities or populations. These focus areas and communities were either specific to different type of facilities within participating health systems (i.e., cancer centers, rehabilitation facilities) or reflected gaps in the 2019 rCHNA:

- Cancer
- Disability
- Immigrant, refugee, and heritage communities
- Youth voice

Finally, secondary data in the form of reports and summaries from other community engagement efforts were also incorporated into the report.

All data were synthesized by HCIF staff and a list of 12 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 qualitative data collection, were also included.

COMMUNITY HEALTH NEEDS

COMMUNITY HEALTH NEEDS	KEY FINDINGS	POTENTIAL SOLUTIONS
1. MENTAL HEALTH CONDITIONS	• Youth and adult community members and community partners prioritize mental health as their top health need. • Significant mental health needs across the region are indicated by high rates of depression among youth and adults, frequent mental distress, and suicide mortality and suicide attempts/ideation among youth. • Trends exacerbated by social isolation, stress, and fear experienced due to the COVID-19 pandemic. • Pandemic-related trauma particularly compounded for those communities also contending with trauma associated with high levels of poverty, community violence, and racism. • Populations particularly affected include youth, older adults, immigrant communities, LGBTQ+ communities, those experiencing homelessness and housing insecurity. • There continues to be a significant lack of community-based, integrated mental health treatment options and a particular dearth of resources for youth with mental health needs and their families.	• Improve care coordination as part of an integrated care model. • Increase awareness of behavioral health resources and services. • Increase access to safe, structured afterschool activities for youth available on weekends and in the evening. • Create spaces for openly discussing mental health for youth to normalize/ destigmatize mental health issues. • Co-locate prevention and behavioral health services in community settings ("one stop shop") where families live, work, learn, and socialize. • Increase access to support groups to address mental health and substance use. • Increase training for healthcare providers, community-based organizations, schools, law enforcement, and others in Mental Health First Aid, trauma-informed care, and cultural competence/sensitivity. • Increase behavioral health workforce capacity and diversity (e.g., language, racial, and ethnic). • Increase individuals with lived experience in the behavioral health workforce. • Provide programming to prevent "burn-out" among behavioral health staff. • Support efforts to increase funding to ensure that all families and children can access evidence-based mental health screening, diagnosis, and treatment.

COMMUNITY HEALTH NEEDS

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2. **ACCESS TO CARE (PRIMARY AND SPECIALTY)**	• Supply of primary care providers across the region compares favorably to national data and trends with uninsured rates are improving regionally, but challenges remain with increasing provider acceptance of new patients with Medicaid coverage. • Barriers to access to primary care for communities are due to lack of providers in neighborhoods, issues of affordability, and language/cultural barriers. • Above issues exacerbated with specialty care, with added challenges posed by even more limited availability of appointments, high cost, and lack of care coordination/linkage with primary care. • Impacts of COVID-19 pandemic include increased enrollment in Medicaid, longer wait times for appointments (especially for specialty care), and gaps in access to preventive services.	• Provide education and information about Medicaid (e.g., eligibility, coverage) and assist with enrollment. • Create high quality free or low-cost health care options to serve those who may be uninsured or underinsured. • Establish comprehensive health centers that would address not only physical health, but also mental health and dental care. • Bring more health and social services directly to underserved communities through health clinics in schools or mobile medical clinics. • Embed social workers in primary care practices, such as family medicine, pediatrics, and OB/GYN offices. • Train all levels of hospital staff and other healthcare providers on delivering "non-biased, culturally appropriate, trauma-informed care." • Provide on-site language interpreters and health education materials in diverse languages. • Increase racial, ethnic, and language diversity of staff and providers to better reflect the communities they serve. • Increase transportation assistance, including adding options for those not eligible for certain benefits. • Expand appointment availability and hours in low access areas. • Address barriers to telehealth (e.g., related to internet or device access or digital literacy).

COMMUNITY HEALTH NEEDS

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3. CHRONIC DISEASE PREVENTION AND MANAGEMENT	• Conditions like heart disease, cancer, stroke, and chronic lower respiratory diseases continue to constitute majority of top 5 leading causes of death for all counties. • Rate of premature cardiovascular deaths significantly higher in Philadelphia County. • Cancer mortality rates highest in Delaware and Philadelphia Counties. • Hypertension-related hospitalization rates highest in Bucks, Delaware, and Philadelphia Counties. • Across and within 5 counties, disparities in burden of chronic disease correlate with poverty, which disproportionately affects communities of color. • COVID-19 pandemic has negatively impacted chronic disease prevention and management. Notably, there have been delays in seeking care, as found in qualitative reports and indicated by lower health care utilization in 2020 as compared to previous years.	• Better inform, educate, and engage the public regarding chronic disease prevention and management. • Engage trusted community leaders to help spread important messages (for example, promoting cancer screening). • Expand successful innovations from the pandemic, such as virtual wellness programs. • Bring screenings and health education to faith-based institutions or where people shop, recreate, or work. • Integrate mental health services into overall care management for people with chronic diseases. • Before patients leave a hospital or clinic, provide screening, referrals, and "warm hand-offs" to community-based health and social services, as well as resources that assist with lifestyle changes for people managing chronic conditions. • Increase networking and collaboration among community organizations and health system partners to improve resource sharing and coordination of services.

COMMUNITY HEALTH NEEDS

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4. SUBSTANCE USE AND RELATED DISORDERS	• Substance use disorders often co-occur with mental health conditions. • Substance use is associated with community violence and homelessness. • Drug overdose rates continue to be high due to the opioid epidemic. The drug overdose rates in Bucks, Delaware, and Philadelphia Counties exceed the overall Pennsylvania rate. It is the leading cause of death for young adults. • The opioid epidemic is associated with increases in other health conditions including HIV, Hepatitis C, and Neonatal Abstinence Syndrome (NAS). • Use of other substances, especially during the COVID-19 pandemic, was of pressing concern to community members and partners. Binge drinking among adults and youth, as well as cigarette, marijuana, and vape use among youth, were raised as increasingly prevalent. High rates of marijuana vaping among youth in the four suburban counties.	• Sustain and expand prevention programs, ranging from school-based educational programs to community drug take-back programs. • Advocate to increase and sustain funding for drug and alcohol prevention programs in schools and other programs. • Broaden and intensify efforts to reduce vaping among youth. • Expand Narcan training and distribution. • Increase medical outreach and care for individuals living with homelessness and substance use disorders. • Encourage use of Certified Recovery Specialists and Certified Peer Specialists in warm handoffs for drug overdose and other behavioral health issues. • Develop texting support services that address underlying issues of substance use, provided by trained peers or qualified therapists to individual clients. • Streamline system navigation for providers and the population at large to facilitate access to outpatient services after discharge from inpatient facilities.
5. HEALTHCARE AND HEALTH RESOURCES NAVIGATION	• Community members and partners widely viewed navigating healthcare services and other health resources as a challenge due to general lack of awareness, fragmented systems, and resource constraints. • Healthcare providers, particularly in the primary and acute care setting, can play an integral role in linking patients directly to health resources or to community health workers or care coordinators. • Navigation includes information as well as transportation. Lack of accessible, affordable transportation options was raised in a large majority (70%) of qualitative meetings, with the need spanning urban and suburban counties.	• Increase public awareness of community resource directories that local health systems have invested in and support community members with using them. • Increase the capacity of healthcare staff to assist community members with navigation by regular education on available resources. • Grow the numbers of professionals serving as community resource or healthcare navigators. • Create permanent social service hubs that serve as “one-stop-shops” for commonly needed resources. • Expand low-cost transportation options.

COMMUNITY HEALTH NEEDS

COMMUNITY HEALTH NEEDS	KEY FINDINGS	POTENTIAL SOLUTIONS
6. RACISM AND DISCRIMINATION IN HEALTH CARE	• Racism recognized as ongoing public health crisis in need of urgent, collective attention. • Higher rates of COVID-19 infection, hospitalization, and mortality experienced by Black communities are examples of inequities stemming from structural racism. • Representatives of communities of color shared their mistrust of healthcare providers and institutions arising from seeing such disparities and personally experiencing discriminatory treatment in health care settings. • Such experiences can lead to forgoing of needed care, resulting in increased morbidity and mortality. • Anti-Asian hate crimes increased during the COVID-19 pandemic. Fear of violence among Asian older adults has led to reluctance in leaving their homes, resulting in increased social isolation and adversely affecting mental and physical health.	• Train and hire people with lived experience to work in communities that have been historically marginalized. • Increase hospital investment in grassroots community organizations that are working to address social determinants of health and related needs. • Expand and improve the training of healthcare providers around anti-racism, structural racism, implicit bias, diversity awareness, cultural competence, and trauma-informed care. • Increase the number of people of color in healthcare leadership positions. • Ensure diversity, equity, and inclusion efforts and plans within healthcare institutions include an explicit focus on racism and discrimination, with focus on policies, care practices, and ongoing measurement. • Create and fund ongoing forums for community leaders to work with health system partners to address issues of racism and discrimination in health care.
7. FOOD ACCESS	• Issues of food access focus primarily on food security. Many community members experience challenges obtaining sufficient food of any kind, as well as issues with accessing healthy food more specifically. • Financial challenges brought on by the COVID-19 pandemic has led to an increase in rates of food insecurity across all counties and sharply rising demand for emergency food assistance. Nearly a quarter of Philadelphia households are receiving Supplemental Nutrition Assistance Program (SNAP) benefits. • Black and Hispanic/Latino communities are disproportionately impacted by food insecurity, as are older adults and immigrant communities.	• Ensure more equitable access to food assistance programs and resources throughout the region by collecting data. • Before patients are discharged from the hospital, provide "warm handoffs" to connect them with community health and social service organizations that address hunger and other needs. • Increase collaboration and resource-sharing between hospitals and community groups working on healthy food access. • Increase outreach to raise awareness and utilization of food assistance programs. • Provide services that distribute food directly to people where they live, especially in neighborhoods with limited or no access to healthy food. • Increase affordable transportation options for people who cannot drive or get rides to emergency food or other needed resources.

COMMUNITY HEALTH NEEDS

COMMUNITY HEALTH NEEDS	KEY FINDINGS	POTENTIAL SOLUTIONS
8. **CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES**	• About 12 percent of the population across the 5 counties were not born in the U.S. As much as 45 percent of residents of some geographic communities report speaking English less than very well. • The need for culturally concordant providers and resources to address language barriers was raised in over 50 percent of qualitative meetings. • Provision of high quality language services (oral interpretation and written translation) is critical for providing equitable care to these communities. • Beyond language access, cultural and religious norms influence individual beliefs about health. Providers and systems equipped to engage patients about these beliefs and integrate them into care is needed.	• Increase the racial, ethnic, and language diversity of staff and providers to better reflect the communities they serve. • Develop organizational language access plans that outline protocols for identifying and responding to language needs. • Explore the development of formalized programs to train and credential bilingual staff (employed for other roles) to serve as medical interpreters. • Provide on-site language interpreters and health education materials in diverse languages. • Develop strong partnerships with community organizations serving diverse communities that involves providing financial support. • Train all levels of hospital staff and other healthcare providers on delivering "non-biased, culturally appropriate, trauma-informed care."
9. **COMMUNITY VIOLENCE**	• Violent crime and homicide rates are 8-10 times higher in Philadelphia compared to suburban counties. • In 2020, Philadelphia lost 447 people to gun violence, the most gun-related homicides in 30 years. It is the leading cause of death for Black men ages 15-43 and Hispanic/Latino men ages 15-31. • Community violence driven by community disadvantage disproportionately impacts N, NW, and SW communities in Philadelphia. • Trauma associated with exposure to gun violence is widely felt in communities, especially among youth. Significant challenges exist with accessing necessary mental health supports to address negative impacts of such exposure. • Women, youth from immigrant communities, and LGBTQ+ communities are at higher risk of interpersonal violence, including intimate partner violence (IPV), sexual assault, and sex trafficking. Reports of increased risk of IPV associated with COVID-19 stay-at-home orders have been shared by local advocates. • Negative social media engagement, including cyberbullying, among youth can be a source of community violence.	• Increase awareness and availability of youth programs to prevent violence, including educational programs, sports, and other recreational activities. • Integrate social and mental health services into existing youth activities. Also provide training for individuals who are trusted by and work with youth (e.g., teaching artists, coaches, teachers, parents) in addressing trauma and other violence-related issues. • Build youth capacity for healthy conflict resolution and create positive outlets for arguments or anger. • Create more safe spaces for people to talk about the violence they experience. • Train all levels of hospital staff and other healthcare providers on delivering "non-biased, culturally appropriate, trauma-informed care." • Increase advocacy for policies to prevent or reduce violence, including initiatives to address poverty and other social determinants that contribute to violence. • Partner with community-based organizations to build on each other's strengths and increase funding opportunities.

COMMUNITY HEALTH NEEDS

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10. HOUSING	• Safe, stable housing is critical for physical and mental health and well-being. Lack of stable housing is associated with 27.3 fewer years of life expectancy. • Health issues associated with housing instability include behavioral health issues (mental distress, depression, developmental delays in children, falls among older adults) and medical conditions such as asthma and lead poisoning. Households may forgo needed health care due to financial strain. • In 2018, 40 percent of Philadelphia households were cost-burdened (when a household spends 30 percent or more of its income on housing costs, including rent, mortgage payments, utilities, insurance, and property taxes). This figure is expected to be higher as a result of the COVID-19 pandemic. • Poor housing conditions like old lead paint, asbestos, infestations, lack of running water or HVAC, and damaged infrastructure disproportionately impact communities with low incomes. • Lack of affordable housing is a major driver of homelessness. • People experiencing homelessness are at increased risk of mental health and substance use disorders and experiencing discrimination and bias in healthcare settings. • Homelessness experienced by youth and older adults are of particular concern for local advocates.	• Drive solutions that prevent homelessness, including advocating for livable wages, more affordable housing, and services that support aging in place. • Advocate for and implement responsible and equitable neighborhood development that avoids displacement and segregation. • Increase investments by hospitals, managed care organizations, and others in supportive housing programs known to be effective in reducing housing insecurity and preventing homelessness. • Explore strategies that aggregate funds to support rental assistance. • Explore development of an equitable acquisition fund to preserve and create affordable housing. • Expand programs that support habitability and raise awareness of available resources for housing repair assistance. • Evaluate existing hospital housing programs for potential expansion, including those that provide home repairs and remediation for high risk youth (e.g., with asthma) and older adults. • Train and encourage health care providers to conduct regular housing insecurity assessments for patients and make referrals as appropriate. Train health professionals and social service providers to use a trauma-informed approach when caring for individuals experiencing homelessness or housing insecurity. • Increase Rapid Re-housing Programs. • Invest in respite housing for individuals in urgent need of transitional housing.

COMMUNITY HEALTH NEEDS

COMMUNITY HEALTH NEEDS	KEY FINDINGS	POTENTIAL SOLUTIONS
11. SOCIOECONOMIC DISADVANTAGE (E.G., POVERTY, UNEMPLOYMENT)	• Individuals living at or near poverty levels have higher rates of adverse health behaviors and outcomes; poverty resulting from structural racism is the underlying determinant for many racial/ethnic health disparities. • Inadequate education, limited opportunities, and unemployment are key drivers of poverty. • Poverty among children and adults tends to cluster in communities; these communities collectively experience trauma and toxic stress, lower life expectancy, limited access to healthcare and health resources, and greater exposure to unhealthy living environments. • Poverty rates are nearly 4 times higher in Philadelphia compared to suburban counties overall, but pockets of high poverty clusters are seen in suburban counties.	• Screen for socioeconomic disadvantage and establish systems for linkage to community resources to address needs. • Partner with local community-based organizations who provide public benefits enrollment assistance to ensure that residents receive all the benefits (e.g., SNAP, Earned Income Tax Credit) for which they are eligible. • Collaborate with community colleges and universities to develop and expand programs focused on skills training and development to increase access to family-sustaining careers. • Train and employ returning citizens. • Advocate for improvements to the disability system to ensure that people with disabilities are able to work without losing attendant care services. • Provide workforce development/pipeline programs with schools. • Increase access to Science, Technology, Engineering, Arts, and Mathematics (STEAM) education for youth.
12. NEIGHBORHOOD CONDITIONS (E.G., BLIGHT, GREENSPACE, AIR/WATER QUALITY, ETC.)	• Greater neighborhood blight (e.g., abandoned homes, vacant lots, trash) is more likely in high poverty areas and is associated with increased community violence. • Lack of maintenance of public spaces, like schools, libraries and recreational facilities create additional health hazards. • Access to outdoor greenspaces and recreation areas like parks and trails are lower in these neighborhoods. The negative impact of such lack of spaces on mental and physical health was shared by community members. • Communities expressed concerns about air pollution and climate change, particularly in S Philadelphia, Delaware County, and flood-prone SW Philadelphia. • Rapid gentrification of some historically low-income neighborhoods creates risk of displacement and housing insecurity, and further racial segregation.	• Support neighborhood remediation and clean-up activities. • Collaborate with local advocates engaged in campaigns to improve air quality, especially in areas that have increased exposure to emissions. • Invest in infrastructure improvements to support active transit near hospitals. • Improve vacant lots by developing gardens and spaces for socialization and physical activity. • Advocate for and implement responsible and equitable neighborhood development that avoids displacement and segregation.

INTRODUCTION

Identifying and addressing unmet health needs of local communities is a core aspect of the care provided by hospitals and health systems across the U.S. The Affordable Care Act (ACA) formalized this role by mandating that tax-exempt hospitals conduct a Community Health Needs Assessment (CHNA) every three years and implement strategies focused on emergent priorities from the assessment. Federal requirements for the CHNA include:

- A definition of the community served by the facility and a description of how the community was determined
- A description of the process and methods used to conduct the CHNA
- A description of how the facility solicited and took into account input received from persons who represent the broad interests of the community it serves
- A prioritized description of the significant health needs of the community identified through the CHNA and a description of the process and criteria used in identifying certain health needs as significant and prioritizing those needs
- A description of resources potentially available to address the significant health needs identified through the CHNA

This assessment is central to not-for-profit hospitals and health systems' community benefit and social accountability planning. By better understanding the service needs and gaps in a community, an organization can develop implementation plans—also mandated by the ACA—that more effectively respond to high priority needs.

At the request of local non-profit hospitals and health systems, the Philadelphia Department of Public Health (PDPH) and the Health Care Improvement Foundation (HCIF) convened an effort to collaboratively develop a regional Community Health Needs Assessment (rCHNA) for four counties of the Southeastern PA (SEPA) region in 2019. This effort represented the first joint CHNA in the region, providing a foundation for future collaboration on both needs assessment and implementation planning to better serve shared SEPA communities.

Once again, local institutions have collaborated on the 2022 rCHNA, enabling continuity of approach, while also providing opportunities to expand and improve upon the last assessment process. Participants recognize that the CHNA is an important part of how health systems, multi-sector partners, and communities work together to achieve meaningful and positive community change. In addition to the shared learning, increased efficiencies, and reduced community burden offered by the collaborative approach, participants have derived particular benefit from mutual support in the face of the COVID-19 pandemic and its cascading impacts. In response to the crises of the past several years, the 2022 rCHNA is explicitly grounded in an approach that seeks to advance health equity and authentic community engagement.

While the basic structure and format of the report are retained from the 2019 effort, the ways in which the 2022 rCHNA departs from the previous process is largely due to a significant increase in size and scope. With the inclusion of additional hospitals and health systems in 2022, the current report not only adds Delaware County to the included service area, but also features full coverage of all ZIP codes in the five-county SEPA region. This has led to the re-defining of geographic communities, as well as increases in the number and types of quantitative and qualitative data in response to the requests of the expanded participant group. Given such differences, as well as the unique impacts of the COVID-19 pandemic on data collection efforts, it is important to note that comparability with the 2019 rCHNA report (especially as related to quantitative data) is limited.

Children's Hospital of Philadelphia

MISSION

Children's Hospital of Philadelphia, the oldest hospital in the United States dedicated exclusively to pediatrics, strives to be the world leader in the advancement of healthcare for children by integrating excellent patient care, innovative research and quality professional education into all of its programs.

VISION

We will distinguish ourselves as the No. 1 children's hospital in the world.

We will put our patients and families at the center of all we do and ensure we meet their unmet needs.

We will grow our footprint and our revenue in order to ensure our ability to invest in and enhance our mission of patient care, research and education.

We will be "high touch" and "high tech" and will be digitally accessible to patients around the world and in our backyard.

We will care for the underserved children in our community.

We will define care and discover cures for children over the next 30 years — and beyond.

VALUES

At Children's Hospital of Philadelphia, we are committed to making breakthroughs for children every day. We advance health care for children through the integration of family-centered, safe and high-quality care with innovative research and quality professional education. Every employee has the ability and opportunity to contribute to breakthroughs in care and service. By defining our collective values, we create the framework for delivering these breakthroughs as we partner with the children and families we serve.

BEDS	FULL & PART-TIME EMPLOYEES	PHYSICIANS	INPATIENT ADMISSIONS	OUTPATIENT VISITS	EMERGENCY DEPT. VISITS
648	15,701	1,852	25,003	1,217,592	65,885

CHOP is the only freestanding, independent (i.e., not affiliated with a health system) pediatric hospital in the Commonwealth of Pennsylvania, thus affording it an unparalleled singular focus on pediatric services. It is one of only three pediatric hospitals in its primary service area. CHOP's Care Network extends throughout the region, with Primary Care practices, Specialty Care and Ambulatory Surgery centers, Urgent Care centers, Newborn & Pediatric Inpatient Care sites, and Home Care services available at more than 50 locations in Pennsylvania and New Jersey.

In January 2022, CHOP opened its second hospital in King of Prussia, Pa., featuring the same world class care as our first hospital, with increased access for the local communities we serve. This facility has 52 private patient-rooms and a 24/7 Emergency Department with 20 rooms.

CORE SERVICES

CHOP houses the world's leading pediatric research enterprise, the CHOP Research Institute, that reflects the hospital's deep and long-standing commitment to improve child health. With nearly 2,600 staff, the Institute carries out groundbreaking research on the science, policy, and treatment of childhood illnesses across our scientific pillars: rare and complex diseases, lifespan research, novel therapeutics, and precision medicine. The Institute focuses on patient-driven research that changes lives — both in the hospital setting and beyond our walls, in outpatient care and in the community. It also has a growing portfolio of health services and community-engaged research led by one of its Centers of Emphasis, PolicyLab. A trailblazing group of initiatives known as Frontier Programs are pioneering new advances in children's health at an astonishing pace. Frontier Programs conduct visionary research that translates to cutting-edge clinical care. Some examples of Frontier Programs include Comprehensive Center for the Cure of Sickle Cell Disease (CuRED), Food Allergy Center, and Center for Pediatric Airway Disorders.

CHOP established the first formal medical training program for pediatric doctors in the United States. As part of the residency program, CHOP offers the Community Pediatrics and Advocacy Program. This longitudinal curriculum prepares medical residents to be child and family advocates and work with community partners towards creating prevention and population health programs.

CHOP consistently invests in programs that benefit communities and strongly believes that the hospital's mission must always reach outside its walls to help the children living in and around its primary service area for community benefit. CHOP has more than 100 community programs that strive to ensure that all children, especially the most vulnerable, experience the wonders of childhood. In 2013, CHOP began the CHOP Cares Community Grant Program, in which a CHOP Community Advisory Board comprised of both CHOP employees and local civic leaders advise a competitive grant process. The program awards small grants to CHOP employees to support work in their own communities that specifically address needs identified in the CHNA.

Among many of CHOP's community initiatives, a few notable programs include:

- **Community Asthma Prevention Program (CAPP)**
  CAPP conducts community service and education projects, community-based asthma research, and asthma interventions to improve the lives of children in communities most affected by asthma, including the CAPP+ program, which provides repairs to patient family homes in West and Southwest Philadelphia.
- **Center for Violence Prevention (CVP)**
  The CVP model works to reduce the incidence and impact of violence and aggression on children and families in the community. CVP includes efforts to reduce: 1) bullying in schools; 2) domestic violence in the home; and 3) violent assault in the community.
- **Homeless Health Initiative (HHI)**
  HHI provides health outreach services through a coordinated, multidisciplinary approach that aims to reduce health disparities and improve healthcare access and health outcomes for children residing in homeless shelters. Some of the services provided in family shelters are CHOP Night medical and dental exams and Operation CHOICES, an obesity prevention program (fitness and nutrition education), and art therapy for mothers and children.
- **Karabots Community Garden (Garden)**
  The Garden, which opened in 2016, donates produce to the West Philadelphia community and hosts cooking demonstrations and educational events throughout the year. The Garden harvests and distributes 2,400 pounds of organic produce annually to patients and families.
- **Center for Child Protection and Health**
  The Center provides services to children and their families for whom a concern for child abuse or neglect has been identified. Services include: Children's Collaborative Clinic for evaluation of suspected child sexual abuse co-located and in partnership with the City of Philadelphia, Safe Place Treatment and Support Program, a comprehensive medical program called Fostering Health Program, and PriCARE, a parent training program to facilitate positive parenting behaviors.
- **Center for Health Equity**
  The Center for Health Equity launched in 2021 to discover, implement and disseminate evidence-based practices and policies to ensure equitable care and achieve the best health for every child in Philadelphia.

ACCOLADES RECEIVED

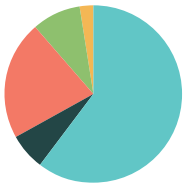
Every year since 2007, when *U.S. News & World Report* published the first ranking of U.S. children's hospitals, CHOP has been among the top-ranked institutions in the country. We are proud to once again be on the prestigious Best Children's Hospitals Honor Roll in the 2021-22 *U.S. News & World Report* rankings as the No. 2 children's hospital in the nation. CHOP also excelled in *U.S. News*' evaluation of specialty areas, ranking in the top eight in each of the 10 areas, with No. 1 rankings for our Division of Endocrinology and Diabetes, Division of Oncology and Division of Orthopedics. A total of five CHOP specialties were ranked in the top three in the nation. *U.S. News* also ranked Children's Hospital No. 1 in the Mid-Atlantic Region, and No. 1 in Pennsylvania.

In recognition as an outstanding employer, CHOP has received several awards, including 2021 Military Friendly Employer designation, 2021 NOD Leading Disability Employer, and has been named "Best Employers for Women" by Forbes in 2021. CHOP has also been recognized as No. 2 in the region and No. 2 in the country by *U.S. News & World Report* and, in 2022, CHOP was ranked as the No. 1 employer in the nation by *Forbes*.

For its impact in the community, CHOP has been named a 2021 honoree of The Civic 50 Greater Philadelphia by Philadelphia Foundation as one of the most community-minded organizations in the region. Our efforts have also been recognized by the Association of American Medical Colleges, which awarded CHOP the Spencer Foreman Award for Outstanding Community Service.

SERVICE AREA DEMOGRAPHICS

Racial Composition



6.5% | Asian*
21.7% | Black*
8.9% | Hispanic/Latino
60.5% | White*
2.4% | Other*

* Non-Hispanic

Age Distribution

0–19 | 20–44 | 45–64 | 65+

Age Distribution under 20

<5 | 5–9 | 10–14 | 15–19

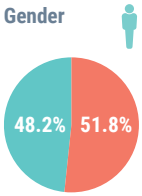
Fluency

6.3% speak English less than very well

Median Household Income

$81,763

Gender



PARTNERSHIPS AND AFFILIATIONS

Although the University of Pennsylvania and CHOP are separate corporate entities with no shared ownership or governance, they have had a close collaborative relationship for more than half a century in furtherance of their respective missions. CHOP has officially been the Department of Pediatrics to the University of Pennsylvania's Perelman School of Medicine since 1929. The relationship between CHOP and the University of Pennsylvania includes collaboration on the performance of basic and clinical research, collaboration in patient care, cooperation in education and training of medical students and residents, and multiple arrangements for the joint use of facilities and equipment.

CHOP has affiliations with 10 hospitals in Pennsylvania and 6 in New Jersey whereby CHOP and the community hospitals collaborate to provide high quality, efficient pediatric care at the host hospitals. CHOP provides the hospitals with newborn and pediatric services including physician staffing, clinical program management, as well as education for the host hospital staff and patients. CHOP views these arrangements as an important part of its mission of improving access to and improving the quality of newborn and pediatric care in the communities it serves.

TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

CHOP defines its targeted service area for community benefit as all ZIP codes in the Greater Philadelphia five-county region. While the Greater Philadelphia region is CHOP's primary service area for community benefit, as a globally recognized children's hospital, CHOP also serves patients from 100 countries as well as all states and the District of Columbia. CHOP also provides primary patient care beyond the five-county Greater Philadelphia region within 14 counties of Southeastern Pennsylvania, and Southern New Jersey.

Impact of Prior Community Health Needs Assessment and Implementation

The top 10 needs identified in the 2019 rCHNA serve as the focus of CHOP's implementation plan. Due to CHOP's long history of working with the community, many of the health needs uncovered by the rCHNA were not unexpected and are actively being addressed by CHOP's existing programs. In response to the 2019 rCHNA, CHOP has worked on cross-collaborative partnerships in the community, continued investing in strategies from previous implementation plans and new.

In 2019 CHOP launched the Healthier Together Initiative, a $25 million initiative to tackle social determinants of health as a path to improving the health of children. This umbrella community impact initiative partners with government agencies, nonprofits and community groups to develop programs that focus on improving four key social determinants of health: housing, hunger, trauma and poverty. In the first two years, Healthier Together has directly impacted over 6,800 individuals in the West and Southwest Philadelphia communities.

In 2020, CHOP established outpatient clinics to treat adolescents with opioid use disorder (OUD) and other substances, including nicotine, alcohol, and marijuana, and provided telehealth consultations for Covenant House, a shelter for marginalized youth experiencing homelessness. To better address the mental and behavioral health needs of children, CHOP expanded Healthy Minds, Healthy Kids, co-locating behavioral health services within 15 primary care offices. To ensure patients had continued access to health care, over the past two years, CHOP provided over 300,000 telehealth visits. A full report of CHOP's progress towards addressing these needs can be found on CHOP's website at chop.edu/CHNA-IP-Progress2022.

In the wake of the COVID-19 pandemic, CHOP experts in infection prevention, policy, advocacy, and vaccinology quickly mobilized to provide guidance to the community and policymakers and mitigate the negative impacts on children and families. At the onset of the pandemic in 2020, CHOP PolicyLab launched a model to forecast COVID-19 transmission nationally. The data from the COVID-Lab model was used by regional and national school leaders and officials from all levels of government — including the White House COVID Task Force — to inform policy and make decisions affecting millions of children and families. CHOP operated the Greater Philadelphia Coronavirus Helpline, a free 24/7 hotline, that has fielded 282,000 calls from the public seeking information and advice. In addition to community testing and vaccination sites, CHOP vaccinated 19,000 Philadelphia school personnel to support the plans to safely reopen schools for children across the city. Furthermore, Dr. Paul Offit, Director of CHOP's Vaccine Education Center, who is a member of the FDA Vaccine Advisory Committee, has been integral to providing expert guidance on the COVID-19 vaccine, both nationally and internationally.

CHOP also increased efforts to address the immediate and pressing needs of the community that were exacerbated by the pandemic. CHOP partnered with the City of Philadelphia and a local, minority-owned business to provide 20,000 meals to public housing residents in West and Southwest Philadelphia. It also expanded financial counseling services at the Karabots Pediatric Care Center and invested in services to prevent child abuse and intimate partner violence.

Doylestown Health

MISSION AND VISION

The **mission** of Doylestown Health is to continuously improve the quality of life and proactively advocate for the health and well-being of the individuals we serve.

With a **vision** to enthusiastically pursue healthcare excellence through collaboration and innovation, we strive to inspire a more vibrant and healthier world for our patients and our community.

We consistently strive for healthcare excellence and provide a continuum of connected providers, quality and excellence in service and accessibility to the community we serve.

SERVICE VALUES

- We **serve** the community
- We strive for **excellence** in our services and programs
- We **respect** the dignity and privacy of all
- We provide **value** through high quality, accessible services
- We seek **innovation** and integration for continuous improvement
- We are **compassionate**
- We are committed to the health and wellness **education** of our community

HISTORY

The Village Improvement Association was the guiding force behind the founding of Doylestown Hospital in 1923, and still governs the operation of the hospital today. Founded in 1895 by a small, but inspired, group of women from Doylestown, the VIA is nationally recognized as the only women's club to own and operate a community hospital. The first meeting was held April 26, 1895 with 14 women present. Since that time the VIA has grown in size and scope to its present membership of over 400 members.

BEDS*	EMPLOYEES	PHYSICIANS	INPATIENT ADMISSIONS	OUTPATIENT VISITS	EMERGENCY DEPT. VISITS
247	3,230	435	16,741	462,356	44,090

* There are an additional 90 beds at the Pine Run Health Center, 106 at Pine Run Lakeview, and 40 at the Pine Run Garden.

Doylestown Health represents a healthcare network that has delivered high quality care to its service area residents for nearly 100 years, with governance from the same organization, The Village Improvement Association of Doylestown, which has served the community for over 120 years. Doylestown Health is a community-focused healthcare network serving generations of patients and families in the northern suburban communities of Philadelphia, including Bucks and Montgomery Counties in Pennsylvania, and Hunterdon and Mercer Counties in New Jersey. Doylestown Health offers top doctors in primary, specialty, urgent, and emergent care services.

The Doylestown Health System includes:

- Doylestown Hospital
- Doylestown Hospital Outpatient Testing
- Doylestown Health Home Care and Hospice
- Doylestown Health Palliative Care
- Doylestown Health Physicians
- Doylestown Health Urgent Care
- Pine Run Retirement Community
- Pine Run Health Center
- Pine Run The Garden
- Pine Run Lakeview Personal Care
- Children's Village — Early Childhood Education

From the beginning, Doylestown Hospital was an emergency and maternity hospital and has continued that emphasis with an expanded emergency department and state-of-the-art VIA Maternity Center where more than 1,200 babies are born each year. The Carol and Louis Della Penna Pediatric Center includes inpatient and outpatient services for children.

Within the Cardiovascular and Critical Care Pavilion, the Woodall Center for Heart and Vascular Care expands the depth and scope of Doylestown Health's nationally recognized cardiovascular services and provides enhanced access to patients throughout the region.

The third floor of the Cardiovascular and Critical Care Pavilion includes the Clark Center for Critical Care Medicine. The state-of-the-art facility allows Doylestown Hospital to accommodate a higher volume of ICU/IMU patients with enhanced patient safety, privacy and comfort.

Doylestown Hospital is designated as a Stroke Resource Center by the American Heart Association and the American Stroke Association, and is also a Joint Commission-certified Primary Stroke Center.

Doylestown Health's Cancer Institute offers patients, families and caregivers access to specialists and advanced screening, diagnostic, treatment and supportive services. It is a nationally accredited Community Cancer Center by the American College of Surgeons (ACoS) Commission on Cancer.

Doylestown Health's Orthopedic Institute offers the latest proven advances in orthopedic medicine to ensure the comfort and safety of patients. On the hospital campus, the Clark Outpatient Rehabilitation Center in the Ambulatory Center offers convenient access to a variety of rehabilitation services.

Doylestown Health Physicians, the staff of employed physicians, continues to grow to meet patient needs throughout our area.

Located just a few miles from the Hospital, the Pine Run Health Center is a short and long-term health center; and even closer is Pine Run Lakeview Personal Care facility. The Pine Run retirement community offers independent living in an active setting with residential apartments and cottages.

ACCOLADES

November 2021 — Doylestown Hospital earned an eleventh consecutive "A" grade for patient safety. Doylestown Hospital received an "A" Leapfrog Hospital Safety Grade for fall 2021. This national distinction recognizes Doylestown Hospital's achievements in protecting patients from harm and error in the hospital. There are only 124 hospitals in the U.S. that have maintained an "A" grade for 11 consecutive cycles and only two in Pennsylvania.

November 2021 — Doylestown Hospital earned a Press Ganey 2021 Guardian of Excellence Award® for Patient Experience. Press Ganey recognizes Doylestown Hospital as a top-performing healthcare organization achieving the 95th percentile or above for performance in patient experience in the Emergency Department.

October 2021 — Doylestown Hospital has received the American College of Cardiology's NCDR Chest Pain—MI Registry Platinum Performance Achievement Award for 2021. Doylestown Hospital is one of only 212 hospitals nationwide to receive the honor.

September 2021 — Doylestown Hospital is ranked 8th in Pennsylvania and 142nd in the U.S. as part of Newsweek's annual list of World's Best Hospitals for 2021. This ranking improved by 2 and 31 places respectively.

August 2021 — Doylestown Hospital received the American Heart Association's Get With The Guidelines®:

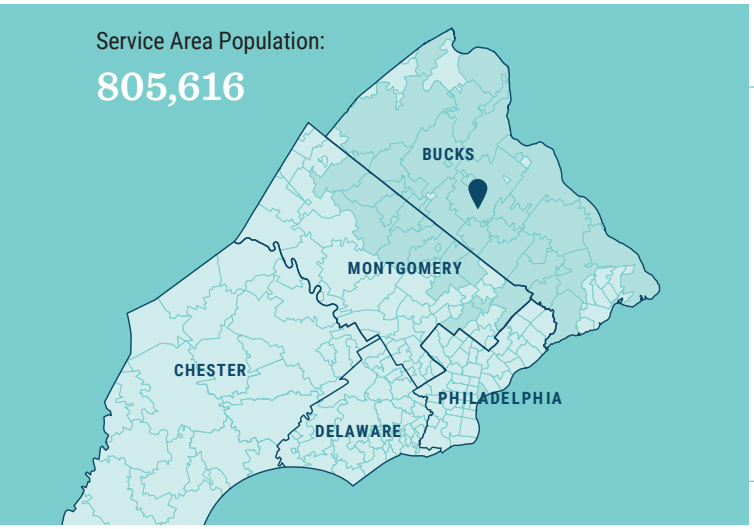
- Stroke Gold Plus Quality Achievement Award
- Heart Failure Gold Plus Quality Achievement Award and Target: Heart Failure℠ Honor Roll.
- Resuscitation (Adult) Gold Quality Achievement Award for commitment to treating in-hospital cardiac arrest, ultimately helping to improve patient survival rates.
- Mission: Lifeline® STEMI Receiving Center and NSTEMI Gold Achievement Awards for implementing specific quality improvement measures to treat patients who suffer severe heart attacks more efficiently and rapidly.

July 2021 — Doylestown Hospital is again ranked as one of the best hospitals in the region and Pennsylvania in the latest U.S. News & World Report Best Hospitals rankings. Doylestown Hospital is 6th in the Philadelphia Metro Area and 12th in Pennsylvania. Doylestown Hospital also achieved "High Performing" status for Aortic Valve Surgery; Back Surgery (Spinal Fusion); Chronic Obstructive Pulmonary Disease (COPD); Colon Cancer Surgery; Heart Attack; Heart Bypass Surgery; Heart Failure; Hip Fracture; Hip Replacement; Kidney Failure; Knee Replacement, and Stroke, in recognition of care that was significantly better than the national average, as measured by factors such as patient outcomes.

June 2021 — The American College of Cardiology recognized Doylestown Health for its demonstrated expertise and commitment in treating patients who come to an electrophysiology (EP) lab for care. Doylestown Hospital was awarded Electrophysiology Accreditation in June 2021 based on rigorous onsite evaluation of the staff's ability to evaluate, diagnose and treat patients who come to the EP lab.

AFFILIATIONS

- Penn Radiation Oncology Doylestown Hospital is a state-of-the-art facility located in The Pavilion on the hospital's campus. It serves as Bucks County's satellite location for the most advanced radiation therapies available.
- Doylestown Health Cardiology at Rockledge in Partnership with Redeemer Health
- Shriners Children's Orthopedics – Doylestown
- CHOP neonatologists/Level II Neonatal Intensive Care Nursery
- MossRehab (12-bed inpatient rehabilitation facility)
- Center for Wound Healing and Hyperbaric Medicine



TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

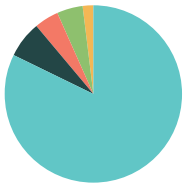
Doylestown Health defines its targeted service area for community benefit as all the ZIP codes falling with the primary, secondary, and tertiary ZIP codes for providing care and services.

Montgomery County: 18054,18915,18936, 18964, 18969, 19001, 19002, 19006, 19038, 19044, 19090, 19438, 19440, 19446, 19454

Bucks County: 18077, 18901, 18902, 18912, 18913, 18914, 18917, 18920, 18923, 18925, 18929, 18932 , 18938, 18940, 18942, 18944, 18947, 18951, 18954, 18960, 18962, 18966, 18972, 18974, 18976, 18977, 18980 , 19020 , 19047, 19053, 19067

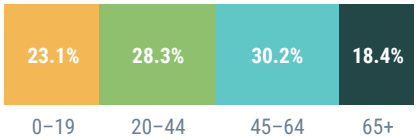
SERVICE AREA DEMOGRAPHICS

Racial Composition



6.8% | Asian*
4.5% | Black*
4.5% | Hispanic/Latino
82.3% | White*
1.9% | Other*
* Non-Hispanic

Age Distribution



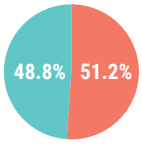
Fluency

4.5% speak English less than very well

Median Household Income

$94,338

Gender



Impact of Prior Community Health Needs Assessment and Implementation

Focus Area 1: Healthy Behaviors

1. Nutrition

- **Education** programs to increase awareness of nutrition's impact on the whole body were implemented, including a healthy meal service for Doylestown Health Associates, interactive demonstrations of healthy sugar/salt consumption amounts, seminars on healthy eating guidelines in varied community settings, and collaboration with United Way Fresh Connect Program involving Doylestown Health registered dietitians providing food, education, and recipes to families with low incomes.
- **Screening** efforts to increase awareness of metrics like waist circumference, BMI, and body fat percentage were advanced through partnerships enabling onsite screenings in community settings (e.g., satellite offices, senior centers, corporate locations, large community events).
- **Resources** in the form of expanded access to lifestyle change programs, including spreading of Doylestown Health's "A Healthy Weigh" weight management program to other sites.

2. Physical Activity

- **Education** programs to raise awareness of the connections between physical activity and health disease, mental health, and overall health and well-being were implemented in various community settings.
- Increased access to **resources** to advance physical activity by growing partnerships with organizations that focus on physical activity through community outreach and Associate Health and Wellness Program.

3. Tobacco

- **Education** initiatives focused on developing partnerships with tobacco cessation providers and exploring additional program delivery modalities beyond in-person, increasing awareness of issues such as preventing vaping among children and teens, and considering ways to incentivize family members of staff (e.g., spouse) to not smoke through the Associate Health and Wellness Program.

Focus Area 2: Mental Health

- **Educational** efforts were focused on increasing awareness of mental and behavioral health conditions and reducing stigma through expansion of the Doylestown Health Mental Health Series to more community partners and Bucks County Health Improvement Partnership Mental Health Stigma Campaign. In addition, Darkness to Light trainings were provided to schools, community organizations, and businesses to prevent child sexual abuse through support from the Beau Biden Foundation and Shoprite of Warminster. Finally, Doylestown Health partnered with Bucks County to offer QPR (question, persuade, refer) suicide prevention training to staff and the community.
- **Behavior modification** initiatives included implementing mindfulness programs to provide children and teens with stress coping mechanisms in community and school settings and growing the BCARES Warm Handoff program through emergency department (ED) and Penn Foundation to reduce recurring ED visits due to substance abuse.
- To enable connection to **resources**, use of 211 United Way was expanded to increase access to care through resource guide and community referrals and partnerships with mental and behavioral health partner in community programming and education.

Focus Area 3: Screenings

- **Education** efforts in community and business settings were increased to address the following focal areas: genetics and breast cancer/genetics and colon cancer, lung cancer, colorectal cancer, skin cancer, blood pressure, and cholesterol.
- Increased **screenings** for uninsured and underinsured populations were offered through breast cancer screenings and a free mammography program, radon screenings to reduce lung cancer risk, and colon cancer/colorectal screenings. In addition, to increase awareness of risk factors and chronic health conditions, the following were offered: blood pressure screenings, cholesterol screenings, biometric screenings in community settings for those who do not currently utilize a primary care doctor to connect them to health system for preventative care, and biometric screenings in business to promote a culture of awareness, health, and well-being.
- A colorectal cancer navigator was hired for Doylestown Health to create screening guidelines, among other key **resources**.

Focus Area 4: Older Adult Health

- **Education** efforts were focused on increasing participation and attendance for programming for older adults (addressing screenings and connecting seniors to physicians and community resources) held in community and business settings, including senior centers, senior expos, senior living facilities, Doylestown Health outreach centers, and Pine Run Retirement Community, a core partner in supporting CHNA outreach efforts.
- To reduce senior isolation, a project to focus on social interaction and health and wellness led by Doylestown Health, senior volunteers, and community partners was implemented.
- Seniors were connected with **resources** and received assistance with navigating the health system through utilization of directories, hospital internal navigators, and support resources, as well as educational programs offered in person or online.

Focus Area 5: Access to Care

New programs have been developed to:

- Increase access to care for those who are uninsured or underinsured, including piloting a platform utilized by Doylestown Health Cancer Navigators to assist cancer patients in accessing transportation for visits and follow-up appointments.
- Increase access to education and screening events by utilizing technology such as interactive webinars, one-on-one phone calls, and health coaching.
- Increase access to primary care and specialty care/follow-up visits by partnering with the township and county.
- Develop collective community partnerships focused on increasing transportation, such as partnering with United Way 211 platform to build out the referral network for community resources.

GVH GRAND VIEW HEALTH

Grand View Health

True to its mission of **leading the community to a healthier future**, Grand View Health provides exceptional care to residents of Bucks and Montgomery Counties. Grand View offers a wide array of inpatient and outpatient services, with specialized expertise in bariatrics, cancer care, cardiology maternity, neurosurgery, orthopedic surgery, women's and children's health, and post-acute care.

In September 2021, the system's flagship location, Grand View Hospital, earned accreditation from the Pennsylvania Trauma Systems Foundation as a Level II Adult Trauma Center, making it possible to deliver lifesaving critical care to the community close to home. The organization is part of the Penn Trauma Network.

Grand View Health has a strategic alliance with Penn Medicine that complements the quality of care delivered across multiple disciplines including orthopedics and cancer. In November 2021, the relationship expanded to include tele stroke emergency consults with Penn Medicine neurologists, and in February 2022, Grand View patients will have access to tele neurology consults as well.

Grand View Health is adding services and opening new facilities to meet the growing demands of the community and accommodate new healthcare technologies. A 190,000-square-foot expansion of Grand View Hospital, scheduled for completion in 2023, will include 52 new patient rooms, a new Emergency Department with 28 treatment rooms and two trauma bays, 10 new operating rooms including four hybrid ORs and a new cardiac catheterization laboratory and diagnostic imaging technology.

BEDS	EMPLOYEES	PHYSICIANS	INPATIENT ADMISSIONS	OUTPATIENT VISITS	EMERGENCY DEPT. VISITS
169	1,800	400	9,740	152,777	26,035

Recognized for excellence- chosen for caring.

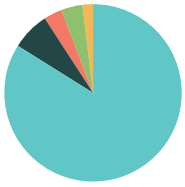
Grand View Health also operates seven outpatient locations in Bucks and Montgomery Counties, many of which offer early morning, evening and weekend hours to make care convenient and highly accessible. The Dublin Outpatient Center opened in October 2021 and the Pennsburg outpatient center opened in August of 2020. The Center for Orthopedics and Neurosurgery is a 12,000-square-foot destination which opened in July 2020. This state-of-the-art center offers patients an extensive array of services, including sports medicine, neurosurgery, and orthopedics experts, physiatry, athletic training and physical therapy, all in one convenient location.

The hospital's cardiology program received the American/Heart/American Stroke Association's Get With the Guidelines® Heart Failure and Afib Gold Plus Quality Achievement Awards in 2021, while the stroke program, designated a Primary Stroke Center by the American Heart Association and Joint Commission, received Silver Plus recognition for 2021. Grand View's PCI program lab received reaccreditation by Corazon in November 2021.

A CHOP pediatrician is always available on site at Grand View Hospital, allowing access to high quality pediatric and neonatal care.

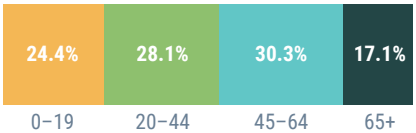
SERVICE AREA DEMOGRAPHICS

Racial Composition



6.9% | Asian*
3.5% | Black*
3.9% | Hispanic/Latino
84.0% | White*
1.7% | Other*
* Non-Hispanic

Age Distribution



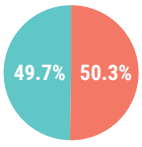
Fluency

3.2% speak English less than very well

Median Household Income

$88,286

Gender



Impact of Prior Community Health Needs Assessment and Implementation

Grand View Health's 2019 Community Health Needs Assessment identified the following health issues in the community:

1. Behavioral Health Diagnosis and Treatment
2. Substance/Opioid Abuse
3. Chronic Disease Prevention
4. Healthcare and Health Resources Navigation

1. Behavioral Health Diagnosis and Treatment

Suicide risk assessments and depression screening are completed in the ED, inpatient acute care, and maternal/child health and home care with referrals to appropriate agencies. Primary care practices screen for depression with referrals to nurses, social workers, mobile crisis, ED, or Penn Foundation.

Grand View Health's objectives in meeting this need included increasing access to behavioral health services through continued development and growth of community partnerships across the healthcare continuum. Additionally, Grand View provides crisis workers from 7a-1130p in the Emergency Room (ER) 7 days per week. Clinicians have access to a Tele Psych robot to support the care of the behavioral health patient in the ER and inpatient areas.

2. Substance/opioid abuse

Grand View Health partners with outside agencies and services to increase patient and community access to substance abuse disorder services for recovery and ongoing treatment. Additionally, the hospital's Opioid Stewardship Committee collaborates with The Hospital and Healthsystem Association of Pennsylvania to create initiatives to reduce the prescribing and administering of opioids for inpatient and outpatient care.

3. Chronic Disease Prevention and Healthcare and Health Resource Navigation

Grand View health objectives to meet this need include increasing awareness of the prevention of chronic diseases through healthy lifestyle choices with a combination of education and community outreach. Additionally, Grand View Health developed community health resource directories to provide more information about services available to patients and community for caregivers and providers to utilize for patient referrals.

Overall, the health needs identified by the CHNA and prioritized by Grand View Health and community stakeholders are being addressed and will continue to be addressed with the incremental resources, outreach and resources of our Trauma program and the completion of the new Pavilion as well as all of the existing services and partnerships in which the GVH health system is engaged.

TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

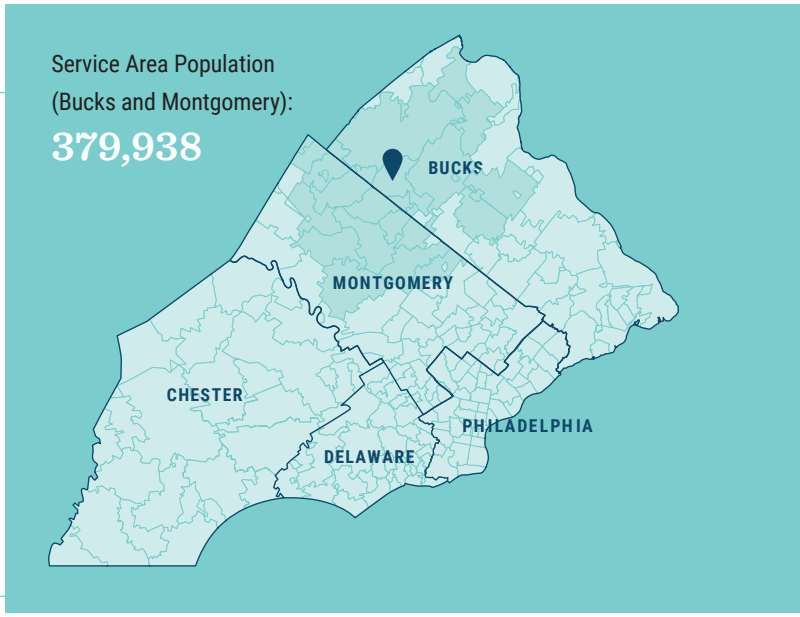
Grand View defines its service area as the following ZIP codes within Bucks and Montgomery counties, which represent the primary and secondary capture areas for the hospital. Additional ZIP codes in Lehigh (18036) and Berks (19504) counties are also part of the Grand View service area and comprise an additional 18,938 residents.

Bucks County: 18901, 18902, 18917, 18923, 18930, 18932, 18942, 18944, 18951, 18955, 18960

Montgomery County: 18041, 18054, 18070, 18073, 18074, 18076, 18964, 18969, 19426, 19438, 19440, 19446, 19454, 19473

Lehigh County: 18036

Berks County: 19504



Jefferson Health

MISSION

We Improve Lives.

VISION

Reimagining health, education and discovery to create unparalleled value.

VALUES

Jefferson Health's values define who we are as an organization, what we stand for and how we continue the work of helping others that began here nearly two centuries ago. These values are:

Put People First:
Service-Minded, Respectful & Embraces Diversity

Be Bold & Think Differently:
Innovative, Courageous & Solution-Oriented

Do the Right Thing:
Safety-Focused, Integrity & Accountability

Jefferson Health, in partnership with Thomas Jefferson University, is dedicated to discovering new treatments and therapies that will define the future of clinical care; providing exceptional primary through complex quaternary care to patients in the communities we serve throughout the Delaware Valley; and educating tomorrow's professionals through transdisciplinary and experiential learning designed for new and emerging fields for the 21st century.

Jefferson Health includes 18 hospitals throughout southeastern Pennsylvania and southern New Jersey. They are: Einstein Medical Center Elkins Park, Einstein Medical Center Montgomery, Einstein Medical Center Philadelphia, Jefferson Abington Hospital, Jefferson Bucks Hospital, Jefferson Cherry Hill Hospital, Jefferson Frankford Hospital, Jefferson Hospital for Neuroscience, Jefferson Lansdale Hospital, Jefferson Methodist Hospital, Jefferson Stratford Hospital, Jefferson Torresdale Hospital, Jefferson Washington Township Hospital, Magee Rehabilitation Hospital, MossRehab, Physicians Care Surgical Hospital, Rothman Orthopaedic Specialty Hospital and Thomas Jefferson University Hospital.

In 2021, Jefferson Health finalized its ownership of Health Partners Plans (HPP), a health maintenance organization that provides CHIP, Medicare Advantage and Dual Eligible Special Needs plans, and a nationally recognized Medicaid plan. Through HPP, Jefferson can continue to advance its value-based care model while reducing costs of healthcare services, particularly among underserved patients and families of the greater Philadelphia region.

Combined, Jefferson Health and Thomas Jefferson University have more than 42,000 employees, which includes nearly 3,500 employed physicians/advanced practice professionals, 9,500 full and part-time nurses and more than 1,900 full and part-time paid faculty. Jefferson is the second largest employer in Philadelphia and the largest health system in Philadelphia based on total licensed beds. Jefferson Health includes over 50 outpatient and urgent care centers; 10 Magnet®-designated hospitals; the NCI-designated Sidney Kimmel Cancer Center; and one of the largest faculty-based telehealth networks in the country that began more than 10 years ago.

Thomas Jefferson University Hospital is one of only 14 hospitals in the country that is a Level 1 Trauma Center and a federally designated Regional Spinal Cord Injury Center.

In 2021, Jefferson Health earned *Digital Health Most Wired* recognition from the College of Healthcare Information Management Executives (CHIME). Jefferson scored in the top 5% of all participating organizations, earning recognition for its technology advancements in acute care, ambulatory care and long-term care.

Also in 2021, nearly 600 Jefferson physicians were named among the region's best by Castle Connolly in *Philadelphia* magazine's 2021 Top Docs™ issue.

COVID-19 Response

Jefferson was able to treat more than 16,000 COVID-19 inpatients — ranking it as the busiest care provider in the Philadelphia region battling this global pandemic. Jefferson was the first health system in the Philadelphia region to institute universal masking guidelines, and at the peak of COVID-19, its infection rate among frontline staff was roughly 1% — a testament to the effectiveness of its safety protocols and the relentless commitment to sourcing adequate supplies of personal protective equipment for staff. This in turn translated to protecting thousands of patients from COVID-19 exposure.

Jefferson was also among the first in the region to arrange external Emergency Department triage tents and mobile-testing sites to keep patient screenings for COVID-19 outside of its hospitals. In parallel, Jefferson, with the largest faculty-based telehealth network in the country, treated more than 500,000 patients virtually throughout the pandemic — keeping both patients and physicians safe. Jefferson Health and the City of Philadelphia also worked closely together to open a COVID-19 testing site in Northwest Philadelphia to offer free, twice-weekly testing throughout the peak of the pandemic.

When the COVID-19 vaccine became available, Jefferson Health assembled a multidisciplinary COVID-19 Vaccine Task Force that worked tirelessly to develop its Real Talk Initiative and Trusted Messenger program to spread accurate and up-to-date information about the vaccine, particularly to Black and Brown communities that had concerns about the vaccine and mistrust of the medical and scientific community. In tandem, Jefferson initiated a mobile community vaccination program that has administered more than 5,200 vaccines in marginalized communities. More than 92% are people of color and 47% non-English speaking.

In the Community

In FY20 Jefferson Health contributed more than $448 million in charitable care and community benefit. Among Jefferson's many efforts in this area is the work of the Jefferson Collaborative for Health Equity (the Collaborative), the community outreach and engagement arm of Jefferson Health charged with addressing the social and structural determinants of health in Philadelphia. Aligned with the CHNA and CHIP, the Collaborative partners with internal and external stakeholders to address the complex issues facing our communities by aligning resources, building partnerships, and forging trust and relationships that create sustainable change. The Collaborative builds on community strength to improve health and well-being in communities, fostering the local Ecosystem necessary to promote health equity and help every family in our targeted communities reach their full potential.

In 2020, Jefferson, in partnership with Temple, launched The Frazier Family Coalition for Stroke Education and Prevention, which is coordinated through the Collaborative to promote the health of North Philadelphia residents through a multifaceted program aimed at reducing the number of strokes. With its office located in the lowest-income zip code in the city, the coalition is countering the lack of access to providers, unmanaged chronic disease, and limited awareness of risk factors that has allowed the rate of stroke to swell in North Philadelphia.

Jefferson and Novartis also initiated a program called "Closing the Gap" to focus on reducing cardiac health disparities across the city's most vulnerable zip codes. Addressing social determinants of health, the program heavily utilizes Community Health Workers to screen, identify, and navigate individuals at high-risk for cardiovascular disease to the care and preventative services they need. The Jefferson Center for Connected Care was also launched to develop and test innovative approaches for a patient-responsive care delivery system. As part of its Reimagine fundraising campaign, Jefferson has set a goal of raising $100 million for health equity initiatives in the greater Philadelphia region.

Jefferson is one of the largest providers in Philadelphia for refugee health care and is one of only four programs in the nation recognized by the Centers for Disease Control and Prevention as a Center of Excellence. In addition to its Center for Refugee Health, Jefferson opened the Hansjörg Wyss Wellness Center in 2021. The Center brings free medical and social services to immigrant and refugee communities. In the fall of 2021, Jefferson and other providers supported an extensive volunteer medical operation at the airport for Afghan evacuees. They offered urgent medical care for 1,600 on site, while providing family-centered testing and vaccinations.

Einstein Medical Center Montgomery

Einstein Medical Center Montgomery (Einstein Montgomery) is a tertiary care medical center located in East Norriton, Montgomery County. Einstein Montgomery opened in September 2012 as part of the Einstein Healthcare Network, a non-profit healthcare organization. As of October 2021 it is part of Jefferson Health.

Einstein Montgomery offers a wide range of healthcare programs and services, from complex care requiring advanced technology and expertise, to preventive medicine and community outreach initiatives. Einstein cares for each person regardless of ability to pay, race, religion or national origin, and recognizes its responsibility to use its resources to elevate the health status of the communities it serves. In addition to Thomas Jefferson University, Einstein Healthcare Network has academic associations with several colleges and universities in the Philadelphia area, including Gwynedd Mercy University, Montgomery County Community College, Philadelphia College of Osteopathic Medicine, University of Pennsylvania and Villanova University.

In July 2019 Einstein Montgomery implemented its first residency programs in family medicine and vascular surgery - the first of many residency programs to transform Einstein Montgomery into a teaching hospital. Anticipated expansion includes emergency medicine, internal medicine, radiology, physical and rehabilitation as well as hospice and palliative care.

BEDS	EMPLOYEES	EMPLOYED PHYSICIANS	ADVANCED PRACTICE PROFESSIONALS	INPATIENT ADMISSIONS	OUTPATIENT VISITS	EMERGENCY DEPT. VISITS
195	1,930	56	44	11,718	188,920	36,643*

**FY21 Statistics*

Einstein Montgomery operates one of the most experienced labor and delivery programs in the region. The hospital employs a unique model of doctors working in close collaboration with midwives, maintains low Cesarean section rates, and hosts a Level III Neonatal Intensive Care Unit (NICU) staffed by neonatologists from Children's Hospital of Philadelphia. Our Women's Resource Center provides a wide range of classes and services making care accessible and flexible. Services include lactation consultation and wellness programs along with prenatal/postpartum group support.

Cancer care at Einstein aims to treat the whole person. From patient navigators to guide the process and coordinate care, to pain management, support groups, rehabilitation, counseling and more. Our Cancer Awareness Program is accredited by the Commission on Cancer, has received the American Cancer Society's Cancer Control Award, and the American Society of Clinical Oncology has recognized our cancer program for improving care through high-quality clinical trials.

Einstein's breast health program includes a team of surgeons, medical oncologists, radiation oncologists, pathologists, radiologists and nurse navigators who work together to deliver exceptional, personalized care. Our breast health program is accredited by the National Accreditation Program for Breast Centers, a program of the American College of Surgeons. Einstein Montgomery's Breast Health Program is also an accredited Breast Imaging Center of Excellence by the American College of Radiology. Einstein partnered with Solis Mammography to bring patient-centered breast screening services to the community.

Einstein Montgomery has been the recipient of many awards and accolades. We are a Certified Chest Pain Center by the Society of Cardiovascular Patient Care with the American College of Cardiology. We also received the American Heart Association/ American Stroke Association's *Get with the Guidelines®-Stroke Gold Plus With Honor Role Elite Award*. The Joint Commission also awarded their *Gold Seal of Approval®* to Einstein Montgomery's Hip and Knee Joint Replacement Program. Healthgrades published its Specialty Excellence Awards recognizing facilities for top line joint replacement and includes Einstein Montgomery.

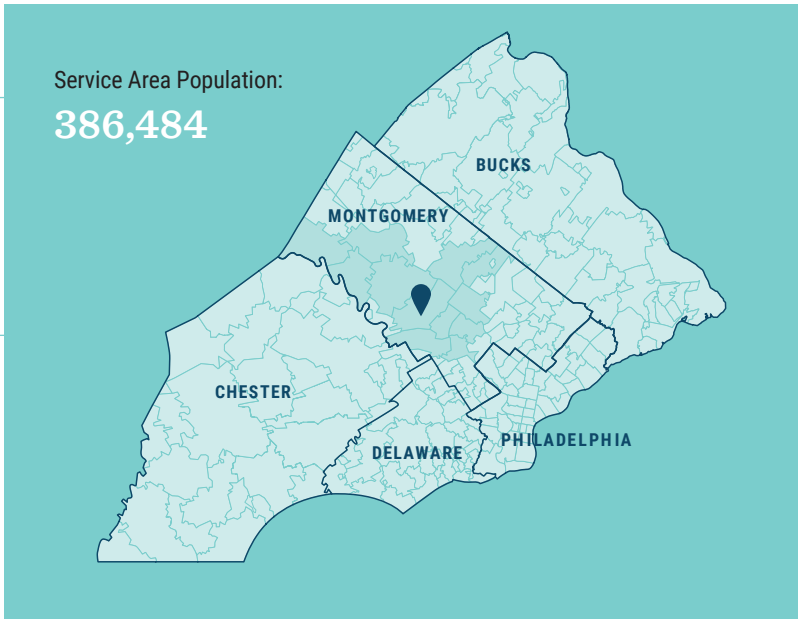
Einstein Montgomery is also designated as a Center of Excellence in Bariatric Surgery by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program. The hospital earned the *2022 Women's Choice Awards* in: Bariatric Surgery; Heart Care; Orthopedics; Cancer Care; Comprehensive Breast Care; Women's Services; and Mammogram Imaging Center. Other accolades include a *Medication Safety Award* from the Institute for Safe Medication Practices for developing a screening tool to prevent respiratory arrest for patients receiving opioids as part of their treatment.

Einstein is a member of the Healthcare Anchor Network, a group of 70+ healthcare systems nationwide that is committed to intentionally applying our institution's long-term, place-based economic power and human capital in partnership with the community to mutually benefit the long-term well-being of both. Einstein's educational commitment includes providing health education to the community, and training and educating medical school students, graduate and practicing physicians, and other healthcare professionals. Einstein also supports clinical research for the purpose of enhancing the quality of patient care and advancing the science of medicine.

TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

Einstein Montgomery defines its targeted service area for community benefit by the following ZIP codes that represent 80 percent of inpatient discharges and outpatient cases.

Montgomery County: 19401, 19403, 19405, 19406, 19422, 19426, 19428, 19446, 19454, 19462, 19464, 19468, 19473



Impact of Prior Community Health Needs Assessment and Implementation

Einstein Montgomery continues to address unmet needs in the county by increasing access to care and expanding its reach. The 2019 implementation plan focused on making access to preventive health services and health care more convenient and easier to navigate. As a result of the Community Health Needs Assessment, Einstein focused the priority health needs across three domains:

1. **Heath Issues –** Physical and behavioral health issues that impact the health and well-being of a community.
2. **Access and Quality of Health Care and Health Resources**
3. **Community Factors –** Social and economic drivers that influence opportunity and daily living.

As a patient-centered medical home, Einstein adheres to quality measures including health screenings aimed to prevent chronic conditions such as hypertension, diabetes and cardiovascular disease as well as to detect various cancers. Einstein Montgomery supports community efforts to promote a healthy lifestyle and provides expertise through health screenings, health risk assessments and education in the community.

Einstein also provides several programs to minimize the health risks associated with tobacco use. Free smoking cessation classes are provided quarterly and include development of culturally relevant, multilingual education materials. We continue to partner with the American Cancer Society to provide community resources for those preparing to quit or recently completing a cessation course.

Einstein is committed to mitigating circumstances that lead to infant mortality through evidence-based best practice in maternity care. The Nurse-Family Partnership is a community-based program serving low income, first-time pregnant women. Clients are assigned a highly trained nurse who provides home visiting and one-to-one guidance during pregnancy and through the child's second birthday. With over forty years of evidence, the Nurse-Family Partnership program follows model elements that support improved birth outcomes, child health and development and economic self-sufficiency. Neonatologists at Einstein Montgomery are leading a multidisciplinary team to examine best practices surrounding Neonatal Abstinence Syndrome (NAS). The team focuses on building relationships with parents, including prenatal outreach and support post discharge. They work closely with Montgomery County's Office of Children and Youth's Plan of Safe Care initiative.

To make healthcare services more accessible, Einstein has implemented many of the proposed solutions from the CHNA and continues to collaborate internally to improve quality care. Tactics include online appointment scheduling, extended appointment hours, and telehealth care coordination.

Einstein provides patient navigation and case management for many chronic conditions and high-burden diseases such as cancer, orthopedics and cardiac care. The Patient Advocates at Einstein provide guidance on issues about access to healthcare services, medical bills or other challenges related to care. Patient Advocates can also help patients and visitors understand Einstein policies, patient rights and responsibilities. Navigation covers physical, psychosocial and economic issues of clinical care, beyond the diagnosis and treatment phases. Financial Counselors are available to assist in applying for public medical assistance, charity care or to help with special circumstances arising from hospitalizations.

Einstein remains committed to improving relationships with community leaders who represent culturally diverse populations and helps bridge gaps in care that may include issues such as health literacy, cultural sensitivity and alternative approaches to accessing services. To better serve the community, Einstein developed multi-language initiatives with program highlights including:

- **Reducing pediatric visits to the Emergency Department –** Pilot program for Latino families to receive group education on when to seek primary care vs emergency care.
- **Baby's First Book –** In partnership with the North Wales Area Library, all babies born at Einstein Montgomery receive a book through the One Book, Every Young Child initiative by the Pennsylvania Department of Education. Multilingual books are available.
- **Community Health Initiatives –** Our ongoing support of community health initiatives include: The International Spring Festival in the North Penn area, Bharatiya Temple's annual healthy heart event, ACLAMO's Family Day, the Korean wellness event in partnership with the Jaisohn Center.

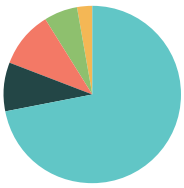
Einstein recognizes that significant population health improvement requires attention to factors beyond clinical care, and continues to address social determinants of health through point of care screenings and community resource development. Care managers work closely with local community resources for food access, housing insecurity and domestic violence. Through partnerships with local agencies, Einstein has also implemented workforce development initiatives that foster career exploration and job readiness. Staff participate in professional development workshops and co-op opportunities with the local vocational schools to provide on the job training and skill development.

Einstein Montgomery was designed to provide a natural healing environment. Located on an 87-acre campus, the award-winning design includes a half-acre healing garden near the main entrance that offers patients and visitors a restful space for conversation and meditation. In Norristown, the Nicholas and Athena Karabots Medical Building houses a produce garden that yields over 500 lbs of fresh produce annually. Garden beds are maintained by Einstein staff and the produce is distributed in the patient waiting rooms. Each year, Einstein Montgomery hosts A Walk Through the Park, an event with proceeds that directly benefit patient needs for cancer care including financial navigation, supportive care and wellness initiatives.

We work collaboratively to explore strategies that promote healthy housing and alleviate homelessness through the existing work initiated by the HealthSpark Foundation's Resiliency Initiative and the Bucks-Mont Collaborative. Einstein continues to leverage internal resources to support local efforts for the health and safety of our homeless population including supplying blankets and hygiene products as well as environmental cleanup efforts within the community.

SERVICE AREA DEMOGRAPHICS

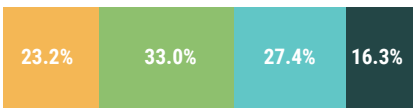
Racial Composition



8.9% | Asian*
10.3% | Black*
6.1% | Hispanic/Latino
72.0% | White*
2.6% | Other*

* Non-Hispanic

Age Distribution



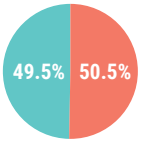
Fluency

4.9% speak English less than very well

Median Household Income

$89,830

Gender



Einstein Medical Center Philadelphia

The Jewish Hospital opened its doors to patients in 1866 in a 22-bed farmhouse in West Philadelphia. These words appeared over the entrance of the Jewish Hospital when it opened: "Dedicated to the relief of the sick and wounded without regard to creed, color or nationality." This credo was groundbreaking for the time, assuring Jewish Civil War veterans, freed slaves, women and children, rich and poor, that they could rely on the hospital for outstanding medical care delivered with compassion and without discrimination. That commitment remains at the heart of Einstein today and remains its guiding principle.

What started as the Jewish Hospital grew to become Einstein Healthcare Network (EHN), a leading, non-profit healthcare system made up of Einstein Medical Center Philadelphia (EMCP), Einstein Medical Center Elkins Park (EMCEP), Einstein Medical Center Montgomery, MossRehab (a provider of comprehensive rehabilitation services), Willowcrest (named one of the best nursing homes in Philadelphia for short-term rehabilitation care by *U.S. News & World Report*), multiple outpatient care centers, and dozens of physician practices throughout Philadelphia and Montgomery Counties. In October 2021 the Einstein Healthcare Network became part of Jefferson Health.

EMCP is a community-based academic medical center situated in North Philadelphia, serving a diverse and disadvantaged population. It also includes EMCEP and MossRehab. EMCP is considered a private healthcare safety-net hospital, bearing a large share of responsibility for caring for the poor as measured by service to Medicaid, Medicare SSI, and uninsured patients.

EINSTEIN MEDICAL CENTER PHILADELPHIA

BEDS	EMPLOYEES	EMPLOYED PHYSICIANS	ADVANCED PRACTICE PROFESSIONALS	INPATIENT ADMISSIONS	OUTPATIENT VISITS	EMERGENCY DEPT. VISITS
782*	6,557	416	198	37,904	1,912,015	134,981**

** Includes Moss Rehab and Willowcrest **FY21 Statistics*

Services include: a full-service maternity unit with a Level III Neonatal Intensive Care Unit; a Level One Trauma Center; advanced heart care, including cardiac catheterization, open heart surgery, and electrophysiology intervention; cutting-edge cancer care; orthopedics and bariatric surgery. Primary care services are provided by Einstein Physicians, a network of physicians, nurses and healthcare specialists dedicated to serving patients throughout every stage of life

EMCP is a tertiary care teaching hospital providing training for more than 450 residents in 35 accredited programs, as well as 800 rotating students from local medical schools. The hospital has established relationships with eight area schools of nursing and provides clinical training for almost 1,400 nursing students each year. EMCP trains more than 3,500 health professional students each year.

EMCEP is a full service medical and surgical specialty hospital. Robotic surgery for urologic and gynecologic procedures and minimally invasive spine and joint replacement surgery. Services include Einstein Bariatrics®, radiology, cardiology, neurology, ophthalmology, neuro-ophthalmology, and more.

EMCP handles many of the area's deliveries, averaging 3,000 births per year. Einstein remains committed to improving perinatal outcomes and the health of infants and toddlers living in the community it serves. To that end, EMCP launched CenteringPregnancy in 2012 and CenteringParenting in 2014. Both programs are models of group care that integrate health assessment, education, and support. Currently, Einstein has the largest CenteringParenting program in the country. EMCP's dedication to obstetrical care has resulted in designation as a Blue Distinction Center for Maternity Care by Independence Blue Cross. EMCP earned designation as a Baby-Friendly birth facility (2019-2023) by the World Health Organization and the United National Fund for providing the best infant care and feeding practices to mothers and babies.

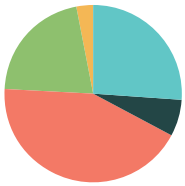
Families Understanding Nutrition (FUN) is a collaborative partnership between Einstein and more than 45 agencies, including the School District of Philadelphia, the Free Library of Philadelphia, and the Montgomery County Intermediate Unit, to provide general nutrition education to low-income families. EMCP provides nutrition education to SNAP-eligible families, primarily focusing on the Head Start and Bright Futures programs.

MossRehab is a national and international leader in rehabilitation medicine, ranked the number one rehabilitation hospital in the region and number nine in the nation by *U.S. News & World Report*. MossRehab provides inpatient and outpatient rehabilitation for stroke and neurological disorders, spinal cord injury, traumatic brain injury, amputation, orthopedic and other conditions. Treatment is personalized and can include physical, occupational, and speech therapy, as well as maintenance and support programs to re-establish independence.

MossRehab offers rehabilitation robotics, helping patients to rehabilitate and transition through inpatient and outpatient care. MossRehab operates six inpatient units and 15 outpatient locations in Philadelphia, Montgomery and lower Bucks counties, as well as in New Jersey and Delaware.

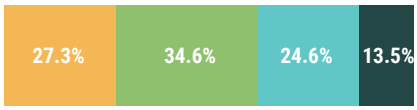
SERVICE AREA DEMOGRAPHICS

Racial Composition



6.6% | Asian*
43.1% | Black*
21.3% | Hispanic/Latino
26.3% | White*
2.8% | Other*
* Non-Hispanic

Age Distribution



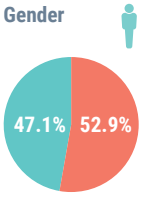
Fluency

13.0% speak English less than very well

Median Household Income

$44,006

Gender



Additionally, MossRehab houses the Moss Rehabilitation Research Institute which aims to develop groundbreaking research with rapid translation to clinical application. In acknowledgment of its expertise in the field of spinal cord injuries, MossRehab was selected to partner with the National Spinal Cord Injury Association to create the Philadelphia Chapter of the National Spinal Cord Injury Association, the first hospital-based chapter in the country.

Einstein's Center for Organ Disease and Transplantation is an established leader in kidney, liver and pancreatic transplantation in the Philadelphia region. The center is staffed by physicians and surgeons specializing in nephrology, hepatology and organ transplantation. These team members work closely with patients, families and referring physicians to best manage a patient's individual treatment. Einstein also offers the latest technology, medications and interventions for kidney, liver and pancreatic disease.

Cancer care at Einstein is about more than just treating the cancer — it's about treating the whole person. From navigators to help patients through the process and coordinate their care, to pain management, support groups, rehabilitation, counseling and more. Einstein's Cancer Awareness Program is accredited by the Commission on Cancer, has received the American Cancer Society's *Cancer Control Award*, and the American Society of Clinical Oncology has recognized Einstein's cancer program for improving care through high-quality clinical trials. Along with top doctors and a full range of support services for patients and their families, it's why our outcomes beat national averages in every type of cancer we treat. Using state-of-the-art diagnostic tools and treatments, cancer specialists develop highly personalized treatment plans to help patients overcome their cancer. Treatment may include highly advanced radiation therapy treatments using a Varian TrueBeam® or Varian Trilogy® linear accelerator, the latest in minimally invasive surgical techniques, and some of the most cutting-edge experimental cancer therapies available anywhere, through a variety of clinical trials.

Among the many accolades EMCP achieved, its Cancer Program was accredited by the Commission on Cancer of the American College of Surgeons. EMCP is also a Breast Imaging Center of Excellence as designated by the American College of Radiology and accredited by the National Accreditation Program for Breast Centers by the American College of Surgeons.

EMCP also earned the American Stroke Association's *Stroke Gold Plus and Honor Roll Elite and Target: Type 2 Diabetes Honor Roll*, an *Advanced Therapy Quality Achievement Award* for adherence to standards of care for stroke patients which speeds recovery and saves lives. EMCP is the first hospital in PA and one of only a few in the country to earn The Joint Commission's advanced certification as a Thrombectomy-Capable Stroke Center in collaboration with the American Heart Association/American Stroke Association. The certification signifies that the hospital meets rigorous standards for performing mechanical endovascular thrombectomy, a surgical procedure used to remove a blood clot from the brain during an ischemic stroke.

EMCP and EMCEP both received *Independence Blue Cross Center of Excellence/Blue Distinction* recognition in several areas. EMCP has been designated a Blue Distinction Center for Spine Surgery and both EMCP and EMCEP were acknowledged for Hip & Knee Surgery and Bariatrics.

Impact of Prior Community Health Needs Assessment and Implementation

A Community Health Needs Assessment (CHNA) was performed in the fall of 2019 to determine the health status and healthcare needs of residents in the Einstein Medical Center Philadelphia and Einstein Medical Center Elkins Park service areas. As a result of this CHNA, EMCP/EMCEP adopted strategies to address the following needs:

- Early prenatal care to reduce infant mortality through implementation of CenteringPregnancy® and a CenteringParenting® programs and Baby Friendly Designation.
- Primary care for low-income adults through the Einstein Community Health Associates primary care network.
- Prescriptions for older adults and low-income populations through Einstein's 340B program.
- Mental health treatment through Einstein's two adult inpatient units, the Outpatient Center, the Community Practice Center and the Crisis Response Center.
- Behavioral health treatment for school-age children through our school-based student assistance programs.
- Services addressing activities of daily living limitations among older adults through multiple programs at MossRehab that include Moss Muscle Builders, arthritis support services, program for individuals with mobility disorders, fall risk assessments and navigation programs for Multiple Sclerosis and Parkinson's diseases.

Einstein's educational commitment includes providing health education to the community, and training and educating medical school students, graduate and practicing physicians, and other healthcare professionals. Einstein also supports clinical research for the purpose of enhancing the quality of patient care and advancing the science of medicine.

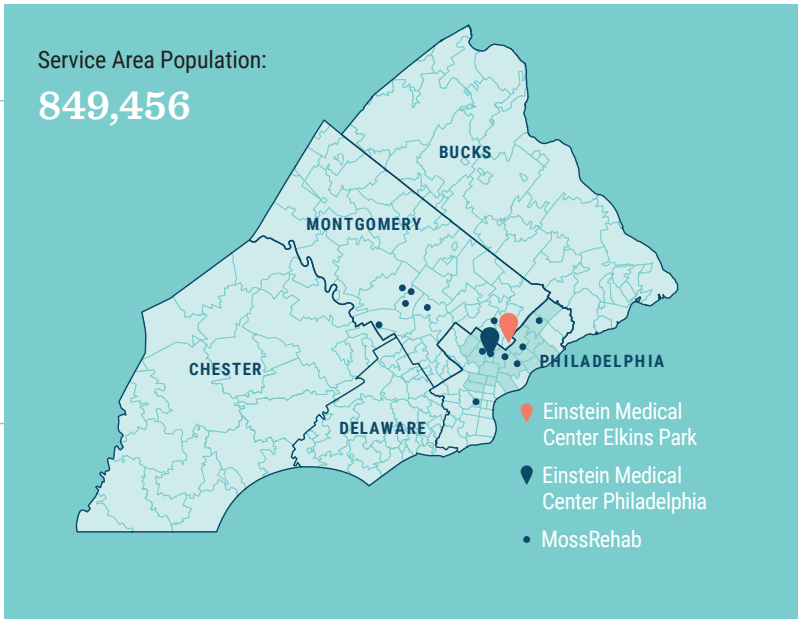
With growing recognition that significant population health improvement requires attention to factors beyond clinical care, Einstein is exploring approaches to identifying and addressing non-medical determinants of health. Such efforts are especially critical in Philadelphia, where high rates of poverty, chronic disease, and obesity persist. Einstein is actively working to implement programs and partnerships to address food insecurity, economic development, education and housing.

TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

Einstein Medical Center Philadelphia defines its targeted service area for community benefit as ZIP codes that represent 75 percent of inpatient discharges and outpatient cases.

Philadelphia County: 19111, 19115, 19116, 19119, 19120, 19121, 19124, 19126, 19132, 19133, 19134, 19135, 19136, 19138, 19140, 19141, 19144, 19149, 19150, 19152

Montgomery County: 19027



Jefferson Abington Hospital

Jefferson Abington Hospital is a regional referral center and teaching hospital located in Abington, Montgomery County, and has served the residents of Bucks and Montgomery counties for over 100 years. Jefferson Abington Hospital offers comprehensive healthcare services at a level not often found in a community hospital, including advanced robotic and minimally invasive surgical techniques, neurovascular care, a Level III neonatal intensive care unit and more. Additional services and specialties include: primary care, obstetrics and gynecology, cardiovascular, orthopaedic and spine, neuroscience, metabolic and bariatric surgery, senior health and more.

Jefferson Abington Hospital, part of Jefferson Health, is committed to improving lives and providing high quality, compassionate care that is easily accessible to the community. The commitment to providing accessible care during the COVID-19 pandemic is what led the hospital to launch a COVID-19 Community Testing Site in March 2020 - the first of its kind in the Philadelphia area.

In 2019, the hospital opened its newest outpatient health center located in Horsham, Montgomery County. Jefferson Health – Horsham is the seventh outpatient facility of its kind that the organization operates in Montgomery and Bucks counties. The 20,000 square-foot, state-of-the-art facility includes three medical practices and a full service laboratory on site.

Also in 2019, Jefferson Health – Abington partnered with Nemours Children's Health to provide pediatric services to infants, children and adolescents of Bucks and Montgomery counties. Through this collaboration, Nemours pediatric hospitalists provide advanced medical care for children in Jefferson Abington Hospital's 15-bed pediatric unit, pediatric consultations in the hospital's Emergency Trauma Center and more.

JEFFERSON ABINGTON HOSPITAL

BEDS	EMPLOYEES	EMPLOYED PHYSICIANS	ADVANCED PRACTICE PROFESSIONALS	INPATIENT ADMISSIONS	OUTPATIENT VISITS	EMERGENCY DEPT. VISITS
655	5,692	273	140	30,837	1,188,500	76,672*

**FY21 Statistics*

In addition to this collaboration, as a major regional teaching facility, Jefferson Abington Hospital also maintains associations with Philadelphia College of Osteopathic Medicine and Sidney Kimmel Medical College at Thomas Jefferson University.

In FY20 and FY21, Jefferson Abington Hospital received numerous awards and accolades for high quality patient care, excellence and safety, including recognition from the Institute for Healthcare Improvement as an *Age-Friendly Health System* (2019). Age-Friendly Health Systems work to implement a set of evidence-based interventions specifically designed to improve care for older adults.

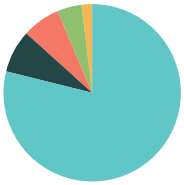
In the area of maternity care, Jefferson Abington Hospital was named to *Newsweek*'s 2020 list of "Best Maternity Care Hospitals," one of fewer than 250 hospitals nationwide to receive this honor. In addition, the Hospital and Healthsystem Association of Pennsylvania (HAP) awarded Jefferson Abington Hospital the *2020 Excellence in Care Achievement Award*, one of three awards the hospital's maternity program earned for its work to reduce opioid use among women who give birth by cesarean section.

In FY21, Jefferson Abington Hospital earned the *Mission: Lifeline-STEMI Receiving Center – Gold Plus Quality Achievement Award* from the American Heart Association for applying the most up-to-date evidence-based treatment guidelines to improve patient care and outcomes in the community. The Hospital was also granted the American Heart Association/American Stroke Association's *Get with the Guidelines Stroke Gold Plus* with *Target: Stroke Elite Honor Roll* and *Target: Type 2 Diabetes Honor Roll* designations.

Jefferson Abington Hospital was ranked seventh in the Philadelphia region and thirteenth in the state in *U.S. News & World Report*'s annual "Best Hospitals" ranking in 2021. The Hospital scored high-performing in 10 categories: aortic valve surgery, congestive heart failure, colon cancer surgery, chronic obstructive pulmonary disease, diabetes, heart attack, hip replacement, knee replacement, kidney failure and stroke. Additionally, Jefferson Abington Hospital was rated high performing in one specialty area: Diabetes & Endocrinology.

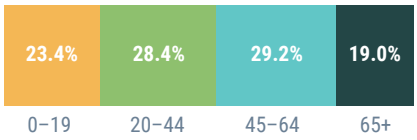
SERVICE AREA DEMOGRAPHICS

Racial Composition



7.8% | Asian*
6.9% | Black*
4.4% | Hispanic/Latino
79.0% | White*
2.0% | Other*
* Non-Hispanic

Age Distribution



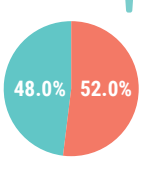
Fluency

4.4% speak English less than very well

Median Household Income

$99,067

Gender

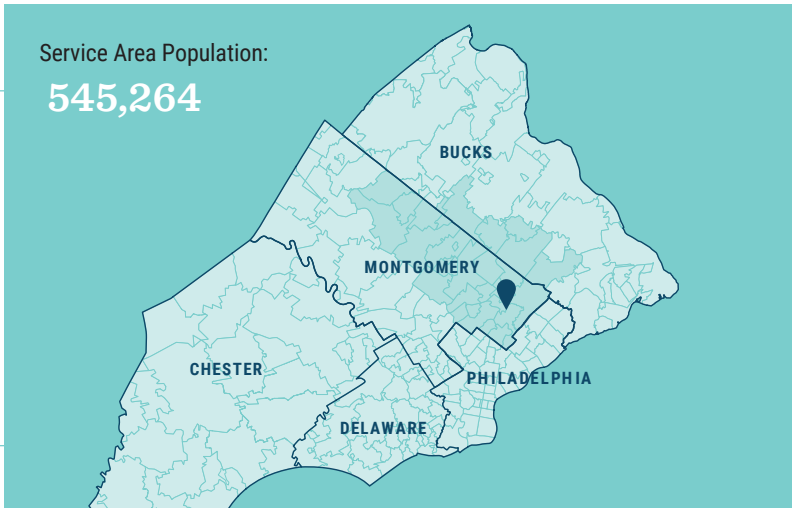


TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

Health systems within Jefferson Health define their service areas as ZIP codes including 75% of admissions, and/or ZIP codes most proximate to all hospitals.

Montgomery County: 18915, 18936, 18964, 18969, 19001, 19002, 19006, 19009, 19012, 19025, 19027, 19031, 19034, 19038, 19040, 19044, 19046, 19075, 19090, 19095, 19422, 19436, 19437, 19438, 19440, 19446, 19454, 19477

Bucks County: 18914, 18929, 18932, 18966, 18974, 18976



Impact of Prior Community Health Needs Assessment and Implementation

Jefferson Abington Hospital develops targeted health outreach programs and screenings in response to the identified needs of our community in concert with the mission of Jefferson Health: We Improve Lives. We work to create the healthiest community by orchestrating targeted outreach for maximum community benefit, while reducing health disparities.

In fiscal year 2020, Jefferson Abington Hospital provided over $101.7 million to individuals in our communities seeking resources for care and education, in alignment with our Community Health Implementation Plan developed in response to our 2019 Community Health Needs Assessment:

- Over $76.2 million in financial assistance and subsidized health services was provided to members of the community. Jefferson Abington Hospital provides access to affordable primary/preventative/specialty care through the following programs:
  - Abington Family Medicine
  - Abington Dental Clinic
  - Corinne Santerian Newborn Center
  - Hartnett Health Services, which recently expanded space to provide better services
  - OB/GYN Clinic
- Jefferson Abington Hospital provides many free or low-cost programs throughout the year designed to educate the community regarding health risk factors, chronic disease prevention or to support early detection through health screenings. In addition to cardiovascular-related health screenings, a free Cancer Screening Day is held annually. Jefferson Abington Hospital collaborates with many community organizations to support community health improvement initiatives.
- Jefferson Abington Hospital also provides programs and services designed to support seniors with activities, information and care close to home. A low-cost "Memory Fitness" program offers physical and social activities on an outpatient basis to sharpen the memory skills of older adults who are experiencing early memory loss. A faith-based advisory council, led by Jefferson Abington Hospital, works together to support and provide/coordinate programming at specific sites for over 300 members of Faith Community Ministries to address chronic disease management.
- Partnering with the Montgomery County Public Safety and the Abington Health Foundation Women's Board, Narcan® kits were made available to patients in Jefferson Abington Hospital's Emergency Trauma Center.
- Throughout fiscal year 2020, Jefferson Abington Hospital provided more than $2.7 million in free health education, screenings, in-kind donations and other community support.
- As a teaching hospital, Jefferson Abington Hospital educates many physicians, nurses and allied healthcare professionals. The Hospital maintains residency programs in family medicine, internal medicine, OB/GYN, general surgery and dentistry. In fiscal year 2020 Jefferson Abington Hospital provided over $22.5 million in medical education programs.

Detailed reports of community benefit activity at both Jefferson Abington Hospital and Jefferson Lansdale Hospital, as well as the Community Health Needs Assessments and Action Plans are available at https://www.abingtonhealth.org/about-us/communitybenefit/.

Jefferson Health – Center City

Jefferson Health - Center City has major programs in a wide range of growing clinical specialties that have been offered to the community for nearly 200 years. Services are provided at Thomas Jefferson University Hospitals, Inc., which includes Thomas Jefferson University Hospital, Jefferson Hospital for Neuroscience and Jefferson Methodist Hospital.

As part of Jefferson Health, Thomas Jefferson University Hospitals, Inc. is the academic medical center for Thomas Jefferson University, a professional, R2 national doctoral university focused on transdisciplinary, experiential education designed to deliver high-impact education and value in architecture, business, design, engineering, fashion and textiles, health, science and social science.

As an academic medical center, Thomas Jefferson University Hospitals stands out among the nation's best hospitals as ranked by *U.S. News & World Report*. In 2021-22, the hospital ranked nationally in six specialties: Cancer; Diabetes and Endocrinology; Gastroenterology and GI Surgery; Ophthalmology; Orthopedics; and Pulmonology. Thomas Jefferson University Hospital also continues to rank highly in the list of top hospitals in Pennsylvania (3rd) and the Philadelphia metro area (2nd). Jefferson Health – Center City hospitals are Magnet®-designated for nursing excellence; less than 7% of hospitals nationwide are Magnet® designated. Additionally, Thomas Jefferson University Hospital has received a 4/5 star rating from Medicare, based on how the hospital performs across different areas of quality, such as treating heart attacks and pneumonia, readmission rates and safety of care.

Several clinical programs have also been recognized for outstanding performance and outcomes. The Sidney Kimmel Cancer Center, nationally ranked by *U.S. News & World Report*, is one of only 70 designated National Cancer Institute (NCI) Centers, and one of only eight NCI-designated Prostate Centers of Excellence in the country. The Center has also received accreditation from the American College of Surgeons National Accreditation Program for Breast Centers (NAPBC) and has top outcomes in bone marrow and stem cell transplantation.

BEDS	EMPLOYEES	EMPLOYED PHYSICIANS	ADVANCED PRACTICE PROFESSIONALS	INPATIENT ADMISSIONS	OUTPATIENT VISITS	EMERGENCY DEPT. VISITS
926	9,935	329	451	39,007	1,445,454	109,706*

FY21 Statistics

Thomas Jefferson University Hospitals' Transplant Institute is among the top-rated transplant programs in the region. For FY20, the Institute achieved a 5/5 rating from the Scientific Registry of Transplant Recipients for one-year liver patient survival transplantation outcomes, and is among the top 8% in the country. The kidney and pancreas transplant programs received a 4/5 rating — also placing them among the top-rated programs in the region for transplant outcomes.

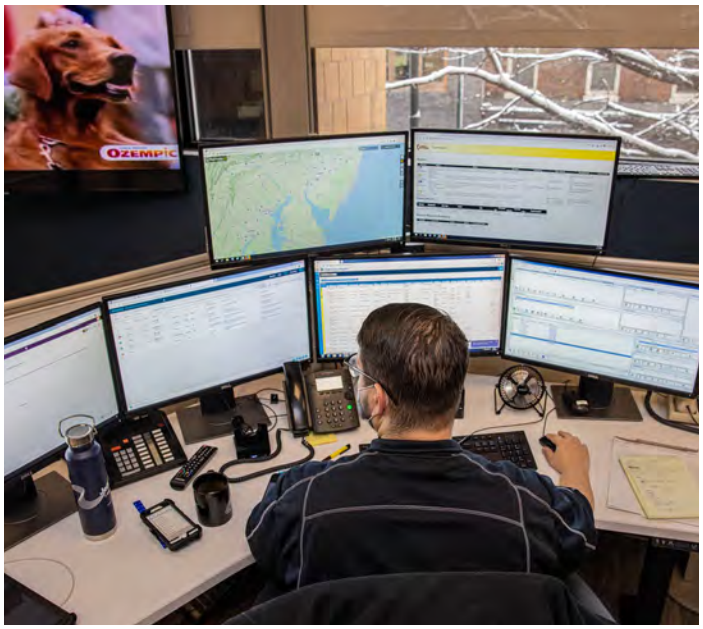
The United Network for Organ Sharing (UNOS) has designated Jefferson as a kidney transplant center for both living and deceased donor kidneys. The Transplant Institute is also part of the American Society of Transplantation's *The Living Donor Circle of Excellence Program* that recognizes organizations with policies to support the wages of a living donor employee who donates a kidney, or a part of their liver.

Rothman Orthopaedics at Jefferson Health includes the Philadelphia Hand to Shoulder Center at Jefferson, 3B Orthopaedics and the Abington Orthopedic & Spine Institute – Jefferson Health. Jefferson's Orthopaedic program located at TJUH is currently ranked #10 by *U.S. News & World Report* and has been seated in the top 20 orthopedic programs for 17 years running. Jefferson's orthopedic program was also the first to earn the advanced Joint Commission certification for Total Hip & Total Knee Replacement. The program is also recognized as a Blue Distinction Center for Spine Surgery. Together, TJUH and Magee Rehab make up one of only 14 federally designated Model Spinal Cord Injury (SCI) Centers in the nation.

The Vickie & Jack Farber Institute for Neuroscience is nationally renowned for expertise in treating brain tumors, spinal cord injuries, aneurysms and arteriovenous malformations. The Institute received the *Get With The Guidelines®–Stroke Gold-Plus Quality Achievement Award* for consistent compliance with quality measures outlined by the American Heart Association/American Stroke Association for the diagnosis and treatment of stroke. Jefferson also received the Association's *Target: Stroke Honor Roll* which recognizes hospitals that achieve improved stroke outcomes through reduced time to treatment with IV thrombolytic (clot buster).

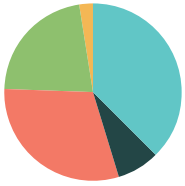
The Institute is also home to the first and only center in Philadelphia dedicated solely to ALS research — the Frances & Joseph Weinberg Research Unit within the Jefferson Weinberg ALS Center. Jefferson is an ALS Association Certified Treatment Center of Excellence. The Institute also includes a comprehensive Parkinson's Disease & Movement Disorder Center — also recognized as a Center of Excellence by the Parkinson's Foundation.

Among this year's *U.S. News & World Report*'s top-ranked programs in pulmonology, the Jane & Leonard Korman Respiratory Institute, in partnership with National Jewish Health, the top respiratory program in the world, provides comprehensive respiratory care and treatment. The Jane & Leonard Korman Respiratory Institute is also one of a select group of specialized centers in the country for the treatment of cystic fibrosis, and one of only two centers in the Philadelphia region.



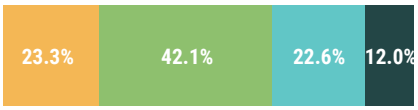
SERVICE AREA DEMOGRAPHICS

Racial Composition



7.8% | Asian*
30.3% | Black*
22.0% | Hispanic/Latino
37.6% | White*
2.3% | Other*
* Non-Hispanic

Age Distribution



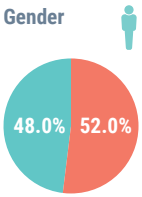
Fluency

10.8% speak English less than very well

Median Household Income

$54,868

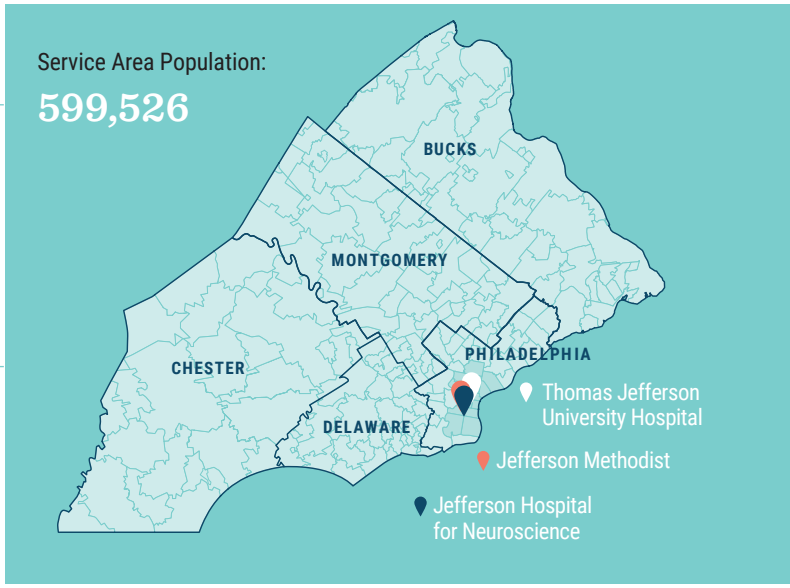
Gender



TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

Health systems within Jefferson Health define their service areas as ZIP codes including 75% of admissions, and/or ZIP codes most proximate to all hospitals.

Philadelphia County: 19102, 19103, 19106, 19107, 19121, 19122, 19123, 19124, 19125, 19130, 19132, 19133, 19134, 19140, 19145, 19146, 19147, 19148



Impact of Prior Community Health Needs Assessment and Implementation

At Jefferson, community benefit is delivered in three distinct ways: charity care and financial aid for individuals and families who cannot afford the cost of hospital services; contribution towards healthcare providers; and a variety of programs and services offered to the community including support groups, health screenings, wellness education and programs that address social determinants of health.

From the 2019 regional Community Health Needs Assessment, Jefferson identified the following priority areas in the three-year implementation plan:

- Substance use and abuse
- Behavioral health
- Access to affordable, culturally appropriate primary and specialty care
- Chronic disease prevention and management
- Social determinants of health

Highlights of the implementation plan include:

Jefferson Opiate Task Force

Jefferson Opiate Task Force focuses on reducing access to opiate pain killers and raising public awareness about addiction enterprise-wide. The Task Force successfully implemented electronic methods to dramatically impact prescribing behavior and provide real-time feedback on guideline adherence. A multi-disciplinary care program with staff, pharmacists and a behavioral health team was implemented. One hundred percent of primary care clinicians were certified on medication-assisted treatment. Patient education materials have been developed and delivered for patient and families regarding pain medication and other methods of pain management. Jefferson's onsite pharmacy continued to provide a drug take back program that is open to all community members.

Mindfulness Program

The Myrna Brind Center for Mindfulness is Philadelphia region's leading provider of mindfulness-based stress reduction programs. To meet the demand of behavioral services arising from the COVID-19 pandemic, the Center has offered free online mindfulness sessions to support the public. During the first three months of the pandemic, nearly 2,300 participated in this online program. The program continues to offer on-going guided mindfulness meditation practices for the community.

Community Health Education

In partnership with community organizations, Jefferson brings healthcare services such as blood pressure screenings, health information and resources, flu vaccinations and other services to community sites. Due to COVID, the number of community events has decreased dramatically, but Jefferson has increased its online educational workshops and offers assistance to overcome technology barriers for patients and community members. To review the list of programs and classes, please visit JeffersonHealth.org/Events

Diabetes Prevention and Management

Multiple programs are open to the community free of charge. JeffPEERS (People, Empowered, Educated, and Ready to Support) is a chronic disease self-management program designed to help adults better manage chronic medical conditions. Diabetes Prevention Program (DPP) supports participants in losing weight and preventing diabetes. Over five cohorts have benefited from this program in the three- year period. The *Learning to Manage and Live with Diabetes* program provides individuals and families living with diabetes and prediabetes with education tools and resources to better self-manage diabetes, reduce complications and improve quality of life.

Cancer Screening and Support

Through the HealthyWomen grant, free mammograms are offered to uninsured and underinsured women. Our Cancer Welcome Center serves patients, families and community members. Comprehensive services including support groups, educational workshops, fitness and wellness sessions, legal assistance and more are offered without charge.

Serving people who experience homelessness

The JeffHOPE (Health Opportunities, Prevention & Education) program supports four homeless shelters and one needle exchange harm reduction program in Philadelphia every week. The team provides acute and basic medical care and helps individuals and families experiencing homelessness access other health and social resources and healthcare providers who are better equipped to care for them long-term. Jefferson also donated lab and pharmaceutical services. In FY20, JeffHOPE served 1,679 people who were experiencing homelessness.

Health Literacy Training

Jefferson participates in a grant-funded partnership with Health Care Improvement Foundation (HCIF) to facilitate a regional coalition of hospitals and community members to improve written and oral communication with patients. This partnership helped to facilitate the initiation of the PA State Health Literacy Coalition. Through this collaboration with HCIF, the health literacy needs of refugee/immigrant communities were assessed in partnership with community-based organizations serving these communities.

Workforce Development and Health

Jefferson's Community Health Worker (CHW) Program aims to transform the way community members engage with healthcare providers and the way healthcare providers engage with the community. Jefferson-trained CHWs meet the unique medical and social needs of the patients and the communities they serve. CHWs are in the Jefferson Emergency Department to provide social determinants of health screenings and connect patients with needed resources, while helping them navigate health care and social service systems.

Community Building

Jefferson has also engaged in a variety of community building activities to improve the community's health and safety by addressing poverty, food insecurity, homelessness, workforce development, built environment and substance abuse. Community building activities are also focused on providing opportunities for youth to explore careers in health care through health awareness education, mentoring and internships.

Jefferson Health – Northeast

Jefferson Health – Northeast, comprised of Jefferson Bucks Hospital, Jefferson Frankford Hospital, and Jefferson Torresdale Hospital, is a division of Jefferson Health and serves patients in Northeast Philadelphia and lower Bucks County.

Jefferson Health – Northeast recently launched several high-quality healthcare specialty services never before available in the immediate Northeast Philadelphia and Bucks County communities.

In October 2020, the newest Sidney Kimmel Cancer Center – Jefferson Health location opened its doors at Jefferson Torresdale Hospital. The facility has already proven to be incredibly important to patients in Northeast Philadelphia and Bucks County, providing them with nationally recognized oncological care - designated by the National Cancer Institute (NCI) - as well as access to a broad range of clinical trials.

In fall 2020, Jefferson Torresdale – in collaboration with the Vickie & Jack Farber Institute for Neuroscience – also launched a Thrombectomy Program. The facility can now evaluate patients and perform endovascular thrombectomy (retrieval of a blood clot from a blood vessel in the brain), followed by individualized, post-procedural care. This life-saving, university-level treatment has had a significant and restorative impact on victims of ischemic stroke in the Northeast Philadelphia and lower Bucks County community.

Also serving Northeast Philadelphia, Jefferson Frankford Hospital has expanded its imaging services to include state-of-the-art 3D mammography. This sophisticated system provides low-dose mammography that takes many images from different angles, showing breast tissue in layers. As a result, women in Northeast Philadelphia have convenient access to more precise, efficient and advanced breast imaging and diagnostics.

In addition, Jefferson Bucks Hospital continues to offer the Bucks County

community world-class, orthopedic care delivered by 3B Orthopaedics. In partnership with the Vickie & Jack Farber Institute for Neuroscience, Jefferson Bucks also expanded neurosurgery and neuro-spine services in 2019 with the addition of world class, fellowship-trained surgeons and highly experience support staff. Since its inception, the program has offered the latest surgical techniques to provide exceptional care, outstanding outcomes, and a better quality of life for our patients.

For 2021-2022, Jefferson Health – Northeast hospitals rank among the best in the nation according to the annual *U.S. News & World Report*. Overall, they ranked 12th in the Philadelphia Metro area, 20th in Pennsylvania and high performing in: Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Diabetes, Heart Attack, Knee Replacement, Kidney Failure and Stroke.

In addition, the Stroke Program at Jefferson Health – Northeast was recognized with the *2021 Get With The Guidelines® - Stroke GOLD PLUS with Honor Roll* and *Target: Type 2 Diabetes Honor Roll Achievement Award*. Jefferson Bucks Hospital and Jefferson Torresdale Hospital's Heart Center have also received the 2021 Mission: Lifeline® STEMI (ST Elevation Myocardial Infarction) Center Gold Plus Recognition Award for implementing specific quality improvement measures outlined by the American Heart Association for the treatment of patients who suffer severe heart attacks.

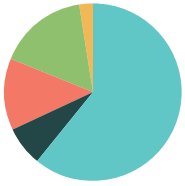
These awards demonstrate the organization's dedication to using the most up-to-date evidence-based treatment guidelines to improve STEMI and stroke patient care and outcomes in the community we serve.

BEDS	EMPLOYEES	EMPLOYED PHYSICIANS	ADVANCED PRACTICE PROFESSIONALS	INPATIENT ADMISSIONS	OUTPATIENT VISITS	EMERGENCY DEPT. VISITS
464	3,774	239	150	24,451	789,738	95,997*

**FY21 Statistics*

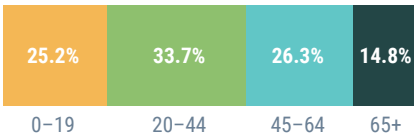
SERVICE AREA DEMOGRAPHICS

Racial Composition



7.1% | Asian*
13.3% | Black*
16.2% | Hispanic/Latino
60.9% | White*
2.4% | Other*
* Non-Hispanic

Age Distribution



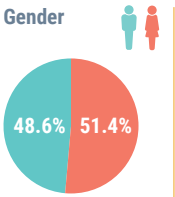
Fluency

11.3% speak English less than very well

Median Household Income

$64,046

Gender



Impact of Prior Community Health Needs Assessment and Implementation

Jefferson Health – Northeast recognizes that by providing quality health care to patients, and education and outreach to the community, it is also enriching the lives and future of our surrounding community. Through many partnerships, Jefferson Health – Northeast seeks to improve the health and well-being of young and older Philadelphia residents through prevention and wellness programs, health education seminars, screenings, and assessments that identify barriers to health, and efforts to address the upstream factors that impact the health of everyone in the community.

Jefferson Health – Northeast completed and published its third Community Health Needs Assessment and three-year Implementation Plan in 2019, which addresses the following priority health needs for the population of Jefferson's Community Benefit area:

- Chronic disease management (diabetes, heart disease and hypertension, stroke, asthma)
- Healthy lifestyle behaviors and community environment
- Access to care
- Health screening
- Mental health assessment
- Early detection

Jefferson Health - Northeast provided community benefit and charitable care in three distinct ways:

- Dollar support for individuals and families who can't afford the cost of hospital services, including those who seek care from our Emergency Medicine Department
- The hospital's contribution towards the education of doctors, nurses and other health professionals
- A variety of programs and services offered to the community including support groups, health screenings and wellness education

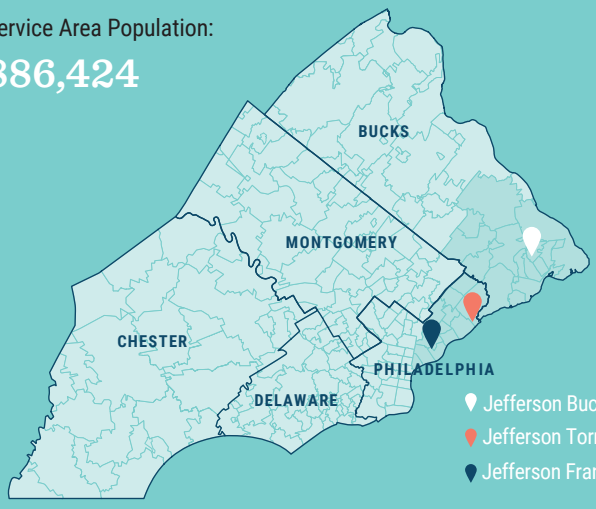
TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

Health systems within Jefferson Health define their service areas as ZIP codes including 75% of admissions, and/or ZIP codes most proximate to all hospitals.

Bucks County: 18940, 18954, 18966, 19007, 19020, 19021, 19030, 19047, 19053, 19054, 19055, 19056, 19057, 19067

Philadelphia County: 19111, 19114, 19115, 19116, 19124, 19125, 19134, 19135, 19136, 19137, 19149, 19152, 19154

Service Area Population:
886,424



Jefferson Lansdale Hospital

Located in Lansdale, Montgomery County, Jefferson Lansdale Hospital provides primary, emergency and specialty care to patients and families in the North Penn community. Specialty care includes an 18-bed Orthopaedic and Spine Institute, a wound care center, gynecology, endocrinology, urology, pulmonology, gastroenterology, general surgery and more.

Jefferson Lansdale Hospital, part of Jefferson Health, is dedicated to improving lives and caring for the community. Jefferson Lansdale Hospital's commitment to the community was evidenced during the COVID-19 pandemic when it began offering COVID-19 vaccines as soon as they became available. A COVID-19 Vaccination Center opened at Jefferson Lansdale Hospital by mid-December 2020 in order to administer vaccines to both employees and community members.

Jefferson Lansdale Hospital is also home to three, impactful Community Health programs for children's health, dental care and elder care. All three programs provide easily accessible care to local underinsured or uninsured patients of all age groups:

- The Children's Clinic provides a full range of affordable primary/preventive care services to children from birth to their 22nd birthday, and a social worker is available to assist families with insurance applications, charity care applications and more.
- The Dental Access Program is designed to provide basic dental services to underinsured and uninsured residents of the greater North Penn community through a network of participating local dentists from the Montgomery-Bucks Dental Society.
- The Adult Day Services Program provides an economic and family-friendly alternative for seniors in need of in-home care, care in a nursing home or an assisted living facility, such as those who are unable to be left at home during the workday due to behavioral health needs, chronic illness or disability.

BEDS	EMPLOYEES	ADVANCED PRACTICE PROFESSIONALS	INPATIENT ADMISSIONS	OUTPATIENT VISITS	EMERGENCY DEPT. VISITS
140	505	1	5,655	66,920	23,715*

**FY21 Statistics*

In FY21, Jefferson Lansdale Hospital began its pursuit of Age-Friendly status. Age-Friendly Health Systems is an initiative of the John A. Hartford Foundation and the Institute for Healthcare Improvement, in partnership with the American Hospital Association and the Catholic Health Association of the United States. Age-Friendly Health Systems and facilities aim to follow an essential set of evidence-based practices and align them with what matters most to older adults patients and their caregivers.

In FY20 and FY21, Jefferson Lansdale Hospital received numerous awards and accolades for high quality patient care, excellence and safety. In 2019, Jefferson Lansdale Hospital was the first in the nation to earn the Joint Commission's *Gold Seal of Approval®* and the American Heart Association's Heart-*Check mark for Acute Heart Attack Ready Certification* in recognition of its care of heart attack patients.

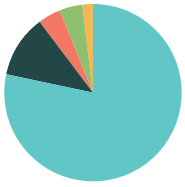
Also in 2019, Jefferson Lansdale Hospital's renowned stroke program earned The American Heart Association/American Stroke Association's *Get With The Guidelines Stroke Gold Plus & Target: Stroke Elite Honor Roll Award* for excellence in providing quality stroke care.

In 2020, Jefferson Lansdale Hospital earned Healthgrades' *Pulmonary Care Excellence Award* for superior clinical outcomes in treating COPD and pneumonia. Additionally, the Gift of Life donor program and Hospital and Healthsystem Association of Pennsylvania (HAP) honored Jefferson Lansdale Hospital with their *Platinum Award*.

Jefferson Lansdale Hospital maintains academic associations with Montgomery County Community College and Gwynedd Mercy University for Nursing and Allied Health Professions.

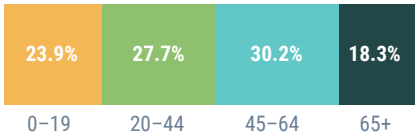
SERVICE AREA DEMOGRAPHICS

Racial Composition



11.3% | Asian*
4.3% | Black*
4.2% | Hispanic/Latino
78.4% | White*
1.7% | Other*
* Non-Hispanic

Age Distribution



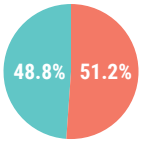
Fluency

5.0% speak English less than very well

Median Household Income

$99,786

Gender

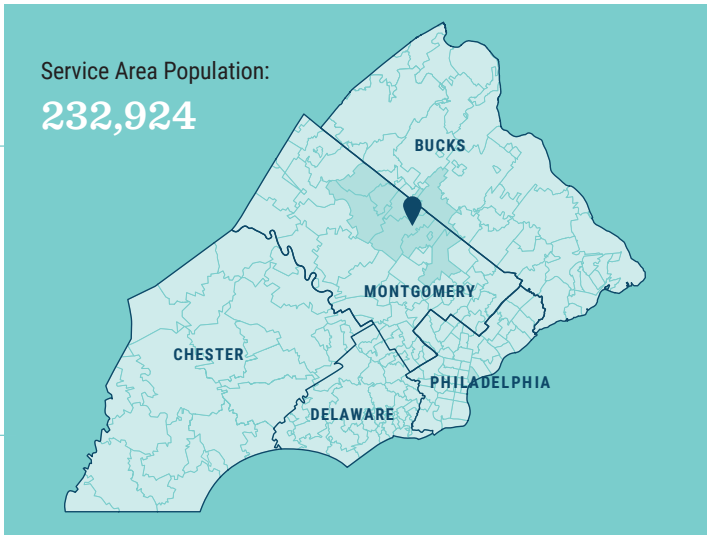


TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

Health systems within Jefferson Health define their service areas as ZIP codes including 75% of admissions, and/or ZIP codes most proximate to all hospitals.

Bucks County: 18914, 18932

Montgomery County: 18915, 18936, 18964, 18969, 19002, 19422, 19438, 19440, 19446, 19454



Impact of Prior Community Health Needs Assessment and Implementation

Jefferson Lansdale Hospital develops targeted health outreach programs and screenings in response to the identified needs of our community in concert with the mission of Jefferson Health: We Improve Lives. We work to create the healthiest community by orchestrating targeted outreach for maximum community benefit, while reducing health disparities.

In fiscal year 2020, Jefferson Lansdale Hospital provided over $8.7 million to individuals in our communities seeking resources for care and education, in alignment with our Community Health Implementation Plan developed in response to our 2019 Community Health Needs Assessment:

- More than $7.8 million was provided to the community in uninsured and underinsured health services, including through Jefferson Lansdale Hospital's Children's Clinic, Adult Day Services Program and Dental Care Access Program. In addition, the Children's Clinic screens all families for food insecurity and provides opportunities for these families to access fresh fruits and vegetables through a partnership program with the Montgomery County Office of Public Health.
- Jefferson Lansdale Hospital provides many free or low-cost programs throughout the year designed to educate the community regarding health risk factors, chronic disease prevention or to support early detection through health screenings. In addition to cardiovascular-related health screenings, a free Cancer Screening Day is held annually.
- Jefferson Lansdale Hospital collaborates with many community organizations to support community health improvement initiatives. A faith-based advisory council, led by Jefferson Abington Hospital, works together to support and provide/coordinate programming at specific sites at over 300 members of Faith Community Ministries to address chronic disease management.
- Partnering with the Montgomery County Public Safety and the Abington Health Foundation Women's Board, Narcan® kits were made available to patients in Jefferson Lansdale Hospital's Emergency Department.
- Throughout fiscal year 2020, Jefferson Lansdale Hospital provided over $79,000 in free health education, screenings, in-kind donations and other community support.
- Jefferson Lansdale Hospital provided over $87,000 in medical education programs in fiscal year 2020, ensuring that students in medical professions have opportunities for internships and clinical rotations.

Detailed reports of community benefit activity at both Jefferson Abington Hospital and Jefferson Lansdale Hospital, as well as the Community Health Needs Assessments and Action Plans are available at https://www.abingtonhealth.org/about-us/communitybenefit/.

Magee Rehabilitation

Magee Rehabilitation, a member of Jefferson Health, is the Philadelphia region's first rehabilitation hospital, opening its doors in 1958. Magee is nationally ranked by *U.S. News & World Report* as among the best in the nation in physical and cognitive rehabilitation.

Comprehensive inpatient and outpatient services are structured to provide lifetime rehabilitation and wellness programs for individuals with:

- Spinal Cord Injury
- Multiple Sclerosis
- Brain Injury
- Work-Related Injury
- Stroke
- Guillain-Barré Syndrome
- Multiple Trauma
- Parkinson's Disease

Magee is home to the nation's first brain injury rehabilitation program to be accredited by the Commission on the Accreditation of Rehabilitation Facilities (CARF). Magee has been accredited by CARF for its rehab programs in:

- Comprehensive Integrated Inpatient Rehabilitation
- Spinal Cord Rehabilitation System of Care
- Brain Injury Program
- Stroke Program (Awarded CARF's Stroke Specialty Program Certification)

BEDS	EMPLOYEES	EMPLOYED PHYSICIANS	ADVANCED PRACTICE PROFESSIONALS	INPATIENT ADMISSIONS	OUTPATIENT VISITS
83	826	12	1	1,094	35,351*

**FY21 Statistics*

With thousands of former patients with spinal cord injuries in its follow-up system, Magee has the clinical experience and the unique peer resources that no other greater Philadelphia rehabilitation program can offer. Since 1978, Magee has partnered with Thomas Jefferson University Hospital to form The Regional Spinal Cord Injury Center of the Delaware Valley. The Center provides for the multidisciplinary coordination of emergency and acute medical/surgical care, rehabilitation beginning at the onset of acute care, vocational-evaluation and training, and lifetime follow-up care for persons with spinal cord injury. Magee is also a founding member of The Christopher Reeve Foundation NeuroRecovery Network.

In 2020, Magee was recognized by Press Ganey with the *Guardian of Excellence Award for Patient Experience*. Magee was also honored by the Studer Group as a *Healthcare Organization of Distinction* in nursing excellence.

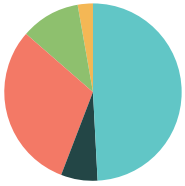
A multi-year construction project was completed in early 2020 to enhance patients' rehabilitation experience, making it as comfortable and home-like as possible. The project touched almost every area of the hospital, from the main entrance lobby to the rooftop Creative Therapy and Healing Gardens. Patient floors were completely renovated with 83 private suites with high-tech room automation capabilities and an array of hotel-like amenities. New therapy gyms include a brand new suite for practicing activities of daily living.

Inpatient services are delivered at Magee's main facility located at 1513 Race Street, in Center City Philadelphia. Outpatient programs are provided in a variety of community settings including the Magee Riverfront outpatient center at 1500 South Columbus Boulevard, Magee at Watermark at 18th and Callowhill Streets and Magee at Oxford Valley which is located at 400 North Buckstown Road in Langhorne. Work injury and pain management services are offered at Magee Riverfront.

Magee Rehabilitation Hospital primarily defines its community as Philadelphia County, surrounding Southeastern Pennsylvania counties, as well as Southern New Jersey and Delaware. The special population served includes adults with disabilities, many of whom have incurred life-changing injuries and illness including, but not limited to, spinal cord injury, stroke, acquired brain injury, amputation, major orthopedic issues and others.

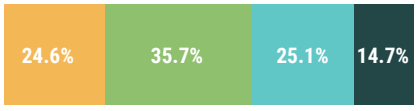
SERVICE AREA DEMOGRAPHICS

Racial Composition



6.7% | Asian*
30.7% | Black*
10.8% | Hispanic/Latino
49.2% | White*
2.6% | Other*
* Non-Hispanic

Age Distribution



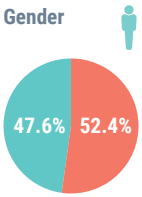
Fluency

7.7% speak English less than very well

Median Household Income

$67,902

Gender

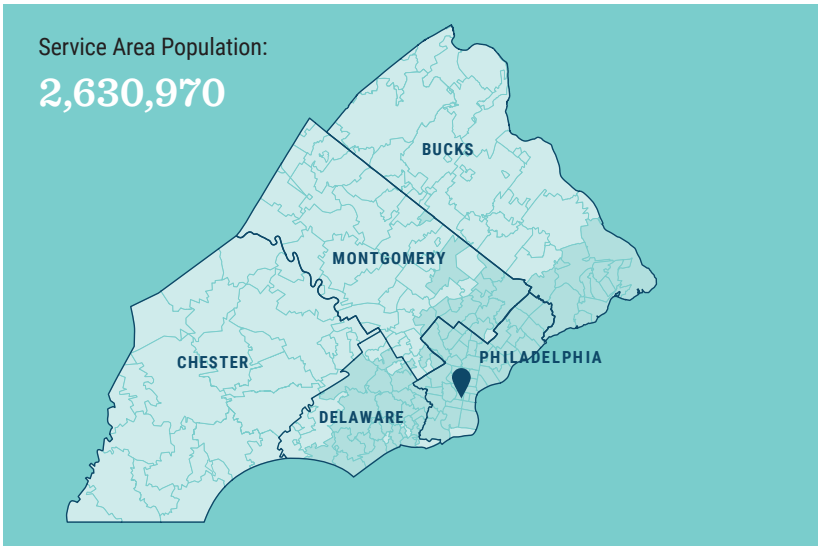


Impact of Prior Community Health Needs Assessment and Implementation

Magee Rehabilitation Hospital develops targeted health outreach and screening programs in response to the identified needs of our community in concert with the mission of Jefferson Health: We Improve Lives.

Magee Rehabilitation Hospital completed and published its Community Health Needs Assessment and three-year Implementation Plan in 2019, which addresses the following priority health needs for the population of the Hospital's Community Benefit area:

- Magee Medical Home: Lifetime follow up services for patients with 'one stop' for specialized medical care commonly needed by individuals living with a disability (e.g., urology, pressure wound management, clinical nutrition).
- Online educational resources provided for persons living with disability and their families.
- Support groups and peer mentor programming to provide education and to decrease isolation.
- Professional educational opportunities with continuing education credits for healthcare industry staff, specifically focused on serving individuals with disabilities.
- Opportunities for exercise and improved healthy living through the Wellness Center at Magee's Riverfront Outpatient facility.
- Access to health screening and preventive health services.
- Wheelchair custom seating clinic.
- Vision clinic.
- Hosted free community events, such as the Wash N Tune, to benefit individuals with disabilities.



TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

Health systems within Jefferson Health define their service areas as ZIP codes including 75% of admissions, and/or ZIP codes most proximate to all hospitals.

Bucks County: 19007, 19020, 19021, 19030, 19047, 19053, 19054, 19055, 19056, 19057, 19067

Delaware County: 19008, 19010, 19013, 19014, 19015, 19018, 19022, 19023, 19026, 19029, 19032, 19036, 19050, 19060, 19061, 19063, 19064, 19070, 19073, 19076, 19078, 19079, 19081, 19082, 19083, 19086, 19087, 19094

Montgomery County: 19001, 19002, 19003, 19004, 19006, 19027, 19031, 19038, 19040, 19044, 19046, 19072, 19075, 19090, 19095

Philadelphia County: 19102, 19103, 19104, 19106, 19107, 19111, 19114, 19115, 19116, 19118, 19119, 19120, 19121, 19122, 19123, 19124, 19125, 19126, 19127, 19128, 19129, 19130, 19131, 19132, 19133, 19134, 19135, 19136, 19137, 19138, 19139, 19140, 19141, 19142, 19143, 19144, 19145, 19146, 19147, 19148, 19149, 19150, 19151, 19152, 19153, 19154

Rothman Orthopaedic Specialty Hospital

ROTHMAN ORTHOPAEDIC SPECIALTY HOSPITAL

Rothman Orthopaedic Specialty Hospital (ROSH) strives to be an innovative specialty hospital dedicated to the needs of the communities it serves. As a musculoskeletal facility, Rothman Orthopaedic Specialty Hospital is dedicated to delivering efficient, high-quality, cost-effective health care. ROSH is part of Jefferson Health.

ROSH strives to provide quality and compassionate care for our patients, incomparable service to our physicians, an empowering workplace for our employees, many of whom live in our community, and a commitment to engagement with our community, setting the standard for superior, patient-focused health care. The hospital's healthcare team is committed to treating each other with honesty, respect and dignity.

Physician-owned hospitals are anomalous in the United States healthcare sector. In 2009, the Rothman Orthopaedic Institute partnered with ValueHealth of Leawood to create just such a hospital in Bensalem, Pennsylvania. The idea was to create a physician-led hospital focused on providing patients with superior surgical outcomes alongside operational efficiencies that increase the number of patients served. Today, ROSH performs over 5,000 elective surgeries each year, amplifying the Rothman Orthopaedic Institute's ability to meet the needs of the greater Philadelphia market.

ROSH is a 24-bed surgical hospital located in Bensalem, Pennsylvania. The 65,000 square-foot facility, with six operating rooms, has the latest medical instrumentation for elective orthopaedic surgery including joint replacements, spine surgery, sports medicine, foot and ankle surgery, shoulder and elbow surgery, hand and wrist and pain management procedures. Ancillary services include laboratory, imaging, MRI, pharmacy and physical therapy.

ROSH is accredited by The Joint Commission for demonstrating compliance with the Joint Commission's national standards for health care, quality and patient safety in hospitals. The Joint Commission's hospital regulations address important functions relating to the care of patients and the management of the hospital organization. The standards are developed in consultation with patients, healthcare experts, providers and measurement experts.

BEDS	EMPLOYEES	PHYSICIANS	INPATIENT ADMISSIONS	OUTPATIENT VISITS
24	140	35	2,250	2,300*

*FY21 Statistics

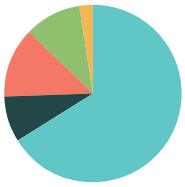
ROTHMAN ORTHOPAEDIC SPECIALTY HOSPITAL

ROSH has consistently been recognized by Healthgrades for excellence and outstanding achievements. These include:

- Healthgrades America's 100 Best Hospitals for Joint Replacement 2021-2022
- Healthgrades Joint Replacement Excellence 2013-2022
- Healthgrades Outstanding Patient Experience Award 2017-2021
- Healthgrades Patient Safety Excellence Award 2019-2021

SERVICE AREA DEMOGRAPHICS

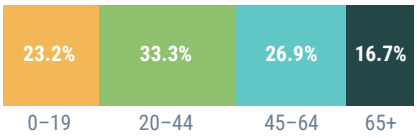
Racial Composition



8.4% | Asian*
12.8% | Black*
10.1% | Hispanic/Latino
66.2% | White*
2.4% | Other*

* Non-Hispanic

Age Distribution



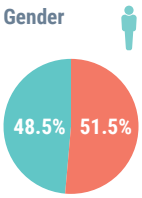
Fluency

8.9% speak English less than very well

Median Household Income

$81,783

Gender



Impact of Prior Community Health Needs Assessment and Implementation

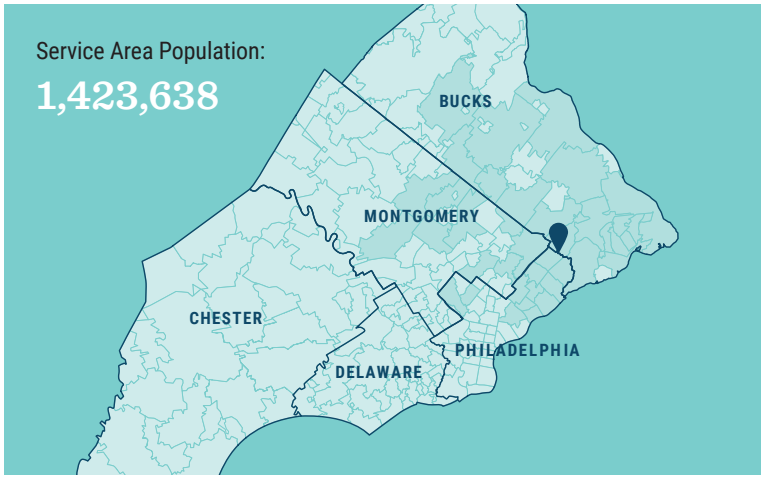
In the hospital's 2019 CHNA, the following priority health needs within the scope of ROSH services for the population of the ROSH Community Benefit areas:

- Substance Abuse, especially Opioid addiction stemming from addiction to pain relievers

Towards the goal of making a positive contribution to reducing the opioid addiction crisis in our community, ROSH:

- Partnered with the Bensalem Community Response Unit to fund responders to substance-related 911 calls. The program pairs a paramedic or EMT with a Certified Recovery Specialist to provide recovery support, education, resources and treatment options.
- Worked collaboratively with pharmacists, surgeons and anesthesia providers to order multi-modality pain relief solutions in lieu of opioids.
- Proactively worked with surgeons to set patient expectations to expect some pain and to seek relief through non-opioid medications.
- Coordinated and marketed drug-take back days to employees and patients through displays and repeat e-mail campaigns.

ROSH community benefit also included financial assistance for elective surgery to individuals in need in our community.



TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

Health systems within Jefferson Health define their service areas as ZIP codes including 75% of admissions, and/or ZIP codes most proximate to all hospitals.

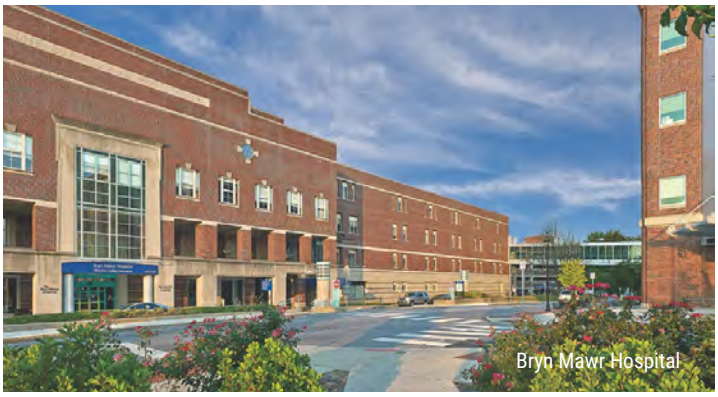
Bucks County: 18901, 18914, 18938, 18940, 18944, 18966, 18974, 18976, 19007, 19020, 19030, 19047, 19053, 19054, 19056, 19057, 19067

Montgomery County: 19002, 19006, 19038, 19040, 19046, 19403, 19422, 19446, 19454

Philadelphia County: 19111, 19114, 19115, 19116, 19119, 19124, 19128, 19135, 19136, 19145, 19146, 19147, 19148, 19149, 19152, 19154

Main Line Health®

Lankenau Medical Center


Bryn Mawr Hospital

Paoli Hospital


Riddle Hospital

Main Line Health

Founded in 1985, Main Line Health is a not-for-profit health system serving portions of Philadelphia and its western suburbs. Main Line Health consists of 5 hospitals, 6 health centers, 40+ offices, 2,000+ physicians and over 11,500+ employees.

At its core are four of the region's most respected acute care hospitals — *Lankenau Medical Center, Bryn Mawr Hospital, Paoli Hospital and Riddle Hospital* – as well as one of the nation's premier facilities for rehabilitative medicine, *Bryn Mawr Rehabilitation Hospital*. Main Line Health also consists of: *Mirmont Treatment Center, HomeCare & Hospice, Main Line Health Centers* (Broomall, Collegeville, Concordville, King of Prussia, Exton and Newtown Square), *Lankenau Institute for Medical Research* and *Main Line HealthCare*. Across our Acute Care hospitals, our core service lines include: Cardiology, Orthopedics & Neurosciences, Cancer, Women's Health, and Behavioral Health. Additionally, Main Line Health fosters key partnerships with Jefferson Health for Cancer, Neurosciences, Trauma, and Transplant; Nemours Pediatrics (but will now be partnering with Children's Hospital of Philadelphia); and Independent Physician groups that serve on our Medical Staff.

Main Line Health has been consistently ranked and recognized among the top hospitals in the Philadelphia region by *U.S. News and World Report*, *The Leapfrog Group*, *Healthcare Equality Index (HEI)*, for equity and inclusion of LGBTQ patients, visitors and employees, the *American Heart Association Mission*, for cardiovascular care, and has system designations for *Magnet*, by *NICHE (Nurses Improving Care for Healthsystem Elders)*. Our physicians also continuously rank among the Top Doctors by *Philadelphia Magazine* and *Main Line Today*.

BEDS	EMPLOYEES	PHYSICIANS	INPATIENT ADMISSIONS	OUTPATIENT VISITS	EMERGENCY DEPT. VISITS
1,314	11,900+	2,056	58,954	955,331	160,258

FY21 Statistics

MISSION

To provide a comprehensive range of safe, high-quality health services, complemented by related educational and research activities, that meet the health care needs and improve the quality of life in the communities we serve.

VISION

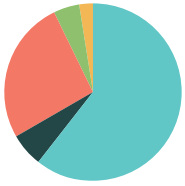
Be the health care provider of choice in our communities by eliminating harm, achieving top decile performance, delivering equity for all and ensuring affordability.

VALUES

- Keep our patients, employees, and medical staff safe
- Deliver high-quality, compassionate care
- Foster an environment of diversity, respect, equity, and inclusion
- Work together as a system to achieve common goals
- Innovate, embrace change, and do the right thing

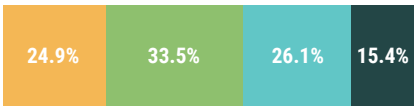
SERVICE AREA DEMOGRAPHICS

Racial Composition



6.1% | Asian*
25.9% | Black*
4.7% | Hispanic/Latino
60.8% | White*
2.5% | Other*
* Non-Hispanic

Age Distribution



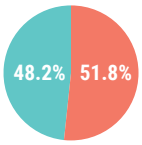
Fluency

3.6% speak English less than very well

Median Household Income

$94,394

Gender



Impact of Prior Community Health Needs Assessment and Implementation

The information provided by community members and leaders informed the 2019 Community Health Needs Assessment for the Main Line Health Acute Care Hospitals and helped us develop 56 initiatives across 8 overall priorities to focus on over the three-year cycle. A separate Community Health Needs Assessment was pursued for our Bryn Mawr Rehab Hospital facility for the 2019 CHNA Implementation Plan, however for the next Community Health Needs Assessment cycle, there will be one implementation plan for the system.

Main Line Health cares for the health and well-being of individual patients, families and communities. Highlighted are Main Line Health initiatives to address needs identified through our 2019-2022 Community Health Needs Assessment:

Behavioral Health

To improve access and care, Main Line Health is:

- Opening of a new 40-bed inpatient psychiatric unit within our Bryn Mawr Hospital campus in February 2022
- Increasing access to outpatient Behavioral Health services at Main Line Health's Women's Emotional Wellness Centers by adding more convenient locations and expanding the number of providers
- Growing the number of primary care practices with integrated Behavioral Health services.
- Expanding outpatient therapy services at Bryn Mawr Hospital, scheduled to open in 2022
- Focusing on screening for depression and other mental illness using measurement-based outcomes, connecting patients to appropriate care

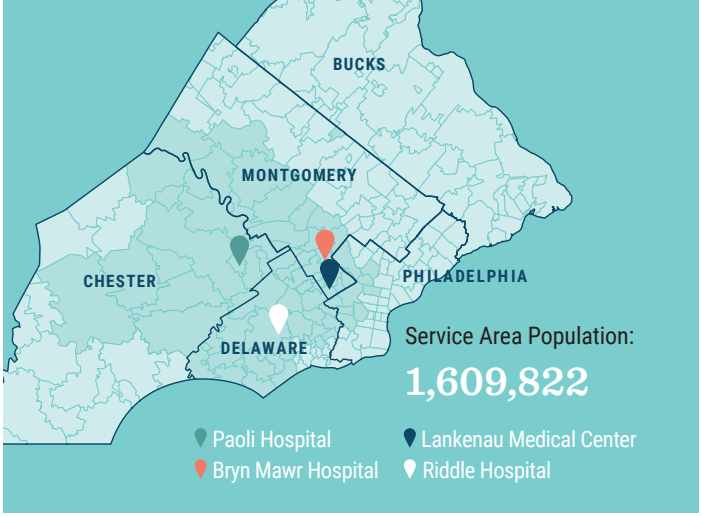
Chronic Disease Prevention and Management

Main Line Health's service lines are focused on initiatives identifying and addressing chronic conditions in our community:

- Main Line Health conducts ongoing screenings to identify and address chronic conditions affecting the Cardiovascular System and Cancer affecting the lung, colon, rectum and breast
- Early detection of diabetes and management of the condition as measured by HbA1C levels is a system priority

Health Care Access and Affordability

Main Line Health has sustained efforts to address food insecurity in our patients. Main Line Health has a farm, The Deaver Farm, on the Lankenau Medical Center Campus. Local farmers grow nutritious produce on campus and, through our Deaver Farm Health Nutrition Program, deliver farm produce directly to our patients' homes, helping our patients who face food insecurity. The Farm also partners with other community partners to host education events and create community awareness about food insecurity.



SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

Main Line Health defines its service area for acute hospitals as 75 percent of each hospitals' discharge market area, resulting in an area that accounts for approximately 85 percent of total discharges. Four parent ZIP codes surrounding Physician's Care Surgical Hospital were also incorporated into the service area.

Chester County: 19301, 19312, 19320, 19333, 19335, 19341, 19355, 19372, 19380, 19382, 19383, 19425, 19460, 19465, 19475

Delaware County: 19008, 19010, 19013, 19014, 19015, 19018, 19023, 19026, 19036, 19050, 19060, 19061, 19063, 19064, 19073, 19082, 19083, 19085, 19086, 19087, 19317, 19319, 19342, 19373

Montgomery County: 19003, 19004, 19035, 19041, 19066, 19072, 19096, 19401, 19403, 19405, 19406, 19426, 19428, 19444, 19453, 19462, 19464, 19468, 19473

Philadelphia County: 19104, 19127, 19128, 19129, 19131, 19132, 19139, 19143, 19144, 19151

Home Care & Hospice

Main Line Health's Home Care & Hospice team has focused on providing convenient care at home through enhanced remote monitoring services for Congestive Heart Failure homebound patients by providing remote monitoring units and tracking usage, and reducing rehospitalization rates for this patient population.

Maternal Health

Main Line Health is focused on providing and improving maternal care in our community by:

- Improving access by adding more OB/GYN providers to our network of providers serving community offering maternal health and prenatal care.
- Offering more access to underserved patients at all MLH facilities and employed practices. We are also working with our independent physician partners to increase access to underserved communities.
- Increasing postpartum depression screening efforts in our outpatient settings

Neurosciences:

Main Line Health is offering comprehensive stroke care to our community by investing in developing thrombectomy capable stroke centers at Bryn Mawr Hospital and Paoli Hospital to increase stroke care services in the community.

Senior Services:

Main Line Health continues ongoing work to reduce falls for patients 65 and older through Fall prevention interventions across our acute care settings.

Diversity, Respect, Equity & Inclusion:

Main Line Health has embedded the DREI principles in our Values:

- Main Line Health has made 9 DREI commitments embedded in our system strategic plan and operationalized by our system steering committee.
  - Re-examining policies and procedures and making changes, with an equity lens, that promote equality, opportunity and inclusion for all.
  - Improving access to primary and specialty care for people in underserved communities.
  - Building trust through community partnerships with the goal of addressing chronic conditions that impact communities of color.
  - Advocating for investments that create innovative solutions to improve access, and provide safe, high-quality health outcomes for all communities in Southeastern Pennsylvania.
  - Hiring and promoting leaders of color and increasing diversity in governance
  - Renewing and expanding each organization's commitment to providing anti-racism, and implicit/unconscious bias training for all staff, volunteers and physicians.
  - Bridging relations between law enforcement and community by offering events aimed at encouraging conversations improving relations and creating trust.
  - Increasing the collection and use of race, ethnicity, language preference and other socio-demographic data.
  - Increasing business partnerships with diverse vendor partners across the organization. Cultivating new relationships, expand current partnerships and continue to monitor MLH progress on diverse spend.
- Main Line Health has established 5 LGBTQ Inclusive Care sites among our primary care practices, and continues to grow, while also focusing on LGBTQ patient-specific education among clinicians and staff across our health system.

Bryn Mawr Rehab Hospital

Bryn Mawr Rehab Hospital is Main Line Health's rehabilitation center, and a leader in the field of physical medicine and rehabilitation, offering both inpatient and outpatient rehab services.

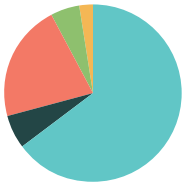
Bryn Mawr Rehab recently ranked as the Best Physical Rehabilitation Center in Pennsylvania by *Newsweek* (#1 in 2020 and #2 in 2021). With more than 50 years of clinical excellence, Bryn Mawr Rehab Hospital provides outstanding therapy and medical care for conditions and injuries as diverse as spinal cord injury, traumatic brain injury, chronic pain and pre-joint replacement. Bryn Mawr Rehab offers a full range of outpatient services, including cancer rehab, post-COVID recovery, comprehensive concussion rehabilitation, driver rehabilitation, assistive technology and vestibular (balance) rehabilitation.

BEDS	EMPLOYEES	PHYSICIANS	INPATIENT ADMISSIONS	OUTPATIENT VISITS
148	491	96	1,868	110,741

**FY21 Statistics*

SERVICE AREA DEMOGRAPHICS

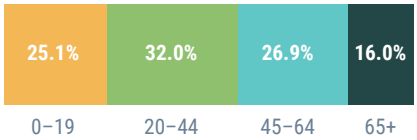
Racial Composition



6.1% | Asian*
21.5% | Black*
5.2% | Hispanic/Latino
64.8% | White*
2.4% | Other*

* Non-Hispanic

Age Distribution



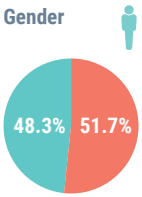
Fluency

3.9% speak English less than very well

Median Household Income

$99,621

Gender

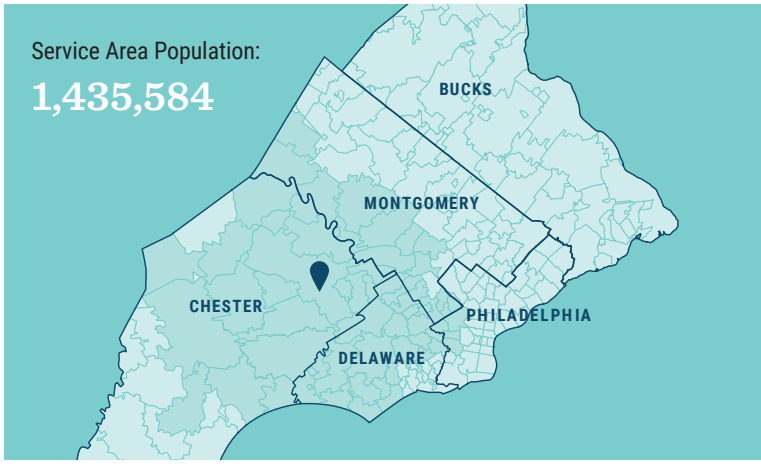


Impact of Prior Community Health Needs Assessment and Implementation

The information provided by community members and leaders informed the 2019 Community Health Needs Assessment for Main Line Health's Bryn Mawr Rehabilitation Hospital and helped us develop 14 initiatives across 3 overall priorities to focus on over the three-year cycle.

Main Line Health has been able to have direct impact on the long-term health and well-being of individual patients, families, and communities through our CHNA initiatives, and here are some key highlights from this cycle:

- **Community Health & Living:**
  Hosting ongoing support group activities for rehab patients and families to offer emotional support and regular social contact to help reclaim an active and satisfying life.
- **Diversity, Respect, Equity & Inclusion:**
  Embedding and highlighting Diversity, Respect, Equity & Inclusion activities and education into regular employee communication and leadership assemblies
- **Injury Prevention:**
  Continuing to enhance Driver Rehab Program, and support patients who are recovering from major injuries or living with a range of disabilities to be able to travel independently again



TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

Bryn Mawr Rehabilitation Hospital's service area is defined as ZIP codes representing 75 percent of discharge market area for the hospital.

Chester County: 19301, 19312, 19320, 19333, 19335, 19341, 19343, 19344, 19348, 19355, 19372, 19380, 19382, 19383, 19390, 19425, 19460, 19465, 19475

Delaware County: 19008, 19010, 19013, 19014, 19015, 19018, 19026, 19050, 19060, 19061, 19063, 19064, 19073, 19082, 19083, 19085, 19086, 19087, 19317, 19319, 19342, 19373

Montgomery County: 19003, 19004, 19041, 19066, 19072, 19096, 19401, 19403, 19405, 19406, 19426, 19428, 19453, 19462, 19464, 19468, 19525

Philadelphia County: 19131, 19139, 19143, 19151

Penn Medicine

Penn Medicine is one of the world's leading academic medical centers, dedicated to the related missions of medical education, biomedical research, and excellence in patient care.

Penn Medicine consists of the Raymond and Ruth Perelman School of Medicine at the University of Pennsylvania, founded in 1765 as the nation's first medical school, and the University of Pennsylvania Health System (UPHS), which together form a $8.9 billion enterprise.

The Perelman School of Medicine and UPHS are committed to improving lives and health through clinical care, research, medical education, and community service. In the 2020 fiscal year, Penn Medicine provided more than $560 million in benefit to the community. The Perelman School of Medicine has been ranked among the top medical schools in the United States for more than 20 years, according to *U.S. News & World Report's* survey of research-oriented medical schools. The School conducts more than $890 million in annual sponsored research and is consistently among the nation's top recipients of funding from the National Institutes of Health, with $495 million awarded in the 2020 fiscal year.

The School of Medicine has more than 775 M.D. students, 1,450 residents and fellows, and 2,800 full-time faculty members. In the City of Philadelphia, UPHS' patient care facilities include: The Hospital of the University of Pennsylvania, Hospital of the University of Pennsylvania – Cedar Avenue, Penn Presbyterian Medical Center, and Pennsylvania Hospital. At the end of fiscal year 2021, UPHS had 1,938 licensed beds in Philadelphia; it is a valued health care resource in the community.

BEDS	FULL-TIME FACULTY	RESIDENTS & FELLOWS	ADULT ADMISSIONS	OUTPATIENT VISITS	EMERGENCY DEPT. VISITS	BIRTHS
1,938	2,810	1,450	71,445	2,549,626	155,588	9,206

UPHS Philadelphia FY21 Profile

The Hospital of the University of Pennsylvania (HUP) was established in 1874 as a teaching hospital to complement the medical education received by students at the Perelman School of Medicine. Today, it has 20 clinical departments and provides training in more than 40 clinical specialties. Major areas of clinical focus across HUP include cardiac care, oncology, neurosciences, and women's health. HUP is one of the only hospitals in this region that performs transplants of all major organs. HUP's campus is a hub for innovative medical care, with a new hospital building, the Pavilion, that opened October 30, 2021. The Pavilion is one of the largest hospital projects in the U.S.—and the largest in the Philadelphia region. The building rises 17 stories on Penn Medicine's West Philadelphia campus as a place where Penn's world-renowned researchers, clinicians, and faculty will continue to pioneer advanced patient care. The $1.6 billion facility houses 504 private patient rooms and 47 operating rooms.

In March 2021, Hospital of the University of Pennsylvania – Cedar Avenue opened as part of a partnership with Public Health Management Corporation (PHMC) offering continuity in access to care and services in West and Southwest Philadelphia in place of a longstanding community hospital that needed to close. This site offers 121 licensed beds and continues to evolve into a multi-faceted and innovative public health campus. Penn Medicine manages the emergency department, inpatient services, and hospital-based behavioral health programming as HUP-Cedar. PHMC has opened a federally qualified health center at the site, which is staffed by clinicians from the Penn Medicine Department of Family Medicine and Community Health, providing community members with access to high-quality, integrated, patient-centered health care. A key element of the campus is a robust community engagement plan that includes regular and ongoing community outreach with stakeholders, thus supporting the engagement of community-based, non-profit social services that address key issues, such as health and wellness education and food insecurity.

Penn Presbyterian Medical Center (PPMC) is consistently recognized as a center of excellence for cardiac care, ophthalmology, and neurosciences. PPMC's campus includes the Musculoskeletal Center's outpatient facility at Penn Medicine University City and the Pavilion for Advanced Care, home to Penn Medicine's Level 1 Trauma Center. The PA Accredited Trauma Center operates around the clock to care for patients who have been critically injured in car accidents, falls, gunshot wounds and through other blunt and penetrating traumas. The Trauma Center at Penn Presbyterian Medical Center serves as a regional resource for injured patients caring for more than 3,000 patients annually, several hundred of whom are transferred from other area hospitals and trauma centers.

Pennsylvania Hospital is the nation's first hospital. Founded in 1751 by Benjamin Franklin and Dr. Thomas Bond, Pennsylvania Hospital has been a leader in patient care, treatment techniques, and medical education for over 270 years. Today its clinical programs include the Spine Center, orthopedics, the Center for Transfusion-Free Medicine, maternity and newborn services, and behavioral health. Pennsylvania Hospital is also home to Penn Medicine Washington Square, the hospital's outpatient facility.

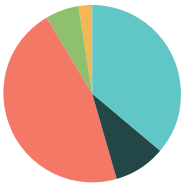
Within our Philadelphia facilities, in keeping with our charitable purpose, UPHS accepts patients in serious need of medical care regardless of their financial status. UPHS also provides care to patients who do not have health insurance or meet the criteria to qualify for its charity care policy. In fiscal year 2020, Penn Medicine, as an institution, provided $300.7 million in charity and underfunded care for patients in need.

The COVID-19 pandemic has reshaped our world and community. In the face of a historic health crisis, Penn Medicine took care of its neighbors in West and Southwest Philadelphia, which like other communities of color across our nation had been unfairly burdened by the pandemic and faced inequity in the COVID-19 testing access and vaccine distribution. As the pandemic spread through the region, Penn Medicine immediately responded by opening community-based testing sites, providing critical access to testing for Philadelphia. In addition, Penn Medicine supported the Sayre Health Center's testing site, one of the longest standing testing sites in the city with non-appointment based access. The Penn Medicine Community Vaccination set up vaccine clinics partnering with trusted neighborhood venues, embracing walk-in appointments and low-tech registration, and operating clinics outside of traditional business hours to vaccinate the most vulnerable members of our community.

Penn Medicine's distribution of the vaccines mirrors Philadelphia's racial composition, and according to city figures, 42 percent of all shots administered to Black patients in Philadelphia came from Penn Medicine. Faculty and staff also launched new initiatives to support community members. Care teams provided nutritional assistance to seniors and other vulnerable populations who were unable to grocery shop during stay-at-home orders at the height of the pandemic, as well as helped local, essential business owners who needed to establish safety protocols and maintain costly supplies of personal protective equipment (PPE) to serve the community during the pandemic.

SERVICE AREA DEMOGRAPHICS

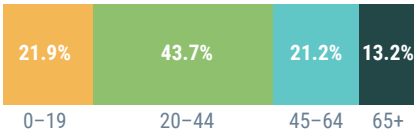
Racial Composition



9.3% | Asian*
45.9% | Black*
6.0% | Hispanic/Latino
36.3% | White*
2.4% | Other*

* Non-Hispanic

Age Distribution



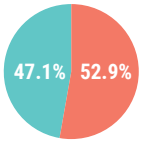
Fluency

6.5% speak English less than very well

Median Household Income

$54,868

Gender



Impact of Prior Community Health Needs Assessment and Implementation

Propelled by our missions of patient care, education, and research, and in response to the needs of our community, Penn Medicine has driven a number of programs to care for our neighbors and improve the well-being of our region:

The Penn Center for Surgical Health (CSH) aims to create sustainable infrastructure for access to high-quality, cost-conscious surgical care before it becomes an emergency, despite socioeconomic, political, racial, cultural or gender-based disparities. CSH pairs patients with a Personal Patient Navigator (PPN)—typically a medical student who has undergone CHS's PPN Training Program—to help patients through obtaining insurance or other funding and understanding and navigating from preoperative through to postoperative care. In its first 8 months, beginning in Fall 2021, CSH has helped 86 patients get 95 surgical procedures.

Puentes de Salud is a 501c3 nonprofit organization providing health, education, and wellness services to uninsured/uninsurable Spanish speakers in Philadelphia. The mission of Puentes is to improve key health and social inequities in the community by direct service provision & partnership with the community. Grounded in addressing the social determinants of health, Puentes advances their mission holistically via three interlocking service areas: a healthcare clinic, education services, and wellness branch. Healthcare services at Puentes include primary, specialty/surgical, and dental care. Their wellness services span art and culture, behavioral health, case management, and food access programs, as well as a robust promotora (community health worker) program. Puentes served more than 6,300 clients and patients in 2021.

The United Community Clinic (UCC) in the First African Presbyterian church is a student-run preventive care clinic founded by medical students and professors that has been treating neighborhood residents for nearly 25 years. For years, partner HIV organizations, like Philadelphia FIGHT, camped out in the clinic to offer testing for patients, but in late 2019, with the help of a Penn Medicine CAREs grant, UCC volunteers certified the space to be a Centers for Disease Control and Prevention-approved testing site so it could be performed by Penn staff. Today, patients who walk through the door are offered free testing during their clinical visit in a private area away from the other services.

In 2020, there were more than 93,000 drug overdose deaths in the United States, and in Philadelphia, death rates increased as well. Penn Medicine's **Center for Opioid Recovery and Engagement** (CORE) provides free peer support for individuals struggling with opioid use and their loved ones. The program provides multiple pathways to recovery by removing barriers and facilitating access to recovery resources. CORE offers hands-on medical and behavioral help to ensure individuals receive continued treatment and are supported within their communities. CORE's opioid use disorder (OUD) care team is made up of Certified Recovery Specialists who use their personal OUD experiences to provide participants with long-term guidance for recovery. CORE also offers enhanced case management services, providing assistance with obtaining housing, education, social service needs, support groups and access to treatment.

The Penn Center for Community Health Workers IMPaCT Program is a standardized, scalable community health worker (CHW) program in which Penn Medicine hires, trains, and deploys trusted laypeople from local communities to help patients address the social determinants of health, including food, housing, transportation, and chronic disease prevention. The program has been delivered to nearly 10,000 high-risk patients and proven in three randomized controlled trials to improve chronic disease control, mental health, and quality of care while reducing total hospital days by 65%. More than 1,000 organizations have accessed Penn's CHW toolkit, and we provide technical assistance to help organizations around the country create, launch, and sustain effective CHW programs.

TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

Penn Medicine defines its service area for Philadelphia-based hospitals as the following ZIP codes in the City of Philadelphia. This targeted service area comprises ZIP codes within a 1.5 miles radius of each of Hospital of the University of Pennsylvania, Penn Presbyterian, and Pennsylvania Hospital.

Philadelphia County: 19102, 19103, 19104, 19106, 19107, 19123, 19130, 19131, 19139, 19142, 19143, 19145, 19146, 19147, 19148, 19151

Inequities in access to cancer screenings for early detection, to cutting-edge treatments, and to participation in clinical trials for the next generation of treatments, contribute to persistent inequities in outcomes for underserved and minority patients. Black patients are 20 percent more likely to get colorectal cancer and 40 percent more likely to die of the disease, and uninsured or underinsured women are 60 percent more likely to die from breast cancer due to barriers to early detection. Penn Medicine's multifaceted efforts to address colorectal cancer screening disparities through the actions of **Abramson Cancer Center** have included community outreach and partnership with the Enon Tabernacle Church for drive-through/walk-through giveaways of at-home screening kits paired with navigation support for patients who need follow-up screening and care, partnership with Black-owned radio station WURD, and mailed at-home kits with research-backed text-messaging protocols to ensure screening in neighborhoods with low rates. The result is a higher rate of screening for Black patients ages 50-75 during the last fiscal year despite the pandemic, compared to the last available pre-pandemic national rate. The Penn Medicine Breast Health Initiative offers free breast cancer screenings and breast health education, among other support services that have reached more than 3,000 uninsured and underinsured women in the region since 2014. Abramson has also engaged in numerous community outreach efforts to boost enrollment of Black patients in research, resulting in nearly doubling of participation rates in the last five years.

Despite well-intentioned providers and advancements in medicine, health and healthcare disparities persist today. While disparities are often viewed through the lens of race and ethnicity, they can occur across many dimensions including socioeconomic status, age, geography (neighborhood), gender identity, sexual orientation, disability status, religious affiliation, primary language, and/or mental health status.

To ensure that Penn Medicine will continue to grow and invest in this priority area, the **Center for Health Equity Advancement** (CHEA) was founded. CHEA is the cornerstone for advancing high quality patient/family-centered care for all, regardless of their personal characteristics, supports community partnerships to tackle barriers to achieving optimal health for all communities we serve, and aims to provide equitable healthcare within inclusive environments that support a diverse workforce and student body. In order to build support for and align mutually reinforcing equity initiatives across the enterprise, Penn Medicine incorporates its Center for Health Equity Advancement Blueprint for Equity and Inclusion within the areas of delivering health care, engaging with our community, creating a diverse workforce, creating the evidence-base to achieve equitable and inclusive care, and empowering stakeholders to advance equity.

The **Penn Medicine CAREs Grant program** was established to offer institutional support to individuals and programs in the form of grants – awarded quarterly – that can be used for the purchase of supplies and other resources needed to perform this important work in the community. Since its inception in 2011, the CAREs program has funded over 800 service initiatives across the region Penn Medicine serves, including programs in community centers, farmers markets, and places of worship from Philadelphia, Lancaster, and Chester counties to the suburbs and shore communities of New Jersey. For a list of our most recently-funded programs, please visit https://www.pennmedicine.org/cares

To read more ways Penn Medicine serves its community, please visit https://communityimpact.pennmedicine.org/

Penn Medicine
Chester County Hospital

Chester County Hospital

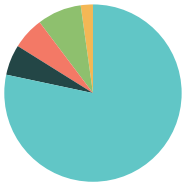
Chester County Hospital is a Penn Medicine hospital dedicated to the health and well-being of the people in Chester County, Pennsylvania, and the surrounding areas.

Chester County Hospital is a 329-bed inpatient facility in West Chester. Its outpatient services extend to satellite locations in Exton, West Goshen, New Garden, Jennersville and Kennett Square. Chartered in 1892 as a 10-bed dispensary, the hospital has been serving Chester County and its surrounding communities for more than 125 years. Chester County Hospital joined the University of Pennsylvania Health System in 2013 as part of its ongoing effort to provide the most progressive services available. In 2020, the hospital completed the largest expansion in its history. The project welcomed a state-of-the-art procedural platform with 15 operating room suites, a 99-bed patient tower, a new main entrance and an expanded and renovated Emergency Department.

BEDS	EMPLOYEES	PHYSICIANS	INPATIENT ADMISSIONS	OUTPATIENT VISITS	EMERGENCY DEPT. VISITS	BIRTHS
329	2,897	842	14,555	488,725	40,634	2,903

SERVICE AREA DEMOGRAPHICS

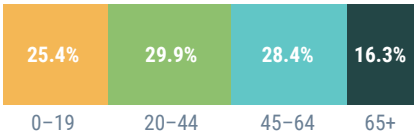
Racial Composition



5.6% | Asian*
5.9% | Black*
8.1% | Hispanic/Latino
78.4% | White*
2.0% | Other*

* Non-Hispanic

Age Distribution



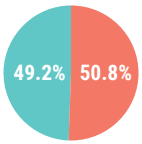
Fluency

4.3% speak English less than very well

Median Household Income

$100,207

Gender



Chester County Hospital offers an array of inpatient and outpatient medical and surgical services, including interventional and structural heart and vascular services; open heart surgery; advanced spine surgery; general, bariatric, orthopaedic and oncological surgery; medical and radiation oncology; wound care and hyperbaric medicine; and comprehensive maternal/infant health services. The hospital also provides home health and hospice care through Penn Medicine at Home; occupational and employee health care; professional and technical education; outpatient laboratory services; radiology and physical therapy services; prenatal and gynecological care for all; and cardiopulmonary rehabilitation.

True to its commitment to provide ways for people to maintain a healthy life, Chester County Hospital makes available a broad scope of high-quality health education programs for the community. Physician lectures give people the opportunity to meet the medical staff and learn about important health concerns. A wide variety of wellness programs and services are available that address specific life-cycle needs, mental health challenges, and chronic disease management.

Cardiovascular, cancer, blood pressure and other screenings are held throughout the year to help identify risk at an early stage. Support groups offer individuals the opportunity to share their experiences with others and learn from a skilled professional about how to manage and cope with health problems. During the COVID pandemic, the hospital quickly transitioned all in-person programming to virtual platforms.

Chester County Hospital also partners with many entities, including local government, foundations, and fellow non-profit organizations to extend the reach of its services in the community.

VISION STATEMENT

To be the leading provider of care in the region and a national model for quality, service excellence and fiscal stewardship.

OUR VALUES

Chester County Hospital focuses on five foundational values that preserve key aspects of its corporate culture while reinforcing and clarifying expectations for the future.

The values are: Innovation, Collaboration, Accountability, Respect, and Excellence and are known internally by their acronym, ICARE.

AWARD-WINNING CARE

Chester County Hospital is continually recognized and awarded for health care excellence. Here are just a few of the honors and acknowledgments we have received.

Centers for Medicare and Medicaid Services

Chester County Hospital has been awarded a five-star rating — the highest possible score — by the Centers for Medicare & Medicaid Services (CMS).

Cancer Commendation

In 2019, the cancer program at the Abramson Cancer Center at Chester County Hospital was granted a three-year accreditation with commendation by the Commission on Cancer (CoC) of the American College of Surgeons. The Breast Health Program was also reaccredited by the National Accreditation Program for Breast Cancers

Chester County Hospital Baby-Friendly

Chester County Hospital has received prestigious international recognition as a designated Baby-Friendly birth facility by Baby-Friendly USA.

Diabetes Education Program: Reaccreditation

The Diabetes Self-Management Program achieved accreditation by the Association for Diabetes Care and Education Specialists (ADCES). Accreditation represents a high level of quality and service to the community, and the ability to better meet the needs of those affected by diabetes.

Magnet Team: Reaccreditation

Chester County Hospital's nursing staff has been recognized by the American Nurses Credentialing Center's (ANCC) Magnet Recognition Program® for its excellence in patient care.

National Diabetes Prevention Program (NDPP)

The Center for Disease Control (CDC) has designated Chester County Hospital with Full Plus Recognition for its diabetes prevention program. This designation is reserved for programs that have effectively delivered a quality, evidence-based program that meets all of the standards for CDC recognition and additional retention thresholds.

Primary Stroke Center

Chester County Hospital has been certified as a Primary Stroke Center by The Joint Commission.

50 Top Cardiovascular Hospitals 2022

Chester County Hospital was named as one of the nation's top performing hospitals by *Fortune* and *IBM Watson Health*. The annual "Fortune/IBM 50 Top Cardiovascular Hospitals" study spotlights leading short-term, acute care, non-federal US hospitals that treat a broad spectrum of cardiology patients.

U.S. News & World Report: 2020/2021

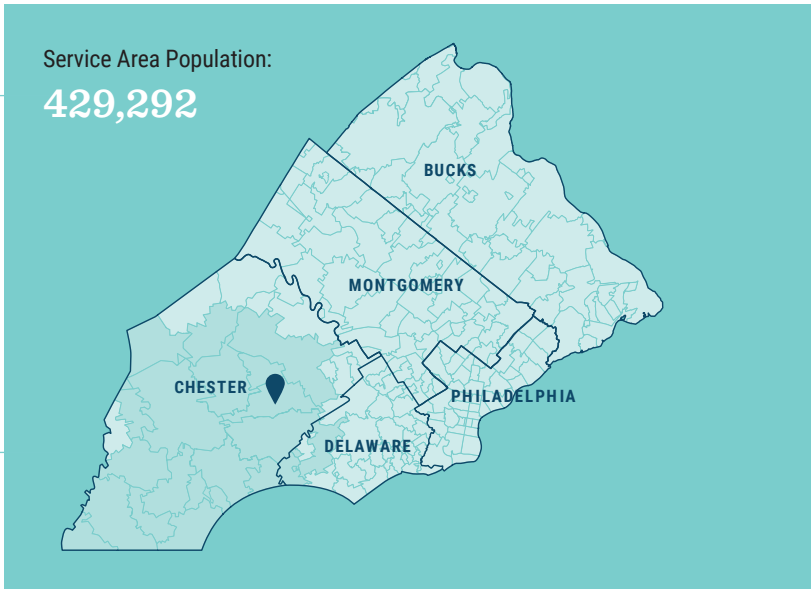
Chester County Hospital is ranked #14 in Pennsylvania and #8 in the Philadelphia Metro Area. The hospital is recognized as High Performing in gastroenterology (GI) and GI surgery, neurology and neurosurgery, pulmonology and lung surgery, as well as heart failure, heart attack, stroke, back surgery, hip replacement, chronic obstructive pulmonary disease (COPD) and pneumonia.

TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

Chester County Hospital's market area is comprised of West Chester and surrounding ZIP codes where the Hospital has greater than 50% share of the market and/or the market contributes greater than 4% of inpatient volumes.

Chester County: 19311, 19316, 19320, 19330, 19335, 19341, 19343, 19344, 19348, 19350, 19352, 19355, 19358, 19362, 19363, 19365, 19367, 19372, 19374, 19375, 19380, 19382, 19390, 19425

Delaware County: 19317, 19319, 19342



Impact of Prior Community Health Needs Assessment and Implementation

The 2019 CHNA and resulting three-year implementation plan identified multiple priorities and actions to address the health needs affecting our community. Highlights of the impact of this plan include the following:

Access to Affordable Specialty Care/ Primary and Preventive Care

- Collaboratively planned with community partners to provide free screenings, labs, and diagnostic radiology services for the underserved population.
- Chester County Hospital's staff and physicians worked closely with local church and civic leaders to provide education about COVID-19 virus and vaccines in order to reduce vaccine hesitancy within our region. Over 20,000 community members were immunized - at the hospital, churches, and community centers.

Chronic Disease Prevention

- Delivered a yearly average of 459 wellness and health education programs that targeted chronic disease prevention and mental health to 8,569 individuals.
- Provided a yearly average of 1,249 nutrition counseling visits with a registered dietitian at no charge to cancer patients in treatment.

Healthcare and Health Resources Navigation

- Expanded nurse navigator capacity by 39% to coordinate high quality, patient-centered care within major disease-specific teams.
- Provided free transportation to an average of 1,680 cancer treatment patients per year.
- Provided convenient access to Medical Assistance and Financial Representatives for enrollment in public benefits and programs.

Linguistically and Culturally Appropriate Healthcare

- The Diversity, Equity and Inclusion Council conducted monthly diversity awareness for all employees.
- Provided a bilingual diabetes educator and dietitian to counsel Spanish-speaking patients with culturally appropriate care for the management of gestational diabetes.

Maternal Morbidity and Mortality

- Implemented the Heart Safe Motherhood Program to enable doctors to remotely monitor new mothers with high blood pressure from the comfort of their own homes. Patients in the hospital's OB clinic, many who are Spanish-speaking, were initially targeted since they have a higher incidence of developing hypertension.
- Provided care for free or at a reduced cost for a yearly average of 406 prenatal patients at the hospital's OB Clinic.

Substance/Opioid Misuse and Use Disorder

- Partnered with Chester County Drug and Alcohol Services to provide education on Opioid Use Disorder (OUD). These quarterly programs also provided participants with NARCAN (naloxone) for the treatment of known or suspected opioid overdose emergencies.
- Provided multiple education programs on OUD to all clinical staff including providers, nurses, pharmacists, case managers and social workers.

Redeemer Health

With an emphasis on providing a continuum of care, Redeemer Health remains true to the mission to Care, Comfort, and Heal that its founders, the Sisters of the Redeemer, began in our region in 1924 — to provide high quality, compassionate care.

As a Catholic healthcare provider, Redeemer Health offers a wide range of healthcare and health-related services, including an acute care hospital, home health and hospice services, three skilled nursing facilities, personal care, a retirement community, low-income housing, an independent living community, a transitional housing program for homeless families, and multiple homes for independent, intellectually disabled adults. With corporate offices in Huntingdon Valley, Pennsylvania, Redeemer Health serves southeastern Pennsylvania and 11 counties in New Jersey, from Union County south to Cape May County.

Among its wide array of clinical services, Redeemer Health places a particular focus on cancer care, women's health, cardiovascular health and orthopedics.

In 2021 Cooper University Health Care and Redeemer Health announced a partnership, creating an integrated cancer program at Holy Redeemer Hospital that is overseen by MD Anderson Cancer Center at Cooper. The partnership expands advanced cancer care in Philadelphia, Montgomery, and Bucks counties by offering access to proven cancer treatment protocols, cancer experts, clinical research, and patient support and education resources through MD Anderson at Cooper.

The hospital has highly regarded programs in obstetrics and gynecology, overseeing 2,836 deliveries in FY21; high-risk maternal-fetal medicine; neonatal intensive care; breast and heart health; and gynecologic oncology.

BEDS	EMPLOYEES	PHYSICIANS	INPATIENT ADMISSIONS	OUTPATIENT VISITS	EMERGENCY DEPT. VISITS
239	3,623	774	9,697	158,334	26,330

MISSION

As a Catholic health system, rooted in the tradition of the Sisters of the Redeemer, we Care, Comfort, and Heal following the example of Jesus, proclaiming the hope God offers in the midst of human struggle.

Redeemer Health also maintains a cutting-edge cardiovascular center at Holy Redeemer Hospital. In August 2021, the health system launched a joint venture with Doylestown Health to expand access to high-quality cardiovascular care in the region from its location in Meadowbrook.

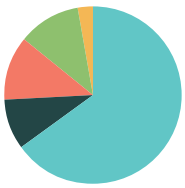
The hospital houses a 24-bed inpatient senior behavioral health unit, a 21-bed transitional care unit, and a wound care center to address the needs of the community it serves. Its orthopedics offerings encompass surgical and nonsurgical treatments and a Sports Medicine Center including therapeutic aquatic facilities.

In recognition of the care it provides, Holy Redeemer Hospital is accredited with commendation by the Commission on Cancer of the American College of Surgeons. The hospital's breast health program is accredited with the National Accreditation Program for Breast Centers. Holy Redeemer Hospital has also been honored with the Get with the Guidelines®-Stroke Gold Plus Quality Achievement Award, the Target: Stroke Honor Roll Elite award, the Target: Type 2 Diabetes Honor Roll award, and the Mission: Lifeline Gold Award STEMI, all from the American Heart Association. It achieved DNV GL certification as a primary stroke center and earned Accreditation for Cardiovascular Excellence. It is designated as an Aetna Institute of Quality in Orthopedics and a Blue Cross Blue Shield Blue Distinction Center for Spine Surgery. The hospital has repeatedly earned an A grade for safety by the Leapfrog Group, a national independent watchdog organization. Additionally, it has earned recognition from the Hospital and Healthsystem Association of Pennsylvania for excellence in patient safety.

Holy Redeemer Hospital holds academic affiliations in nursing with several local colleges and universities, including Drexel University, Gwynedd Mercy University, Holy Family University, Johns Hopkins University, Thomas Jefferson University, LaSalle University, and Villanova University.

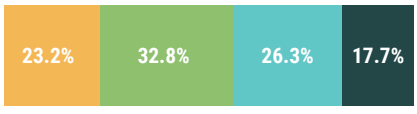
SERVICE AREA DEMOGRAPHICS

Racial Composition



9.3% | Asian*
11.7% | Black*
11.2% | Hispanic/Latino
65.0% | White*
2.7% | Other*
* Non-Hispanic

Age Distribution



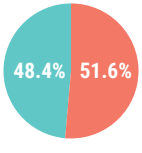
Fluency

13.3% speak English less than very well

Median Household Income

$64,046

Gender



TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

Holy Redeemer Hospital defines its targeted service area as the following ZIP codes in Bucks, Montgomery, and Philadelphia counties. These areas represent 75 percent of Holy Redeemer Hospital's inpatient admissions plus nearby areas.

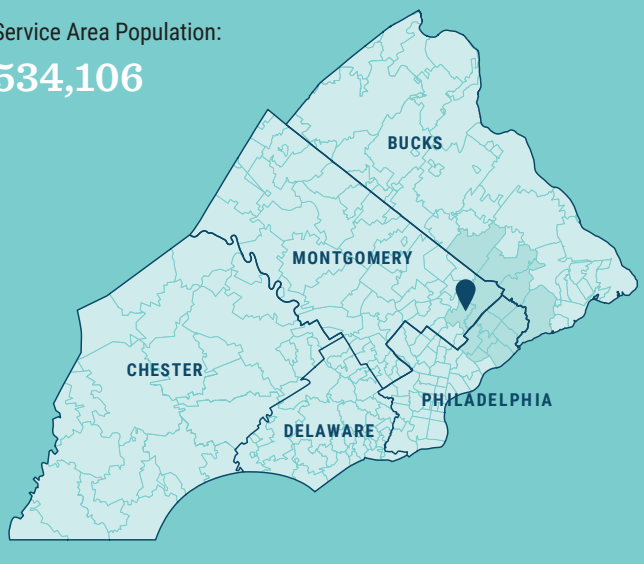
Bucks County: 18966, 18974, 19020, 19053

Montgomery County: 19006, 19009, 19046

Philadelphia County: 19111, 19114, 19115, 19116, 19136, 19149, 19152, 19154

Service Area Population:

534,106



Impact of Prior Community Health Needs Assessment and Implementation

Redeemer Health's 2019 priorities were based on three criteria: problem magnitude; strategic plan alignment; and resource availability. Ranked needs and actions performed since the development of the implementation plan include the following:

Chronic Disease Prevention

Included a focus on nutrition, exercise, screenings, and smoking cessation activities to have an impact on prevention, identification and management of health conditions. Activities included a five-week Healthy Kids run in person and virtually; healthy cafeteria committee with consumer education, food labels and recipes; diabetic and nutrition counseling; partnership with Simplex Health to provide intensive diet management services for community members and staff; free smoking cessation classes; added two certified smoking counselors; free breast cancer screenings to the un/underinsured; free Zoom webinars on cancer topics including breast, colon, lung, and cervical; participated in community events providing education and resources; community garden; and education through social media and email publications, among other activities.

Behavioral Health Diagnosis and Treatment

Continued colocation of behavioral health therapists in physician practice offices; increasing access during the pandemic by providing telehealth appointments which have continued at the convenience of patients; 24/7 telephone support line; Zoom support group meetings; through the COACH collaborative pursuing trauma informed care training in multiple areas throughout the system; and information on support resources through social media and email publications.

Substance/Opioid Use and Abuse

Developed a program for prenatal and postpartum women addicted to opioids, using a trauma informed approach which will include providing support for neonatal abstinence syndrome babies and connection to supportive services for the mothers and families. Hired an OB navigator and a behavioral health counselor. Established resources and a referral process from the physician practices as well as established a screening tool to identify women in need.

Maternal Morbidity and Mortality

Developed a program for prenatal and postpartum women addicted to opioids as a support for their NAS babies and families. Participated in the PA Perinatal Quality Collaborative with other organizations, using best practices, monthly and quarterly learning sessions, and support of a PA-PWC coach to improve the clinical conditions which increase morbidity and mortality. Opened a location in northeast Philadelphia with co-located obstetric, pediatric urgicare, lab and diagnostic services, providing improved access for women to obtain prenatal and postpartum services.

Access to Affordable Specialty Care

Opened a location in northeast Philadelphia with multiple services to increase access to care. In the cancer center, added a social worker who identifies social determinants, access to transportation services, added two nurse navigators to help patients access care, as well as a financial counselor to identify patients with financial needs, connecting them to pharmaceuticals, food, grants and copay assistance. Single electronic health record implemented to coordinate care and call center added for ease of scheduling. A full-time Russian and Ukrainian interpreter was hired, more documents were translated into other languages and more language lines were added.

Food Access and Affordability

Continued to operate our three food pantries throughout the pandemic, delivering food when able through the newly developed Food Access Support Technology platform, a project of Penn Medicine's Center for Health Equity Advancement. Provided fresh produce and when able a choice model. Continued working with the COACH collaborative on identifying and providing resources for food insecure patients. Added a comfort cupboard with food and other basic needs in the cancer center. All cancer patients are assessed by the financial counselor and given access to the comfort cupboard.

TEMPLE HEALTH
TEMPLE UNIVERSITY HOSPITAL

Temple University Hospital

Temple University Health System's mission is to provide access to the highest quality of health care in both community and academic settings. In furtherance of the mission of Temple University Health System, the mission of Temple University Hospital is to support Temple University and its Health Sciences Center's academic programs by providing the clinical environment and service to support the highest quality teaching, training and research programs for health care students and professionals. We embrace our values of Respect, Service and Quality.

As the chief clinical training site for the Lewis Katz School of Medicine at Temple University, Temple University Hospital (TUH) is a nonprofit academic medical center that trains the next generation of healthcare professionals. We are an indispensable provider of healthcare for America's largest city without a public hospital. Dedicated to improving the health and quality of life in our neighborhoods, we provide access to medical care across all specialties with the same high quality care regardless of economic status. TUH is a Level 1 Trauma Center, Burn Center verified by the American Burn Association and has a Neo-Natal Intensive Care Unit.

Temple University Hospital's commitment to healthcare equity transcends every aspect of our business model. This includes decisions around access points, care delivery, operations, employment and workforce training from entry level throughout the spectrum of health professions education. At Temple, this is resulting in quality outcomes and opportunity that exceed those in less challenged communities.

BEDS	EMPLOYEES	PHYSICIANS	ADVANCED PRACTICE PROVIDERS	INPATIENT ADMISSIONS	OUTPATIENT VISITS	EMERGENCY DEPT. VISITS
879	6,000	609	219	38,288	1,000,000+	151,641

In addition to Temple University Hospital's main campus in North Philadelphia, our Episcopal Campus is home to Temple Hospital's behavioral health services, including a Crisis Response Center, emergency room and offers a wide range of adult psychiatric services. Episcopal's Behavioral Health program is recovery treatment oriented, offering a welcoming approach and hope for those afflicted with mental illness and co-occurring substance use disorders.

Temple University Hospital's Jeanes Campus, located in Northeast Philadelphia, is the nation's only Quaker-founded hospital. Operating for over 90 years, Jeanes combines the services of a community hospital with the advanced capabilities of an academic medical center. Our Northeastern Campus provides outpatient services in a convenient neighborhood setting.

As our chief clinical teaching site, Temple University Hospital has 46 accredited medical specialty residency programs training over 670 medical residents and fellows each year. Our medical residency programs focus on the "human side" of medicine, teaching residents to treat the whole patient by considering the cultural experiences and communities of those served. Residents enhance their clinical education by engaging in service projects benefiting our communities, preparing them to care for a wide range of populations and health conditions.

In addition to our medical residency programs, we provide clinical rotations to thousands of nursing, social work, physician assistant and behavioral therapy students annually from Temple University, the Community College of Philadelphia and many other academic institutions.

Our affiliated Temple Center for Population Health promotes our health equity and population health efforts. Its mission is to attain a sustainable model of health care delivery through clinical and business integration, community engagement, and academic distinction to promote healthy populations. The Center includes a comprehensive inpatient and outpatient community health worker program, chronic disease management programs for at risk populations and more.

NOTABLE AWARDS AND DISTINCTIONS

In recognition of our business model and inclusive culture, TUH is ranked the most racially inclusive hospital in Pennsylvania and the 12th most inclusive hospital in the United States in 2021 by the Lown Institute.

TUH also received a Leapfrog Safety Grade "A" and is in the top 20% in Safety and top 10% in Efficiency in the nation on Vizient's academic medical center scorecard.

Among our many other national and regional recognitions, Leapfrog designated TUH a Top Teaching Hospital with its 2021 Leapfrog Top Hospital Award for Outstanding Quality and Safety. TUH is the only academic medical center in Philadelphia to earn this award, widely acknowledged as one of the most competitive awards U.S. hospitals can receive, bestowed upon less than 7% of eligible hospitals.

Temple University Hospital offers an extensive range of nationally and regionally renowned medical and surgical services to meet the needs of patients in the Philadelphia region and beyond, a few of which we highlight below.

Temple Heart & Vascular Institute

Our Heart & Vascular Institute is a hub of innovative clinical care, research, and education. The Institute has 27 specialized programs and over 100 cardiovascular caregivers, many nationally renowned. Our staff draw upon their collective experience and our state-of-the-art facilities and technology to deliver high-quality, personalized care for the entire range of cardiovascular conditions from high blood pressure to advanced heart failure and transplantation. We offer patients the newest minimally invasive procedures, mechanical assist devices, artificial hearts, and advanced surgeries, including complex hybrid procedures and multi-organ transplantation.

Temple Lung Center

Temple is an international leader in developing new therapies for serious lung diseases. Our Lung Center has over 20 specialized lung disease programs that provide highly focused care from physicians who are trained in specific conditions. A distinguishing feature of the Center is its innovative research program that is unraveling the mechanisms of lung disease, discovering new treatments and testing lifesaving devices. Our robust slate of clinical trials – the largest in the nation for non-cancer related pulmonary disease – provides patients with access to novel therapies. TUH also has the nation's # 1 lung transplant program in volume with the best one-year survival rates in the Philadelphia region and state of Pennsylvania.

Transplant Program

Temple University Hospital has a nearly 40-year history of excellence in organ transplantation, having performed Philadelphia's first heart transplant in 1984. Today, in addition to hearts, we transplant lungs, livers, kidneys, and pancreases with excellent results. The Fox Chase-Temple University Hospital Bone Marrow Transplant Program has among the best outcomes in the nation. Our transplant teams have pioneered methods to improve organ donor health and avoid post-transplant complications.

Digestive Disease Center

Our Digestive Disease Center's large clinical practice and active research program enable us to apply the latest techniques to treat even the most challenging cases involving the esophagus, stomach, small intestine, gallbladder, colon, and liver. Our areas of specialization include colorectal surgery, esophageal disorders, bariatric surgery, gastrointestinal cancer, inflammatory bowel disease, motility disorders, and therapeutic endoscopy. In addition, our thoracic surgeons are part of the Digestive Disease Center team, performing upper gastro intestinal surgeries, often robotically. These include surgeries for esophageal cancers, Barrett's esophagus, gastroesophageal reflux disease and achalasia.

Neurosciences Center

The Temple Neurosciences Center offers advanced care for conditions of the brain, spine, and nerves. Specialized neurological programs contained within our Center address medical conditions such as stroke, multiple sclerosis, epilepsy, movement disorders, neuromuscular disease, and amyotrophic lateral sclerosis (ALS). Our Center is home to the nationally respected Muscular Dystrophy Association/ALS Center of Hope and a stroke program that has been nationally recognized for its high success rate in treating complex stroke patients. The Center's strong basic science and clinical research program provide patients with options for complex neurological conditions that other hospitals may not offer.

Orthopedics & Sports Medicine

Temple's Orthopedics and Sports Medicine team includes many of Southeast Pennsylvania's most respected surgeons and rehabilitation specialists. Our team provides advanced, personalized treatments for a wide range of injuries and conditions. This includes injuries of the foot and ankle, hand, knee, shoulder, elbow, and spine. Our orthopedic specialists also have special expertise in orthopedic trauma, joint replacement, sports medicine, and physical therapy. Our experts combine their experience and research with the latest technology and minimally invasive treatment techniques to help patients achieve a pain-free life.

TUH PATIENT PROFILE

HEALTH COVERAGE	AGE	CHRONIC CONDITIONS	LANGUAGES	BEHAVIORAL HEALTH	SUBSTANCE MISUSE
86% have government health coverage: 45% Medicaid; 41% Medicare	**62%** are 50 years of age or older	**70%** suffer from one or more chronic health conditions	**12%** do not speak English as primary language	**51%** have behavioral health diagnosis	**25%** have substance use disorder diagnosis

Service Area Population:
558,193

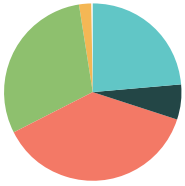
TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

Temple University Hospital's primary service area is comprised of 12 ZIP codes representing where approximately 70% of patients seen on an inpatient and observation basis reside.

Philadelphia County: 19111, 19120, 19121, 19122, 19124, 19125, 19132, 19133, 19134, 19135, 19140, 19149

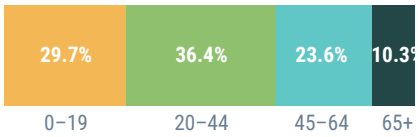
SERVICE AREA DEMOGRAPHICS

Racial Composition



6.4% | Asian*
37.5% | Black*
30.0% | Hispanic/Latino
23.8% | White*
2.4% | Other*
* Non-Hispanic

Age Distribution



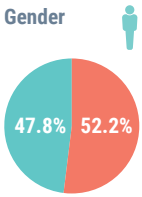
Fluency

14.9% speak English less than very well

Median Household Income

$35,405

Gender



Impact of Prior Community Health Needs Assessment and Implementation

In TUH's 2019 CHNA, six areas of focus were prioritized based our community's greatest needs:

1. Chronic Disease
2. Access to Healthcare
3. Mental Health Treatment Access and Education
4. Substance Use Disorder Treatment Integration
5. Violence Prevention and Intervention
6. Moms and Newborns

Through a collaborative process with community stakeholders, TUH developed an implementation plan with numerous strategies, goals and programs to address community needs including those described in our Community Benefit Report. See: https://www.templehealth.org/locations/temple-university-hospital/about/community-health Additional programs developed since the 2019 CHNA include the following innovative programs to improve outcomes and advance health equity:

» Multi-Visit Patient Clinic

Provides a full continuum of care for patients with high emergency department use and frequent inpatient admissions. Upon discharge, Community Health Workers link patients with follow-up healthcare and provide meals, transportation, home lists and other social supports. Patients enrolled in the clinic show a 40% reduction in emergency department use, 21% reduction in inpatient utilization and over 50% increase in outpatient services use, demonstrating they are seeking more appropriate care in effective settings.

» Trauma Victim Advocate Program

We provide social, emotional, and material support to violently-injured patients and patients from their time of entry into our hospital through discharge. Our 24/7 advocate team offers counseling and facilitate access to victim's services that aid with post-traumatic recovery and community re-integration. They provide referrals to crime agencies to assist with relocation, recovery of lost wages, unpaid medical bills and mental health services.

» Certified Peer Recovery Specialist Team

We hired a team of Recovery Specialists with lived experience and specialized training that link overdose patients and families with needed services after treatment in our Emergency Departments and Crisis Response Center.

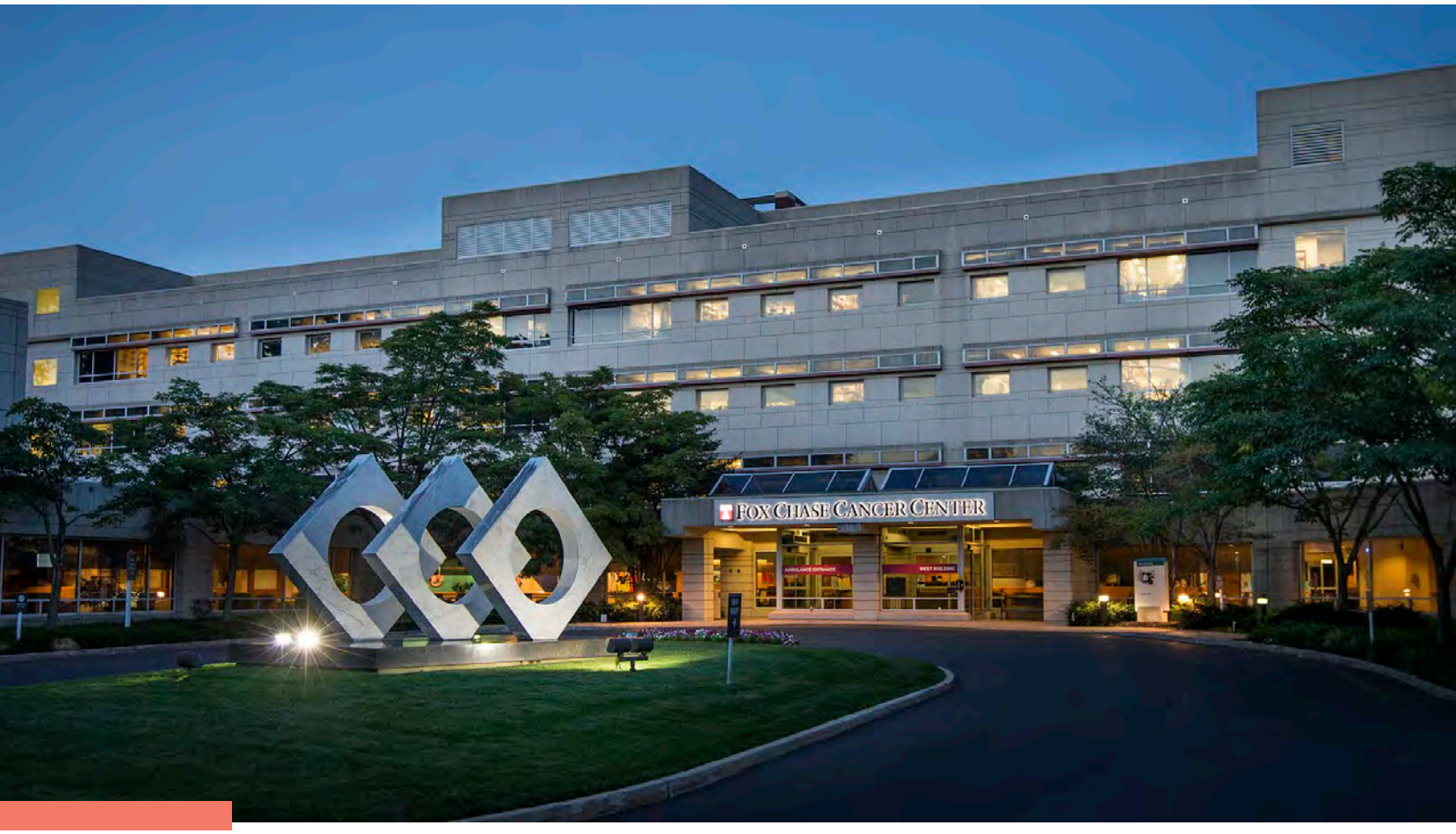
» Vision Program

Our Volunteers in Spiritual Interactions from Our Neighborhood (VISION) program trains community members to serve as volunteer chaplains in our hospital. They support patients and families during crisis by providing spiritual and cultural services.

» Healing Through Work

Our partnership with the Pennsylvania Commission on Crime and Delinquency and Philadelphia Works connects victims of gun violence with gainful employment to disrupt the cycle of interpersonal violence, open pathways and bring stability to lives. A full-time workforce development specialist on our trauma team enrolls participants, help set career goals, creates access to career pathways, and provides ongoing training and mentorship.

More detail on TUH's past CHNA Implementation Plan, Community Benefit Programs and progress in addressing community needs can be found on our Community health page. See: https://www.templehealth.org/locations/temple-university-hospital/about/community-health



Fox Chase Cancer Center

MISSION

To prevail over cancer, marshaling heart and mind in bold scientific discovery, pioneering prevention, and compassionate care.

Fox Chase Cancer Center is committed to clinical excellence, research expertise, and community health. Fox Chase was founded in 1904 as the American Oncologic Hospital by a group of prominent Philadelphia physicians and laymen concerned with rising cancer deaths in the city. In 1974, the hospital combined with the *Institute for Cancer Research*, founded in 1927, to create Fox Chase Cancer Center as one of the nation's first Comprehensive Cancer Centers designated by the National Cancer Institute. Fox Chase joined Temple University Health System in 2012, which furthered expanded its research and treatment expertise and accomplishments.

Throughout its history, Fox Chase has been committed to treating all individuals for cancer regardless of race, creed, or color. The center has created a legacy of nationally competitive basic, translational, and clinical research, as well as special programs in cancer prevention, detection, survivorship, and community outreach.

Located in the heart of Northeast Philadelphia, Fox Chase's main campus serves the surrounding community with state-of-the-art cancer technology, leading physicians, novel therapies, and cutting-edge clinical trials. Patients outside of the main campus's immediate area can also access this one-of-a-kind care through Fox Chase's campuses on Broad Street in North Philadelphia, East Norriton, and Buckingham.

BEDS	EMPLOYEES	PHYSICIANS	ADVANCED PRACTICE PROVIDERS	INPATIENT ADMISSIONS	OUTPATIENT VISITS	SURGICAL PROCEDURES
100	2,100	119	53	3,484	140,503	4,940

Fox Chase medical teams know that a cancer journey does not end once a patient finishes treatment. That is why cancer care at Fox Chase extends across the cancer spectrum, from diagnosis through survivorship. With nurse navigators to help patients find their way through facilities, translators to assist patients with critical communication, and support groups for patients in all stages of the cancer journey, Fox Chase creates a welcoming environment for those it serves.

A leader in cancer prevention and risk assessment, Fox Chase established one of the first risk programs in the country in 1991 for individuals with a family history of breast and/or ovarian cancer. This program serves as a national model and led to risk-assessment services at Fox Chase for other cancer types. Today, Fox Chase's *Department of Clinical Genetics* builds on this pioneering spirit to offer the most comprehensive risk assessment program in the greater Philadelphia area. Its cancer risk-assessment team of physicians, nurses, and genetic counselors helps individuals and families determine their risk of getting cancer through clinical and genetic evaluation and screening. The team then designates steps to help an individual reduce their cancer risk.

In addition to providing outstanding oncology care, Fox Chase is an epicenter for cancer research. Over the last 90 years, Fox Chase's *Institute for Cancer Research* has made several seminal discoveries that shaped the future of cancer prevention and treatment, including identifying tumor suppression, reprogramming tumor cells, understanding genetic cancer risks, advances in radiotherapy, and many others. Two Fox Chase researchers have been Nobel Prize recipients and the center has received many other research accolades.

The translational research of Fox Chase's research institutes and programs impacts patients directly. *The Cancer Epigenetics Institute* at Fox Chase facilitates academic-to-industry and academic-to-academic partnerships with the goal of promoting discovery in cancer epigenetics. Its discovery efforts aim to reduce the morbidity and mortality associated with cancer by focusing on biomarker research and therapeutic interventions.

Fox Chase's *Marvin & Concetta Greenberg Pancreatic Cancer Institute* is another asset of a center committed to achieving breakthroughs in early detection and treatment. The Pancreatic Cancer Institute features collaboration between Fox Chase scientists, researchers, and physicians. The institute's vision includes finding new ways to detect cancer earlier, extend the lives of pancreatic cancer patients, and to eventually find a cure.

Fox Chase has also been designated a *National Pancreas Foundation Center* by the National Pancreas Foundation, a nonprofit organization that provides support for patients with pancreatic cancer and other pancreas-related diseases. Fox Chase is the only institution in the Philadelphia region to earn this designation.

In addition to these research strengths, Fox Chase has many programs in-house and offsite as part of its commitment to community health improvement. Fox Chase's Community Outreach programs are available to everyone, but the center makes a special effort to reach populations and neighborhoods that experience health disparities, which includes populations that experience a higher cancer burden, because Fox Chase believes that everyone deserves the same access to high-quality health care. The center's *Mobile Screening Unit*, in partnership with the Flyers Charities, provides cancer screening and prevention to community members in Philadelphia and beyond.

As part of its community health improvement efforts, Fox Chase Cancer Center has many programs to address cancer disparities and encourage diversity in research. These programs include the *Cancer Prevention Project of Philadelphia* (CAP3), which educates community members on the importance of cancer prevention and screening. It helps the community better understand the value of cancer disparity research and participation in research studies.

In 2006, a Fox Chase researcher founded the *African Caribbean Cancer Consortium* to investigate and respond to increasing cancer vulnerability among African-descended populations worldwide. The group is in the process of establishing a *Caribbean Regional Center of Research Excellence* in partnership with the University of the West Indies-Mona in Jamaica. It is the planned first step toward developing a broader network of Caribbean centers of excellence that will grow to address diabetes, heart disease, and stroke.

Fox Chase recognizes that the beginning of its compassionate culture begins with cultivating interest among young adults in STEM programs. Under the *Immersion Science Program*, Fox Chase established classroom laboratories in 11 Philadelphia schools with support from the Howard Hughes Medical Institute.

The program enhances the science and math foundation of participants, thus building confidence and preparing students for rigorous science, technology, engineering, and math majors. *Of the 1,000 students who benefit from the program annually, 80% are from the School District of Philadelphia; 75% receive paid positions in research labs as undergraduates and 22% become published authors prior to college graduation.*

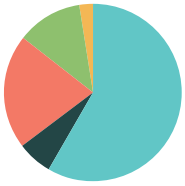
NOTABLE RECOGNITIONS

The special brand of care offered at Fox Chase has earned it widespread recognition. Fox Chase doctors are consistently ranked among the best in their specialties in *Philadelphia* Magazine's Top Doctors list, and the center's nursing teams have received the Magnet designation for excellence in nursing services by the American Nurses Credentialing Center's Magnet Recognition Program. Fox Chase is the first in Pennsylvania and first acute specialty hospital in the United States to receive Magnet status.

Fox Chase programs are frequently recognized for excellence among their peers. For two years in a row, the *Fox Chase Bone Marrow Transplant Program's* performance for one-year survival has been above the expected survival rate when compared to similar programs in the United States. It is the only center with this distinction in the tristate area of Pennsylvania, New Jersey, and Delaware.

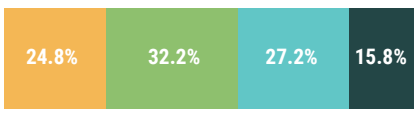
SERVICE AREA DEMOGRAPHICS

Racial Composition



6.3% | Asian*
21.0% | Black*
11.8% | Hispanic/Latino
58.5% | White*
2.4% | Other*
* Non-Hispanic

Age Distribution



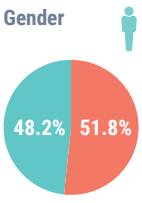
Fluency

7.7% speak English less than very well

Median Household Income

$80,843

Gender



Impact of Prior Community Health Needs Assessment and Implementation

As a result of Fox Chase's 2019 Community Health Needs Assessment, the center strategically focused on the following four (4) priority areas:

» Improve cancer screening, navigation, and education:

To address health insurance issues and lack of access to care, Fox Chase enhanced community access to preventive cancer screening and programs and provided navigation services to those patients that need follow-up services or have financial, language, or other barriers. In addition, Fox Chase delivers evidence-based cancer education and resources to address the regional cancer burden. The center's *Community Cancer Screening Program* provides community-based breast cancer and other types of screening through the Mobile Screening Unit (MSU). The MSU helps ensure equal access to care among the medically underserved populations that may have many barriers to obtaining proper health care, including a lack of health insurance.

» Reduce chronic disease through cancer prevention

Fox Chase delivers evidence-based cancer screening, smoking cessation services, and nutrition education. One example of this is the *Community Tobacco Treatment Program*. This five-week smoking cessation program is delivered by a health educator with a national certificate in tobacco treatment practice and a certified nurse practitioner. This program was brought into community partner sites in underserved areas where smoking rates are high to help address barriers to seeking cessation counseling. It has also been run virtually in order to further increase access.

» Provide caregiver support

Fox Chase addresses mental health concerns among caregivers through support groups and a patient-to-patient network. The *Caregiver Network* is a telephone-based support program that connects trained caregivers to new caregivers.

» Prevent prescription drug abuse

Fox Chase established an *Opioid Stewardship Committee* that developed a hospital-wide education campaign to educate patients and family members about the use of opioids in cancer care. In addition, providers prescribe less opioids in an effort to reduce the quantity of these medicines prescribed to opioid-naïve surgical patients.

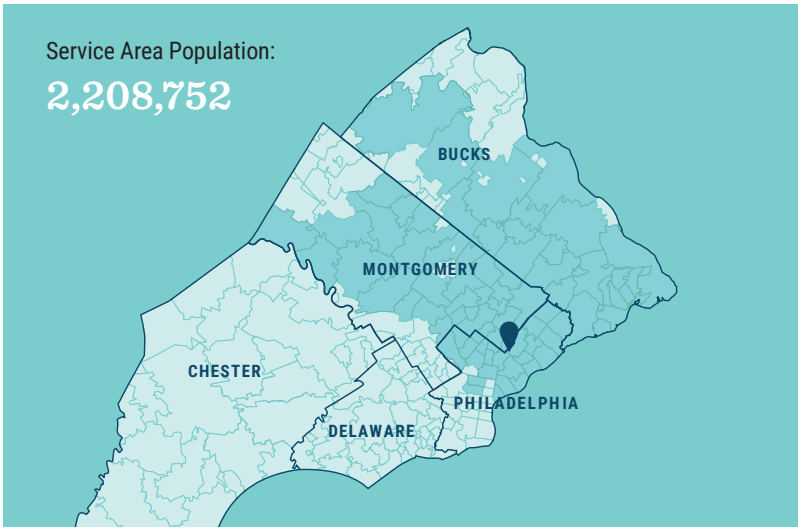
TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

The Fox Chase Cancer Center's Service Area is comprised of 80 ZIP codes. These are the ZIP codes from which about 67% of our patients seen on an inpatient or outpatient basis reside. These ZIP codes span Philadelphia, Bucks and Montgomery counties.

Bucks County: 18901, 18902, 18914, 18925, 18929, 18938, 18940, 18944, 18951, 18954, 18966, 18974, 18976, 19007, 19020, 19021, 19030, 19047, 19053, 19054, 19055, 19056, 19057, 19067

Montgomery County: 18964, 18969, 19001, 19002, 19006, 19012, 19025, 19027, 19031, 19034, 19038, 19040, 19044, 19046, 19075, 19090, 19095, 19401, 19403, 19422, 19426, 19438, 19440, 19444, 19446, 19454, 19462, 19464, 19468, 19473

Philadelphia County: 19111, 19114, 19115, 19116, 19118, 19119, 19120, 19121, 19124, 19125, 19126, 19128, 19132, 19133, 19134, 19135, 19136, 19137, 19138, 19140, 19141, 19144, 19149, 19150, 19152, 19154



Full copies of the past Community Health Needs Assessment, related implementation plan, and progress reports are available at https://www.foxchase.org/community/community-health.

Mercy Catholic Medical Center, Mercy Fitzgerald Hospital Campus

Mercy Fitzgerald Hospital is guided by its Catholic-health core values of reverence, stewardship, integrity, safety, justice, and commitment to the underserved. It is a community teaching hospital that offers a full array of acute-care services and health programs to promote the physical and spiritual well-being of its patients.

Trinity Health Mid-Atlantic is a Regional Health System that includes Mercy Fitzgerald Hospital in Darby, Pa.; Nazareth Hospital in Northeast Philadelphia; Saint Francis Hospital in Wilmington, Del.; St. Mary Medical Center in Langhorne, Pa. and home health and LIFE programs. Trinity Health Mid-Atlantic is a member of Trinity Health, one of the largest multi-institutional Catholic health care delivery systems in the nation.

MISSION:

All Trinity Health Mid-Atlantic hospitals and Trinity Health serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

CHNA RESPONSE:

Each of the hospitals will use the community health needs assessment findings to develop community benefit programs and services to address the top three prioritized health needs and social influencers of health needs. Those selected will be those that are within the hospital's area of expertise and aligns with its mission to serve the vulnerable and underserved in the area.

BEDS	EMPLOYEES	PHYSICIANS	INPATIENT ADMISSIONS	OUTPATIENT VISITS	EMERGENCY ROOM VISITS
183	1,232	126	6,462	83,355	27,048

Established in 1933 by the Sisters of Mercy, the 183 bed hospital is located in Darby, Pa. and is a certified Primary Stroke Center. Mercy Fitzgerald Hospital offers comprehensive cardiovascular care, emergency care, the nationally accredited cancer care with Mercy Cancer Center which is affiliated with a nationally accredited cancer center, a NAPBC-accredited breast health program, orthopedic care, advanced diagnostic and interventional radiology, physical rehabilitation, wound care, community outreach programs and more.

- **Named a high-performing hospital by U.S. News & World Report 2021–22** in four specialty areas: heart failure, kidney failure, diabetes and COPD
- **Best Hospital in Delco** for 2018-2021 as voted by the readers of *Delaware County Daily Times*

For further information on how Mercy Fitzgerald Hospital will address unmet health and social influencers of health needs, we invite you to review our Community Health Improvement Plan at: Mercy Catholic Medical Center CHNAs (trinityhealthma.org)

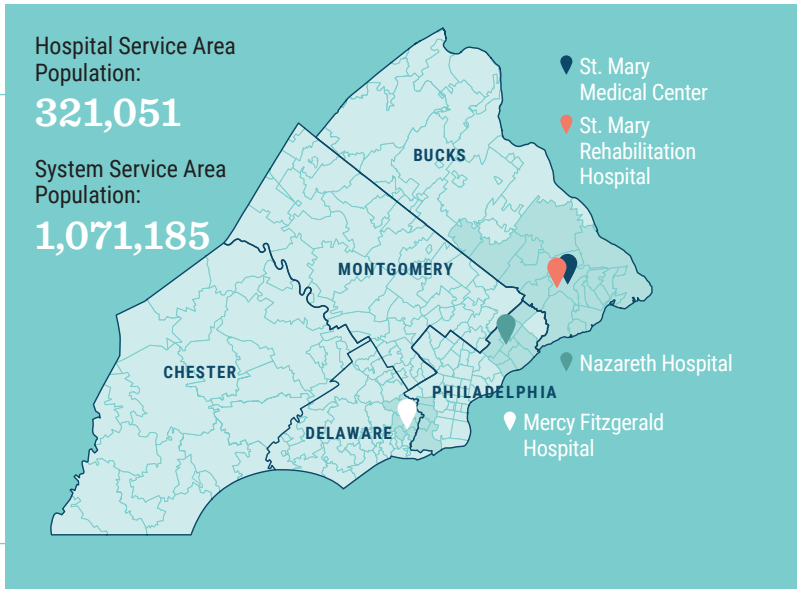
TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

Trinity Health Mid-Atlantic defines its service area in the metro region as the ZIP codes from which the following percents of inpatient discharges are derived from each facility: St. Mary Medical Center and St. Mary Rehabilitation Hospital (88 percent), Nazareth Hospital (79 percent), and Mercy Fitzgerald Hospital (84 percent).

Bucks County: 18940, 18954, 18966, 18974, 18976, 18977, 19007, 19020, 19021, 19030, 19047, 19053, 19054, 19055, 19056, 19057, 19067

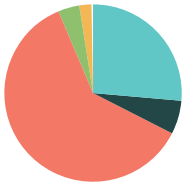
Delaware County: 19018, 19023, 19026, 19036, 19050, 19079, 19082

Philadelphia County: 19111, 19114, 19115, 19116, 19135, 19136, 19139, 19142, 19143, 19149, 19152, 19153



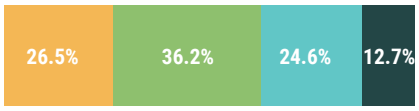
HOSPITAL SERVICE AREA DEMOGRAPHICS

Racial Composition



6.0% | Asian*
61.2% | Black*
4.0% | Hispanic/Latino
26.6% | White*
2.3% | Other*
* Non-Hispanic

Age Distribution



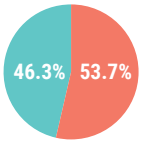
Fluency

5.8% speak English less than very well

Median Household Income

$48,250

Gender



Impact of Prior Community Health Needs Assessment and Implementation

Mercy Catholic Medical Center identified and prioritized their significant health needs in the 2019 CHNA. The Trinity Health of the Mid-Atlantic Region prioritization work group then ranked the needs by prevalence, severity, available data, magnitude of persons affected, and the ability of the hospital to impact the need. The needs were categorized and ranked under three categories: (1) Navigational & Equitable Access to Care; (2) Healthy Living; (3) Behavioral Health.

» Navigational & Equitable Access to Care

Improve access to healthcare services for persons who are poor and vulnerable by addressing the following three needs:

(1) Access to health care for low-income residents and the uninsured

(2) Access to health care for the elderly; and

(3) Access to health care for the immigrant population.

In Fiscal Year 2021, Mercy Fitzgerald Campus and Mercy Philadelphia Campus provided Medicaid enrollment for 2,026 uninsured eligible patients and access for uninsured and underinsured at Mercy Physician Network clinic. The continuation of COVID-19 necessitated direction of resources to assist with access to care and COVID-19 vaccines in underserved communities. Mercy Fitzgerald participated in COVID-19 vaccines and education for 2,799 individuals as part of the "It Starts Here Campaign" in collaboration with faith-based organizations and the Delaware County Task Force. Mercy Fitzgerald donated the use of their Heli-pad site to Delaware County for community-based vaccines.

» Healthy Living

(1) Address Overweight and Obesity

(2) Nutrition, specifically Food Insecurity

Playworks, a school-based program, continued to remain on pause due to COVID-19. Mercy Fitzgerald continued to address the social influencer of health, food insecurity. Although the hospital-based program was paused due to COVID-19, food insecurity was addressed in vulnerable communities through coordination of nonprofit local and regional food distribution weekly with food and produce donations to assist those in need as identified by local faith leaders, and through distribution of thousands of grocery store gift cards and holiday turkeys to those in need.

» Behavioral Health

Improve access to Mental and Behavioral Health Care by addressing the need for this service for community residents.

In Fiscal Year 2021, Mercy Fitzgerald's "PREVENT" opioid prevention program remained on pause due to school closures related to COVID-19. The substance use disorder drug relapse prevention program, Positive Recovery Solutions, was expanded to Philadelphia and Montgomery Counties and administered Vivitrol to adults monthly. The remaining behavioral health community engagement activities have been paused, including campus-based National Alliance for Mental Illness (NAMI)-led mental health support groups, addiction counselor and Mental Health First Aid training.

Nazareth Hospital

Founded in 1940, Nazareth Hospital is guided by its Catholic-health core values of reverence, stewardship, integrity, safety, justice, and commitment to the underserved.

Trinity Health Mid-Atlantic is a Regional Health System that includes Mercy Fitzgerald Hospital in Darby, Pa.; Nazareth Hospital in Northeast Philadelphia; Saint Francis Hospital in Wilmington, Del.; St. Mary Medical Center in Langhorne, Pa. and home health and LIFE programs. Trinity Health Mid-Atlantic is a member of Trinity Health, one of the largest multi-institutional Catholic health care delivery systems in the nation.

MISSION:

All Trinity Health Mid-Atlantic hospitals and Trinity Health serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

CHNA RESPONSE:

Each of the hospitals will use the community health needs assessment findings to develop community benefit programs and services to address the top three prioritized health needs and social influencers of health needs. Those selected will be those that are within the hospital's area of expertise and aligns with its mission to serve the vulnerable and underserved in the area.

BEDS	EMPLOYEES	PHYSICIANS	INPATIENT ADMISSIONS	OUTPATIENT VISITS	EMERGENCY ROOM VISITS
189	1,017	86	7,880	55,670	34,615

Located in Northeast Philadelphia, and with 189 licensed beds and 28 skilled nursing beds, Nazareth Hospital is a community teaching hospital and provides a full array of healthcare services, including emergency care, surgery, vascular services, wound care services, cardiac care, orthopedic and rehabilitation services, and cancer care.

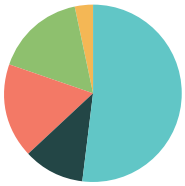
Nazareth Hospital is a nationally certified Primary Stroke Center and Chest Pain Center and has earned national accreditations for heart failure care and PCI.

- U.S. News 2021 High Performing Hospital - Kidney Failure
  Nazareth Hospital earned the distinction from U.S. News & World Report as a "high-performing hospital" for kidney failure.
- Recipient of the Get with The Guidelines® - Stroke Gold Plus with Honor Roll and Target: Type 2 Diabetes Honor Roll from the American Heart Association/American Stroke Association.

For further information on how Nazareth Hospital will address unmet health and social influencers of health needs, we invite you to review our Community Health Improvement Plan: Nazareth Hospital CHNAs (trinityhealthma.org)

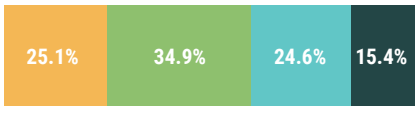
HOSPITAL SERVICE AREA DEMOGRAPHICS

Racial Composition



11.0% | Asian*
17.4% | Black*
16.2% | Hispanic/Latino
52.1% | White*
3.3% | Other*
* Non-Hispanic

Age Distribution



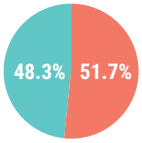
Fluency

17.5% speak English less than very well

Median Household Income

$51,711

Gender



TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

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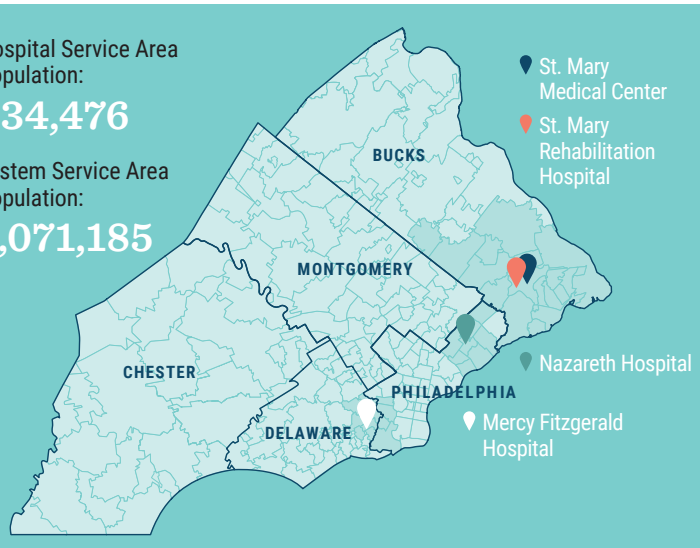
Delaware County: 19018, 19023, 19026, 19036, 19050, 19079, 19082

Philadelphia County: 19111, 19114, 19115, 19116, 19135, 19136, 19139, 19142, 19143, 19149, 19152, 19153

Hospital Service Area Population:
334,476

System Service Area Population:
1,071,185



Impact of Prior Community Health Needs Assessment and Implementation

The CHNA conducted in 2019 identified 13 significant health needs within the Nazareth Hospital community. The needs were prioritized based on a cross-functional workgroup comprised of internal and external stakeholders' vigorous group discussion and consensus-building to rank and prioritize the unmet health needs. Based on group discussion and agreement utilizing the nominal group planning and simplex methods, the health needs were grouped and ranked into three categories from 1 to 3, beginning with the most important to address for this CHNA cycle: (1) Navigational and Equitable Access to Care, (2) Healthy Living, (3) Behavioral Health.

Navigational and Equitable Access to Care

In Fiscal Year 2021, Nazareth Hospital enrolled 1,259 eligible patients in Medicaid through a contract with Healthcare Receivables Specialists, Inc (HRSI). Patients in the target population were provided with assistance (as needed) in scheduling primary care and specialty care visits, and a resource list for securing lower cost prescription medications. Transportation was provided for 114 established patients for medically necessary care. Space was identified at Nazareth Hospital for a medical clinic. GME Residency clinic has been established.

Emergence of COVID-19 necessitated direction of resources to assist with access to care and COVID-19 vaccines in underserved communities. Nazareth Hospital participated in COVID-19 vaccines and education for 3,019 individuals as part of the "It Starts Here Campaign" to address those in need.

Healthy Living: (1) Nutrition, (2) Overweight and Obesity, and (3) Physical Activity

In Fiscal Year 2021, Nazareth Hospital addressed social influencers of health including access to healthy food through distribution of grocery store gift cards and a food drive to benefit 100 families assisting those in need with access to healthy foods. In partnership with Holmesburg United Methodist Church & Caring for Friends, meals were packed and distributed weekly in the Northeastern Philadelphia community. The Playworks school-based program training continues to remain on pause due to school closure related to COVID-19.

Behavioral Health: Improve access to mental and behavioral health care for community residents.

Substance use disorder drug relapse prevention program, Positive Recovery Solutions, was expanded to Philadelphia Department of Corrections and administered Vivitrol to inmates monthly. The prevention program for school-aged youth remained on hold due to COVID-19. Adjustments in Trinity Health of the Mid-Atlantic Region to behavioral health leadership, along with hospital visitor restrictions due to COVID-19, resulted in deferral of both the NAMI support group meetings and Mental Health First Aid training for colleagues.

Our community benefit activities included going directly into underserved communities/populations and providing COVID vaccine education and administration. Part of our community benefit portfolio includes providing access to primary care physicians in a medically underserved area. In addition, we maintain a 24-hour emergency room, an open medical staff, and a board comprised largely of independent members of the community. The organization extends privileges to all qualified physicians in the community.

Nazareth Hospital continued implementing a Smoke Free Campus that includes all buildings and was expanded to include all tobacco and smokeless tobacco products including e-cigarettes, vapors, and chewing tobacco. In addition, the New Hire Policy encourages all new colleagues to take advantage of smoking cessation classes and smoking cessation aids.

Mercy Health System, now Trinity Health of the Mid-Atlantic Region as of July 1, 2019, is a member of The Breathe Free Pennsylvania Coalition, a combined group representing the American Heart Association, the American Stroke Association and the American Cancer Society in Pennsylvania and contiguous states. The Coalition is focused on improving the existing Clean Indoor Air Law in Pennsylvania by reducing the loopholes and exceptions that allow for smoking indoors in establishments such as casinos, eliminating exceptions to the statewide smoking ban, and providing for local ordinances.

St. Mary Medical Center and St. Mary Rehabilitation Hospital

Established in 1973, St. Mary Medical Center is guided by its Catholic-health core values of reverence, stewardship, integrity, safety, justice, and commitment to the underserved. Located in Langhorne, Pa., and with 371 licensed beds, St. Mary is a community teaching hospital and offers state-of-the-art technology and highly skilled physicians and clinical professionals to provide advanced care for complex cases.

Trinity Health Mid-Atlantic is a Regional Health System that includes Mercy Fitzgerald Hospital in Darby, Pa.; Nazareth Hospital in Northeast Philadelphia; Saint Francis Hospital in Wilmington, Del.; St. Mary Medical Center in Langhorne, Pa. and home health and LIFE programs. Trinity Health Mid-Atlantic is a member of Trinity Health, one of the largest multi-institutional Catholic health care delivery systems in the nation.

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CHNA RESPONSE:

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St. Mary offers advanced non-invasive treatments, adult and pediatric emergency services, inpatient medical and rehabilitation facilities, along with supportive health and wellness programs.

St. Mary is designated by the Commonwealth of Pennsylvania as a Level II Trauma Center. St. Mary has a nationally accredited hip and knee replacement program, an NAPBC-accredited breast program, a Commission on Cancer-accredited cancer program and is a member of the Penn Cancer Network.

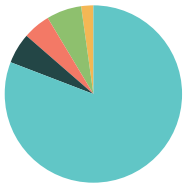
- U.S. News & World Report – High-Performing Hospital
  Named a high performing hospital in kidney failure, heart failure, heart attack, knee replacement, diabetes and COPD.
- Get With The Guidelines® – Target: Stroke Honor Roll Elite Plus/Gold Plus Quality Achievement Award
- Get With The Guidelines® Heart Failure Gold Quality Achievement Award

St. Mary Rehabilitation Hospital is a free-standing 50 bed inpatient rehabilitation facility which offers highly specialized and comprehensive care to patients facing the challenges of recovering from complex illness or injury. This state-of-the-art hospital opened in spring 2014 in partnership with Center Healthcare Corporation (St. Mary Medical Center joint venture 59%).

For further information on how St. Mary Medical Center and St. Mary Rehabilitation Hospital will address unmet health and social influencers of health needs, we invite you to review our Community Health Improvement Plan: St. Mary Medical Center CHNAs (trinityhealthma.org)

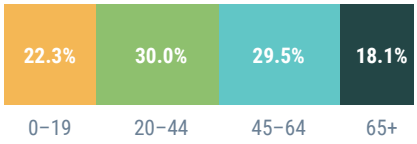
HOSPITAL SERVICE AREA DEMOGRAPHICS

Racial Composition



5.5% | Asian*
5.2% | Black*
6.4% | Hispanic/Latino
80.9% | White*
2.0% | Other*
* Non-Hispanic

Age Distribution



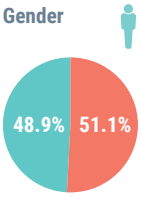
Fluency

5.3% speak English less than very well

Median Household Income

$82,087

Gender



TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

Trinity Health Mid-Atlantic defines its service area in the metro region as the ZIP codes from which the following percents of inpatient discharges are derived from each facility: St. Mary Medical Center and St. Mary Rehabilitation Hospital (88 percent), Nazareth Hospital (79 percent), and Mercy Fitzgerald Hospital (84 percent).

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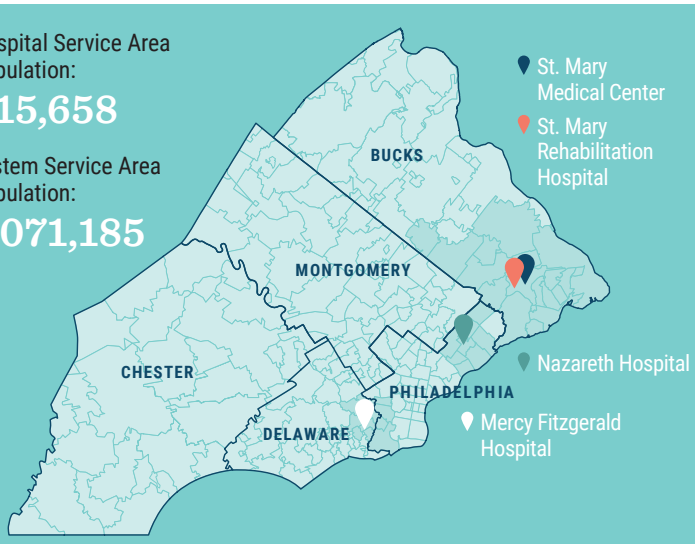
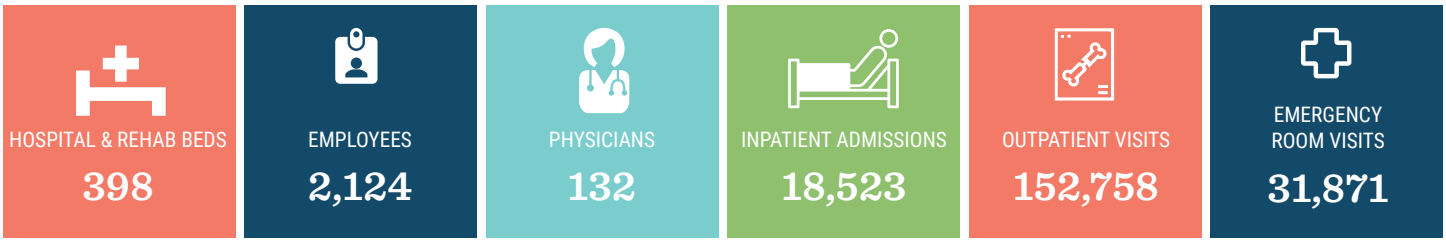
Delaware County: 19018, 19023, 19026, 19036, 19050, 19079, 19082

Philadelphia County: 19111, 19114, 19115, 19116, 19135, 19136, 19139, 19142, 19143, 19149, 19152, 19153

Hospital Service Area Population:
415,658

System Service Area Population:
1,071,185





Impact of Prior Community Health Needs Assessment and Implementation

St. Mary Medical Center:

SMMC addressed the following three unmet health needs from the 2019 CHNA:

1) Access to mental health care

SMMC provided access to quality mental health services for low-income uninsured persons diagnosed with a behavioral health disorder, in partnership with health and social service agencies through our community benefit grants program. Family Service Association (FSA) provided mental health counseling and treatment for 95 individuals at the St. Mary Adult Health and Children's Health Centers. Mental health screening and intervention included assessment, individual and family therapy, medication monitoring, depression screenings, and psychiatric referral as needed for low-income uninsured patients at the above referenced health centers. SMMC also awarded grant support to FSA for school-based mental health counseling services for 23 students in crisis. Paired t-test showed significant improvements in problem severity and in day-to-day functioning following counseling. There was a 28% reduction in severity of issues; 7% increase in functional score, able to handle daily issues; 27% improvement in hopefulness. SMMC is continuing to explore co-location of medical and behavioral health services through expansion of St. Mary Family Medicine Residents at the Family Service Association Behavioral Health Clinic. A new Program Director Family Medicine Residency was hired to oversee these residents in Spring 2021.

2) Access to substance abuse treatment

SMMC purchased a motorhome to establish mobile drug and alcohol relapse prevention services in partnership with Positive Recovery Solutions. Positive Recovery Solutions provided monthly drug relapse prevention services in the motorhome for 11 patients. Lenape Valley Foundation Crisis Services continues to provide detox/recovery stabilization services for patients presenting with substance use disorder in St. Mary ED.

3) Access to care for the uninsured, especially those living in poverty

SMMC provided primary and preventive health care services for low-income uninsured eligible adults and children through support and enrollment into Medicaid and St. Mary financial assistance programs. In FY21, 31,174 Medicaid beneficiaries received services at St. Mary, and 11,671 patients qualified and received St. Mary financial assistance. At the St. Mary Children's Health Center, 4,427 children received medical care, and the Mother Bachmann Maternity Center delivered 315 babies. St. Mary also provided primary and preventive care for 821 at the St. Mary Adult Health Center. Trinity Health has partnered with FindHelp.org social network platform to promote connection to health care and social services.

St. Clare pharmacy provided free or reduced cost prescription medications through both the St. Mary financial assistance program and the Dispensary of Hope free medication program (uninsured living at or below 300% federal poverty level). A monthly social media campaign was launched to further promote the Dispensary of Hope program to help reach eligible patients and community members during the COVID pandemic. Monthly outreach continued to July 2021.

St. Mary Rehabilitation Hospital:

SMRH addressed the following unmet health need in fiscal year 2021:

Access to substance abuse treatment

Positive Recovery Solutions mobile drug and alcohol relapse prevention services is available on St. Mary campus for local residents and patients from St. Mary Medical Center and Rehabilitation Hospital.

PARTNER ORGANIZATIONS

In addition to the participating hospitals and health systems, the organizations below provided support to the rCHNA process. More details about each organization's role are highlighted below.

Chester County Health Department

The Chester County Health Department's mission is to provide public health leadership as well as personal and environmental health services to residents and visitors so that they may grow, live and work in healthy and safe communities. Since its founding in 1968, Chester County Health Department has consistently provided exceptional public health leadership, programs and services to Chester County residents. The Health Department embraces the public health principle of "community as client," promoting the health of families, populations, and communities through coordinated efforts across the Bureaus of Administrative and Support Services, Personal Health Services, Environmental Health Protection, and Population Health. The Health Department provides a full range of public health programs, including nurse home visiting; immunization clinics; food supplements through the Women, Infants and Children program; sexually transmitted disease testing; restaurant inspections; sewage and water permits; disease investigation and surveillance; emergency planning and response; community health assessment and planning; health promotion; and much more.

Chester County Health Department supported community engagement for focus group-style community conversations with Chester County residents and community organization representatives.

Delaware County Health Department

The central focus of the new Delaware County Health Department is to create thriving and healthy communities. Priorities such as health equity, education, safe and affordable housing, nutrition, green space, racial justice, and employment opportunities will lead to positive health outcomes for all Delaware County residents and have a meaningful impact on their quality of life. As the first health department established in Pennsylvania in 33 years, the Delaware County Health Department has the unique opportunity to provide public health leadership that embodies the principles of Public Health 3.0, a national model for public health in the 21st Century. Through coordinated efforts across the Environmental Health Division, Personal Health Division, Population Health Division, and with strong support from a dedicated Epidemiology Team, the health department will offer public health capacities and services for residents to achieve health equity, maintain healthy environments, support the health of moms and babies, control communicable diseases, respond to health emergencies, and promote safe and healthy lifestyles. The Health Department provides a full range of public health programs including Vaccines for Children (VFC), STI testing and education, retail food service inspections, emergency planning and response, disease investigation and surveillance, health education, and more. The Delaware County Health Department will partner with other government agencies such as municipal health entities, aging, mental health, and criminal justice agencies, non-profits, small businesses, and major employers, public schools, trade schools, colleges and universities, hospitals, and other healthcare facilities, community partners, groups, and individuals- to ensure an authentic community voice is present to drive the positive health outcomes every single resident deserves.

Delaware County Health Department supported community engagement for focus group-style community conversations with Delaware County residents and community organization representatives.

Health Care Improvement Foundation

The Health Care Improvement Foundation (HCIF) is an independent nonprofit organization based in Philadelphia that is dedicated to the vision of healthier communities through equitable, accessible, and quality health care. HCIF seeks to drive superior health care through collaboration and shared learning. Using skills in program design, coaching, facilitation, measurement, and evaluation, HCIF's team of experts convenes diverse partners around common goals for healthcare improvement to implement solutions that no market participant could achieve individually. Since its inception, HCIF has been recognized as an outstanding example of how advances in quality care can be achieved through large-scale collaboration.

HCIF's population health work is grounded in collaborative initiatives advancing health literacy, chronic disease prevention and management, and community health improvement. HCIF facilitates the Collaborative Opportunities to Advance Community Health (COACH) initiative sponsored by the Hospital and Healthsystem Association of Pennsylvania. Through COACH and other initiatives, HCIF builds system capacity and cross-sector partnership opportunities to more effectively address social determinants of health and advance health equity in the five-county southeastern Pennsylvania region.

HCIF provided overall project management and led qualitative data collection, synthesis, health need prioritization, and report development processes.

Montgomery County Office of Public Health

It is the Mission of the Montgomery County Office of Public Health (OPH) to provide public health services and foster collaborative actions that empower our community to improve its health and safety. Our Vision is to optimize the health and wellness of individuals and families through innovative practices. The OPH takes great pride in being ranked #1 in Health Factors and #4 in Health Outcomes in the state of Pennsylvania by the Robert Wood Johnson Foundation.

The OPH is Project Public Health Ready (PPHR) certified and recognized by the National Association of County and City Health Officials (NACCHO) for our capacity and capability to plan for, respond to, and recover from public health and other emergencies.

OPH supported community engagement for focus group-style community conversations with Montgomery County residents and community organization representatives.

Philadelphia Association of Community Development Corporations

Philadelphia Association of Community Development Corporations (PACDC) works to create an equitable city where every Philadelphian lives, works, and thrives in a neighborhood that offers an excellent quality of life. As a membership association, we foster strong community development corporations and non-profit community organizations by enhancing their skills and advocating for resources and policies to create a just and inclusive Philadelphia.

The work of community development improves health outcomes by improving the context in which people live and the quality of lives that they lead. PACDC has played a leadership role in securing more than $640 million for affordable homes and neighborhood economic development, and worked to reform the city's vacant property system to get blighted properties back in productive reuse. Our Community Development Leadership Institute has trained more than 3,000 people representing community development corporations, civic associations, and other practitioners looking to better understand issues affecting lower-income residents and neighborhoods, ranging from gentrification and blight to neighborhood-driven real estate development, and their intersection with arts, health, education, and community engagement.

PACDC led community engagement efforts for focus group-style community conversations with Philadelphia residents.

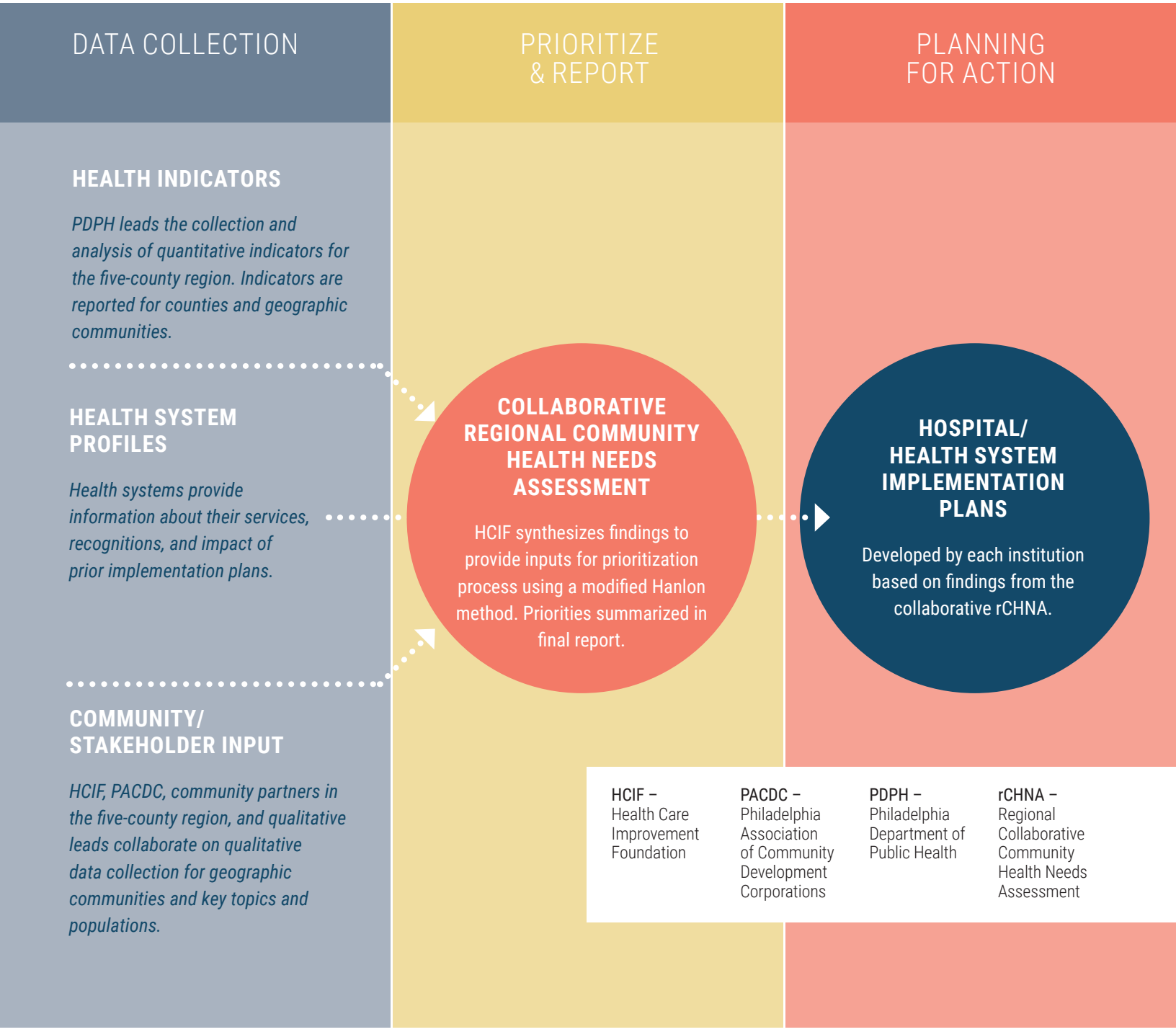
Philadelphia Department of Public Health

The Philadelphia Department of Public Health (PDPH) promotes and protects the health of all Philadelphians and provides a safety net for the most vulnerable. The agency leads programs to prevent communicable diseases; prevent chronic diseases and promote healthy behaviors; prevent environmental health risks; investigate outbreaks of disease; respond to public health emergencies; and promote the health of women, children, and families. In addition, the department operates the eight City Health Centers that provide primary care to more than 80,000 Philadelphians. PDPH has been on the vanguard of public health, proposing policy solutions to problems like smoking and obesity, and intends to continue that tradition with creative solutions to both long-standing urban health problems and new crises.

PDPH led the integration process to extract, transform, and load (ETL) data to a unified repository from multiple sources. PDPH also conducted analyses of quantitative metrics used to inform the status of health and well-being in the five-county region and contributed to the report's development.

OUR COLLABORATIVE APPROACH

Hospitals/health systems and supporting partners collaboratively developed the community health needs assessment process and report to identify regional health priorities and issues specific to each participating institution's service area. Based on these priorities, hospitals/health systems produce implementation plans to respond to unmet health needs. These plans may involve further collaboration or coordination to address shared priorities.



HCIF – Health Care Improvement Foundation

PACDC – Philadelphia Association of Community Development Corporations

PDPH – Philadelphia Department of Public Health

rCHNA – Regional Collaborative Community Health Needs Assessment

GOVERNANCE

A Steering Committee, composed of representatives from participating hospitals/health systems and supporting partner organizations, guided the development of the regional community health needs assessment (rCHNA). The Steering Committee met regularly to plan, provide feedback, and reach consensus on key decisions about approaches and strategies related to data collection, interpretation, and prioritization. Staff from Health Care Improvement Foundation (HCIF), Philadelphia Department of Public Health (PDPH), and Philadelphia Association of Community Development Corporations (PACDC) comprised the project team.

Steering Committee Representatives

Name	Title	Institution
Jeanne Franklin, MPH, PMP	Public Health Director	Chester County Health Department
Ashley Orr, MPH	Population Health Director	Chester County Health Department
Meghan Smith, MPH	Health Planning & Promotion Supervisor	Chester County Health Department
Falguni Patel, MPH	Manager, Community Impact	Children's Hospital of Philadelphia
Rebecka Rosenquist, MSc	Health Policy Director, PolicyLab	Children's Hospital of Philadelphia
Rosemarie Halt, MPH	Chair	Delaware County Board of Health
Monica Taylor, PhD, MS	Chair	Delaware County Council
Allyson Gilmore, MBA	Director, Marketing & Outreach	Doylestown Health
Kellye Remshifski, MS, CHES, NBH-HWC	Wellness and Outreach Manager	Doylestown Health
Joan Boyce	Senior Director, Government Relations & Public Affairs	Einstein Healthcare Network (Jefferson Health)
Brandi Chawaga, M.Ed.	Director, Community Wellness	Einstein Healthcare Network (Jefferson Health)
Donna Manning	Executive Director, Post Acute Care	Grand View Health
Cynthia Westphal, MSN, RN, NE-BC	Chief Nursing Officer/Vice President, Patient Care Services	Grand View Health
Susan Choi, PhD	Senior Director, Population Health	Health Care Improvement Foundation
Mojisola Delano, MPH, MS	Consultant	Health Care Improvement Foundation
Kelsey Salazar, MPH	Director	Health Care Improvement Foundation
Cassidy Tarullo, MPP	Project Coordinator	Health Care Improvement Foundation
Marianna Calabrese, MA	Manager, Community Benefit	Jefferson Health
U. Tara Hayden, MHSA	Vice President, Community Health Equity, Jefferson Collaborative for Health Equity	Jefferson Health
Sasha Mendez	Program Manager, Community Health Benefits & Engagement, Jefferson Collaborative for Health Equity	Jefferson Health

Yawei Song, MSW, LSW*	Former Community Benefits Coordinator, Center for Urban Health	Jefferson Health
Sharon Larson, PhD	Professor and Executive Director, Main Line Health Center for Population Health Research at Lankenau Institute for Medical Research	Main Line Health
Robert Lorenz*	Former Manager, Strategic Planning and Analytics	Main Line Health
Debbie McKetta, MS, CLSSGB	Manager, Strategic & Service Line Planning	Main Line Health
Ruth Cole, RN, MPH	Director, Division of Clinical Services	Montgomery County Office of Public Health
Nicole Rafalko, MPH, CPH	Epidemiology Research Associate	Montgomery County Office of Public Health
Laura Lombardo	Manager, Community Relations	Penn Medicine
Courtney Summers, MSW	Administrator, Division of Community Health	Penn Medicine
Garrett O'Dwyer	Health Programs & Special Projects Manager	Philadelphia Association of Community Development Corporations
Frank Franklin, PhD, JD, MPH	Deputy Health Commissioner	Philadelphia Department of Public Health
Jonas Miller, MGIS, PMP	Data Visualization Engineer	Philadelphia Department of Public Health
Claire Newbern, PhD, MPH*	Former Chief Epidemiologist	Philadelphia Department of Public Health
Anne Catino, RN, BSN, MS, NEA-BC	Vice President/Chief Nursing Officer	Redeemer Health
Barbara Tantum, MBA, MHA	Director of Planning	Redeemer Health
Andrew Kunka, JD, MPAP	Community Benefit & Special Projects Manager	Temple Health
Lakisha Sturgis, RN, BSN, MPH, CPHQ	Director, Community Care Management, Temple Center for Population Health	Temple Health
Laureen Carlin	Director, Community Health and Well-Being and Volunteer Services	Trinity Health Mid-Atlantic
Joann Dorr, RN, BSN	Regional Director, Community Health and Well-Being	Trinity Health Mid-Atlantic
Lisa Kelly, RN, MBA*	Former Director, Community Health and Well-Being and Volunteer Services	Trinity Health Mid-Atlantic

* Some institutions experienced staffing transitions during the year; this list represents all those who represented an entity during the rCHNA planning process.

METHODS: DATA COLLECTION AND ANALYSIS

HEALTH INDICATORS

PDPH advised the Steering Committee on the selection of quantitative health indicators. The list of indicators for the 2019 report provided a starting point, and indicators were removed and added based on the following considerations:

- **Availability of the data source.** Some indicators were not included due to discontinued data sources, lack of updated data, or inaccessibility of the data.
- **Uniqueness.** Some indicators that were redundant with other measures were removed.
- **Granularity and quality of the data.** For new indicators, those with data available at the ZIP code level for all five-county ZIP codes and for which data quality and completeness could be verified were prioritized. For some indicators of strong interest, if only county-level data were available, those estimates were included as well.
- **Current interest.** Indicators related to COVID-19 were added.

The PDPH team, which included experts in epidemiological and geospatial analyses, compiled, analyzed, and aggregated over 60 health indicators from varied data sources. The table below presents information about the included indicators.

Indicator	Details	Year(s)	Source
ABOUT THE COMMUNITY			
Population	Total population size	2019	American Community Survey, Census Bureau (5-yr)
Age distribution by gender		2019	American Community Survey, Census Bureau (5-yr)
Race/ethnicity		2019	American Community Survey, Census Bureau (5-yr)
Educational attainment	High school as highest education level (26+ years)	2019	American Community Survey, Census Bureau (5-yr)
Income	Median household income	2019	American Community Survey, Census Bureau (5-yr)
Social Vulnerability Index	Percentile ranking of 4 socioeconomic indicators	2018	CDC/ATSDR Social Vulnerability Index
Foreign-born status	Born outside of United States	2019	American Community Survey, Census Bureau (5-yr)
Ability to speak English	Speak English less than "very well" (5+ years)	2019	American Community Survey, Census Bureau (5-yr)
Disability status	With a disability	2019	American Community Survey, Census Bureau (5-yr)
Leading causes of death	Top 5 causes	2019, 2020	Vital Statistics, PA Department of Health
GENERAL			
All-cause mortality	Rate per 100,000	2019, 2020	Vital Statistics, PA Department of Health
Life expectancy by gender	Years	2019, 2020	Vital Statistics, PA Department of Health
Years of potential life lost before 75	Years	2019, 2020	Vital Statistics, PA Department of Health
COVID-19			
COVID-19 fully covered vaccination	Rate per 100,000 (as of 11/30/21)	2020-2021	Pennsylvania Department of Health
COVID-related emergency department utilization	Rate per 100,000	2020	HealthShare Exchange
COVID-related hospitalization	Rate per 100,000	2020	PA Health Care Cost Containment Council
COVID-related mortality	Rate per 100,000	2020	Pennsylvania Department of Health

CHRONIC DISEASE & HEALTH BEHAVIORS			
Adult obesity prevalence	Body mass index 30-99.8 among adults 18+ years	2018	Behavioral Risk Factor Surveillance System
Diabetes prevalence	Told by a doctor that they have diabetes	2018	Behavioral Risk Factor Surveillance System
Diabetes-related hospitalization	Rate per 100,000	2019, 2020	PA Health Care Cost Containment Council
Hypertension prevalence	Told by a doctor that they have high blood pressure	2017	Behavioral Risk Factor Surveillance System
Hypertension-related hospitalization	Rate per 100,000	2019, 2020	PA Health Care Cost Containment Council
Potentially preventable hospitalization	Rate per 100,000	2019, 2020	PA Health Care Cost Containment Council
Premature cardiovascular disease mortality	Death before 65 years, rate per 100,000	2019, 2020	Vital Statistics, PA Department of Health
Major cancer incidence	Prostate, breast, lung, colorectal cancers; rate per 100,000	2019	Vital Statistics, PA Department of Health
Major cancer mortality	Prostate, breast, lung, colorectal cancers; rate per 100,000	2019	Vital Statistics, PA Department of Health
Mammography screening	Mammogram in the past 2 years among women 50-74 years	2018	Behavioral Risk Factor Surveillance System
Colorectal cancer screening	Fecal occult blood test, sigmoidoscopy, or colonoscopy among adults 50-75 years	2018	Behavioral Risk Factor Surveillance System
Physical inactivity prevalence	No leisure time physical activity	2018	Behavioral Risk Factor Surveillance System
INFANT & CHILD HEALTH			
Asthma hospitalization	Children <18 years, rate per 100,000	2019, 2020	PA Health Care Cost Containment Council
Infant mortality	Deaths before age 1 per 1,000 live births	2019, 2020	Vital Statistics, PA Department of Health
Low birthweight births	Percent low birthweight (<2,500 grams) births out of live births	2019, 2020	Vital Statistics, PA Department of Health
Preterm births	Percent preterm (before 37 weeks gestation) births out of live births	2019, 2020	Vital Statistics, PA Department of Health
BEHAVIORAL HEALTH			
Adult binge drinking	5+ (men) or 4+ (women) alcoholic drinks on one occasion in past 30 days	2018	Behavioral Risk Factor Surveillance System
Adult smoking	Current smoker status	2018	Behavioral Risk Factor Surveillance System
Drug overdose mortality	Rate per 100,000	2019, 2020	Vital Statistics, PA Department of Health
Opioid-related hospitalization	Rate per 100,000	2019, 2020	PA Health Care Cost Containment Council
Substance-related hospitalization	Rate per 100,000	2019, 2020	PA Health Care Cost Containment Council
Poor mental health	Poor mental health for 14+ days in past 30 days	2018	Behavioral Risk Factor Surveillance System
Suicide mortality	Rate per 100,000	2019, 2020	Vital Statistics, PA Department of Health
Youth binge drinking	5+ alcoholic drinks in a row on ≥1 days in past 30 days among teens, county-level only	2019	Youth Risk Behavior Surveillance System, Pennsylvania Youth Survey*
Youth ever attempted suicide	Suicide attempt ever among teens, county-level only	2019	Youth Risk Behavior Surveillance System, Pennsylvania Youth Survey*
Youth mental health	Depressed/sad most days or sad/hopeless almost every day 2+ weeks in past 12 months among teens, county-level only	2019	Youth Risk Behavior Surveillance System, Pennsylvania Youth Survey*
Youth smoking	Smoked cigarettes in past 30 days among teens, county-level only	2019	Youth Risk Behavior Surveillance System
Youth vaping	Used electronic vapor products in past 30 days among teens, county-level only	2019	Youth Risk Behavior Surveillance System

INJURIES			
Fall-related hospitalization	Rate per 100,000	2019, 2020	PA Health Care Cost Containment Council
Gun-related emergency department utilization	Rate per 100,000	2019, 2020	HealthShare Exchange
Homicide mortality	Rate per 100,000	2019, 2020	Vital Statistics, PA Department of Health
ACCESS TO CARE			
Health insurance (public) status - Adults	Adults 19-64 years with Medicaid	2019	American Community Survey, Census Bureau (5-yr)
Health insurance (public) status - Children	Children <19 years with public insurance	2019	American Community Survey, Census Bureau (5-yr)
Health insurance status - Population	Population without insurance	2019	American Community Survey, Census Bureau (5-yr)
Health insurance status - Children	Children <19 years without insurance	2019	American Community Survey, Census Bureau (5-yr)
Emergency department utilization	Rate per 100,000	2019, 2020	HealthShare Exchange
High emergency department utilization	5+ visits in 12 months, rate per 100,000	2019, 2020	HealthShare Exchange
SOCIAL & ECONOMIC CONDITIONS			
Poverty status - Population	Population in poverty	2019	American Community Survey, Census Bureau (5-yr)
Poverty status - Children	Children <18 years in poverty	2019	American Community Survey, Census Bureau (5-yr)
Employment status	Adults 19-64 years unemployed (not in labor force)	2019	American Community Survey, Census Bureau (5-yr)
Household type	Householders living alone who are 65+ years	2019	American Community Survey, Census Bureau (5-yr)
Food insecurity	Population experiencing food insecurity, county-level only	2019	Feeding America
Households receiving food assistance	Households receiving Supplement Nutrition Assistance Program (SNAP) benefits	2019	American Community Survey, Census Bureau (5-yr)
Housing cost burden	Households who spend >30% of income on housing	2019	American Community Survey, Census Bureau (5-yr)
Housing lead risk	Homes with potential lead risk	2019	American Community Survey, Census Bureau (5-yr)
Housing occupancy status	Vacant housing units	2019	American Community Survey, Census Bureau (5-yr)
Violent crime rate	Rate per 100,000, county-level only	2018	PA Uniform Crime Reporting System

Note: Only crude rates are reported.

* *Youth Risk Behavior Surveillance System data only for Philadelphia County; similar items collected for Bucks, Chester, Delaware, and Montgomery County through the Pennsylvania Youth Survey (data limited to high school students only)*

Depending on the availability of the data, indicators were summarized at these levels:

- **County level** – For all five counties
- **Geographic community level** – These represent clusters of ZIP codes grouped into 46 distinct geographic communities, based on guidance from Steering Committee members.

The Steering Committee had a strong interest in examining how indicators varied by race, ethnicity, or other demographic characteristics to identify potential disparities. However, many geographic communities did not have a sufficient sample size for specific racial/ethnic groups to enable rigorous comparison for a given health indicator. In addition, the availability and quality of such demographic data was inconsistent across indicators. The health indicators are therefore not disaggregated by these characteristics for the current report. Wherever possible and appropriate, secondary analyses comparing health outcomes or factors by such characteristics are presented in relevant sections throughout the report.

COMMUNITY INPUT

A critical complement to the quantitative data represented by the health indicators is qualitative data that capture the perspectives, priorities, and ideas of those who live, learn, work, and play in local communities. Though no formal written comments on the 2019 rCHNA were received upon solicitation, feedback from partners provided to Steering Committee and project team members informed the development of the current process. Building on the qualitative data collection approach developed for the 2019 rCHNA, the Steering Committee and project team sought to expand, enhance, and refine strategies to thoughtfully gather and incorporate community input into the 2022 rCHNA. A subset of the Steering Committee, as well as several additional representatives from participating health systems, formed a Qualitative Team to guide the planning process. HCIF also engaged two experts in qualitative data collection and analysis as consultants to serve as Qualitative Leads.

Qualitative Team Members

Name	Title	Institution
Kathy Gorman	Sr. Vice President, Strategic Planning and Marketing	Chester County Hospital
Falguni Patel, MPH	Manager, Community Impact	Children's Hospital of Philadelphia
Rebecka Rosenquist, MSc	Health Policy Director, PolicyLab	Children's Hospital of Philadelphia
Kellye Remshifski, MS, CHES, NBH-HWC	Wellness and Outreach Manager	Doylestown Health
Allison Zambon, MHS, MCHES	Program Manager, Office of Community Outreach	Fox Chase Cancer Center - Temple University Health System
Keith Hammerschmidt	Executive Director, Grand View Healthcare Partnership	Grand View Health
Rickie Brawer, PhD, MPH	Qualitative Lead Consultant	Health Care Improvement Foundation
Susan Choi, PhD	Senior Director, Population Health	Health Care Improvement Foundation
Mojisola Delano, MPH, MS	Consultant	Health Care Improvement Foundation
Kelsey Salazar, MPH	Director	Health Care Improvement Foundation
Cassidy Tarullo, MPP	Project Coordinator	Health Care Improvement Foundation
Jean Wallace, PhD, MPH	Qualitative Lead Consultant	Health Care Improvement Foundation
Marianna Calabrese, MA	Manager, Community Benefit	Jefferson Health
U. Tara Hayden, MHSA	Vice President, Community Health Equity, Jefferson Collaborative for Health Equity	Jefferson Health
Sasha Mendez	Program Manager, Community Health Benefits & Engagement, Jefferson Collaborative for Health Equity	Jefferson Health
Yawei Song, MSW, LSW*	Former Community Benefits Coordinator, Center for Urban Health	Jefferson Health
Deborah Mantegna, RN, MSN	System Director, Community Health and Outreach; Manager, Volunteer Services, Riddle Hospital	Main Line Health
Debbie McKetta, MS, CLSSGB	Manager, Strategic & Service Line Planning	Main Line Health
Heather Klusaritz, PhD, MSW	Director of Community Health Services, Penn Medicine Center for Health Equity Advancement; Associate Director, Center for Community & Population Health, DFMCH	Penn Medicine
Barbara Tantum, MBA, MHA	Director of Planning	Redeemer Health
Joann Dorr, RN, BSN	Regional Director, Community Health and Well-Being	Trinity Health Mid-Atlantic

** Some institutions experienced staffing transitions during the year; this list represents all those who represented an entity during the rCHNA planning process.*

Special thanks to Michele Francis, MS, RD, CDCES, LDN, Director, Community Health & Wellness Services at Chester County Hospital and Maureen Hennessey, Ed.D., MPA, Manager, Community Health and Outreach at Bryn Mawr Hospital (Main Line Health) for invaluable assistance with community outreach and engagement.

Recognizing that no single data collection effort could comprehensively reflect the unique experiences and specific needs of all communities in the region, the approach was grounded in mixed methods that incorporated focus group discussions, interviews, surveys, and a wide array of secondary sources. The core of the primary data collection process again focused on hearing from geographic community residents and staff from local organizations who serve these communities, as well as more closely examining particular topics and populations. However, several changes were made in order to accommodate situational realities, as well as increase the depth and breadth of coverage:

- Primary data collection was undertaken by the project team October 2021 – February 2022. To ensure the safety of participants in light of the COVID-19 pandemic, all focus group discussions were held virtually, using the Zoom platform.
- Focus group-style, 90-minute "community conversations" were held to gather input from residents (and in some cases, those who provide services for those residents) of a subset of the 46 geographic communities. The Steering Committee guided the selection of communities, with higher need communities for whom recent qualitative data was not available being identified for inclusion. To accommodate the expanded service area, the number of conversations increased to 26: Bucks (3), Chester (4), Delaware (3), Montgomery (5), and Philadelphia (11). In addition, several interviews were conducted with key informants unable to join a session.
- To capture the insights of those who provide important health, human, and social services in each of the counties, 21 60*-minute focus group discussions centered on "spotlight" topics were conducted with organization and local government agency representatives. (Again, a limited number of interviews were conducted with those who were unable to participate in the focus groups.) A list of potential topics was generated by the Steering Committee based on priorities from past CHNAs. From this list, four topics were selected per county through consensus vote by Steering Committee members whose organizations serve that county.

The topics selected for each county are as follows:

Topic	Bucks	Chester	Delaware	Montgomery	Philadelphia
Access to care			X		
Behavioral health	X	X	X	X	X
Chronic disease	X	X	X	X	X**
Food insecurity		X	X	X	
Housing and homelessness					X
Older adults and care	X				
Racism and discrimination in health care					X
Substance use	X	X		X	
Violence					X

** For those counties opting not to have a separate substance use discussion (Delaware and Philadelphia), the behavioral health discussion was extended to 90 minutes, in recognition of the interrelationship between these topics.*

*** Chronic disease was also discussed in a focus group discussion conducted in Philadelphia as part of data collection supporting the cancer focus area, to be addressed in the section below.*

The project team either undertook directly or supported partners with targeted primary data collection to better understand the needs of particular communities or populations. These focus areas and communities were either specific to different type of facilities within participating health systems (i.e., cancer centers, rehabilitation facilities) or reflected gaps in the 2019 rCHNA:

Cancer.
New to the 2022 rCHNA. In addition to cancer-related information gathered from community conversation and spotlight discussions described above, partner cancer centers shared findings from focus groups with community advisory board members they conducted.

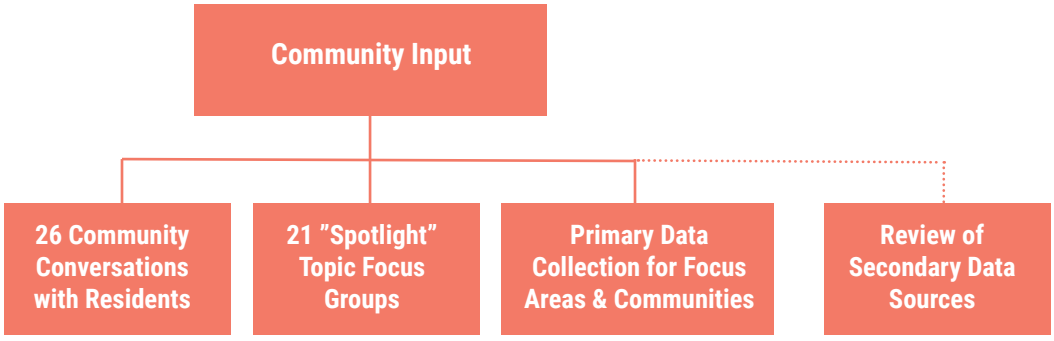
Disability.
HCIF worked with a subcommittee of rehabilitation facilities to develop and administer an online survey of people with disabilities.

Immigrant, refugee, and heritage communities.
Community organizations were provided support and funding to collect data about health needs in their communities (through surveys, focus groups, and interviews) or share relevant secondary data.

Youth voice.
Recognizing the opportunity to grow from the small-scale effort in the 2019 rCHNA, HCIF supported youth-serving organizations with funding and resources to conduct discussions about health with youth and report back findings.

Secondary data in the form of reports and summaries from other community engagement efforts were important inputs for this report. For example, the 2020 Pennsylvania LGBTQ Health Needs Assessment served as a key data source for the LGBTQ+ Communities section. A full list of sources incorporated is included in the "Resources" section.

The graphic below summarizes the major components of community input for the report:



QUALITATIVE DATA COLLECTION AND ANALYSIS

The Qualitative Team guided the development of discussion guides (see online Appendix) for both the community conversations and the spotlight discussions. These were adapted from those used for the 2019 rCHNA and included questions addressing community assets; community health challenges and barriers (including those related to social determinants of health, access to care, COVID-19); specific needs of older adults, children and youth, and additional underrepresented groups; and potential solutions for particular needs.

In light of the unique challenges posed by the virtual format of the discussions, the Qualitative Team provided critical feedback on the development of materials such as Zoom how-to guides and flyers to promote the discussions and facilitate online registration. Anticipating the challenges of the digital divide and potential discomfort with the online format, the project team and the Qualitative Team also prioritized strategies such as offering additional preparation sessions for interested participants needing technical support, as well as working closely with trusted community organizations who could facilitate community resident participation. Those organizations interested in serving in this role and more generally assisting with recruitment were offered funding to support their time. In Philadelphia, PACDC led community engagement efforts through its network of community development corporations and other partners.

Values guiding participant engagement included valuing community members' time and expertise (one expression of this was providing community members with $25 Visa gift cards for their participation) and ensuring that voices of marginalized communities were well-represented in the discussions. With these values in mind, Steering Committee members contributed suggestions of partner organizations for outreach (to participate in meetings themselves or assist with community member engagement), which were organized into a centralized partner database. HCIF conducted outreach based on this database, researched additional organizations, and employed a snowball technique to elicit other potential partners. Steering Committee members, PACDC, partner organizations, and HCIF used varied methods to promote the discussions, including phone and email outreach, social media posts, intranet outreach, listserv posts, and posting flyers in community locations.

In advance of discussions, HCIF fielded questions, assisted with registration, and provided regular reminders to registrants to maximize participation rates. Despite best efforts, it is important to note limitations to the data collection process:

- Ensuring sufficient numbers of participants (at least 5-6) for all sessions was challenging. Despite significant outreach, some meetings had lower registrations; feedback from community organizations indicated their own challenges with having enough time to devote to recruitment (owing largely to increases in their work due to COVID-19-related impacts) and community members' reluctance to join an online meeting (whether due to online meeting fatigue or unfamiliarity with Zoom). In addition, higher no-show rates relative to in-person meetings were observed, suggesting that registrants may have found it easier to forget or change their minds about participation.
- To begin to assess representation in the discussions, optional demographic questions were added to the online registration form for each session. Given the extent of missing data it is difficult to draw firm conclusions, but a lack of racial/ethnic diversity in the spotlight topic discussions with organization representatives was evident, suggesting important opportunities for intentional and thoughtful engagement in future data collection efforts.

The Qualitative Leads facilitated all discussions with technical support by the HCIF team. All discussions were recorded and transcribed for later analysis; only the project team and Qualitative Leads had access to the recordings and transcripts. Transcripts were imported as Word documents into NVivo software (release 1.5.1, QSR International) to manage, code, and interpret qualitative data from focus groups and interviews. Both Qualitative Lead consultants identified recurrent themes from the transcripts, agreed on a set of codes, coded for these themes, and generated summaries featuring themes and accompanying quotes. To ensure confidentiality, participants were assigned numbers in the transcripts to replace names, and care was taken to avoid disclosing any individual's identity in the summaries.

Based on the coding, the consultants identified significant overlap in common themes across geographic communities and spotlight topics. To minimize redundancy and ensure summaries were based on adequate sample size, the Qualitative Leads developed the following for each type of discussion for inclusion in the report:

- **Geographic communities** – County-level summaries for Bucks, Chester, Delaware, and Montgomery Counties; five summaries for distinct geographic sections of Philadelphia County (individual summaries for each of the 26 community conversations are available in the online Appendix)
- **Spotlight topics** – Topic summaries that aggregates across counties; given the overlap between Behavioral Health and Substance Use, these topics were combined into one summary.

Summaries are organized around key sections of the discussion guide. Within each section, themes are generally presented in order of greatest frequency of mention; in some cases, for reasons of flow, related topics may be presented together. Themes are accompanied by illustrative quotes to capture participants' voices as much as possible.

DETERMINING AND PRIORITIZING COMMUNITY HEALTH NEEDS

The project team synthesized a full list of community health needs based on the health indicators and findings from the community engagement components. Related community health needs were consolidated to produce the final list of 12 high priority community health needs, representing three categories: health issues, access and quality of healthcare and health resources, and community factors.

A modified Hanlon rating method was used to prioritize the community health needs.

- For each health need, the project team assigned scores for both Criterion 1: Size of the Health Problem (based on relevant health indicators) and Criterion 2: Importance to Community (based on the frequency a given community health need was mentioned during qualitative data collection).
- Each participating hospital/health system scored the remaining three criteria (Capacity to Address, Alignment with Hospital/Health System Mission and Strategic Direction, Existing Collaborations/Interventions) using the below ranking guidance and with input from internal stakeholders and external partners. A final score was computed for each health need by weighting the score for each criterion (see percentages in table below) and adding the weighted scores.

	Size of Health Problem Magnitude of health priority based on size of population(s) impacted (15%)	**Importance to Community** Magnitude of health priority based on community input (30%)	**Capacity to Address** Availability of effective/ feasible interventions (25%)	**Alignment with Hospital/ Health System Mission and Strategic Direction** (20%)	**Existing Collaborations/ Interventions** (10%)
9 or 10	>25%	>40	High Effectiveness/ High Feasibility	Very consistent with mission AND strategic direction	Yes, strong existing partnerships AND initiatives
7 or 8	10 to 25%	31 - 40	High Effectiveness/ Moderate Feasibility	Relatively consistent with mission AND strategic direction	Yes, existing partnerships AND initiatives
5 or 6	1 to 9.99%	21 - 30	Effective/Feasible	Consistent with mission AND strategic direction	Yes, existing partnerships OR initiatives
3 or 4	0.1 to 0.99%	11 - 20	Low Effectiveness /Low Feasibility	Relatively consistent with mission NOT strategic direction	Yes, existing partnerships, no current initiatives
1 or 2	0.01 to 0.09%	1 - 10	Low Effectiveness/ Not Feasible	Consistent with mission NOT strategic direction	Weak, existing partnerships OR initiatives
0	<0.01%	0	Not Effective/ Not Feasible	Not consistent with mission OR strategic direction	No, existing initiatives or partnerships
Need 1	Score 0-10	Score 0-10	Score 0-10	Score 0-10	Score 0-10
Need 2	Score 0-10	Score 0-10	Score 0-10	Score 0-10	Score 0-10
Need 3	Score 0-10	Score 0-10	Score 0-10	Score 0-10	Score 0-10
Need 4	Score 0-10	Score 0-10	Score 0-10	Score 0-10	Score 0-10
Need 5	Score 0-10	Score 0-10	Score 0-10	Score 0-10	Score 0-10

Ranking Guidance

Community Health Needs

- An aggregate score for each community health need was calculated as an average of the scores for that health need across all participating hospitals/health systems. The health needs were then prioritized from highest to lowest final aggregate score.
- As a final check, the 'PEARL' test was applied to each health need to screen out any community health needs that did not meet the following feasibility factors:
  - Propriety – Is a program for the health problem suitable?
  - Economics – Does it make economic sense to address the problem? Are there economic consequences if a problem is not carried out?
  - Acceptability – Will a community accept the program? Is it wanted?
  - Resources – Is funding available or potentially available for a program?
  - Legality – Do current laws allow program activities to be implemented?

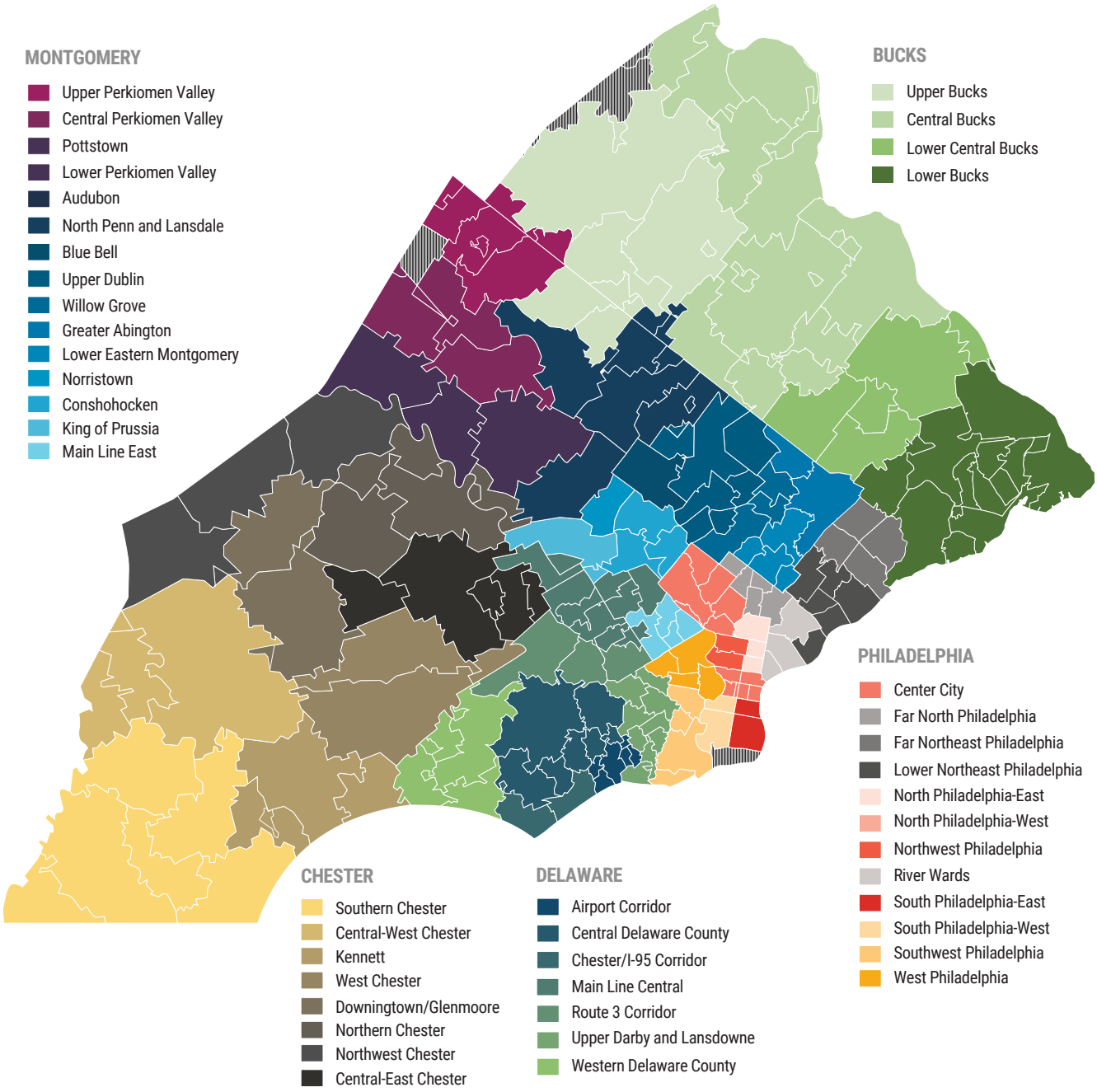
No health needs were eliminated based on the PEARL test.

FINAL REPORT

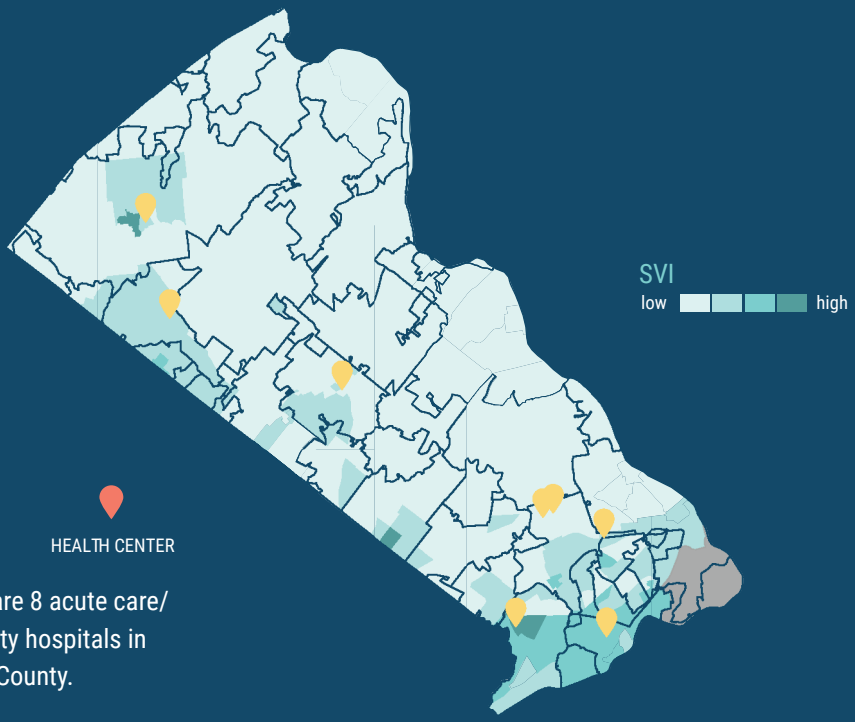
- The final CHNA report was drafted by the HCIF team and presented to the hospital/health systems for review and revision.
- This report was presented and approved by the Board of Directors of each hospital/health system.

ABOUT THE SERVICE AREA

The overall service area includes Bucks, Chester, Delaware, Montgomery, and Philadelphia and represents a diverse population of 4,111,039. All ZIP codes in the five counties were grouped into 46 distinct geographic communities, as shown below. In the next section, each quantitative county profile is followed by relevant summaries of qualitative data collected through geographic community conversations in that county, as well as quantitative profiles of the geographic communities within each county.



BUCKS COUNTY



HOSPITAL HEALTH CENTER

There are 8 acute care/ specialty hospitals in Bucks County.

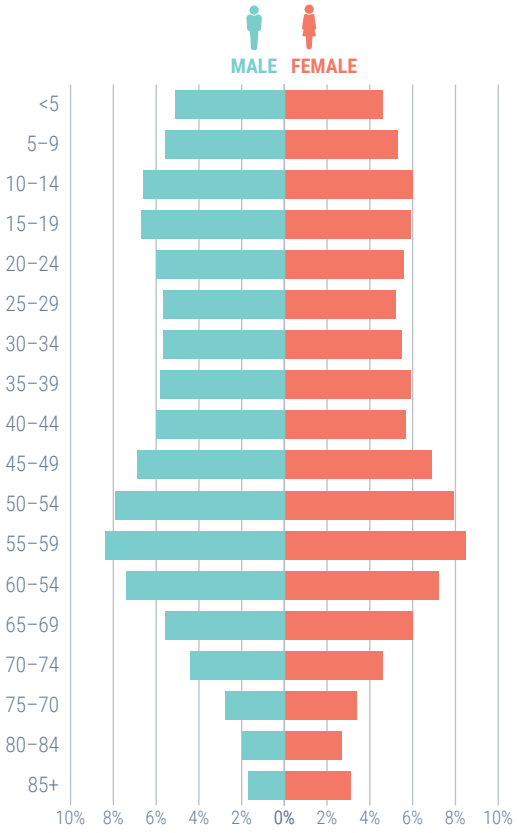
Social Vulnerability Index (SVI)

0 0.05 1

Median Income	$93,749
High school as highest education	23.6%
Food Insecurity	7.2%
With a Disability	10.7%
Violent Crime Rate	74.0 per 100,000

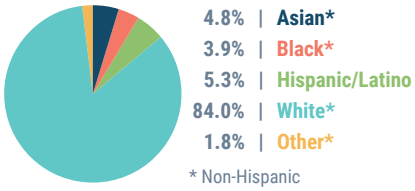
AGE DISTRIBUTION

Bucks County has an estimated population of 614,495, with the largest proportion of residents between the ages of 50 and 59.

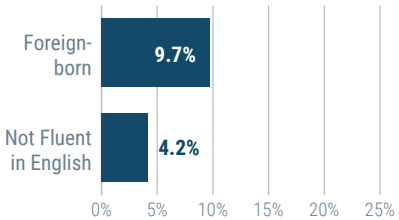


RACE/ETHNICITY/LANGUAGE

84% of residents are non-Hispanic White. Hispanic/ Latino residents make the next largest population, comprising 5.3% of the county's residents.



Nearly 10% of residents are foreign-born and about 4% speak English less than "very well."



COVID-19 | Rates per 100,000

Fully Vaccinated	55,875.8
COVID-related:	
• Emergency Department Use	190.2
• Hospitalization	398.9
• Mortality	145.1

MORTALITY

Leading Causes of Death

1. Cancer
2. Heart disease
3. COVID-19
4. Cerebrovascular diseases
5. Chronic lower respiratory diseases

YOUTH BEHAVIOR

Attempted Suicide	9.3%
Feeling Depressed/ Sad/Hopeless	39.0%
Binge Drinking	15.9%
Cigarette Smoking	3.6%
Vaping	28.8%

COMMUNITY PERSPECTIVES

This summarizes focus group-style community conversations conducted with residents of three geographic communities: one each in Central Bucks, Lower Bucks, and Upper Bucks.

Community Assets

Multiple participants from all three focus groups value the **built environment in their communities, especially parks, trails, and open space.**

- *"Walkability is, to me, very important. I can walk in town, I can walk to the post office, I can walk pretty much anywhere as opposed to have to drive all the time."*
- *"Places like Peace Valley Park. I know through this pandemic just being able to go there, and just look at the water and just look at nature having open spaces, that is so important."*
- *"There's a big robust selection of state and public parks people can go to... you always go to Falls Township and see kids playing soccer... A lot of physical stuff going on there, a lot of fishing, getting close to nature."*

A **strong sense of community and ample community organizations** were highlighted as assets by a majority of participants in all groups, as well as a "huge donation spirit" in the area.

- *"There is availability of services for people...whether it's a pantry or home health or whatever else. I feel there is always somewhere I can refer a client based on their situation."*
- *"We've so many churches, a synagogue, religious institutions, a stone's throw from everything pretty much ... And I think that was something that carried a lot of our community--probably like a lot of other communities across the country--through the pandemic, especially. So, I think there's a really large faith-based aspect to things that benefit the community."*
- *"I live in a neighborhood where it's not unusual to stop and talk to my neighbors on my way in and out. So, that provides that social aspect. Especially for my neighbor who's like 90 years old, to be able to talk and knock on our door and make sure they're okay, especially coming through COVID."*

Across the groups, many participants commented on **convenient access to healthy food in grocery stores and from local farms**, such as a farmers market in Doylestown that's *"extremely popular."* However, several acknowledged that **access to nutritious, affordable food is challenging for many residents with low incomes and those living in rural areas of the county.**

Good access to quality health care was mentioned in two groups. *"We're fortunate that around us there's so many doctors right within a couple of miles,"* shared one participant. Several mentioned the availability of facilities for substance use recovery, although the demand for these services can exceed capacity. *"We have a surplus of providers here for drug and alcohol. The only issue with that is, is we have so much population that needs those services that sometimes there's not enough beds in the area, especially at the detox level of care."*

Public transportation, such as SEPTA trains and Doylestown DART buses, was mentioned as a valued resource, though these services may not be universally accessible (described below).

Key Challenges

A pandemic-related surge in behavioral health issues, including substance use, among youth and adults, was a top concern for participants in all three groups. Participants noted difficulties with both accessing and affording behavioral health care, especially during the pandemic, along with ongoing stigma as a barrier to seeking care for these issues.

- *"I think something needs to be done about mental health. It's an access issue to getting them help, because you can't … get through telephone lines, you can't get appointments with therapists. And it's not something that can always be put off for weeks, when you're feeling like you need help."*
- *"I can tell you that the people that need mental health that come into the ER can sit in that ER for days on end, waiting … to be moved to a facility that can take care of their mental health needs,"* said a participant who works in health care.

Participants in two groups briefly mentioned that **obesity, cardiovascular disease, and diabetes** are major health concerns in their communities: *"Women do not understand how heart disease is the number one killer, not breast cancer like they think. But it's heart disease, and we should just do better again with the education of those things."* Another, commenting on diabetes, said: *"People, you know, are not eating healthy and … eating a lot of canned foods and process ed foods, and all of these things … are probably contributing to it."*

Across the three groups, participants discussed a **number of barriers to health care access, including difficulty navigating insurance policies and finding providers who would accept their coverage.** Lack of adequate insurance coverage for behavioral health issues was cited as a key concern in all three groups.

- *"Sometimes it's hard for people to get the insurance; once you get the insurance, finding a provider that accepts your insurance [is difficult], and then trying to get an appointment on top of that. And if you're a new patient, it's a lot longer for you to be able to be seen."*
- *"A lot of the doctors in the area don't take Medicaid; they take insurance companies like Aetna and Blue Cross,"* said a participant who could not find a provider to accept her child's Medicaid policy.
- *"Insurance is not good for mental health, it's very much lacking in the health system. It's never been a priority, and right now, it needs to be more of a priority than anything."*
- *"There's just so little for it [behavioral health] under people's insurance plans. … I mean, if you're looking at … an out of pocket of $100 a session, and that maybe they need a session every week … it becomes a big stumbling block."*

Staffing shortages in the health care system, along with hesitancy among many to seek care due to fear of COVID exposure, are delaying medical appointments amid the pandemic.

- *"As many healthcare providers are encountering, it's very difficult to attract and keep healthcare workers. Folks are leaving. You know, pay is increasing, which is a good thing, but it is very difficult. Turnover has increased, I think across the board, and it's just hard to maintain access and services when you are constantly struggling with staffing,"* said a participant who works in health care.
- *"Sometimes [it's] difficult to get in with specialists. I mean I think that's just something that's a problem across the board. It's really hard to do that. … I don't think it's specific to this community, but I know … people have struggled with that, just trying to get appointments."*

Social Determinants of Health

Several participants who work in health care raised concern about **delays in preventive care** due to the pandemic, as many people put off scheduling checkups and other routine preventive care visits. One predicted that patients are going to "*be at least two, three years into this now before they even get in for their routine yearly exams, which is scary because what's gonna happen next year when everybody decides to come back?*"

The **shift toward telehealth during the pandemic has been a mixed blessing**, participants in the three groups said. "*I think telehealth does have its strong points, I do think it's very good in mental health, because you can actually speak to somebody and not have to get out for the appointments,*" said a participant. Another noted that "*show rates [attendance] for appointments actually increased when they switched to virtual. … People actually kept their appointments a little better.*"

However, virtual health care is a barrier for those who lack digital access or skills, including many older adults. Telehealth also may not be suitable for some types of medical visits or patients, such as mental health visits for young children. Some who have digital access simply prefer to see their providers in person. "*The first time I did it was over video chat, and it was nice, because I could do it from home*," said a participant. "*But I prefer to go in person to everything. I like to be able to speak face to face with someone … just like that human interaction and stuff like that.*"

The **cost of living in Bucks County** was discussed by participants in several groups and, in the words of one participant, the county is a *"very expensive place to live for low wage employees."*

For some individuals, even those at 200% of poverty level, **finding affordable housing, paying for health care, and being able to meet other needs are major challenges**. A participant whose organization provides social services spoke of the hardships for workers with low wages and little or no job security. *"People who are in really dire situations … tell us that they can't afford to take time off to address [mental or physical health issues] because they are concerned about losing a job."* Another noted, for many families: *"Struggling day to day to pay your bills and keep your family fed and all of those things … it really puts an undue stress, strain on people."*

Participants in all three groups discussed a range of housing concerns, including lack of affordable housing and issues related to homelessness and habitability.

- Several commented on increasing development of high-rent luxury apartment buildings in their area, reducing options for affordable or subsidized housing.
- Homelessness was discussed in two groups, along with the need for more public awareness of resources to address homelessness and its associated stigma. A participant with relevant expertise noted: ***"Most people are homeless not because of drugs and alcohol or even mental health. Sometimes it's because of lack of support…just trying to break down that stigma of homelessness in the first place… this stigma that says that in this wealthy county we don't have problems…Right now there are probably upwards of 800 kids that are about to be homeless or are currently homeless. The wait time to get into the shelter right now for single males or females is 10-12 weeks."***
- Housing safety and habitability issues were brought up in one group. Participants discussed a boarding house that had recently been condemned for health and safety violations, causing residents to be displaced.

Food insecurity exists in the county, but is often hidden from view, several participants said.

- "*Central Bucks ... does appear to be more affluent, but there's definitely pockets that ... are struggling. And I do think that sometimes people are not aware of that. I think it's hard for, especially, children, going to school in the district who may have food insecurity.*"

In addition, access to healthy food may be limited for those in rural areas or without a vehicle.

- "*When you get over towards Ottsville and Riegelsville ... there really aren't a whole lot of resources up there for food," said one participant. Another said: "If you live in some of those lower-income communities and you don't have a car, it's (food) not as accessible.*"

Lack of reliable and affordable transportation, as well as the distance to primary and specialty health care services, are barriers for some, especially older adults, commented multiple participants across the groups.

Children and Youth

Behavioral health issues among young people, including substance use problems, were cited as key concerns by participants in all groups. Adding to these concerns are lack of affordable care, a shortage of behavioral health providers and crisis-care beds, and low awareness among youth and parents on how and where to seek care.

- "*I know numerous people ... that have overdosed, died, that I just graduated with [from high school a few years ago]. I feel like in some spots, like there's not enough awareness about mental health and about getting help for like issues like that.*"
- "*When we try to get the mental and behavioral support for young kids in our site, we don't, we don't. There are not enough people out there doing that work.*"
- "*With COVID, there's just been experience after experience after experience that I've heard first-hand where ... parents picking up the phone to call for a teenager or for somebody in their 20s cannot get anybody to call them back. And I know the mental health system is stressed with COVID. But when you're not getting an answer, there's discouragement and that doesn't help people that are facing mental issues.*"
- One participant knew a young boy who had to travel to Florida to get treatment for depression. *"Like, that's how far he had to go to try to get the help that he needs--which is really sad, because you should be able to stay with your family or close to your family. There's just not enough resources."*

For children and adults, financial barriers also hamper access to behavioral health care, which is often not adequately covered by health insurance policies, several participants noted.

- "*Insurance is, you know, it's not good [adequate] for mental health, it's very much lacking in the health system. It's never been a priority, and right now, it needs to be more of a priority than anything,*" said a participant.
- A young adult added, *"I feel like some [young people with mental health issues], they just don't know where to turn to. ... Like, we're young. We don't have a lot of money. ... They need more affordable options."*

Youth vaping was raised as a concern in two groups.

- A participant who works for a behavioral health organization said that vaping not only is common among high school students, but *"we're even seeing it as young as elementary school, but middle school, definitely. And even older teens are expressing concern about their younger peers in middle school that are vaping."*
- Another said: *"One of the things that I keep hearing from the schools is that there's a lot of kids that are vaping and they are vaping in the bathrooms...and out in the open vaping."*

Access to vaping products is too easy for young people, a participant with expertise on this issue stressed.

- *"Even though now you have to be technically 21 to buy products, there are certain stores that sell to minors and kids know that. ... They'll also get things from peers or share it with their friends, or they'll get people to buy it for them. ... And a lot of them get it online, including ... the cartridges for marijuana. A lot of these devices are interchangeable, you can use them for vaping either one, so it's easy to access."*

Lack of structured activities, along with increasing use of social media and other forms of screen time, is harmful for young people's health and social development, multiple participants across the three groups noted. Several also cited unhealthy eating and lack of physical activity as contributing to childhood overweight, obesity, and diabetes.

- *"I think cell phones and tablets are addictive for young kids. ... Right now, kids won't get off the tablets, the phones. I think cutting out Wi-Fi for so many hours a day is something we as parents and grandparents need to do, and make the kids go outside and play."*
- *"I agree with everyone on concerns about screen time and social media regarding youth. We see a correlation with the uptick in reported mental health concerns, which have increased since smart phones became largely available. Smart phones also contribute to very easy access to alcohol, tobacco, and other drugs. Kids can easily acquire drugs like marijuana in about 15-30 minutes by simply using their phones,"* said a participant who works for a behavioral health organization.
- *"There are a huge number of students...like one out of three that are obese, that are not eating...fruits, vegetable, and greens. During COVID, many of them came back and said they ate cereal for breakfast, cereal for lunch, cereal for dinner, and on the weekends they would eat together as a family kind of like celebratory pizza and cheese sticks...So like no education about how important it is to have those (healthy) elements of their diet."*

A few **other issues related to the health of young people** were briefly noted:

One participant discussed the need to raise awareness among students, parents, and school staff about the **risk of human trafficking of youth, stemming from unsafe use of the internet**. *"I think a lot of time people don't realize that even happens in Bucks County; they think it happens somewhere else. Especially online too, you know."*

Issues with **bullying in schools, including of LGBTQ+ youth**, were mentioned.

Participants cited a range of other needs for some children, including glasses for those whose parents can't provide them; dental health support, such as toothbrushes and referrals to dentists; and healthy snacks and other food in schools and afterschool programs, including for children with special dietary needs.

Note: For additional information on needs and opportunities to improve the health of older adults in Bucks County, please see the spotlight section on *Older Adults and Care in Bucks County*.

Older Adults

As the county's older adult population grows, **more services in the community—and better awareness of existing services—are needed to help older people age in place, especially those on fixed or limited incomes,** participants said in all three groups.

- *"I think that we, as a county, need to be really prepared for this. … As the numbers [of seniors] increase, are we going to have enough county services to provide … for the needs of these people who choose to age in place?"*
- *"There are a lot of older adults who are growing older in their own homes by themselves, they're on a fixed income. Oftentimes, the income doesn't keep up with the taxes that they're having to pay. And the services that they need, they no longer can mow their lawn, plow their driveways, they become shut in… In part this is due to older adults brought up thinking that Social Security was supposed to support them and give them an income the entire rest of their life. So, we're seeing a lot of poor seniors needing supports and services that we just don't necessarily have, but they're not Medicaid eligible quite yet."*
- *"A lot of people don't know that there is the [Bucks County] Area Agency on Aging, and I've worked with some of those people in the past, and they're a great resource, and they want to help people, and they're really strong advocates. … That's a big thing, too--not only having people that can provide those services, but also knowing that those services are available."*

For many older adults, increased social isolation during the pandemic has taken a toll on their mental and physical health, several participants shared. One who regularly helps her elderly mother said: *"I do her bills … everything for her now. I didn't use to, but you know, through the pandemic, I've just seen her decline and decline. She's not remembering things, because she was isolated for so long. So, I think our elderly that do not have family [to help care for them] are just very vulnerable right now."* Another commented that COVID-related restrictions on hospital visitors have meant that some hospitalized older adults are unable to have a family member or friend present to help them understand their health issues and care plans.

Lack of understanding about Medicare and covered services is another concern. Older adults can be overwhelmed by the amount of Medicare information as well as phone or online insurance scams, leading to fear, distrust, and reluctance to act. In addition, older adults may not realize that hearing aids or vision and dental care may not be covered by their Medicare plan.

Ageism can adversely impact the treatment of older adults, both in health care and society in general. *"Simple ageism; people assume that when you get older, you're constantly in decline, and then you're just going to simply pass away. And that's not necessarily a healthy way to look at the older adult population. Seniors have and still continue to contribute to the society, they can maintain their health, they can still thrive. So oftentimes the medical community and sometimes social service agencies [are] thinking that seniors have nothing else to give back."*

Other health-care related issues, mentioned by one or more participants, include **a shortage of home health workers and lack of medical providers trained in geriatrics**. *"There is a severe shortage of direct care workers to help people in their homes. So while we want to keep people out of the nursing home and keep them in the community, there's just not enough staff to do it. … We often have the funds to pay for home care for some seniors through state-funded programs, but we cannot find the resources [home health workers] to do it. So, I'd have to say that is my number one issue and the issue we face on a daily basis."*

The **need for assistance with transportation** was cited as a challenge to accessing health care and other services for some older adults. Older adults may have mobility issues that preclude them from public transportation and face concerns about being charged additional fees if they are late for or miss their scheduled appointment. In addition, family supports may not be available. Many adults need assistance in scheduling transportation for ongoing health care services such as post-surgery follow-up visits and physical therapy.

Another concern raised is **the use of same-day surgery for older adults**, who may be sent home before they are able to function safely on their own. A participant who lives in a senior living development said she knows many older adults who've had same-day orthopedic surgery. *"Some of the problem right now with orthopedics is they have this 'fast track,' or whatever you want to call it. And they take the patient in, they do the surgery, and they send them home the same day. … It's very problematic, and dangerous too, because they still have the anesthesia in them, and they're on pain meds. And if they don't have anybody at home, or if they have a spouse that's about the same age, it really causes a problem."*

The **digital divide and use of technology** pose additional problems for older adults trying to access services and information, many participants said. Barriers to telehealth and other uses of the internet may stem from lack of computer equipment or skills, or physical impairments that make it hard to use technology. *"My mom's 79 years old, legally blind, hard of hearing, she cannot make an appointment because she can't, when you say press one, press two, it's just overwhelming…So they're not user friendly for the older population. I just know, I have to make all our phone calls,"* said a participant.

Other Groups

Immigrant communities. Several participants noted the need to build trusting relationships with people who are undocumented or have limited English proficiency to facilitate their access to health and social services. *"Once we connect in and we build that relationship… and then trying to find the services that can consistently help them and then to feel safe with that. … And that's for across the board, mental health, food, health, even with school, communications with school."*

People who are neurodivergent. Two participants spoke about the needs of adults who are neurodivergent, such as those with autism, attention-deficit/hyperactivity disorder (ADHD), dyslexia, or other neuro-developmental conditions. Housing and employment security are concerns for these individuals, commented one participant. *"Most neurodiverse adults live with their aging parents, and when those parents go, there's [not] a place where these adults can go. They typically go with another family member. … There's just not a lot of options."* Another noted that, because many cannot drive, *"the opportunities for adults [who are neurodivergent] are not as plentiful as they are for their neurotypical peers."* A nonprofit was mentioned, Neuro Diverse Living, that provides cohousing in Bucks, Lehigh, and other surrounding counties to help these individuals gain independence and integrate more fully into society.

People with mobility limitations. One participant brought up the need for improvements to public trails and local parks to promote equitable access for those with special needs, including better wheelchair and walker access.

Pandemic Impacts

Several participants spoke about the **need for clearer public health communications as COVID-19 guidelines evolve during the pandemic.** One participant shared: *"Once the [COVID vaccine] booster started rolling out, I heard a lot of people say like, 'Oh, I didn't even realize that they were available that I could get them yet.' … I think that's important, too, just the communication there and how information is disseminated, especially when it's such important health information."* Having to go online to access pandemic-related resources, such as to find COVID-19 testing sites or schedule a vaccination appointment, was cited as a challenge for those who lack digital access or skills.

Participants in two groups spoke about **the difficulty that masks pose for communication among people with hearing impairment** who rely on reading lips and seeing facial expressions to fully understand the meaning of what is being said.

Suggested Actions

Address the need for affordable housing in the county, including resources to help older adults to age in place.

Suggestions offered by participants included creating more affordable senior housing through public-private ventures, working with organizations such as Habitat for Humanity and others to improve habitability, and building "tiny homes" to address homelessness. More county-wide planning to address affordable housing needs among residents with lower incomes and older adults also is needed.

Raise awareness of community health and social services by providing information in settings where people commonly go, as well as online.

"Promotion of all resources to all people," said a participant. Creating and distributing a booklet listing available resources was suggested. One person noted that the Direct Services Coalition in Bucks County already publishes a resource directory but *"I don't think many people know about it, unless they are providers."*

Especially, raise awareness of mental health resources in schools and the community, urged several participants in two groups.

To increase awareness among youth, a young adult who graduated from high school a few years ago said: *"I think high schools should address the issue. Guidance counselors should make kids aware and tell them it's okay to need help."*

Another participant called for raising awareness of the Pennsylvania Student Assistance Program, a free, state-mandated program in schools to help students with substance use or other mental health issues. *"I don't think a lot of people are aware of it, … but it's just a really good [program] as far as the youth population goes."*

Another suggestion was to post signs in the community to help direct people to mental health resources: "*So, anybody who's walking down the street can look at a sign hanging in a store. If you're depressed or sad or you need help, you're a drug addict or whatever the case may be, they can call this helpline to get some resources."*

Increase access to affordable behavioral health care for youth and adults, including more robust insurance coverage.

"Even if these kids have insurance on a parent's plan, mental health in terms of insurance coverage is, to me, severely lacking," one said. Another suggested that "*health insurance is not the answer for mental health and maybe we need to look at mental health in a different way to fund it differently so that people have access."*

Participants in several groups also recommended **more efforts to reduce the stigma associated with seeking care for behavioral health issues**--for example, through education and support to encourage people to talk about their mental health issues.

Bring more integrated health and social services directly into the community to reduce barriers to access.

For example, create mini-resource centers in schools and other community settings with co-located services, such as health care, employment training and assistance, food resources, financial assistance, and care coordination. *"It would be interesting to have a one-stop-shop place so if you need mental health assistance, need to talk with a doctor, food resources, it's just easy access, so there isn't a bunch of transportation needed."*

Suggested Actions

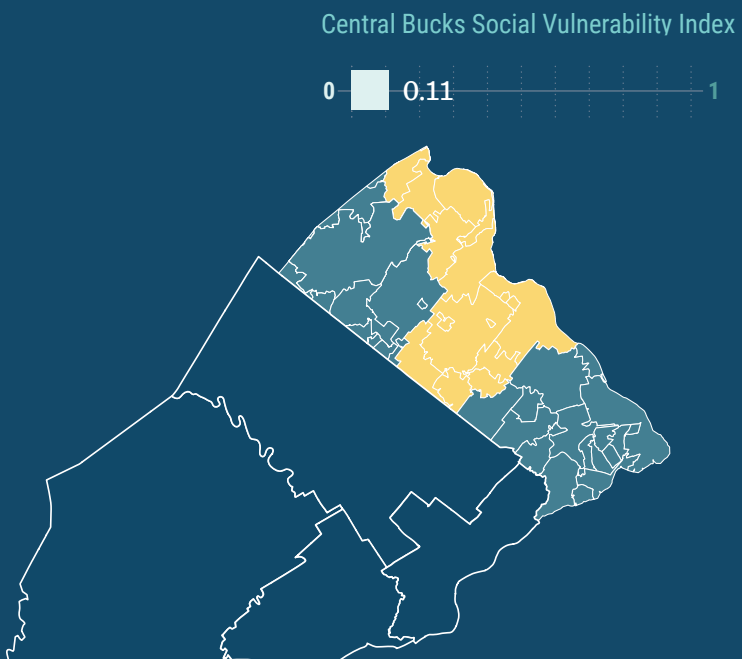
Provide more structured activities to promote physical activity and healthy social development among children and youth.	A participant noted the need for activities to enable "*non-athletic youth to socialize face-to-face not via devices*." Another suggested "*more opportunities for youth to volunteer and this way they could be less on their devices and socialize more.*" Expanding social and emotional learning programs in schools to improve students' social development and mental health was recommended: "*There's more of a need for social emotional learning in schools [amid the pandemic].*" Another suggestion: create more intergenerational opportunities to address community needs, such as for older adults to mentor youth and young people to teach computer skills to older adults.
Expand community education programs to promote health and improve detection and prevention of common diseases.	*"Some people just don't have the knowledge to know how to take care of themselves,"* commented a participant. *"I just think there's so much that we in the community can do, and maybe through the hospitals … [for example], to know what the risk factors are for heart disease, to know about a stroke, what are the signs and symptoms?"*
Address various training needs to improve health care access and delivery, several participants said.	One suggested training advocates to help people who are uninsured or under-insured apply for Medicaid or other subsidized health insurance, such as through Pennie, the state's health insurance exchange website. Another recommended more training for health and community service providers in trauma-informed care.
Several participants suggested strategies to fund community health initiatives.	To help fund more health education, one advised creating *"focused partnerships with pharma and insurance companies in the area to invest more in community health and health outcomes."* Another suggested working with foundations and other funders to support community collaborations and coalitions, and incentivizing staff from community organizations to participate in the coalitions.

CENTRAL BUCKS

ZIP CODES: 18077 , 18901, 18902, 18912, 18913, 18914, 18920, 18923, 18925, 18929, 18930, 18938, 18942, 18947, 18972, 18976, 18980

This community is served by:

- Children's Hospital of Philadelphia
- Doylestown Health
- Fox Chase Cancer Center
- Grand View Health
- Jefferson Abington Hospital
- Jefferson Lansdale Hospital
- Rothman Orthopaedic Specialty Hospital
- Trinity Health Mid-Atlantic



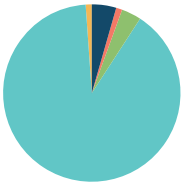
POPULATION

141,585

MEDIAN HOUSEHOLD INCOME

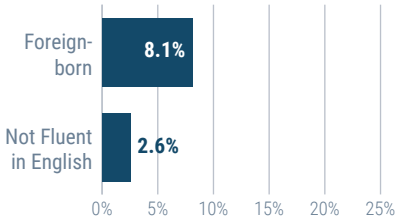
$106,410

RACE/ETHNICITY/LANGUAGE

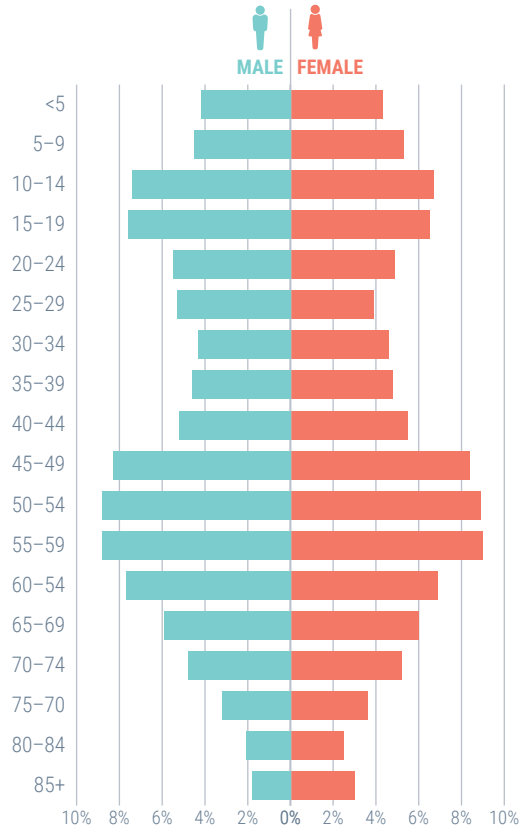


4.7% | Asian*
1.1% | Black*
3.5% | Hispanic/Latino
89.6% | White*
1.1% | Other*

* Non-Hispanic



AGE DISTRIBUTION



LEADING CAUSES OF DEATH

1. Cancer
2. Heart disease
3. COVID-19
4. Cerebrovascular diseases
5. Chronic lower respiratory diseases

EDUCATIONAL ATTAINMENT

High school as highest education level: 16.1%

PEOPLE WITH DISABILITIES

8.1%

summary health measures

		Central Bucks		Bucks County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	801.6	966.2	962.0	1,126.0
	Life expectancy: Female (in years)	84.5	83.3	82.4	81.0
	Life expectancy: Male (in years)	81.1	79.1	78.0	75.8
	Years of potential life lost before 75	5,274	5,692	34,081	39,538
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	185.0	N/A	190.2
	COVID-related hospitalization rate (per 100,000)	N/A	259.2	N/A	398.9
Chronic Disease & Health Behaviors	Adult obesity prevalence	29.2%		30.2%	
	Diabetes prevalence	9.1%		9.8%	
	Diabetes-related hospitalization rate (per 100,000)	79.8	63.6	134.2	129.7
	Hypertension prevalence	29.5%		30.2%	
	Hypertension-related hospitalization rate (per 100,000)	367.3	332.0	444.1	397.0
	Potentially preventable hospitalization rate (per 100,000)	952.8	659.0	1,092.4	875.1
	Premature cardiovascular disease mortality rate (per 100,000)	9.9	19.1	20.3	22.0
	Major cancer incidence rate (per 100,000)	287.5		308.7	
	Major cancer mortality rate (per 100,000)	69.9		91.4	
	Colorectal cancer screening	70.6%		68.6%	
	Mammography screening	77.3%		76.6%	
	Physical inactivity (leisure time) prevalence	18.2%		20.6%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	5.4	--	9.4	2.3
	Infant mortality rate (per 1,000 live births)	--	--	2.7	5.7
	Percent low birthweight births out of live births	6.4%	4.4%	7.6%	6.0%
	Percent preterm births out of live births	6.5%	5.7%	9.5%	8.4%
Behavioral Health	Adult binge drinking	19.8%		19.6%	
	Adult smoking	13.8%		16.0%	
	Drug overdose mortality rate (per 100,000)	10.6	14.1	30.8	31.1
	Opioid-related hospitalization rate (per 100,000)	11.3	9.9	57.8	41.1
	Substance-related hospitalization rate (per 100,000)	175.2	124.3	347.6	276.6
	Poor mental health for 14+ days in past 30 days	11.6%		12.8%	
	Suicide mortality rate (per 100,000)	16.2	10.6	15.6	11.6
Injuries	Fall-related hospitalization rate (per 100,000)	5,105.3	5,964.9	3,098.0	3,124.5
	Gun-related emergency department utilization (per 100,000)	15.9	--	7.0	4.5
	Homicide mortality rate (per 100,000)	--	--	1.0	2.2
Access to Care	Adults 19-64 years with Medicaid	4.4%		7.8%	
	Children <19 years with public insurance	15.4%		22.5%	
	Population without insurance	2.4%		4.0%	
	Children <19 years without insurance	1.4%		2.4%	
	Emergency department utilization (per 100,000)	12,040.8	12,432.2	20,404.7	16,826.5
	High emergency department utilization (per 100,000)	66.5	254.7	389.4	311.2
Social & Economic Conditions	Population in poverty	3.9%		5.6%	
	Children <18 years in poverty	4.1%		6.7%	
	Adults 19-64 years unemployed	1.3%		2.0%	
	Householders living alone who are 65+ years	37.9%		36.8%	
	Households receiving SNAP benefits	1.4%		4.1%	
	Households that are housing cost-burdened	11.0%		13.4%	
	Housing with potential lead risk	39.8%		45.8%	
	Vacant housing units	8.9%		5.8%	

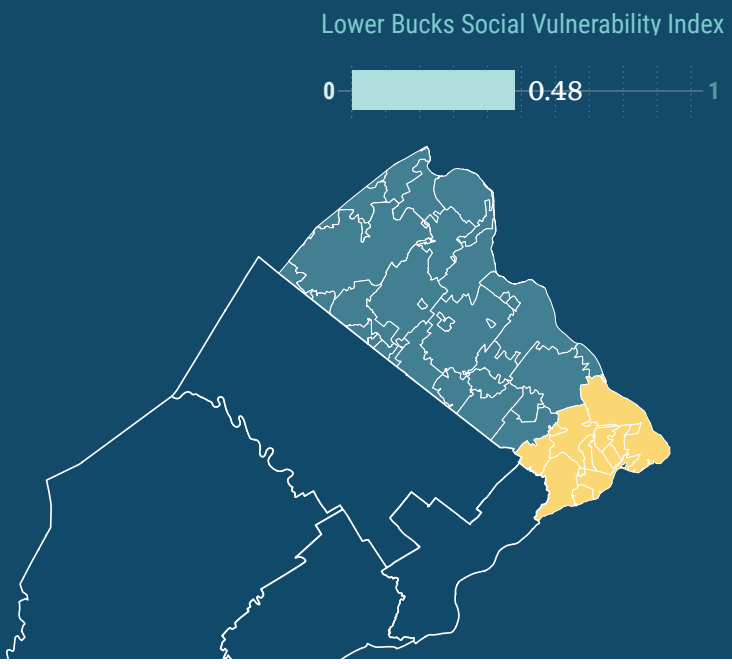
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

LOWER BUCKS

ZIP CODES: 19007, 19020, 19021, 19030, 19047, 19053, 19054, 19055, 19056, 19057, 19067

This community is served by:

- Children's Hospital of Philadelphia
- Doylestown Health
- Fox Chase Cancer Center
- Jefferson Health - Northeast
- Magee Rehabilitation
- Redeemer Health
- Rothman Orthopaedic Specialty Hospital
- Trinity Health Mid-Atlantic



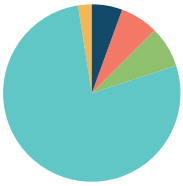
POPULATION

274,155

MEDIAN HOUSEHOLD INCOME

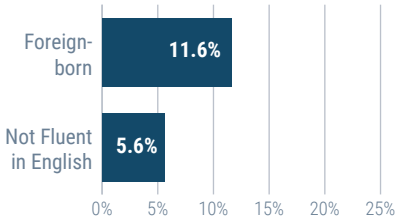
$76,690

RACE/ETHNICITY/LANGUAGE

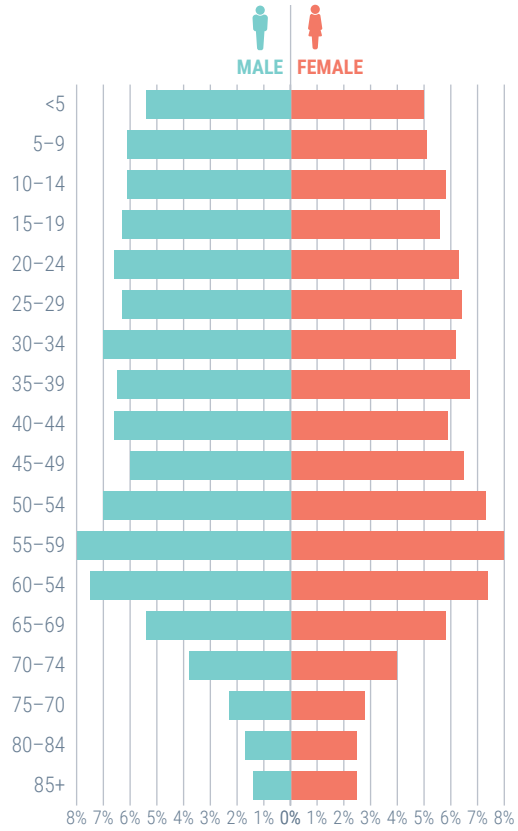


5.8% | Asian*
6.8% | Black*
7.6% | Hispanic/Latino
77.3% | White*
2.3% | Other*

* Non-Hispanic



AGE DISTRIBUTION



LEADING CAUSES OF DEATH

1. Cancer
2. Heart disease
3. COVID-19
4. Chronic lower respiratory diseases
5. Drug overdose

EDUCATIONAL ATTAINMENT

High school as highest education level **28.0%**

PEOPLE WITH DISABILITIES

12.8%

summary health measures

		Lower Bucks		Bucks County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	950.9	1,108.9	962.0	1,126.0
	Life expectancy: Female (in years)	81.4	79.3	82.4	81.0
	Life expectancy: Male (in years)	75.4	73.5	78.0	75.8
	Years of potential life lost before 75	19,106	22,259	34,081	39,538
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	232.0	N/A	190.2
	COVID-related hospitalization rate (per 100,000)	N/A	497.9	N/A	398.9
Chronic Disease & Health Behaviors	Adult obesity prevalence	31.1%		30.2%	
	Diabetes prevalence	10.2%		9.8%	
	Diabetes-related hospitalization rate (per 100,000)	188.9	185.3	134.2	129.7
	Hypertension prevalence	30.3%		30.2%	
	Hypertension-related hospitalization rate (per 100,000)	497.2	445.7	444.1	397.0
	Potentially preventable hospitalization rate (per 100,000)	1,224.9	1,037.7	1,092.4	875.1
	Premature cardiovascular disease mortality rate (per 100,000)	30.3	30.6	20.3	22.0
	Major cancer incidence rate (per 100,000)	268.8		308.7	
	Major cancer mortality rate (per 100,000)	96.3		91.4	
	Colorectal cancer screening	67.0%		68.6%	
	Mammography screening	76.3%		76.6%	
	Physical inactivity (leisure time) prevalence	22.2%		20.6%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	4.8	--	9.4	2.3
	Infant mortality rate (per 1,000 live births)	5.0	7.7	2.7	5.7
	Percent low birthweight births out of live births	9.3%	7.0%	7.6%	6.0%
	Percent preterm births out of live births	9.4%	7.6%	9.5%	8.4%
Behavioral Health	Adult binge drinking	19.6%		19.6%	
	Adult smoking	17.6%		16.0%	
	Drug overdose mortality rate (per 100,000)	49.6	45.2	30.8	31.1
	Opioid-related hospitalization rate (per 100,000)	99.6	65.3	57.8	41.1
	Substance-related hospitalization rate (per 100,000)	526.0	401.2	347.6	276.6
	Poor mental health for 14+ days in past 30 days	13.7%		12.8%	
	Suicide mortality rate (per 100,000)	15.7	9.1	15.6	11.6
Injuries	Fall-related hospitalization rate (per 100,000)	10,110.9	9,862.6	3,098.0	3,124.5
	Gun-related emergency department utilization (per 100,000)	6.7	5.1	7.0	4.5
	Homicide mortality rate (per 100,000)	2.2	3.6	1.0	2.2
Access to Care	Adults 19-64 years with Medicaid	10.8%		7.8%	
	Children <19 years with public insurance	29.9%		22.5%	
	Population without insurance	5.2%		4.0%	
	Children <19 years without insurance	3.5%		2.4%	
	Emergency department utilization (per 100,000)	31,806.7	23,120.7	20,404.7	16,826.5
	High emergency department utilization (per 100,000)	741.9	446.0	389.4	311.2
Social & Economic Conditions	Population in poverty	7.4%		5.6%	
	Children <18 years in poverty	9.5%		6.7%	
	Adults 19-64 years unemployed	2.5%		2.0%	
	Householders living alone who are 65+ years	36.9%		36.8%	
	Households receiving SNAP benefits	9.7%		4.1%	
	Households that are housing cost-burdened	17.3%		13.4%	
	Housing with potential lead risk	63.8%		45.8%	
	Vacant housing units	4.4%		5.8%	

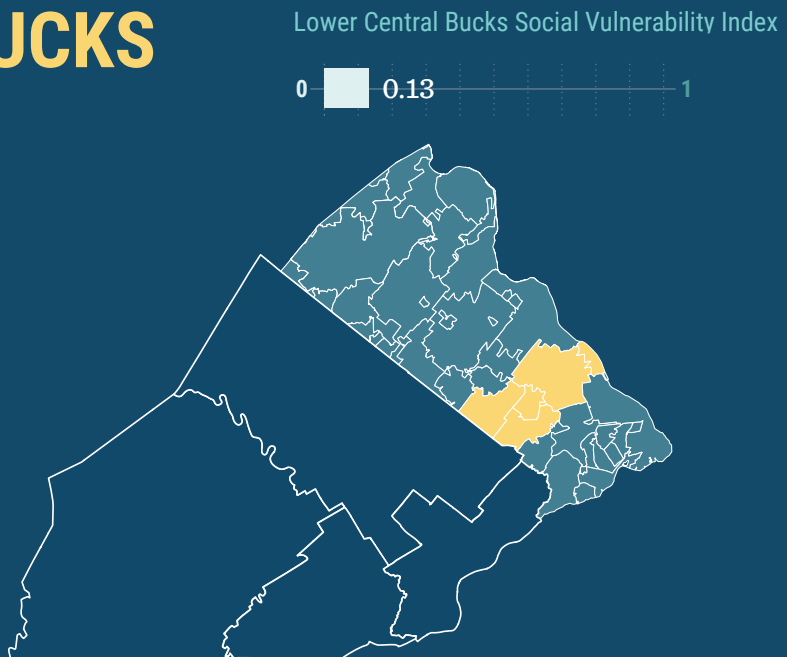
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

LOWER CENTRAL BUCKS

ZIP CODES: 18940, 18954, 18966, 18974, 18977

This community is served by:

- Children's Hospital of Philadelphia
- Doylestown Health
- Fox Chase Cancer Center
- Jefferson Abington Hospital
- Jefferson Health - Northeast
- Redeemer Health
- Rothman Orthopaedic Specialty Hospital
- Trinity Health Mid-Atlantic



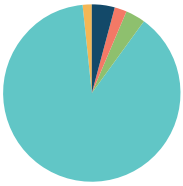
POPULATION

120,822

MEDIAN HOUSEHOLD INCOME

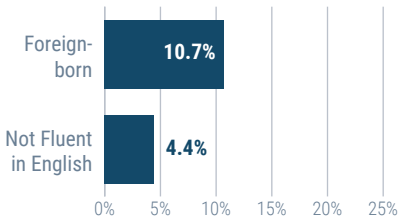
$115,295

RACE/ETHNICITY/LANGUAGE



4.3% | Asian*
2.2% | Black*
3.6% | Hispanic/Latino
88.2% | White*
1.5% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

1. Heart disease
2. Cancer
3. COVID-19
4. Cerebrovascular diseases
5. Alzheimer's disease

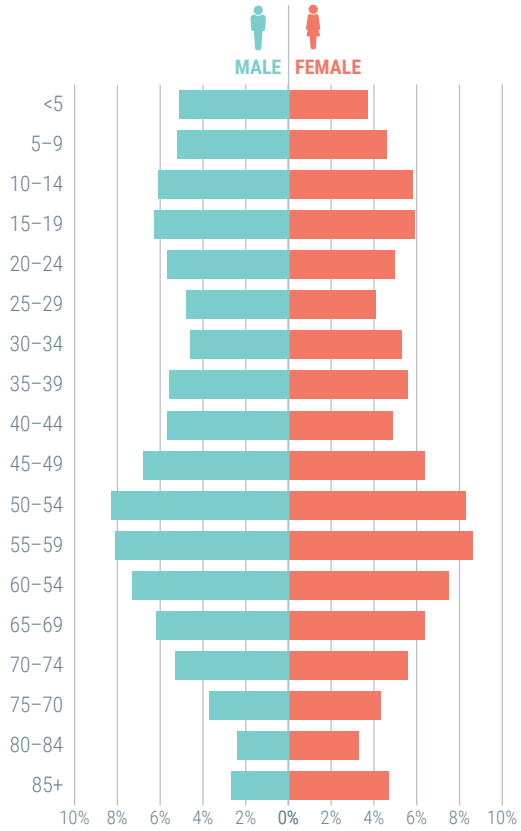
EDUCATIONAL ATTAINMENT

High school as highest education level **19.6%**

PEOPLE WITH DISABILITIES

9.9%

AGE DISTRIBUTION



summary health measures

		Lower Central Bucks		Bucks County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	1,115.7	1,311.0	962.0	1,126.0
	Life expectancy: Female (in years)	84.3	82.2	82.4	81.0
	Life expectancy: Male (in years)	80.6	77.4	78.0	75.8
	Years of potential life lost before 75	4,392	6,204	34,081	39,538
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	215.2	N/A	190.2
	COVID-related hospitalization rate (per 100,000)	N/A	436.2	N/A	398.9
Chronic Disease & Health Behaviors	Adult obesity prevalence	28.8%		30.2%	
	Diabetes prevalence	9.8%		9.8%	
	Diabetes-related hospitalization rate (per 100,000)	88.6	104.3	134.2	129.7
	Hypertension prevalence	31.1%		30.2%	
	Hypertension-related hospitalization rate (per 100,000)	515.6	415.5	444.1	397.0
	Potentially preventable hospitalization rate (per 100,000)	1,197.6	889.7	1,092.4	875.1
	Premature cardiovascular disease mortality rate (per 100,000)	9.1	15.7	20.3	22.0
	Major cancer incidence rate (per 100,000)	331.1		308.7	
	Major cancer mortality rate (per 100,000)	110.9		91.4	
	Colorectal cancer screening	70.8%		68.6%	
	Mammography screening	76.7%		76.6%	
	Physical inactivity (leisure time) prevalence	19.2%		20.6%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	3.9	--	9.4	2.3
	Infant mortality rate (per 1,000 live births)	--	7.8	2.7	5.7
	Percent low birthweight births out of live births	6.3%	6.8%	7.6%	6.0%
	Percent preterm births out of live births	5.9%	7.2%	9.5%	8.4%
Behavioral Health	Adult binge drinking	18.8%		19.6%	
	Adult smoking	13.8%		16.0%	
	Drug overdose mortality rate (per 100,000)	16.6	22.3	30.8	31.1
	Opioid-related hospitalization rate (per 100,000)	40.6	31.5	57.8	41.1
	Substance-related hospitalization rate (per 100,000)	239.2	198.6	347.6	276.6
	Poor mental health for 14+ days in past 30 days	11.6%		12.8%	
	Suicide mortality rate (per 100,000)	7.4	14.9	15.6	11.6
Injuries	Fall-related hospitalization rate (per 100,000)	7,407.4	7,454.2	3,098.0	3,124.5
	Gun-related emergency department utilization (per 100,000)	3.1	3.1	7.0	4.5
	Homicide mortality rate (per 100,000)	--	--	1.0	2.2
Access to Care	Adults 19-64 years with Medicaid	4.5%		7.8%	
	Children <19 years with public insurance	13.9%		22.5%	
	Population without insurance	2.8%		4.0%	
	Children <19 years without insurance	1.6%		2.4%	
	Emergency department utilization (per 100,000)	21,914.9	16,764.6	20,404.7	16,826.5
	High emergency department utilization (per 100,000)	380.0	242.1	389.4	311.2
Social & Economic Conditions	Population in poverty	4.0%		5.6%	
	Children <18 years in poverty	3.9%		6.7%	
	Adults 19-64 years unemployed	1.7%		2.0%	
	Householders living alone who are 65+ years	50.6%		36.8%	
	Households receiving SNAP benefits	2.2%		4.1%	
	Households that are housing cost-burdened	14.6%		13.4%	
	Housing with potential lead risk	31.8%		45.8%	
	Vacant housing units	2.7%		5.8%	

* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

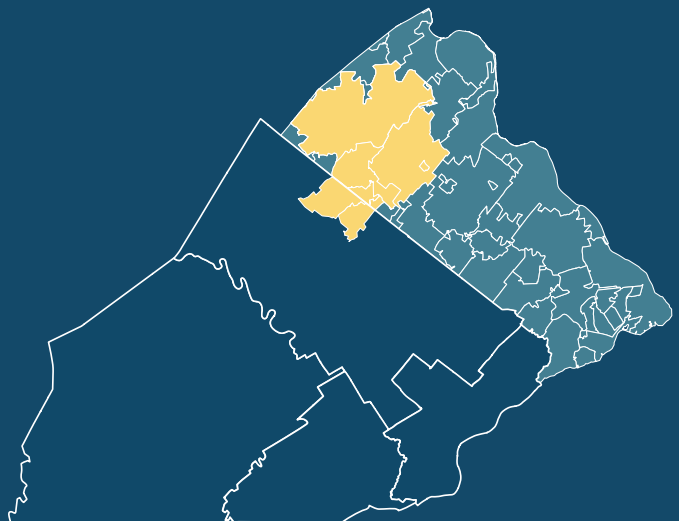
UPPER BUCKS

ZIP CODES: 18917, 18935, 18944, 18951, 18955, 18960, 18962, 18964, 18969, 18970

This community is served by:

- Children's Hospital of Philadelphia
- Doylestown Health
- Fox Chase Cancer Center
- Grand View Health
- Jefferson Abington Hospital
- Jefferson Lansdale Hospital
- Rothman Orthopaedic Specialty Hospital

Upper Bucks Social Vulnerability Index



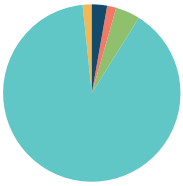
POPULATION

106,949

MEDIAN HOUSEHOLD INCOME

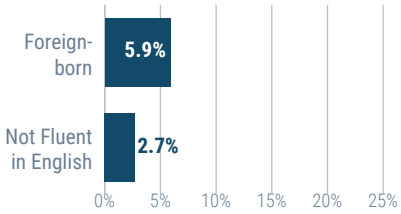
$78,457

RACE/ETHNICITY/LANGUAGE



3.0% | Asian*
1.6% | Black*
4.5% | Hispanic/Latino
88.9% | White*
1.6% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

1. Cancer
2. Heart disease
3. COVID-19
4. Cerebrovascular diseases
5. Alzheimer's disease

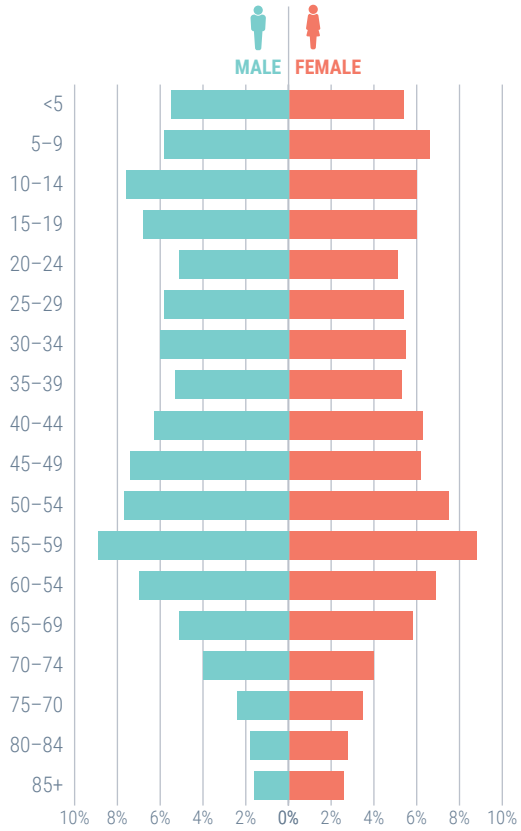
EDUCATIONAL ATTAINMENT

High school as highest education level **28.9%**

PEOPLE WITH DISABILITIES

9.6%

AGE DISTRIBUTION



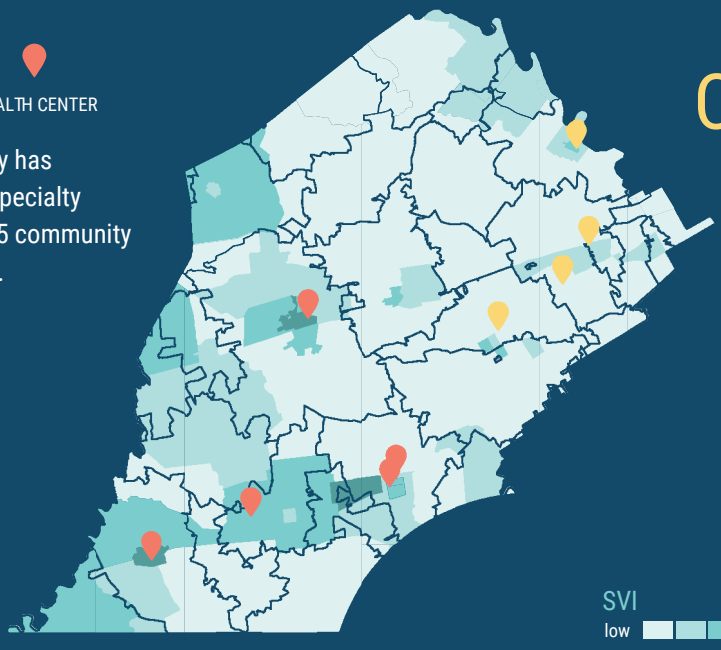
summary health measures

		Upper Bucks		Bucks County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	967.8	1,075.3	962.0	1,126.0
	Life expectancy: Female (in years)	80.8	81.5	82.4	81.0
	Life expectancy: Male (in years)	78.0	76.8	78.0	75.8
	Years of potential life lost before 75	6,219	5,371	34,081	39,538
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	101.9	N/A	190.2
	COVID-related hospitalization rate (per 100,000)	N/A	307.6	N/A	398.9
Chronic Disease & Health Behaviors	Adult obesity prevalence	30.9%		30.2%	
	Diabetes prevalence	9.6%		9.8%	
	Diabetes-related hospitalization rate (per 100,000)	112.2	92.6	134.2	129.7
	Hypertension prevalence	29.7%		30.2%	
	Hypertension-related hospitalization rate (per 100,000)	319.8	337.5	444.1	397.0
	Potentially preventable hospitalization rate (per 100,000)	910.7	769.5	1,092.4	875.1
	Premature cardiovascular disease mortality rate (per 100,000)	23.4	14.0	20.3	22.0
	Major cancer incidence rate (per 100,000)	273.0		308.7	
	Major cancer mortality rate (per 100,000)	79.5		91.4	
	Colorectal cancer screening	67.9%		68.6%	
	Mammography screening	75.7%		76.6%	
	Physical inactivity (leisure time) prevalence	21.7%		20.6%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	18.3	--	9.4	2.3
	Infant mortality rate (per 1,000 live births)	--	--	2.7	5.7
	Percent low birthweight births out of live births	5.4%	5.2%	7.6%	6.0%
	Percent preterm births out of live births	5.8%	5.1%	9.5%	8.4%
Behavioral Health	Adult binge drinking	20.0%		19.6%	
	Adult smoking	17.6%		16.0%	
	Drug overdose mortality rate (per 100,000)	25.2	23.4	30.8	31.1
	Opioid-related hospitalization rate (per 100,000)	14.0	12.2	57.8	41.1
	Substance-related hospitalization rate (per 100,000)	230.0	229.1	347.6	276.6
	Poor mental health for 14+ days in past 30 days	13.7%		12.8%	
	Suicide mortality rate (per 100,000)	20.6	16.8	15.6	11.6
Injuries	Fall-related hospitalization rate (per 100,000)	6,231.2	6,131.1	3,098.0	3,124.5
	Gun-related emergency department utilization (per 100,000)	--	--	7.0	4.5
	Homicide mortality rate (per 100,000)	--	--	1.0	2.2
Access to Care	Adults 19-64 years with Medicaid	7.5%		7.8%	
	Children <19 years with public insurance	24.7%		22.5%	
	Population without insurance	4.5%		4.0%	
	Children <19 years without insurance	2.1%		2.4%	
	Emergency department utilization (per 100,000)	22,390.6	17,873.4	20,404.7	16,826.5
	High emergency department utilization (per 100,000)	294.9	237.5	389.4	311.2
Social & Economic Conditions	Population in poverty	6.5%		5.6%	
	Children <18 years in poverty	9.1%		6.7%	
	Adults 19-64 years unemployed	1.8%		2.0%	
	Householders living alone who are 65+ years	30.2%		36.8%	
	Households receiving SNAP benefits	4.3%		4.1%	
	Households that are housing cost-burdened	13.6%		13.4%	
	Housing with potential lead risk	42.4%		45.8%	
	Vacant housing units	3.7%		5.8%	

* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

HOSPITAL HEALTH CENTER

Chester County has 4 acute care/specialty hospitals and 5 community health centers.



CHESTER COUNTY

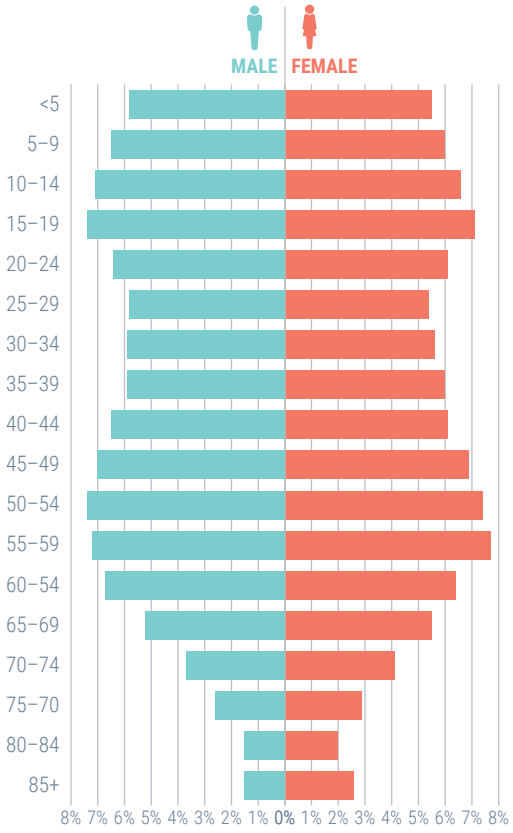
Social Vulnerability Index (SVI)

0 — 0.14 — 1

Median Income	$98,576
High school as highest education	17.4%
Food Insecurity	6.3%
With a Disability	8.7%
Violent Crime Rate	73.7 per 100,000

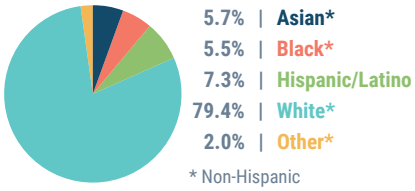
AGE DISTRIBUTION

Chester County has an estimated population of 550,830, with the largest proportion of residents between the ages of 45 and 59.

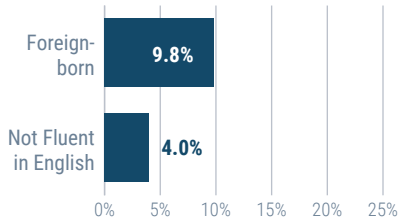


RACE/ETHNICITY/LANGUAGE

79.4% of residents are non-Hispanic White. Hispanic/Latino residents make the next largest population, comprising 7.3% of the county's residents.



About 10% of residents are foreign-born and 4% speak English less than "very well."



COVID-19 | Rates per 100,000

Fully Vaccinated	61,756.4

COVID-related:

• Emergency Department Use	445.0
• Hospitalization	274.1
• Mortality	110.2

MORTALITY

Leading Causes of Death

1. Heart disease
2. Cancer
3. COVID-19
4. Cerebrovascular diseases
5. Chronic lower respiratory diseases

YOUTH BEHAVIOR

Attempted Suicide	7.9%
Feeling Depressed/ Sad/Hopeless	39.0%
Binge Drinking	14.0%
Cigarette Smoking	3.8%
Vaping	25.2%

COMMUNITY PERSPECTIVES

This summarizes focus group-style community conversations conducted with residents of four geographic communities: one each in Central-East Chester, Central-Wester Chester, Southern Chester, and West Chester.

Community Assets

Open space and parks were identified in all groups as promoting physical and mental well-being. Walkable communities and indoor physical activity venues also were highlighted.

- ***"This is the first time that I've lived in a place where I have the choice of so many community parks, where I can walk and get out, and enjoy the fresh air. That to me is an asset, being five minutes within open space that's safe and welcoming."***
- ***"There's sports leagues from the time kids are from five on, you name the sport– every Saturday out in the parks. … There are a lot of activities, especially sports for children to be involved in throughout the county."***
- Indoor programs, like "Mall Walkers" at Exton Mall, promote affordable physical activity.

Accessible health care, including for under- or uninsured individuals, is another asset. *"Community Volunteers in Medicine has doctors, nurses, mental health staff available to walk in, even if insurance is a barrier,"* said one participant. Another commented on the value of health information provided by local hospitals: *"I follow a lot of the local health hospitals and health systems on social media and find a lot of helpful information that way."*

In all groups, social service organizations are valued for supporting those in need, such as people experiencing homelessness or food insecurity.

- ***"Chester County's fortunate to have a strong network of social service agencies that run the gamut of community needs. I think the strength of those organizations has really shown throughout the pandemic. … That the county believes in us and commits to us."***

The Alliance for Health Equity was recognized for facilitating coordination among local organizations: *"Their ability to bring us [organizations] together and take us out of our individual silos, and really push us as a network to be collaborators."*

Access to healthy food is abundant, including the emergency food system. *"[There are] farmers markets around here where small businesses come and sell their fruits and veggies,"* said one participant. Emergency food providers such as the West Chester Food Cupboard and Chester County Food Bank are important assets: *"There's a lot who are in need, and the Chester County Food Bank is a place where they can go to get fresh vegetables, and all kinds of foods, and that's in walking distance for the people that … come to my church."*

Youth programs provide safe, fun opportunities for young people to connect and engage with the community. *"I work with teenagers … there's local organizations and programs for them, too, like the Garage Community and Youth Center in West Grove, and the Lighthouse in Oxford. [The Lighthouse], it's faith based, it's helping with mental health, gives the kids something fun to do after school, a place to let off some steam and be part of their community, and also be a part of a spiritual community as well. I see a lot of kids being involved in that, and it really is helping them out,"* shared one participant.

A "strong sense of community among residents" was noted across groups. *"The community is rich with resources and answers amongst the people who live, eat, breathe, sleep, work, educate themselves there. That's where the secret sauce is.… The sense of community contributes greatly to its health."* Numerous community events also promote social cohesion and information sharing about programs, services, and resources available in the local community.

Key Challenges

Common physical health concerns cited by participants include high blood pressure, diabetes, heart disease, respiratory disease, and kidney disease. *"I think diabetes and hypertension are easily the top two; cholesterol, hyperlipidemia is probably a close third,"* commented one participant. Another said: *"If you walk into a dialysis clinic, the amount of people there on dialysis, you'd be surprised. And so you wonder, why there is so much health challenges with kidneys?"* Oral health care, which is not covered by many insurance plans, was another concern: *"I've seen people very ill due to teeth and the hospital couldn't help."*

In the West Chester area, several participants perceived high rates of respiratory diseases and cancer, which they linked to environmental contaminants.

- *"In the lower east end of the borough, I would say there is more respiratory problems, there's more cancers here in the area, because this section is more or less a toxic section. This didn't just start, it's a generational thing, from my grandparents up until now."*

Health behaviors, such as smoking, unhealthy eating, and reluctance to seek care or take prescribed medications, pose challenges to chronic disease prevention and management.

- *"[People] bragging that 'I haven't been to the doctor in ten years,' as a good thing or 'I never go to the doctor.'... We have some work to do getting people to take their medication and go to the doctor."*
- *"I'm concerned about smoking, the amount of people I see smoking ... with asthma, COPD."*
- *"A lot of it [challenges with healthy eating] comes with work hours. You come home, you don't have time to cook a good healthy meal or you may not have the money to buy healthy food. Instead, you go for something that's quick and easy."*

Behavioral health, including substance use among youth and adults, was cited as a top priority across all groups.

- *"With the kids, that's more like vaping and drinking, that kind of typical teen stuff you'd see, and with drugs in there too. But I think with the adults, it's more just drugs, like harder drugs. A lot of parents are involved with that as well, with different substance abuse. So, I think just overall, that it's pretty prevalent in the community."*
- *"Sometimes I see those that are addicted to pain medications. They're having difficulty with pain management, and they go to the hospital, because they're hoping to get morphine to ease it. So that lasts for a little while, and then they're back with the urge of wanting prescription pain meds again. I've heard of people sharing medications or trying to get medication from other people in the community. And so, I think that addiction to pain medications, or people who deal with chronic pain need to be on our list [of key concerns]."*

Navigating the healthcare system, including behavioral health care and insurance issues, is a common challenge. Lack of access to Medicaid and Medicare providers is another barrier.

- *"I think overall, the system needs to be easier to navigate. Because it's overwhelming trying to figure it out ... Finding a provider that doesn't have a long wait of many months. Finding a good provider that takes your insurance ... many providers don't ... and we pay out of pocket."*
- Another participant voiced *"frustration with navigating the whole process...We didn't finally get on the right path until maybe a year or two into the whole fiasco. Which is, if you ask me, way too long to finally have a doctor say to you, 'by the way, if you have a mental health diagnosis, you're qualified for X, Y and Z.' And we're like, why wasn't this shared with us a year or two ago, why are we being bounced around?"*
- *"A lot of people in my neighborhood do [have Medicaid]. And unfortunately, we have to travel outside of West Chester a lot of times to get help. It's feeling like, to a certain extent we don't belong here, and that certain providers just don't want to deal with us simply because of the insurance that is associated with us."*

Long wait times to schedule medical appointments are a major concern, leading to delayed care. Delayed access to affordable behavioral health care is especially challenging, as is a shortage of bilingual behavioral health providers.

- *"To have somebody wait three months to get in for med management is unacceptable. ... If you're on some sort of anti-anxiety medication or [another] medication, you have to be under the care of a healthcare practitioner, a psychiatrist or whoever's writing that to you."*
- *"I am concerned about access to care for some physical health issues as well. Some specialists don't have available appointments for months. Dermatology is one. Physical therapy is hard to secure currently."*
- *"One of the biggest challenges we see with our participants [who are housing insecure] is having readily available mental health access. ... Sometimes appointments can be three, four, six months out, and that doesn't help the need right now. There is a limited number of available mental health professionals, or mental health professionals that are in-network, for a majority of the families that we work with,"* shared a participant who works at a community organization.
- *"Finding bilingual therapists and counselors is almost near impossible, or any that have availability to take on new clients or that understand the nuanced cultural needs of our students and families. We have many students and parents that are struggling with mental health issues that do not have access to any services,"* said a participant who works in a school district.

Acute care beds for behavioral health patients are often unavailable, necessitating long stays in the emergency department or traveling considerable distances for care. The situation is especially difficult for families with children needing acute behavioral health care, or those who lack transportation.

- A participant whose child has an intellectual disability disclosed: *"It's difficult because there's no short-term care facilities for people with developmental disabilities here. It got to the point where his safety [their son] really was a concern. We went to the ER because you have to have medical clearance in order to get an emergency placement. We sat in the ER for four days because there was no placement for him ... And then to hear, 'the only place we can send him is Pittsburgh.' It's super frustrating."*
- *"I've seen others in a situation where they've been in a mental health crisis, and the services for them here just isn't available. We would have to go to Coatesville or even Paoli. I don't drive, so a lot of times until I got my insurance changed from one particular Medicaid provider to another, I would have to travel on two buses."*

For community organizations whose staff members often are the first to notice or talk to people experiencing behavioral health issues, the lack of resources for referrals and support is another concern.

- *"As a service provider, it feels like a very big challenge to find those support systems when they're needed. If someone walks into my facility and it's apparent they could benefit from some mental health counseling, I find that when I make a phone call looking for support, assistance, referral--unless that person's in crisis of causing harm to themselves or others--my only recourse is to be a friendly shoulder. And I feel like that's a huge burden on me ... because I don't feel I have the training or the resources to potentially be talking somebody off of a ledge. ... I think we have got to stop brushing mental health under the rug, and admit that it's here, and admit that we're not doing a good job with it, and really start figuring out some solutions."*

Social Determinants of Health

Apprehension about the closing of two hospitals in the county (Tower Health's Jennersville and Brandywine Hospitals) was voiced.

- *"Don't close area hospitals, we need them. People shouldn't have to drive 30 minutes if they have an emergency. Like, that's a scary thought. We need to find a way to keep hospitals open in the communities."*

Participants expressed mixed views on e-health, including telehealth and the use of online health portals.

- *"I would say that access to healthcare professionals using technology maybe created some ease. But, relating to my mom, who is currently addressing metastatic breast cancer, there's a big difference between meeting with your oncologist on the phone, or on Zoom, and meeting your oncologist in-person, and being able to discuss your personal health needs."*
- **There is frustration with using online health portals to provide or receive sensitive personal information.** *"You get an email that says welcome to our portal, now sit down and include all of this information. At a certain age you don't want things coming to you via the computer asking lots of sensitive information every time you see a doctor. ... It's great when they're [the doctors] in the same system, but if you happen to have doctors in multiple systems, then you're in multiple portals, and that can be a little bit intimidating."*

Systemic racism. Several participants discussed systemic racism in the county and the need to look "*through an equity lens*" at disparities in community access to food, transportation, and other essential needs. Participants linked community violence and poor health outcomes, particularly for mental health, to these inequities and called for more conversations that consider racism and equity as part of solutions to improve health outcomes.

Housing security and habitability. Lack of affordable, safe housing impacts the physical and mental health of many across the county.

- *"We work with those facing homelessness and one of the struggles in this community is finding affordable housing. If people can't find affordable housing, that's a trauma of its own. It relates to mental health; it relates to all types of other issues. Finding affordable housing in Chester County has become a huge issue."*
- *"Many families live in ... unsafe housing ... it's overcrowded, there is mold, it's just generally not safe. It can be very stressful, it can cause a lot of anxiety to live in those situations."*

Transportation. Transportation was identified as an issue in all groups, with particular need in rural areas and for people without a car or a driver's license.

- *"For individuals with mental health issues, it's very difficult for them to get to their appointments. It's difficult to sometimes even get their medications because of a lack of transportation ... Even though we do have some mobile mental health, it's limited, because the issue really is vast in our area."*
- *"The paratransit service in Chester County is the Rover buses. When it works, it works great, and when it doesn't work, it doesn't work. Having to rely on a service such as that to get to a doctor's appointment, whether that's preventive care, or a scheduled surgery - you may have to leave your house as early as six o'clock in the morning to be dropped off at the hospital for a ten o'clock appointment, and not be picked up until six o'clock at night."*
- *"I don't want to pigeonhole it specifically to mushroom workers, but that's the majority of those we see ... who may not have a car, who may not have a license, who may not be eligible for a license. ... They usually pay an arm and a leg to somebody who does have a car. And then hopefully they get there on time. ... The public busing basically only goes parallel to Route 1, so there's not much else if you need to get to a specialist in Philly, it's just not easy."*

Limited income and cost of living. Participants commented on rising prices for food, exercise classes, and other items, as well as difficulty paying for essential needs including health care.

- *"Housing, food, gas, everything, it's more expensive this year. That's a barrier to health."*
- *"Some things are free, like the trails and parks. But a gym is not typically free and I would love to be able to go back and exercise, but just the prices of things have increased."*
- *"To be healthy and stay healthy you can't, because you can't afford the medicine you need. And you try to go around it by taking something else that probably is not as good."*
- *"For a lot of our families in the mushroom industries, for example, a lot of those types of jobs pay by production, they don't pay hourly. So, if you take off work you lose a big chunk of your paycheck, and that's causing a lot of our families to avoid seeking medical care."*

Built environment. Concerns about diminishing open space due to development were noted.

- *"The green space … promotes calm. We moved here for the open space, which is disappearing. … There's something to be said about preserving unused land."*

Access to healthy, affordable food. While food access is plentiful in most areas of the county, some communities lack supermarkets, creating additional barriers especially for those lacking transportation.

- *"There're no grocery stores basically in [West Chester] anymore. If you don't have transportation, it's difficult to take the bus to go to the supermarket to ShopRite to Acme, there's no bus for Giant. … You may not be able to pay for Lyft or an Uber driver, so you depend on friends, relatives, or you find yourself going to [drug stores or convenience marts], that's not healthy." Another shared: "While Coatesville is walkable, there are not grocery stores. We have some on the outskirts, but from 1st to 13th Avenue, there's limited access to groceries."*

Awareness of health and social services. Participants across the county noted the public is often unaware of community resources.

- *"Luckily, we found services, but as many have mentioned, we had to really hunt and educate ourselves to find those services to help us."*

Digital divide. Limited access and ability to use technology to navigate health care and other resources are barriers for some, as is lack of broadband access in some areas.

- *"There is such a dependence on technology and apps for appointments, results, messaging providers, etc. Anyone without a smart phone or not tech savvy can struggle with this."*
- *"For some, the only access they have to technology is their phones, and that doesn't necessarily give them the same opportunities to connect with healthcare providers for the kinds of services that they need."*
- *"There's a lot of … access to technology issues in certain parts of the area, and more in rural areas. … And some of the broadband service that's out in Oxford and Nottingham, and out that way, isn't that reliable."*

Language and cultural barriers. For immigrant communities, accessing information in their native language and finding providers who understand their culture can be difficult.

- *"Getting resources, whether for physical or mental health, to people that meets their culture and meets their language [needs]. … And just educating people to help address some of the stigma around mental health. … The cultural challenge and the linguistic challenges - breaking down those barriers, so everyone is getting equitable healthcare."*
- *"There are indigenous languages that very few people have mastered or who can interpret … very few people professionally can."*

Children and Youth

Behavioral health issues among youth, including substance use, were highlighted as a major concern across all groups.

- *"I've seen children of all colors, all backgrounds suffer. It goes across social, economic divides, and hits rich, poor, all folk are going through it."*

Multiple factors contribute to behavioral health challenges among youth, including stress, grief over losses during the pandemic, pressure to succeed, and social exclusion.

- *"There's a lot of stress put on kids outside of school just in their day-to-day life. ... Some of the older siblings have to be parents. They have to come home and take care of the little ones. And then they also have homework, and they get in trouble for not doing the homework, and then they're stressed at school, and school is a negative place to be then. ... We see youngsters all the time with their own kids or taking care of their siblings. ... I guess having to be a grownup when you're a kid, it leads to negative coping mechanisms, whether it's food or technology or substances,"* said a participant who works in a school district.
- *"Little ones are grieving parents [who] are incarcerated. They are grieving grandparents lost through COVID. They are grieving the loss of friends. I think young people grieve for other young people, when they hear about school shootings. Even if you don't know that school, you've never been to that town, the fact that somebody went to school today and was killed, I think has a broader effect than any of us realize."*
- *There's a lot of pressure to achieve at least in the [school] district. ... There's a lot of pressure to succeed on our students in general."*
- *"Kids in our county, who are on the fringes, like maybe the lesbian [and] gay population, like the kids who are kind of not always feeling like they're included, who are trying to find their paths, their space, their niche. Maybe there's programs available for these kids just to help guide them along, so they can find their way, so they're not feeling like an outcast. There's a lot of kids that are on the fringes, and they just need help in some way."*

As is true for adults, stigma and lack of awareness about mental health create barriers to seeking care for children and youth:

- *"A few years ago, we lost students to drug overdose. The thing is, people don't necessarily want to talk about it, it's hidden – we keep that among the family."*
- *"The awareness of mental health is just not there, especially for certain cultural groups. It has a negative connotation. ... I think there should be some education on mental [health] awareness at the junior and high school level, so that people can access this help. They can understand that it's a natural part of life to get help when they have these challenges."*

Some youth resort to self-harm as a way to cope with distress and emotional pain

- A participant who is a school nurse shared: *"They're cutting themselves, they don't know how to cope with different situations, and really don't have resilience."*

Suicide among youth was described as "a huge issue."

- *"The biggest thing from my perspective is mental health, and especially in our school district … just losing the children by horrible means, by their own hands. I feel like it's getting out of control."* Another participant said: *"It [suicide] is definitely complex. But I also think kids are impulsive. I don't think they understand the finality of it."*

Substance use, including vaping and alcohol use, is common among youth. Participants questioned the ease with which youth can obtain these and other regulated substances.

- *"There's a lot of vaping … it's widespread and common. … I don't know how it's available to them, but they're getting it easily."*
- *"We've entered a period where people can buy drugs online. Kids have access to cell phones; they have access to computers. That definitely goes hand-in-hand with mental health."*

Many participants highlighted the need to encourage healthier lifestyles among youth.

- *"Education in schools for a healthy lifestyle, you need to start them early on. … When you educate children in elementary and middle school years, that's lifelong learning."*

Multiple participants emphasized the need for increased access to equitable and affordable behavioral health services for young people.

- *"Our children and teens have been through a nightmare in the past year and a half, and I feel like they're the group that's being ignored as far as their mental health. I think that people are less concerned when it's children, but in reality, there has to be more services."*
- *"The rich can send their child to Florida to a treatment center because they have the money to do it, but [others] do not have that."*

Schools are feeling the impact of widespread behavioral health issues among students.

- **The need for every school district to provide behavioral health services was emphasized.** Noting that a typical school district experiences at least one or two student suicides each year, one participant talked about the inequity of mental health services across districts: *"There's the haves, and the have-nots, and our district is able to have mental health professionals within the school, but not every district is able to do that, or able to afford that in Chester County."*
- **The pandemic has worsened mental health for the whole school community.**

  "The school systems are going through their own mental health crises, students and teachers. The teachers need support, the support staff need support. … So, if you've ever been an educator… you know your work is beyond classroom teaching. When kids came back to school, that backlog [for mental health services], it just doubled … it's really difficult to handle the need right now."

  "As a result of anxiety, depression, and other mental health disorders, we do end up seeing truancy issues, because the kids are not receiving the supports that they need to get through what they're dealing with."

Children and youth need more structured activities and safe places for play. However, not all can take advantage of some activities due to cost, transportation challenges, and working parents. Also, access to physical activity resources is not equitably distributed across the county.

- *"You don't see children playing outside anymore and youth need to be encouraged to get out of their homes,"* said one participant. Another noted: *"Youth struggle because they need something to do and they turn to sedentary lifestyles or not being healthy [and] vaping or drinking or stuff like that."*

- *"A lot of children have to come home after school. … A lot of folks cannot afford organized sports activities. And because parents are working, they can't get the children there."*
- *"We don't have access to as many resources or activities for our kids to be a well-rounded as, say, like a West Chester or a Unionville,"* noted one from southern Chester County.

Participants cited the need to improve healthy eating and sufficient sleep among youth.

- *"A lot of the children are living off of McDonald's. … To get healthy food, they're picking up whatever they can. Some kids only eat a bag of chips … they are drinking sodas, and Gatorade, and those type of things, whatever's convenient, or what you can get at the corner store. That's very unhealthy."*
- *"According to the [American Academy of Pediatrics], teens need to start school at 8:30 or later. … I've been advocating for this, at least with Downingtown [School District]. And I know some districts in Chester County have moved to a later school s tart. I do think it has a negative impact on the mental health of our teenagers."*

Multiple participants raised concerns about excessive social media use among young people. Social media was described as "addicting" and contributing to mental health and substance use issues. Social media also was negatively viewed regarding youth sexuality.

- *"I feel [social media is] addicting for a lot of the kids. And there's a place for it. But I feel that's a large reason why kids are becoming depressed and despair, like compare and despair. … They feel like they're failures, because they can see everybody else's life … and then just seeing other kids showing their bodies off, one might be thinner than the other, heavier than the other. … I definitely think that plays a big role in the kids' mental state."*
- *"Kids and problems with the use of phones, social media, the sexting thing, the inappropriate pictures, access to porn. It's a problem, obviously made possible by technology. I know kids are texting pictures that they should not be back and forth … I don't think kids realize the dangers that they get themselves into. … We need to have more education for families and kids about what's appropriate, what's not appropriate."*

Several participants raised issues about transitioning the care of older teens from pediatric to adult health services.

- A participant whose child has special needs commented: *"My daughter … was in a place that only saw children under 18. And now that she's 18, she has to go somewhere else. So, you call around … you got to wait three months, because that's just how it is with new patients, right? I don't think that's appropriate to make somebody wait that long when they're on medication and need that management in order to keep up with the prescriptions and making sure that the dosing and everything is okay."*
- Another participant spoke about the disruption of family support: *"When your teen turns 18 and they're a young adult, the parent role is completely closed. Providers don't want to talk to you. I understand that they're an adult, and you want to encourage that independence. … If there's someone in the family that has a mental health issue, it's going to impact the family and to include the family as much as possible in the treatment [is important]. … Of course, we want to respect the privacy of our family member. But there needs to be a balance."*

Older Adults

Older adults often face stigma as part of the aging process and are assumed by society to be frail, sick, and socially isolated. While resources that promote healthy aging are available, they may not be accessed until problems have arisen. As one participant put it:

- *"We don't make aging an attractive topic in Chester County, not in Pennsylvania, not in America. We talk about aging … in such negative connotations, we joke about old people, we poke fun at getting gray hair. But this whole notion that getting old means we have to get sick, we have to get frail, we have to hurt, we have to ache, we have to not have friends -- it's been such a misnomer over so many generations. Not only do we have to combat the social norms of aging, we also have to combat the conditions that social norms have been allowed to cause."*

This participant added:

"Most people learn about an organization like [a] senior center when they're in a moment of crisis, and it's just unfortunate that they haven't found it before that crisis, so that they could have the fun, and the access to things that could help them live better, and healthier."

Loss of friends and independence can impact mental well-being of older adults A participant who works with older adults commented:

- *"I had a woman that stated — 'Here I am, 93, and all of my friends are dead. Why am I living?' She doesn't want to be a burden on her family members. I think grief dictates a lot of issues as it relates to health."*

Transportation barriers can worsen social isolation and access to services.

- *"They [older adults] struggle with transportation more than any other population. They use the TransNet … and still they are late,"* said a participant who works with older adults. Another commented: *"Coordinating public transportation with social service providers, such as the six senior centers in the county, and coordinating rides for people to come to our facilities each day can be a challenge. … I think until we fix this transportation piece, we're still leaving people isolated and reliant on the services that they can find within walking distance to their home."*

More community and senior centers that "*feel like home*" are needed to support healthy aging and socialization. One participant shared that with aging, friendships were often lost and ways to "*stay active and connected*" were needed. Others said:

- *"I would love to see every community have its own senior center. There's one in West Chester, but that doesn't help people that [don't live locally]. You want to come and feel uplifted and happy. It's for people that we … care about. Make it homey, not like a hospital."*
- *"Adults need a social area — an area to express their pent-up emotions or desires because most times they're alone. The one partner that they had for 40 years … is just getting sick, and they have to now be caring for somebody else. They need a space just to vent, talk about it, share, and so, those kinds of places that they can go to and spend a day away from home, and then come back to responsibilities."*

Living on a fixed income is challenging for many older adults, who may have to choose between food, health care, and other basic necessities.

- *"I have a mother who's 92, and still paying school taxes and that makes her go into her monthly budget. Because older people are very committed to their dignity and responsibility, she'll go without something else. … Maybe she won't do things to stay healthy, like buying her medications, and going to the doctor - which deals with her mental health … and things become overwhelming."*

Older adults need more opportunities for physical activity and mental stimulation.

- *"A lot of the same concerns we have with our youth are the same concerns with our seniors. Every doctor I've ever spoken to has shared with me that to stave off some aging diseases, stay active mentally and physically. We're doing a disservice to the younger generation and the senior generation for not making opportunities for our seniors along with our children to do those two things."*

Navigating health care can be a challenge for older adults and their caregivers. Caregivers may lack the knowledge to help aging relatives make informed health decisions. A participant with caregiver responsibilities shared:

- *"My mother's doctor hasn't had a conversation with her about memory, and what she perceives to be her memory issues. And I don't know how we address this. … I just hate having the conversation with my mother, not knowing what's clinically appropriate for someone who's 80 years old and having memory issues."*

Care coordination among providers can be problematic. Having a relative or other person who can advocate on behalf of an older patient being admitted or discharged from a health facility is ideal, but not always possible. A participant caring for her mother said:

- *"I've seen breakdowns between nursing homes and hospitals with the care instructions. … I've met my mom at the hospital … nothing was sent, nothing was asked for, thank goodness I was there. I don't know what people do when, when no one meets them there, which has been hard with COVID."*

Applying for home healthcare can be complex and time consuming, delaying needed services.

- *"I've been through a process to get a caregiver to [help] me take care of my mother,"* shared one participant. *"You have to go through the paperwork, the line, the referral, the checking your finances, to checking your deed. In the meantime, the need for the care goes on. I'm two months into still trying to get a caregiver for two or three hours a day to help me, because I still work. … But I'm still going through the paperwork of it all."*

Technology is challenging for many older adults, who may need help using it to schedule appointments, obtain information, or use telehealth. An older participant said:

- *"I'm just learning to use my smart phone. My phone is smarter than me. You're not used to a phone, or a computer. So that keeps you out of the loop for information if you don't have anyone assisting you in the family."* Another commented: *"Some older adults prefer 'one-on-one' communication, because sometimes you just want to talk things out."*

Some participants questioned whether the county has adequate plans in place to support current and future services for older adults, including support for aging in place.

- *"I'm in my 50s. … But I'm thinking, what's going to happen in 10 to 20 years … is the county preparing for the aging population? You know, services available for older folks, whether it's in-home supports or assisted living, or just assisting older people. … I don't know how well the county's prepared or what's out there and what's available."*

Other Groups

Individuals with disabilities or limited English proficiency are populations whose health challenges are sometimes overlooked, several participants said. People with disabilities, such as hearing or vision impairments, need information presented in ways they can access and act on.

- *"People with disabilities, both physical and mental, often fall through the cracks, along with people whose first language isn't English."*

Another participant, a minister, noted the challenge of providing information in multiple formats and languages to accommodate people with different needs.

- *"How can we, who don't have a challenge, easily access or learn their language [such as sign language or Braille]? Even at church now, we have to put the program in as many different languages we can. We have to be looking at having somebody to sign the sermon [for people who are hearing impaired]. How do we cater to their needs in terms of putting information out there for them?"*

Pandemic Impacts

Several participants spoke about the need to address misinformation and improve public health communications, especially regarding the pandemic and vaccination. Lack of awareness on how to find vaccine information and appointments was highlighted, particularly for those with lower incomes, limited English proficiency, or lack of access to technology.

- *"A lot of misinformation and reluctance around anything COVID-related or vaccine-related, that's a big thing out here. There's not much of a push from local healthcare providers or the school systems or anything like that to really push the positives of the vaccine, and the steps to take against COVID. … I think they could find different ways to reach out to people."*
- *"It seems that until recently healthcare providers in this area did not really care about whether people were getting even the regular vaccinations … there was no PR about going to the Chester County Health Department if you have no insurance or things like that. It just didn't seem like a priority to reach out to the lower income folks in the neighborhood. And that's not just people of color, or our Hispanic and Latino neighborhood, but it's even the poor Caucasians as well."*
- *"For people trying to register to get their vaccinations early on, if they didn't speak English, they had to navigate how to get to someone who spoke Spanish or actually have a translator to help them get a scheduled appointment. During the pandemic I talked to a lot of people for whom English wasn't their first language, so they would bring someone to the phone to get scheduled for an appointment. … They didn't have a computer or a translator."*

One participant also noted that **health care visits now seem to be COVID-19-focused, despite whatever other health concern may have prompted the visit**.

- *"You go to the doctors and they're so COVID focused– they just test you for COVID and you're negative. … Well, what about strep or flu or do I have pneumonia without COVID? They don't check your ears like they used to. … Why aren't they doing that when they used to do that when we come in sick?"*

On a positive note, while the pandemic created many challenges, caring for family members at home was enabled for some. A participant who cares for a parent with dementia shared:

- *"I wonder if we were both working our full-time schedules in pre-COVID land, how we would've been able to take care of her in that situation, with both of us having to work and not be in the home? It would've almost been impossible."*

Suggested Actions

Several participants commented on lessons learned during the pandemic to promote vaccination.	These efforts, which are working well and could be expanded to address other concerns in the future, include building community connections and using "trusted messengers" for outreach and education. *"It's just a matter of having a specific, sincere outreach, and tapping the right individuals that can connect with those people that need to vaccinated. And that was with all minority groups - Black groups, Hispanic groups, aging groups, you name it, we had groups of all race or ethnicities that were impacted by our outreach here for the pandemic."* Enlisting such "trusted messengers" for outreach is seen as a way to help ensure equitable access to information. *"Who is the conduit that you're using to get those messages across? Because if they're coming from someone that you trust, that you have confidence in, that you believe in, you're more than likely to listen to those messages."*

Participants across the county offered a wide range of other suggestions to address health and social service needs, including these actions:

Increase health services for children and youth, including improved access to mental health services.	*"One thing that's needed to increase equity across the schools in the county is for all schools, elementary through high school, to have mental health professionals on staff."* Also suggested was increasing assistance for youth transitioning from pediatric to adult health care and advocating for later high school start times to prevent mental health issues linked to sleep deprivation.
Expand health education in schools and other venues to promote mental health and healthy behaviors.	Education for students and parents also is needed to address the impact of social media and the internet on youth. One suggested including speakers with lived experience who can speak directly to the consequences of unhealthy choices—for example, a heavy smoker who *"wants to talk to you about why … you should not do that, because now they're on oxygen 24 hours a day. They [youth] need to see the consequences of the choices that they're making."*
Increase access to afterschool activities that promote healthy lifestyles.	A related suggestion: create volunteer and mentorship opportunities for youth at hospitals or other community sites. *"Have kids come and serve or do something at hospitals or some sort of a care facility, just to get them exposed. … Maybe, they could have a mentorship … match young adults or older teens with a peer mentor, someone else who's similar in age or maybe slightly older can be a partner."*
Expand services to support healthy aging.	Increase access to local, safe, and home-like community centers that meet the needs of older adults, including access to health and social services and opportunities for social connection, physical activity, and mental stimulation.
Preserve and encourage use of open space and parks	Ideas include community gardens, children's play, and other activities that foster community engagement.

For hospitals and providers, put more *"emphasis on prevention, what prevents diabetes, what prevents high blood pressure, and keep reinforcing those messages."*

Suggested Actions

Expand access to affordable, timely behavioral health services, including crisis centers and outpatient care.

Other related suggestions include:

- Expand the number and diversity of behavioral health providers. Also, multicultural role models are needed to build trust and inspire youth of all backgrounds to enter health care and related fields: *"It's important that our children see reflections of themselves in their teachers, in their healthcare providers, in the people that are charged with caring for them and educating them. … A Latino child should see a doctor that speaks their language and looks like them, a Black child should see a health provider that looks like them, that relates to them. That's an important message when we're asking people to trust. It's about where the message comes from, but also where the care comes from."*
- Increase access to behavioral health services where people live, work, or go to school. For example, increase the use of mobile vans to bring health and social services to the community. *"It would be great to have that available, to come to people, come out here [southern Chester County] for primary care or mental health."* Also, address navigation challenges to access behavioral health services, such as insurance issues or transportation to care.

Raise community awareness about racial trauma and resources to address this issue.

For example, the Chester County Racial Trauma and Resiliency Collaborative can help individuals get needed assistance and educate the community. Funding to support these efforts is needed.

Increase awareness of and access to community health and social services.

Address communication barriers, such as developing an easy-to-use system that centralizes information about community health and social services.

"Knowing what's out there, what's available and how to access it…Compiling services that are available in Chester County with the focus on the mental health and maybe substance abuse programs."

Address the digital divide, such as broadband access and assistance in navigating technology, particularly for older adults.

Consider communication preferences, such as use of phone or computer to schedule appointments and communicate with providers. Also, create a hotline staffed by social or community health workers to advise callers with health or social service needs:

"Give them a telephone number, and they can call and talk to a real person, and someone that can listen to their issue and … and give them some advice."

Address communication needs for those with hearing or vision impairments as well as those who may experience cultural or language barriers.

"We need culturally sensitive, culturally aware organizations to be everywhere. We [need to] focus on the Spanish and the English-speaking communities, but we also need to focus on the rural vs the urban communities, the lower income versus the sufficient. … Sometimes I feel when you send somebody to one of the big-name specialty centers, they kind of talk to you as if you're just like them, but you may not be, and that can be off-putting."

Suggested Actions

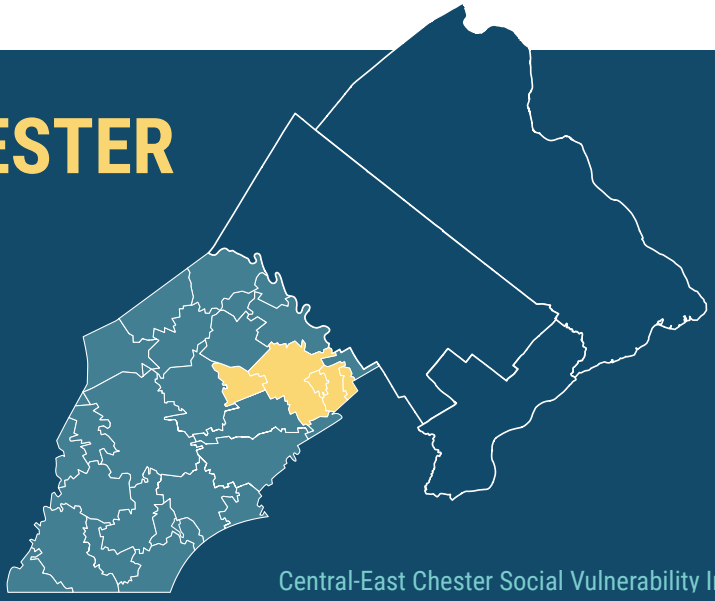
Facilitate community-driven solutions by engaging community members in identifying and assessing issues, then developing and implementing desired strategies.	*"When you talk about solutions for communities, you've got to have people from the community in those spaces. It can't just be the folks that say they have expertise. … First thing, step aside and hear what the community has to say, what are their solutions? How can they be empowered?"*
Increase coordination and collaboration among county health and social service organizations, to improve service delivery and avoid duplicated efforts.	The Chester County Health Department, hospitals, and other healthcare organizations should continue to build connections with the faith-based community, local leaders and other trusted messengers to get accurate information to the community, with support from organizations such as the Alliance for Health Equity to facilitate collaboration. *"If they [hospitals] work with local leaders, not just to bring them into the hospital for the vaccine, but for them to come into the community, to talk to the community members … to bring it down to grassroots, use the clergy who are preaching to the people, work with them to bring it into the community."*

CENTRAL-EAST CHESTER

ZIP CODES: 19301, 19312, 19333, 19341, 19345, 19355

This community is served by:

- Bryn Mawr Rehab Hospital
- Chester County Hospital
- Children's Hospital of Philadelphia
- Main Line Health



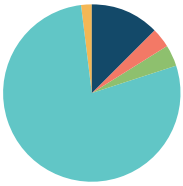
POPULATION

69,915

MEDIAN HOUSEHOLD INCOME

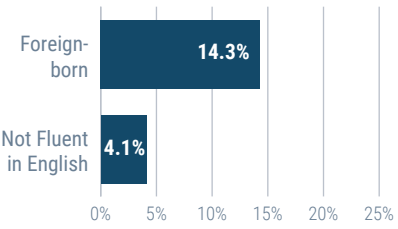
$114,315

RACE/ETHNICITY/LANGUAGE



12.6% | Asian*
3.7% | Black*
3.9% | Hispanic/Latino
78.1% | White*
1.8% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

1. Heart disease
2. Cancer
3. COVID-19
4. Cerebrovascular diseases
5. Chronic lower respiratory diseases

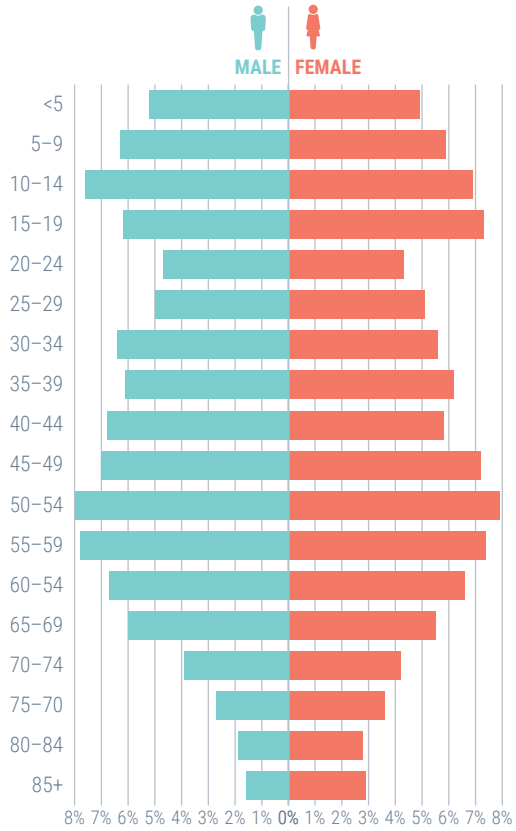
EDUCATIONAL ATTAINMENT

High school as highest education level **10.2%**

PEOPLE WITH DISABILITIES

8.1%

AGE DISTRIBUTION



summary health measures

		Central-East Chester		Chester County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	758.1	872.5	755.1	867.8
	Life expectancy: Female (in years)	83.9	82.4	83.8	82.6
	Life expectancy: Male (in years)	81.6	81.7	79.8	78.6
	Years of potential life lost before 75	2,785	2,449	22,739	22,899
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	228.8	N/A	445.0
	COVID-related hospitalization rate (per 100,000)	N/A	253.2	N/A	274.1
Chronic Disease & Health Behaviors	Adult obesity prevalence	23.3%		25.8%	
	Diabetes prevalence	7.8%		8.4%	
	Diabetes-related hospitalization rate (per 100,000)	41.5	41.5	86.7	96.8
	Hypertension prevalence	27.9%		28.3%	
	Hypertension-related hospitalization rate (per 100,000)	301.8	264.6	316.6	294.5
	Potentially preventable hospitalization rate (per 100,000)	778.1	607.9	853.2	724.6
	Premature cardiovascular disease mortality rate (per 100,000)	18.6	11.4	18.5	16.9
	Major cancer incidence rate (per 100,000)	266.0		242.9	
	Major cancer mortality rate (per 100,000)	55.8		72.8	
	Colorectal cancer screening	72.3%		69.5%	
	Mammography screening	78.5%		77.6%	
	Physical inactivity (leisure time) prevalence	15.3%		18.2%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	--	--	3.7	2.4
	Infant mortality rate (per 1,000 live births)	--	--	4.7	4.8
	Percent low birthweight births out of live births	5.2%	8.4%	6.0%	6.5%
	Percent preterm births out of live births	5.9%	5.4%	8.5%	7.9%
Behavioral Health	Adult binge drinking	17.8%		18.6%	
	Adult smoking	11.6%		15.0%	
	Drug overdose mortality rate (per 100,000)	17.2	10.0	20.0	19.6
	Opioid-related hospitalization rate (per 100,000)	8.6	12.9	20.6	18.9
	Substance-related hospitalization rate (per 100,000)	214.5	175.9	235.8	193.9
	Poor mental health for 14+ days in past 30 days	10.3%		12.4%	
	Suicide mortality rate (per 100,000)	8.6	11.4	11.5	9.6
Injuries	Fall-related hospitalization rate (per 100,000)	9,437.4	8,997.6	3,128.6	3,182.5
	Gun-related emergency department utilization (per 100,000)	15.7	--	9.0	8.3
	Homicide mortality rate (per 100,000)	--	--	--	--
Access to Care	Adults 19-64 years with Medicaid	4.1%		6.6%	
	Children <19 years with public insurance	13.5%		20.2%	
	Population without insurance	2.6%		5.1%	
	Children <19 years without insurance	1.7%		4.7%	
	Emergency department utilization (per 100,000)	15,051.4	11,555.1	12,930.7	14,072.9
	High emergency department utilization (per 100,000)	187.0	123.5	168.1	185.0
Social & Economic Conditions	Population in poverty	4.0%		6.3%	
	Children <18 years in poverty	3.5%		7.4%	
	Adults 19-64 years unemployed	1.6%		1.8%	
	Householders living alone who are 65+ years	39.6%		35.7%	
	Households receiving SNAP benefits	1.6%		7.7%	
	Households that are housing cost-burdened	12.2%		11.3%	
	Housing with potential lead risk	47.6%		39.0%	
	Vacant housing units	4.4%		4.7%	

* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

CENTRAL-WEST CHESTER

ZIP CODES: 19310, 19320, 19358, 19365, 19367, 19372

This community is served by:

- Bryn Mawr Rehab Hospital
- Chester County Hospital
- Children's Hospital of Philadelphia
- Main Line Health

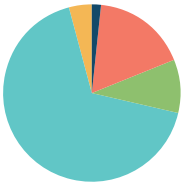
POPULATION

67,902

MEDIAN HOUSEHOLD INCOME

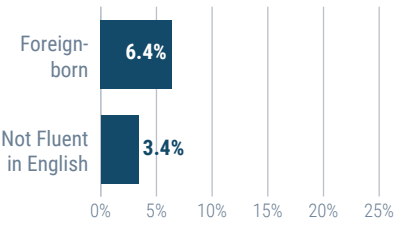
$65,650

RACE/ETHNICITY/LANGUAGE



1.8% | Asian*
17.2% | Black*
9.7% | Hispanic/Latino
67.1% | White*
4.1% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

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

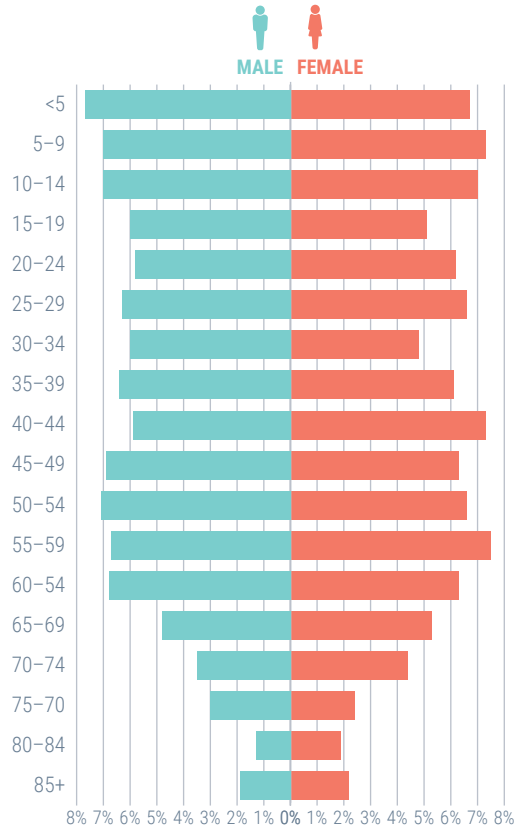
EDUCATIONAL ATTAINMENT

High school as highest education level **29.1%**

PEOPLE WITH DISABILITIES

11.5%

AGE DISTRIBUTION



summary health measures

		Central-West Chester		Chester County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	860.1	1,036.8	755.1	867.8
	Life expectancy: Female (in years)	81.0	79.7	83.8	82.6
	Life expectancy: Male (in years)	76.3	74.8	79.8	78.6
	Years of potential life lost before 75	4,938	4,622	22,739	22,899
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	578.8	N/A	445.0
	COVID-related hospitalization rate (per 100,000)	N/A	374.1	N/A	274.1
Chronic Disease & Health Behaviors	Adult obesity prevalence	30.0%		25.8%	
	Diabetes prevalence	10.6%		8.4%	
	Diabetes-related hospitalization rate (per 100,000)	160.5	151.7	86.7	96.8
	Hypertension prevalence	32.1%		28.3%	
	Hypertension-related hospitalization rate (per 100,000)	469.8	465.4	316.6	294.5
	Potentially preventable hospitalization rate (per 100,000)	1,210.6	1,047.1	853.2	724.6
	Premature cardiovascular disease mortality rate (per 100,000)	30.9	33.9	18.5	16.9
	Major cancer incidence rate (per 100,000)	243.0		242.9	
	Major cancer mortality rate (per 100,000)	100.1		72.8	
	Colorectal cancer screening	65.6%		69.5%	
	Mammography screening	76.8%		77.6%	
	Physical inactivity (leisure time) prevalence	23.4%		18.2%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	6.0	4.2	3.7	2.4
	Infant mortality rate (per 1,000 live births)	--	--	4.7	4.8
	Percent low birthweight births out of live births	8.1%	7.5%	6.0%	6.5%
	Percent preterm births out of live births	9.2%	8.2%	8.5%	7.9%
Behavioral Health	Adult binge drinking	17.7%		18.6%	
	Adult smoking	20.2%		15.0%	
	Drug overdose mortality rate (per 100,000)	36.8	41.2	20.0	19.6
	Opioid-related hospitalization rate (per 100,000)	42.7	30.9	20.6	18.9
	Substance-related hospitalization rate (per 100,000)	425.6	300.4	235.8	193.9
	Poor mental health for 14+ days in past 30 days	15.0%		12.4%	
	Suicide mortality rate (per 100,000)	11.8	--	11.5	9.6
Injuries	Fall-related hospitalization rate (per 100,000)	6,940.9	7,525.1	3,128.6	3,182.5
	Gun-related emergency department utilization (per 100,000)	--	16.2	9.0	8.3
	Homicide mortality rate (per 100,000)	--	--	--	--
Access to Care	Adults 19-64 years with Medicaid	12.3%		6.6%	
	Children <19 years with public insurance	39.1%		20.2%	
	Population without insurance	8.5%		5.1%	
	Children <19 years without insurance	8.4%		4.7%	
	Emergency department utilization (per 100,000)	15,643.6	21,466.1	12,930.7	14,072.9
	High emergency department utilization (per 100,000)	155.1	325.6	168.1	185.0
Social & Economic Conditions	Population in poverty	10.4%		6.3%	
	Children <18 years in poverty	15.1%		7.4%	
	Adults 19-64 years unemployed	2.5%		1.8%	
	Householders living alone who are 65+ years	20.4%		35.7%	
	Households receiving SNAP benefits	27.3%		7.7%	
	Households that are housing cost-burdened	20.2%		11.3%	
	Housing with potential lead risk	57.6%		39.0%	
	Vacant housing units	6.0%		4.7%	

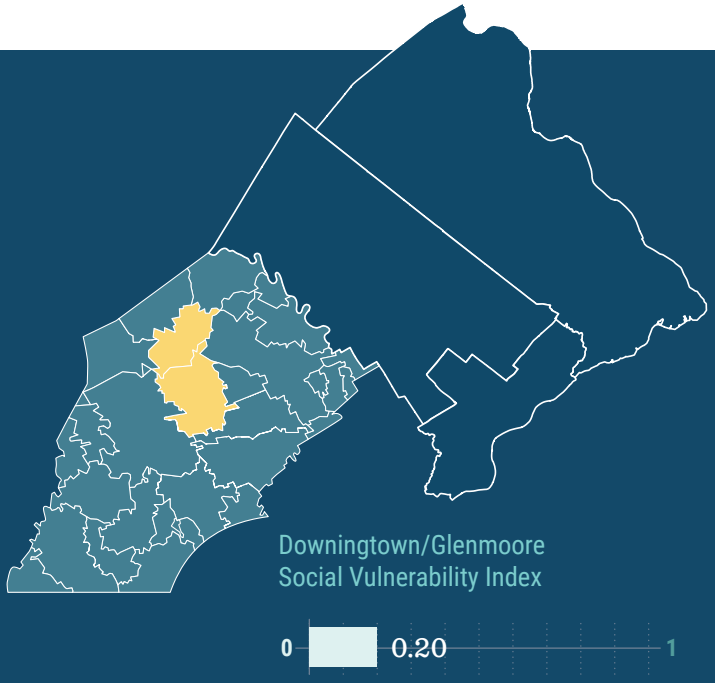
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

DOWNINGTOWN/ GLENMOORE

ZIP CODES: 19335, 19343

This community is served by:

- Bryn Mawr Rehab Hospital
- Chester County Hospital
- Children's Hospital of Philadelphia
- Main Line Health



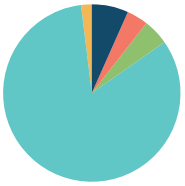
POPULATION

56,772

MEDIAN HOUSEHOLD INCOME

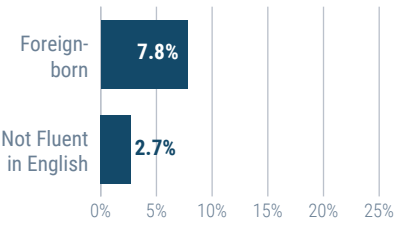
$124,518

RACE/ETHNICITY/LANGUAGE



6.9% | Asian*
3.7% | Black*
4.9% | Hispanic/Latino
82.7% | White*
1.7% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

1. Cancer
2. Heart disease
3. COVID-19
4. Cerebrovascular diseases
5. Chronic lower respiratory diseases

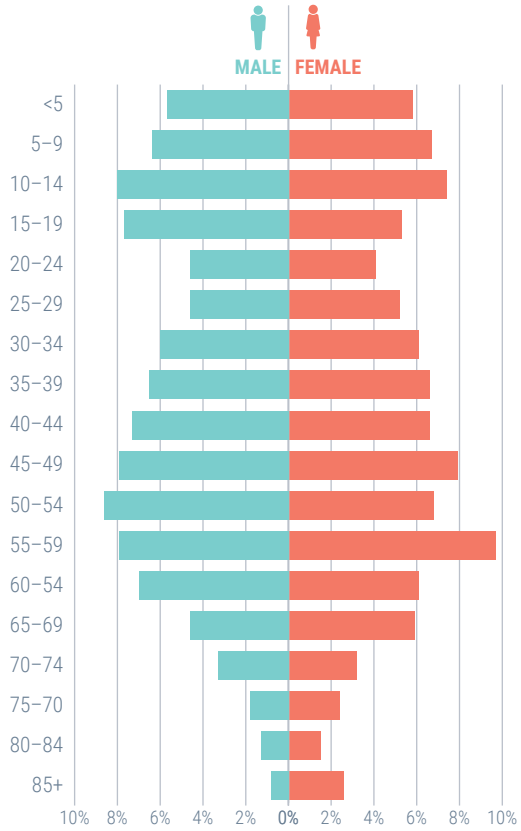
EDUCATIONAL ATTAINMENT

High school as highest education level **15.1%**

PEOPLE WITH DISABILITIES

8.0%

AGE DISTRIBUTION



summary health measures

		Downingtown/Glenmoore		Chester County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	641.2	681.7	755.1	867.8
	Life expectancy: Female (in years)	83.1	82.9	83.8	82.6
	Life expectancy: Male (in years)	80.6	79.6	79.8	78.6
	Years of potential life lost before 75	2,245	2,386	22,739	22,899
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	285.4	N/A	445.0
	COVID-related hospitalization rate (per 100,000)	N/A	229.0	N/A	274.1
Chronic Disease & Health Behaviors	Adult obesity prevalence	25.3%		25.8%	
	Diabetes prevalence	7.7%		8.4%	
	Diabetes-related hospitalization rate (per 100,000)	72.2	79.3	86.7	96.8
	Hypertension prevalence	27.0%		28.3%	
	Hypertension-related hospitalization rate (per 100,000)	251.9	220.2	316.6	294.5
	Potentially preventable hospitalization rate (per 100,000)	679.9	579.5	853.2	724.6
	Premature cardiovascular disease mortality rate (per 100,000)	14.1	14.1	18.5	16.9
	Major cancer incidence rate (per 100,000)	218.4		242.9	
	Major cancer mortality rate (per 100,000)	74.0		72.8	
	Colorectal cancer screening	69.9%		69.5%	
	Mammography screening	78.1%		77.6%	
	Physical inactivity (leisure time) prevalence	16.5%		18.2%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	5.8	--	3.7	2.4
	Infant mortality rate (per 1,000 live births)	--	--	4.7	4.8
	Percent low birthweight births out of live births	4.9%	6.1%	6.0%	6.5%
	Percent preterm births out of live births	6.6%	5.8%	8.5%	7.9%
Behavioral Health	Adult binge drinking	19.3%		18.6%	
	Adult smoking	14.4%		15.0%	
	Drug overdose mortality rate (per 100,000)	12.3	17.6	20.0	19.6
	Opioid-related hospitalization rate (per 100,000)	22.9	--	20.6	18.9
	Substance-related hospitalization rate (per 100,000)	190.2	199.0	235.8	193.9
	Poor mental health for 14+ days in past 30 days	11.8%		12.4%	
	Suicide mortality rate (per 100,000)	10.6	14.1	11.5	9.6
Injuries	Fall-related hospitalization rate (per 100,000)	7,898.3	9,069.6	3,128.6	3,182.5
	Gun-related emergency department utilization (per 100,000)	7.4	2.0	9.0	8.3
	Homicide mortality rate (per 100,000)	--	--	--	--
Access to Care	Adults 19-64 years with Medicaid	6.5%		6.6%	
	Children <19 years with public insurance	15.2%		20.2%	
	Population without insurance	2.6%		5.1%	
	Children <19 years without insurance	1.5%		4.7%	
	Emergency department utilization (per 100,000)	13,045.9	12,366.1	12,930.7	14,072.9
	High emergency department utilization (per 100,000)	102.5	143.2	168.1	185.0
Social & Economic Conditions	Population in poverty	3.7%		6.3%	
	Children <18 years in poverty	3.4%		7.4%	
	Adults 19-64 years unemployed	2.0%		1.8%	
	Householders living alone who are 65+ years	30.9%		35.7%	
	Households receiving SNAP benefits	4.5%		7.7%	
	Households that are housing cost-burdened	8.8%		11.3%	
	Housing with potential lead risk	25.5%		39.0%	
	Vacant housing units	3.1%		4.7%	

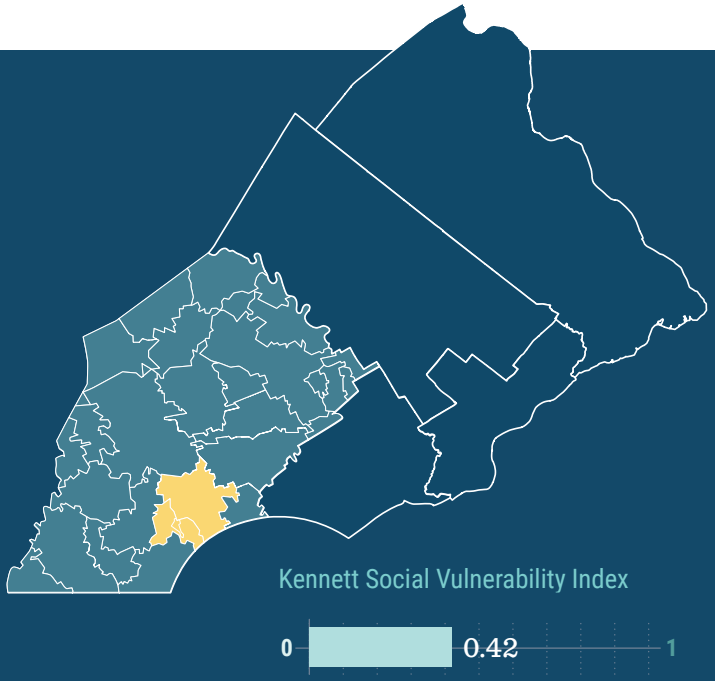
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

KENNETT

ZIP CODES: 19311, 19348, 19374, 19375

This community is served by:

- Bryn Mawr Rehab Hospital
- Chester County Hospital
- Children's Hospital of Philadelphia



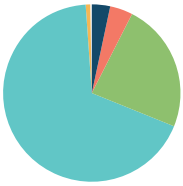
POPULATION

34,019

MEDIAN HOUSEHOLD INCOME

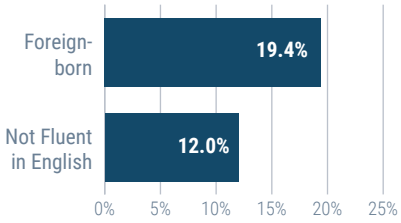
$90,193

RACE/ETHNICITY/LANGUAGE



3.4% | Asian*
4.3% | Black*
23.4% | Hispanic/Latino
67.6% | White*
1.0% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

1. Heart disease
2. Cancer
3. COVID-19
4. Chronic lower respiratory diseases
5. Unintentional injuries (excluding drug overdoses)

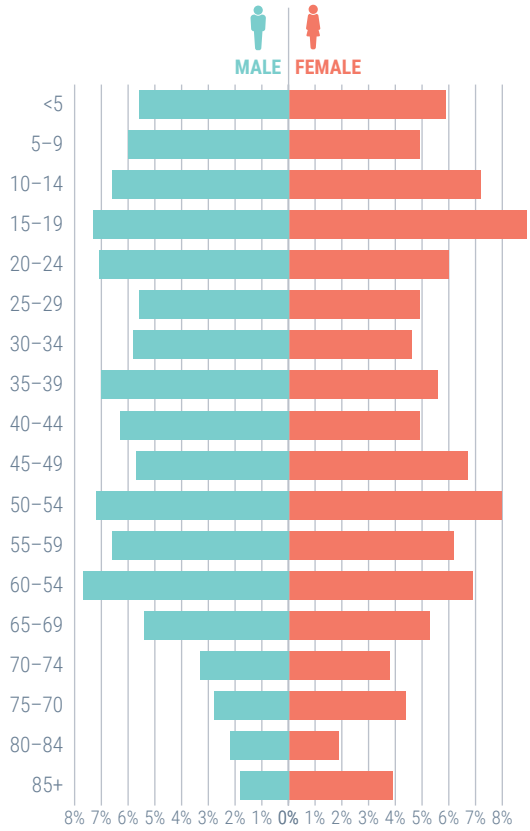
EDUCATIONAL ATTAINMENT

High school as highest education level **21.5%**

PEOPLE WITH DISABILITIES

8.6%

AGE DISTRIBUTION



summary health measures

		Kennett		Chester County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	720.2	731.9	755.1	867.8
	Life expectancy: Female (in years)	88.1	86.8	83.8	82.6
	Life expectancy: Male (in years)	81.4	81.1	79.8	78.6
	Years of potential life lost before 75	1,015	1,212	22,739	22,899
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	299.8	N/A	445.0
	COVID-related hospitalization rate (per 100,000)	N/A	282.2	N/A	274.1
Chronic Disease & Health Behaviors	Adult obesity prevalence	26.6%		25.8%	
	Diabetes prevalence	9.3%		8.4%	
	Diabetes-related hospitalization rate (per 100,000)	58.8	32.3	86.7	96.8
	Hypertension prevalence	29.5%		28.3%	
	Hypertension-related hospitalization rate (per 100,000)	220.5	223.4	316.6	294.5
	Potentially preventable hospitalization rate (per 100,000)	673.2	514.4	853.2	724.6
	Premature cardiovascular disease mortality rate (per 100,000)	--	--	18.5	16.9
	Major cancer incidence rate (per 100,000)	217.5		242.9	
	Major cancer mortality rate (per 100,000)	73.5		72.8	
	Colorectal cancer screening	67.4%		69.5%	
	Mammography screening	77.1%		77.6%	
	Physical inactivity (leisure time) prevalence	20.7%		18.2%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	--	--	3.7	2.4
	Infant mortality rate (per 1,000 live births)	--	--	4.7	4.8
	Percent low birthweight births out of live births	4.3%	6.0%	6.0%	6.5%
	Percent preterm births out of live births	5.0%	5.6%	8.5%	7.9%
Behavioral Health	Adult binge drinking	17.8%		18.6%	
	Adult smoking	15.5%		15.0%	
	Drug overdose mortality rate (per 100,000)	29.4	--	20.0	19.6
	Opioid-related hospitalization rate (per 100,000)	--	--	20.6	18.9
	Substance-related hospitalization rate (per 100,000)	132.3	76.4	235.8	193.9
	Poor mental health for 14+ days in past 30 days	12.6%		12.4%	
	Suicide mortality rate (per 100,000)	--	--	11.5	9.6
Injuries	Fall-related hospitalization rate (per 100,000)	3,872.8	3,492.4	3,128.6	3,182.5
	Gun-related emergency department utilization (per 100,000)	--	--	9.0	8.3
	Homicide mortality rate (per 100,000)	--	--	--	--
Access to Care	Adults 19-64 years with Medicaid	6.7%		6.6%	
	Children <19 years with public insurance	26.4%		20.2%	
	Population without insurance	9.2%		5.1%	
	Children <19 years without insurance	5.4%		4.7%	
	Emergency department utilization (per 100,000)	15,841.9	15,088.4	12,930.7	14,072.9
	High emergency department utilization (per 100,000)	429.4	249.4	168.1	185.0
Social & Economic Conditions	Population in poverty	5.4%		6.3%	
	Children <18 years in poverty	11.8%		7.4%	
	Adults 19-64 years unemployed	1.3%		1.8%	
	Householders living alone who are 65+ years	51.0%		35.7%	
	Households receiving SNAP benefits	1.1%		7.7%	
	Households that are housing cost-burdened	3.1%		11.3%	
	Housing with potential lead risk	30.2%		39.0%	
	Vacant housing units	3.8%		4.7%	

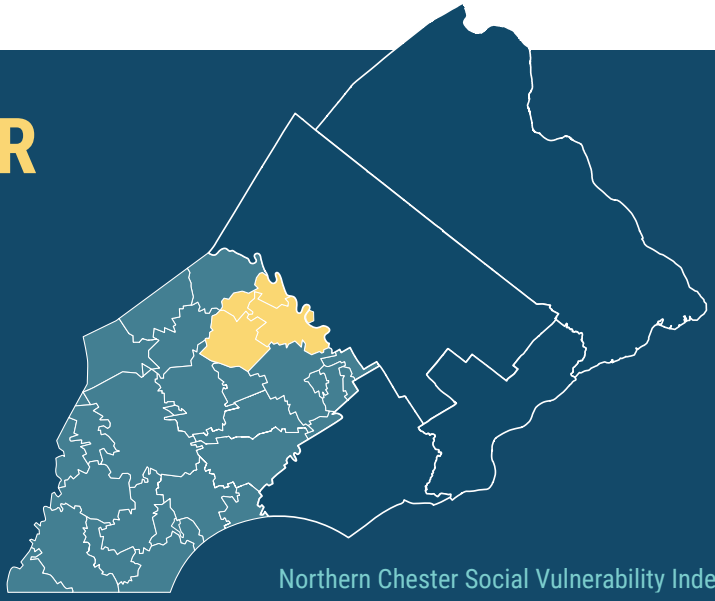
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

NORTHERN CHESTER

ZIP CODES: 19425, 19453, 19460, 19475

This community is served by:

- Bryn Mawr Rehab Hospital
- Chester County Hospital
- Children's Hospital of Philadelphia
- Main Line Health



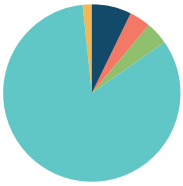
POPULATION

71,005

MEDIAN HOUSEHOLD INCOME

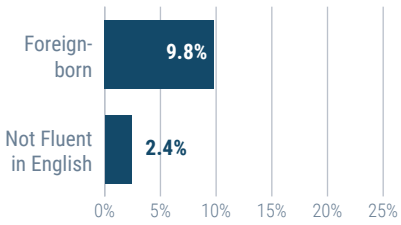
$105,010

RACE/ETHNICITY/LANGUAGE



7.4% | Asian*
3.8% | Black*
4.2% | Hispanic/Latino
83.1% | White*
1.5% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

1. Cancer
2. Heart disease
3. COVID-19
4. Cerebrovascular diseases
5. Unintentional injuries (excluding drug overdoses)

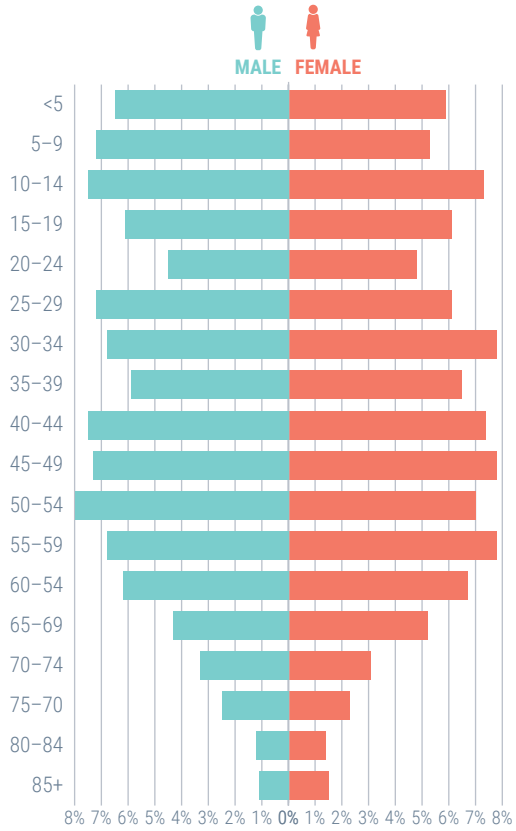
EDUCATIONAL ATTAINMENT

High school as highest education level **15.9%**

PEOPLE WITH DISABILITIES

8.1%

AGE DISTRIBUTION



summary health measures

		Northern Chester		Chester County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	822.5	814.0	755.1	867.8
	Life expectancy: Female (in years)	80.5	80.2	83.8	82.6
	Life expectancy: Male (in years)	77.6	77.6	79.8	78.6
	Years of potential life lost before 75	3,523	3,168	22,739	22,899
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	545.0	N/A	445.0
	COVID-related hospitalization rate (per 100,000)	N/A	280.3	N/A	274.1
Chronic Disease & Health Behaviors	Adult obesity prevalence	25.4%		25.8%	
	Diabetes prevalence	7.8%		8.4%	
	Diabetes-related hospitalization rate (per 100,000)	90.1	74.6	86.7	96.8
	Hypertension prevalence	27.0%		28.3%	
	Hypertension-related hospitalization rate (per 100,000)	301.4	267.6	316.6	294.5
	Potentially preventable hospitalization rate (per 100,000)	840.8	716.9	853.2	724.6
	Premature cardiovascular disease mortality rate (per 100,000)	16.9	15.5	18.5	16.9
	Major cancer incidence rate (per 100,000)	240.8		242.9	
	Major cancer mortality rate (per 100,000)	84.5		72.8	
	Colorectal cancer screening	70.1%		69.5%	
	Mammography screening	77.7%		77.6%	
	Physical inactivity (leisure time) prevalence	17.1%		18.2%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	--	--	3.7	2.4
	Infant mortality rate (per 1,000 live births)	--	--	4.7	4.8
	Percent low birthweight births out of live births	5.6%	5.2%	6.0%	6.5%
	Percent preterm births out of live births	5.7%	5.8%	8.5%	7.9%
Behavioral Health	Adult binge drinking	19.2%		18.6%	
	Adult smoking	14.5%		15.0%	
	Drug overdose mortality rate (per 100,000)	32.4	15.5	20.0	19.6
	Opioid-related hospitalization rate (per 100,000)	23.9	25.4	20.6	18.9
	Substance-related hospitalization rate (per 100,000)	219.7	236.6	235.8	193.9
	Poor mental health for 14+ days in past 30 days	12.0%		12.4%	
	Suicide mortality rate (per 100,000)	19.7	11.3	11.5	9.6
Injuries	Fall-related hospitalization rate (per 100,000)	10,165.7	10,362.3	3,128.6	3,182.5
	Gun-related emergency department utilization (per 100,000)	4.8	6.7	9.0	8.3
	Homicide mortality rate (per 100,000)	--	--	--	--
Access to Care	Adults 19-64 years with Medicaid	6.9%		6.6%	
	Children <19 years with public insurance	17.2%		20.2%	
	Population without insurance	3.9%		5.1%	
	Children <19 years without insurance	3.7%		4.7%	
	Emergency department utilization (per 100,000)	10,652.1	14,284.5	12,930.7	14,072.9
	High emergency department utilization (per 100,000)	106.7	168.4	168.1	185.0
Social & Economic Conditions	Population in poverty	6.2%		6.3%	
	Children <18 years in poverty	6.0%		7.4%	
	Adults 19-64 years unemployed	1.6%		1.8%	
	Householders living alone who are 65+ years	30.3%		35.7%	
	Households receiving SNAP benefits	7.1%		7.7%	
	Households that are housing cost-burdened	12.9%		11.3%	
	Housing with potential lead risk	42.7%		39.0%	
	Vacant housing units	3.4%		4.7%	

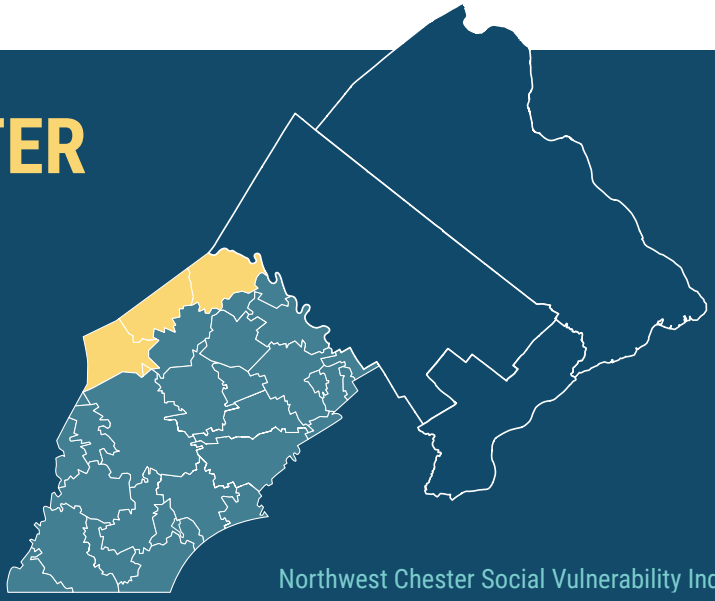
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

NORTHWEST CHESTER

ZIP CODES: 19316, 19344, 19465, 19520

This community is served by:

- Bryn Mawr Rehab Hospital
- Chester County Hospital
- Children's Hospital of Philadelphia
- Einstein Medical Center Montgomery
- Fox Chase Cancer Center
- Main Line Health



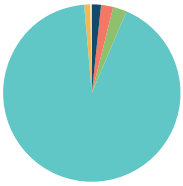
POPULATION

35,415

MEDIAN HOUSEHOLD INCOME

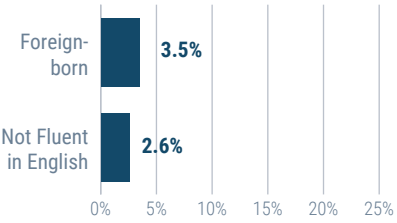
$79,672

RACE/ETHNICITY/LANGUAGE

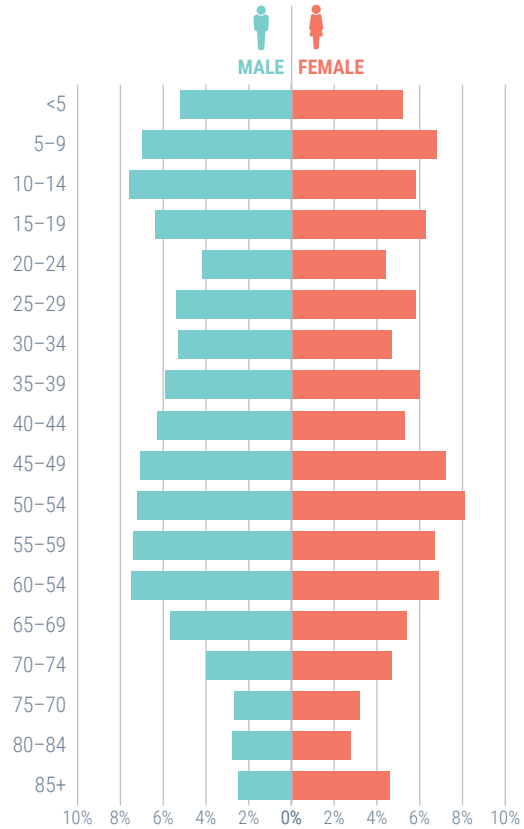


1.7% | Asian*
2.2% | Black*
2.5% | Hispanic/Latino
92.4% | White*
1.3% | Other*

* Non-Hispanic



AGE DISTRIBUTION



LEADING CAUSES OF DEATH

1. Heart disease
2. Cancer
3. COVID-19
4. Cerebrovascular diseases
5. Unintentional injuries (excluding drug overdoses)

EDUCATIONAL ATTAINMENT

High school as highest education level **26.7%**

PEOPLE WITH DISABILITIES

11.7%

summary health measures

		Northwest Chester		Chester County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	988.3	1,174.6	755.1	867.8
	Life expectancy: Female (in years)	83.5	82.2	83.8	82.6
	Life expectancy: Male (in years)	80.3	76.0	79.8	78.6
	Years of potential life lost before 75	1,815	2,156	22,739	22,899
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	392.5	N/A	445.0
	COVID-related hospitalization rate (per 100,000)	N/A	228.7	N/A	274.1
Chronic Disease & Health Behaviors	Adult obesity prevalence	26.5%		25.8%	
	Diabetes prevalence	9.3%		8.4%	
	Diabetes-related hospitalization rate (per 100,000)	135.5	129.9	86.7	96.8
	Hypertension prevalence	31.0%		28.3%	
	Hypertension-related hospitalization rate (per 100,000)	412.3	338.8	316.6	294.5
	Potentially preventable hospitalization rate (per 100,000)	1,166.2	889.5	853.2	724.6
	Premature cardiovascular disease mortality rate (per 100,000)	19.8	36.7	18.5	16.9
	Major cancer incidence rate (per 100,000)	262.6		242.9	
	Major cancer mortality rate (per 100,000)	64.9		72.8	
	Colorectal cancer screening	68.8%		69.5%	
	Mammography screening	75.9%		77.6%	
	Physical inactivity (leisure time) prevalence	20.1%		18.2%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	--	--	3.7	2.4
	Infant mortality rate (per 1,000 live births)	--	--	4.7	4.8
	Percent low birthweight births out of live births	6.6%	4.5%	6.0%	6.5%
	Percent preterm births out of live births	5.4%	5.8%	8.5%	7.9%
Behavioral Health	Adult binge drinking	18.2%		18.6%	
	Adult smoking	17.1%		15.0%	
	Drug overdose mortality rate (per 100,000)	16.9	28.2	20.0	19.6
	Opioid-related hospitalization rate (per 100,000)	--	--	20.6	18.9
	Substance-related hospitalization rate (per 100,000)	257.0	180.7	235.8	193.9
	Poor mental health for 14+ days in past 30 days	13.1%		12.4%	
	Suicide mortality rate (per 100,000)	--	25.4	11.5	9.6
Injuries	Fall-related hospitalization rate (per 100,000)	5,312.7	5,282.3	3,128.6	3,182.5
	Gun-related emergency department utilization (per 100,000)	16.7	11.6	9.0	8.3
	Homicide mortality rate (per 100,000)	--	--	--	--
Access to Care	Adults 19-64 years with Medicaid	8.2%		6.6%	
	Children <19 years with public insurance	21.0%		20.2%	
	Population without insurance	8.2%		5.1%	
	Children <19 years without insurance	10.7%		4.7%	
	Emergency department utilization (per 100,000)	10,207.6	15,445.2	12,930.7	14,072.9
	High emergency department utilization (per 100,000)	101.3	193.6	168.1	185.0
Social & Economic Conditions	Population in poverty	6.9%		6.3%	
	Children <18 years in poverty	10.9%		7.4%	
	Adults 19-64 years unemployed	1.4%		1.8%	
	Householders living alone who are 65+ years	37.5%		35.7%	
	Households receiving SNAP benefits	4.7%		7.7%	
	Households that are housing cost-burdened	12.1%		11.3%	
	Housing with potential lead risk	42.4%		39.0%	
	Vacant housing units	4.7%		4.7%	

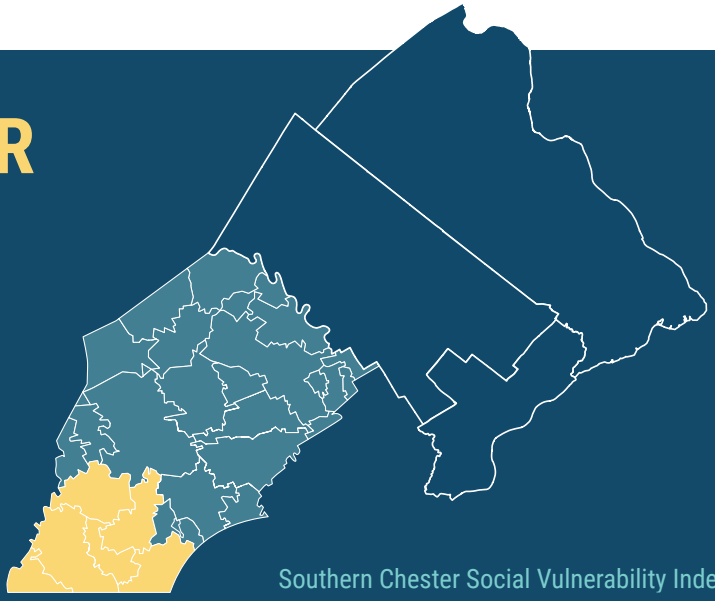
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

SOUTHERN CHESTER

ZIP CODES: 19330, 19350, 19352, 19362, 19363, 19390

This community is served by:

- Bryn Mawr Rehab Hospital
- Chester County Hospital
- Children's Hospital of Philadelphia



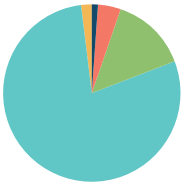
POPULATION

65,687

MEDIAN HOUSEHOLD INCOME

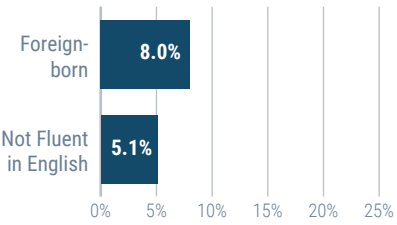
$96,982

RACE/ETHNICITY/LANGUAGE

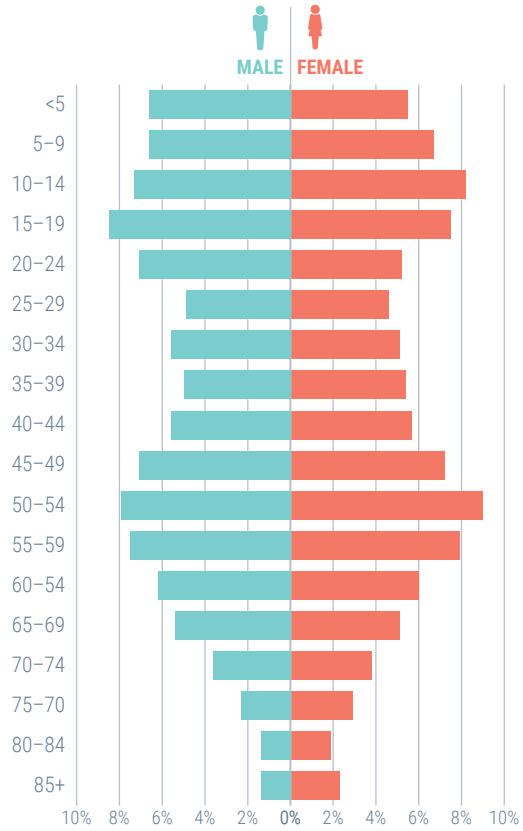


1.3% | Asian*
4.1% | Black*
13.8% | Hispanic/Latino
78.9% | White*
1.7% | Other*

* Non-Hispanic



AGE DISTRIBUTION



LEADING CAUSES OF DEATH

1. Heart disease
2. Cancer
3. COVID-19
4. Chronic lower respiratory diseases
5. Cerebrovascular diseases

EDUCATIONAL ATTAINMENT

High school as highest education level **24.9%**

PEOPLE WITH DISABILITIES

8.7%

summary health measures

		Southern Chester		Chester County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	636.4	755.1	755.1	867.8
	Life expectancy: Female (in years)	84.9	84.4	83.8	82.6
	Life expectancy: Male (in years)	80.4	78.1	79.8	78.6
	Years of potential life lost before 75	2,386	2,609	22,739	22,899
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	232.9	N/A	445.0
	COVID-related hospitalization rate (per 100,000)	N/A	220.7	N/A	274.1
Chronic Disease & Health Behaviors	Adult obesity prevalence	27.7%		25.8%	
	Diabetes prevalence	9.0%		8.4%	
	Diabetes-related hospitalization rate (per 100,000)	56.3	112.7	86.7	96.8
	Hypertension prevalence	29.0%		28.3%	
	Hypertension-related hospitalization rate (per 100,000)	293.8	242.1	316.6	294.5
	Potentially preventable hospitalization rate (per 100,000)	764.2	660.7	853.2	724.6
	Premature cardiovascular disease mortality rate (per 100,000)	15.2	12.2	18.5	16.9
	Major cancer incidence rate (per 100,000)	173.6		242.9	
	Major cancer mortality rate (per 100,000)	57.9		72.8	
	Colorectal cancer screening	66.9%		69.5%	
	Mammography screening	76.3%		77.6%	
	Physical inactivity (leisure time) prevalence	20.8%		18.2%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	--	--	3.7	2.4
	Infant mortality rate (per 1,000 live births)	--	--	4.7	4.8
	Percent low birthweight births out of live births	5.8%	7.6%	6.0%	6.5%
	Percent preterm births out of live births	7.0%	6.7%	8.5%	7.9%
Behavioral Health	Adult binge drinking	18.6%		18.6%	
	Adult smoking	17.8%		15.0%	
	Drug overdose mortality rate (per 100,000)	10.7	16.7	20.0	19.6
	Opioid-related hospitalization rate (per 100,000)	9.1	--	20.6	18.9
	Substance-related hospitalization rate (per 100,000)	181.2	120.3	235.8	193.9
	Poor mental health for 14+ days in past 30 days	14.0%		12.4%	
	Suicide mortality rate (per 100,000)	--	--	11.5	9.6
Injuries	Fall-related hospitalization rate (per 100,000)	4,519.6	4,939.5	3,128.6	3,182.5
	Gun-related emergency department utilization (per 100,000)	--	6.8	9.0	8.3
	Homicide mortality rate (per 100,000)	--	--	--	--
Access to Care	Adults 19-64 years with Medicaid	6.9%		6.6%	
	Children <19 years with public insurance	24.5%		20.2%	
	Population without insurance	8.5%		5.1%	
	Children <19 years without insurance	8.9%		4.7%	
	Emergency department utilization (per 100,000)	10,483.5	14,576.9	12,930.7	14,072.9
	High emergency department utilization (per 100,000)	151.9	181.1	168.1	185.0
Social & Economic Conditions	Population in poverty	6.7%		6.3%	
	Children <18 years in poverty	9.2%		7.4%	
	Adults 19-64 years unemployed	2.1%		1.8%	
	Householders living alone who are 65+ years	44.4%		35.7%	
	Households receiving SNAP benefits	4.8%		7.7%	
	Households that are housing cost-burdened	8.7%		11.3%	
	Housing with potential lead risk	22.6%		39.0%	
	Vacant housing units	5.3%		4.7%	

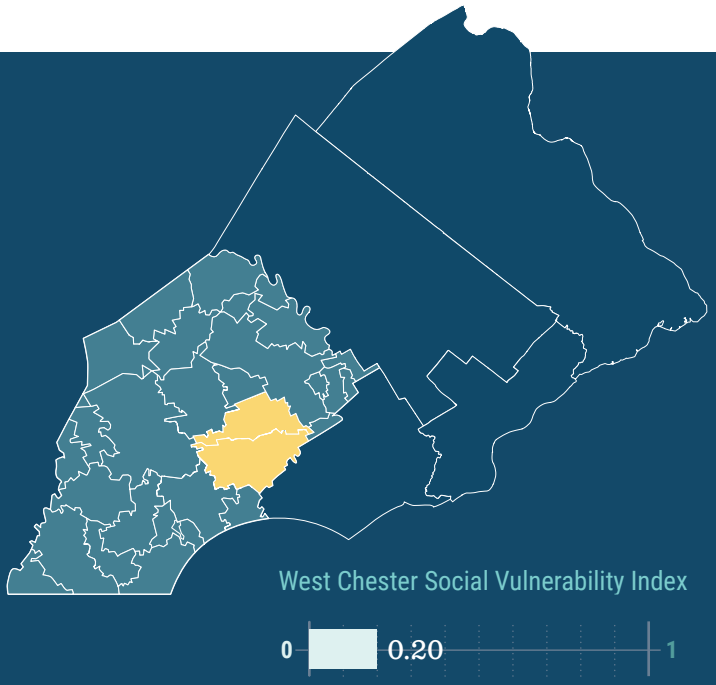
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

WEST CHESTER

ZIP CODES: 19380, 19382, 19383

This community is served by:

- Bryn Mawr Rehab Hospital
- Chester County Hospital
- Children's Hospital of Philadelphia
- Main Line Health



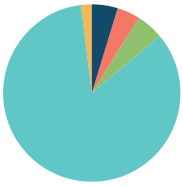
POPULATION

109,114

MEDIAN HOUSEHOLD INCOME

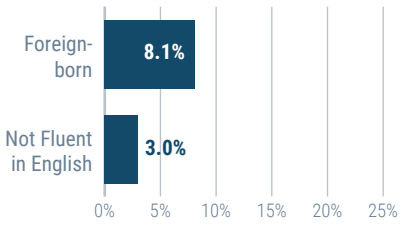
$102,263

RACE/ETHNICITY/LANGUAGE

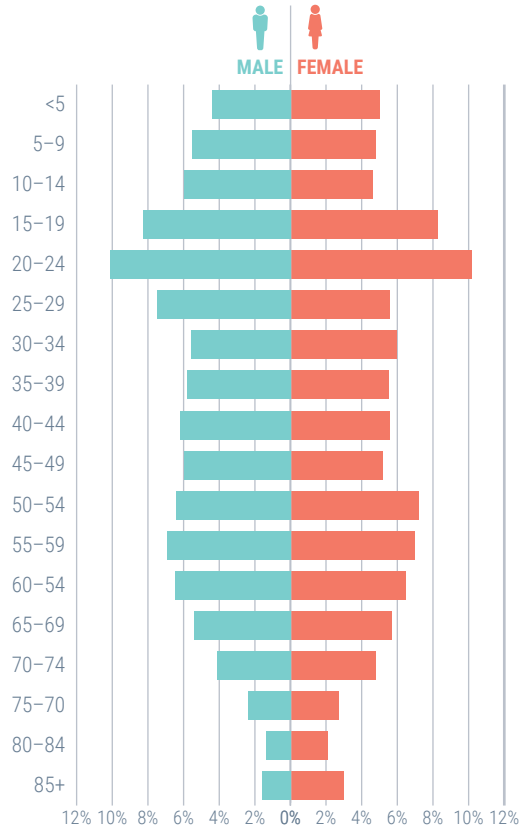


4.8% | Asian*
4.3% | Black*
4.8% | Hispanic/Latino
84.1% | White*
1.8% | Other*

* Non-Hispanic



AGE DISTRIBUTION



LEADING CAUSES OF DEATH

1. Heart disease
2. Cancer
3. COVID-19
4. Cerebrovascular diseases
5. Unintentional injuries (excluding drug overdoses)

EDUCATIONAL ATTAINMENT

High school as highest education level **12.2%**

PEOPLE WITH DISABILITIES

8.1%

summary health measures

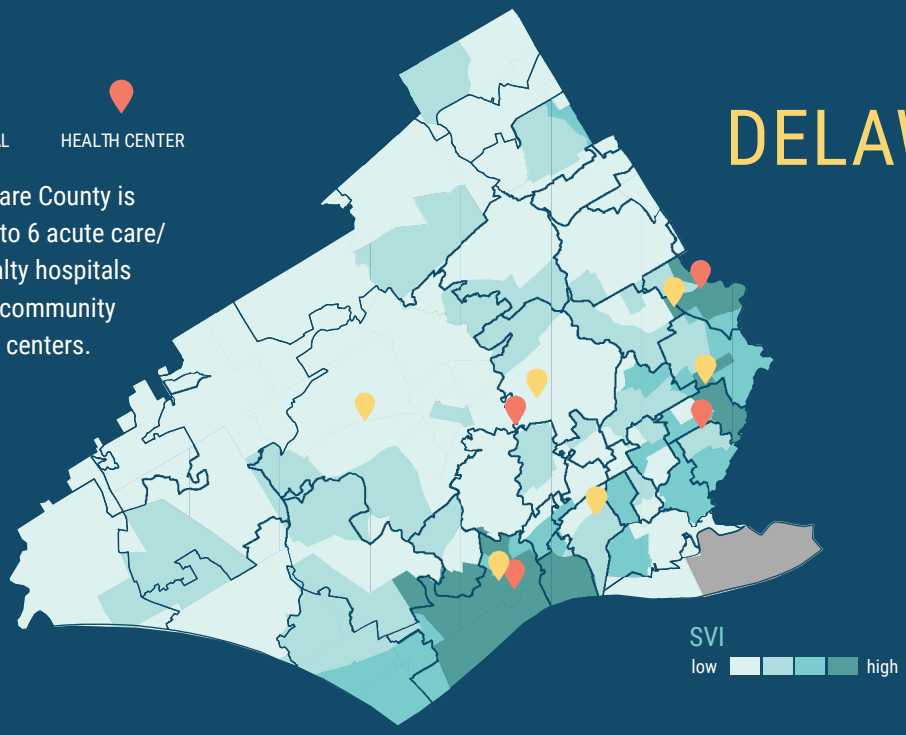
		West Chester		Chester County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	717.6	884.4	755.1	867.8
	Life expectancy: Female (in years)	85.6	83.6	83.8	82.6
	Life expectancy: Male (in years)	80.4	78.8	79.8	78.6
	Years of potential life lost before 75	3,685	3,871	22,739	22,899
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	243.8	N/A	445.0
	COVID-related hospitalization rate (per 100,000)	N/A	256.6	N/A	274.1
Chronic Disease & Health Behaviors	Adult obesity prevalence	24.3%		25.8%	
	Diabetes prevalence	7.7%		8.4%	
	Diabetes-related hospitalization rate (per 100,000)	59.6	77.0	86.7	96.8
	Hypertension prevalence	26.8%		28.3%	
	Hypertension-related hospitalization rate (per 100,000)	262.1	287.8	316.6	294.5
	Potentially preventable hospitalization rate (per 100,000)	736.8	685.5	853.2	724.6
	Premature cardiovascular disease mortality rate (per 100,000)	13.7	11.0	18.5	16.9
	Major cancer incidence rate (per 100,000)	230.0		242.9	
	Major cancer mortality rate (per 100,000)	65.1		72.8	
	Colorectal cancer screening	71.2%		69.5%	
	Mammography screening	78.2%		77.6%	
	Physical inactivity (leisure time) prevalence	16.7%		18.2%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	--	--	3.7	2.4
	Infant mortality rate (per 1,000 live births)	--	--	4.7	4.8
	Percent low birthweight births out of live births	6.3%	6.4%	6.0%	6.5%
	Percent preterm births out of live births	5.5%	6.1%	8.5%	7.9%
Behavioral Health	Adult binge drinking	19.0%		18.6%	
	Adult smoking	13.6%		15.0%	
	Drug overdose mortality rate (per 100,000)	15.6	18.3	20.0	19.6
	Opioid-related hospitalization rate (per 100,000)	6.4	13.7	20.6	18.9
	Substance-related hospitalization rate (per 100,000)	189.7	164.0	235.8	193.9
	Poor mental health for 14+ days in past 30 days	12.4%		12.4%	
	Suicide mortality rate (per 100,000)	11.9	7.3	11.5	9.6
Injuries	Fall-related hospitalization rate (per 100,000)	8,944.9	8,931.0	3,128.6	3,182.5
	Gun-related emergency department utilization (per 100,000)	1.8	2.0	9.0	8.3
	Homicide mortality rate (per 100,000)	--	--	--	--
Access to Care	Adults 19-64 years with Medicaid	4.9%		6.6%	
	Children <19 years with public insurance	15.3%		20.2%	
	Population without insurance	3.3%		5.1%	
	Children <19 years without insurance	2.3%		4.7%	
	Emergency department utilization (per 100,000)	11,184.2	8,768.4	12,930.7	14,072.9
	High emergency department utilization (per 100,000)	134.1	134.4	168.1	185.0
Social & Economic Conditions	Population in poverty	8.1%		6.3%	
	Children <18 years in poverty	4.1%		7.4%	
	Adults 19-64 years unemployed	1.8%		1.8%	
	Householders living alone who are 65+ years	31.1%		35.7%	
	Households receiving SNAP benefits	2.6%		7.7%	
	Households that are housing cost-burdened	17.2%		11.3%	
	Housing with potential lead risk	33.3%		39.0%	
	Vacant housing units	4.3%		4.7%	

* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

DELAWARE COUNTY

HOSPITAL HEALTH CENTER

Delaware County is home to 6 acute care/ specialty hospitals and 4 community health centers.



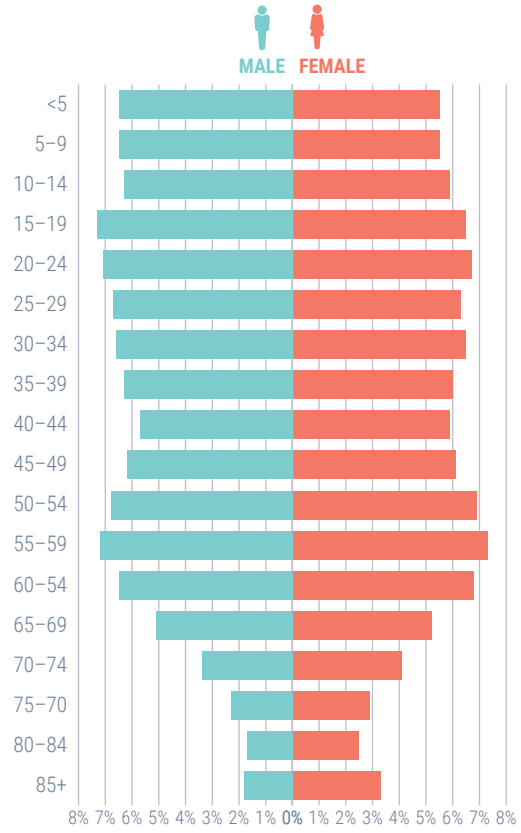
Social Vulnerability Index (SVI)

0 — 0.58 — 1

Median Income	$88,429
High school as highest education	23.8%
Food Insecurity	8.5%
With a Disability	11.8%
Violent Crime Rate	272.5 per 100,000

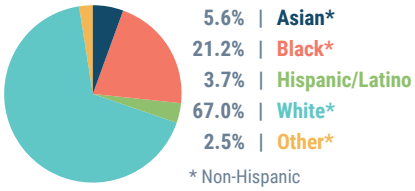
AGE DISTRIBUTION

Delaware County has an estimated population of 567,266, with the largest proportion of residents between the ages of 45 and 59.

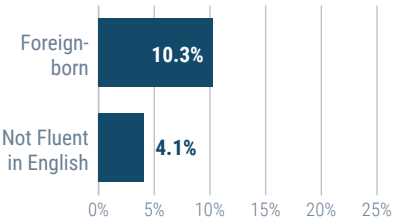


RACE/ETHNICITY/LANGUAGE

67% of residents are non-Hispanic White. Non-Hispanic Black residents make the next largest population, comprising 21.2% of the county's residents.



About 10% of residents are foreign-born and about 4% speak English less than "very well."



COVID-19 | Rates per 100,000

Fully Vaccinated	55,860.1

COVID-related:

• Emergency Department Use	713.4
• Hospitalization	564.8
• Mortality	177.9

MORTALITY

Leading Causes of Death

1. Heart disease
2. Cancer
3. COVID-19
4. Cerebrovascular diseases
5. Chronic lower respiratory diseases

YOUTH BEHAVIOR

Attempted Suicide	11.3%
Feeling Depressed/ Sad/Hopeless	43.6%
Binge Drinking	14.7%
Cigarette Smoking	3.4%
Vaping	23.9%

COMMUNITY PERSPECTIVES

*This summarizes focus group-style community conversations conducted with residents of four geographic communities: one each in Central Delaware County, Chester/I-95 Corridor, Upper Darby & Lansdowne, and Main Line Central.**

Community Assets

Participants in most Delaware County focus groups said **hospitals and other health care services are major assets in the county.**

- *"We're very fortunate where we live, because we have such major medical centers, teaching hospitals, research, we have excellent hospitals in the area, and quite a few to service the population."*

Another noted that urgent care centers in Brookhaven and Aston have been *"a positive for Delaware County and [the] Chester [City] area, specifically. That has been a great help."*

Many participants across groups spoke highly of **local community organizations, including faith-based institutions, emergency service providers, senior centers, and nonprofits that provide a wide range of programs and resources:**

- *"We have a network of senior centers that I think are good, we have county ones and we have Surrey Services [a nonprofit serving older adults], which help keep the elderly from being isolated and offer them services."*
- *"The senior center, I think has done a good job over the years in giving out various information about health, including exercise classes. ... My mother was doing exercise classes for 20 years at the PALM [Positive Aging in Lower Merion Center, in Ardmore], and she swears that's what's kept her as active as she is."*
- Organizations such as Catholic Social Services in Chester *"promote healthy lifestyles and healthy eating ... it makes it very easy for a lot of people in our community [who] cannot afford to buy a lot of things."*
- *"Another great resource in Delaware County, which encompasses Chester, is the Delaware County Chamber of Commerce website."*

Another mentioned the Delco Area Resource Network (DARN), a Facebook page that shares resources and ideas to build community.

Access to healthy food, both in grocery stores and food pantries, was highlighted in all groups:

- *"A lot of our food pantries, they are giving out the right food. They're particularly focused on giving out healthy products, not just a lot of junk food, but healthy products."*
- *"The church I attend ... we have a food pantry, so that has been a benefit to the community."*

In the Upper Darby/Lansdowne area, a participant noted *"several grocery stores where you can get fresh and healthy foods"* as well as many ethnic food markets and restaurants offering food and cuisine from Caribbean, African, and numerous other cultures.

One church in the Ardmore area has a community garden that gives away fresh produce and has hosted free COVID vaccine clinics open to the public

** There are several ZIP codes that span Delaware and Montgomery Counties. The Main Line Central group included participants from both counties. Therefore information from this discussion is included in both Delaware County and Montgomery County geographic community meeting summaries.*

A long-time Ardmore resident commented on the **strong sense of community** in her area, saying:

- *"You have people in the community check up on you or checking in or making a phone call or dropping something off. They're very supportive around here, which is the beauty of this town."*

Another participant mentioned that **local social media groups also help foster community connections**.

- *"There's a lot of social media groups, like the Buy Nothing groups, that … connect community members, new folks. That has been a really good, I feel, connection--allowing people, especially people who are new or who may not [know] people, to get things that they need, and also form a community."*

In the Upper Darby/Lansdowne group, participants noted the **walkability of many neighborhoods and generally good public transportation, such as buses and a trolley**. *"There's bus routes that crisscross the entire community, and if you know how to use it … it's very convenient,"* said a participant who also noted the buses were not always on time.

Several participants mentioned the benefit of nearby **green space and other recreational spaces**:

- *"As a lifelong resident, Haverford College and their nature trail have been valuable for me. … Just a place to be able to experience – lift your spirits by experiencing the different seasons, walking through the woods, I love that."*
- *"The Ardmore playground, especially during the summertime, man, there's always a basketball game going on."*

Multiple participants voiced enthusiasm about the **new Delaware County Health Department**, becoming operational in early 2022.

- *"I do think the health department that's starting in our county is going to be a huge benefit."*

Key Challenges

Obesity, diabetes, and cardiovascular conditions such as high blood pressure and high cholesterol are common throughout the county, participants in all groups said. In the Chester/I-95 corridor group, several participants also commented on **high rates of cancer, thyroid disorders, and respiratory conditions, such as asthma and emphysema**, which they associated with air pollution from nearby industrial plants.

- *"We also have, because of the high pollution from the plants, thyroid issues and asthma, [and] not being able to go out."*

Several participants reported **long waits for scheduling medical appointments, leading to delayed or avoided care** for preventive services, such as mammograms, and other health services. Concern also was expressed about the pandemic's impact on health care providers, both in terms of their wellbeing and their capacity to meet demand for medical services:

- *"We are losing so many providers because of COVID. How are all the people in the area going to receive medical care? If you have to wait two or three months to get a doctor's appointment, what's that doing to your health?"*
- *"Clearly, the hospitals lack capacity to deal with things that are non-COVID, right? I think the ICUs are pretty much packed if not near packed with COVID. … I do wonder what is being done to care for the mental health of medical providers on the other side of COVID as well, cause they're just dealing with it day in and day out."*

Behavioral health issues among adults and youth were a top concern among multiple participants in all groups. Stress, trauma and grief associated with the pandemic have increased demand for mental health services, at a time when health system capacity is strained.

- *"This is trauma. I don't think there's many people who haven't lost someone or know someone that's lost someone either to COVID or something that's indirect."*

Many participants also cited a **shortage of therapists** available to meet the growing demand for behavioral health care during the pandemic, resulting in long appointment delays.

- *"Mental health is a big issue as well as substance abuse, and that includes drug use and alcohol."*
- *"I had to wait five months because of my insurance to see a local [mental health] counselor here in Delaware County."*
- *"More people needing mental health treatment. … They may be short staffed in service [and] … the demand is so great."*

Lack of adequate insurance coverage for behavioral health issues was discussed in two groups, as was concern that **many mental health providers only accept private payment, so that people must pay out of pocket for services**.

- *"We're private paying for my son. It's quite an expense, but you have to have good care,"* noted a participant, who was unable to find mental health providers who were accepting new patients or the family's insurance.
- Several participants commented that people with severe mental illness often were discharged from inpatient care settings before they were well enough to return to the community. As one participant put it: *"My mental health situation is up to my insurance carrier. I can be cuckoo for Cocoa Puffs all day long, and if that insurance guy says we will [only cover care] for 21 days, [then on] day 22 I'm back out on the street."*

Stigma associated with mental health issues is another barrier to care.

- *"I think that the mental health stigma is a long-standing thing that we have to work on as a community. A lot of people feel that if they are seeking treatment for any sort of mental health concern--even if it's like anxiety, which everyone has--that there's a stigma to it, that they feel like they're being judged for that."*

A participant said that services in the county for those with substance use problems are **geared more toward long-term users than those with less severe or first-time issues.**

- *"There's not much out there for a first-time offender [such as a DUI citation] to get services."*

Other challenges include the **cost of prescription drugs and co-pays, as well as an overall lack of healthcare capacity**, exacerbated by the pandemic. *"The cost of prescriptions are just ridiculous for some items [and] seem like they go up every year,"* said one participant. Another commented that local providers are *"so booked up they're not taking new clients,"* forcing her to go into Philadelphia to find care.

Other challenges to accessing care and maintaining health, mentioned by one or more participants, include:

Lack of affordable dental health care.

- *"Dental health is a big one. A lot of Medicare doesn't cover dental health for our seniors and disabled. Even Medicaid, for adults, dental health is not covered the way it should be. And of course, dental health is tied to heart health. And overall, [for] mental health. If you … have a bad smile, it's gonna affect your mental health as well."*

Need for continued outreach and community-based services to boost COVID vaccination rates.

- *"I think efforts should be continued to be sure that everyone, if possible, can be vaccinated to try to prevent this thing, because it definitely hasn't gone [away]. I know you can't make people take the vaccine, but somehow, they just have to realize that they're not only hurting themselves but they're hurting the people that are around them, you know?"*

Social Determinants of Health

Transportation. Participants in all groups cited a lack of convenient and affordable transportation options for people who do not drive, making it difficult to access health care and other essential services.

- *"Transportation, that is a huge barrier to getting to appointments, not having enough public transportation."*
- *"If you don't have a car, you're very limited. And we see a lot [of] people carrying a lot of [grocery] bags, even from the Acme [supermarket] all the way across Lansdowne Avenue."*
- *"It is really a matter of access to the services. If you don't have access to them, it doesn't matter what's out there, you have to have the insurance, you have to have the transportation, you have to have the support."*

An older adult participant commented:

- *"The regional line that goes through Philadelphia-- good luck climbing up the stairs on that thing, you know? And even though we ride for free on SEPTA, it's – transportation is hard."*

Other transportation issues mentioned include **lack of bike lanes and noise pollution**, both from traffic on major roads, such as Lancaster Avenue, and commercial jets with low overhead flight patterns were noted.

- *"I used to ride my bike up Ardmore Avenue when I was younger, and last week, I tried to do the same thing, I almost got killed, you know? There's no bike lanes or anything."*

Lack of awareness and information about health and social services. Participants in two groups emphasized the need for better information access, especially for those who do not use the internet or have limited English proficiency. Information resources need to be adapted for people who have impaired vision or need other accommodations.

- *"Finding out about the local things that's going on in Chester is literally impossible. I see a lot of people in Chester that want hope, that want change, they want to eat healthy, they want to do things [but] they just can't access information. So, how do we change that narrative?"*
- *"I can see, but I am visually impaired, and I can't always use the computer--that's part of the reason why I need papers [print materials to read] sometimes."*

Digital divide. While younger and tech-savvy people tend to value telehealth for its convenience, its use can be a barrier to care for those who lack digital capability, including many older adults.

"I actually love the telehealth. I don't have to take time off work. I can just go to an appointment and be done with it. My [elderly] mom, on the other hand, refuses to do any telehealth appointments. Also, just lack of knowledge on how to use technology to access those telehealth [visits] has proven to be very difficult for her. ... So, I think it's proven to be good for some, very difficult for others. Again, that's the economic divide."

Housing affordability and the ability for older adults to age in place are key challenges for those living on fixed or limited incomes:

- *"Ardmore has been over-developed and overpriced [so] that those of us who have lived here for years are being forced out of our homes."*
- *"I definitely feel like I'm being priced out of my own home. The older neighbors are all passing on, and those of us who are left are really under the gun to try and keep our properties up to standard with a limited income."*

Participants in two groups discussed the county's **high rate of childhood lead poisoning** from chipped or peeling paint in older houses and other **housing-related health and safety issues**:

- *"A lot of unsafe houses in the community--a lot of houses they [have] leaking roofs, flooding basements, mold, asbestos, definitely lead, chipping paint, [and] corroded windowsills where young children are crawling and touching things."*
- *"If I had my way and all the money in the world, I'd make sure ... every house in Delaware County is lead free, free of lead-based paint."*

Access to healthy food and nutrition education. Participants discussed the need for better access to fresh, affordable food in some areas, along with nutrition education. *"There are some communities in Delaware County that do not have access to proper grocery stores,"* said a participant from the Upper Darby/Lansdowne group. Another concern: many small markets selling mostly processed foods high in salt or sugar.

- ***"There should be more places that have, you know, fresh produce at reasonable prices."***

Another shared: *"They have a farmer's market in Bryn Mawr, but the prices are pretty darn high."* Eating out also poses challenges due to cost: *"All the new restaurants that are coming up are very pricy for people on fixed incomes."*

Nutrition education also is needed to encourage healthier food choices, several participants said, such as helping people adapt favorite recipes using healthier ingredients and cooking methods.

Structural racism. In one group, all participants prioritized the need to address longstanding systemic racism to improve health and social equity in their communities.

- ***"The constant disinvestment and structural racism have everything to do with long-term health. And unless that's addressed, the long-term stability or bringing up communities just won't happen."***

Built environment. In the Chester/I-95 corridor group, issues with trash and lack of usable green space were discussed.

- ***"I think to make this community a healthy place to live, they need to clean up more around here, as far as like the trash. People put their trash all out, you know, on the days that are not even supposed to [have trash] picked up. And it's just a mess. ... In the summer, you can't hardly sit out there because ... you probably got rodents and everything else running around."***

A participant also commented on inability to use a local park because of saturated wet ground from nearby Ridley Creek.

Financial stress. Despite the Main Line's reputation as a wealthy area, participants cited a number of social and environmental determinants that impede health and well-being for some, especially older adults and people living on fixed or limited incomes.

One participant dubbed it

- ***"the myth of the Main Line. ... People just sort of think if you live on the Main Line, you are [in] the healthy-wealthy group. And we need to recognize that there are children going hungry in this area."***

Another added:

- ***"The financial impact of COVID has really put financial strain on a lot of older adults and families."***

Recent consumer price inflation has added to the financial strain for some.

- ***"The price of gas, the price of food, the price of everything has increased so much that it has put a strain on families, and it definitely has impacted the aging population."***

Also of note: **Ardmore is divided between Montgomery and Delaware Counties.** A few participants said that residents living in the Montgomery County area of Ardmore have access to more robust services than those residing in Delaware County, at least with regard to county services for the aging. *"That's a really big issue, because there are a lot of elderly people living in Delaware County that are totally neglected,"* said one participant.

Children and Youth

Lack of physical activity and unhealthy eating, leading to childhood obesity, were discussed as major concerns for children and youth in all three groups. Many participants also commented that **excessive screen time and use of social media among youth interfere with healthy social development**.

- *"Kids don't play anymore outside like they used to because of the video games, social media, and things of that nature. ... When I was a kid, we went outside, we played--we didn't know we were exercising, running up and down the street, and in and out of each other's houses, and things of that nature. But kids don't do that now. ... the social media and the video games, that can't be good."*
- Cost can be a barrier for participation in local youth sports leagues. *"The fees can get hefty, depending on the sport. And that would create a barrier for some families to allow their kids to be part of something that they should be."*
- *"They come home from school, and they on the phone, they on their Xbox and all that stuff, and eating junk or whatever, and that's not healthy. And that's why you see a lot of kids that are so much overweight. ... Kids today don't know how to play outside, you know?"*
- Virtual schooling during the pandemic had emotional effects for some: *"The kids weren't in school, and not being around their peers, all of that has had some emotional effects on our children, and part of staying healthy, I believe, mentally and emotionally, is interaction with your peers."*
- *"Another thing that really affects health is so many [of] these kids are on social media, not getting outside, not getting physical exercise, not interacting with peers. ... They'll be texting somebody sitting right next to them, instead of being face to face and having spontaneous interactions."*
- *"Kids do need some type of structured activities. A lot of times there's no resources put in place in communities for children, I mean, especially in underserved communities."*
- *"In the Chester/I-95 corridor area, air pollution from nearby industrial plants can prevent children from playing outside,"* one participant said. When safe recreation is limited, youth are more vulnerable to being *"indoctrinated into a gang."*

The pandemic's impact on mental health among young people was a major concern for participants, **along with delayed and limited access to mental health care.** A number of participants stressed the **urgent need for more therapists to care for the growing number of young people with behavioral health issues.** Another participant emphasized the need for **more culturally competent therapists to provide care for the area's diverse immigrant populations.**

- *"Affordable therapy is just very lacking right now. I think social isolation has been rough on the kiddos,"* said a participant who works with youth. *"The wait right now for mental health treatment for children is three to five months or longer for us to be able to get them connected to somebody who is trained, who can actually work with them on a fee that is affordable for the families."*
- A participant with experience in placing children who need behavioral health care commented that wait times for appointments are *"are at the least, five months. That's to even see a therapist. You can have an intake appointment with their assessment needs, and then, after that, you're supposed to be assigned a therapist. Typically, in the past, it would take four weeks, let's say four to six weeks. In the pandemic, it's five months."*

Several participants also raised concern about the **high rate of substance use among children and youth**, which they said has increased during the pandemic.

- ***"We've had kids as young as 11, 12 on cocaine. I think it's a contribution of the high pressure of mental health, the need to numb themselves and escape. And I think alcohol is somewhat normalized to a point where it's like, is it normal or is it alcoholism, right?"***

"I'm just sort of thinking about in terms of our young people, their involvement with drugs and weapons. … It's more of a problem now than it used to be," added another participant, who cited the recent murder of a young man in the community over a gun argument.

During the pandemic, domestic violence also has increased, said a participant who works with youth.

- ***"We have definitely seen [an] increase for children who are witnesses to domestic violence, sometimes resulting in homicide, and that has increased more, especially during COVID."***

In addition, she mentioned **an increase in online sexual exploitation of children**, which she attributed to lack of safeguards to ensure children's internet safety, such as adequate education and supervision.

A concern was raised that in some mental health clinics, waiting rooms mix children with adult patients, some with serious behavioral health issues:

- ***"When I took my son, and he was younger, into one of these mental health clinics, they're in there with drug offenders and criminal offenders. And that's not really a good mix to have your vulnerable child in what may be a more dangerous population or just older, you're trying to shelter and protect your child. And yeah, they're seeing things that maybe they shouldn't see or be exposed to yet."***

Another participant noted the **potential for family conflicts to arise over a young person's consent to receive mental health services**. In Pennsylvania, she said, children aged 14 years and older can independently consent to receiving behavioral health care. But conflicts can occur. For example:

- ***"If a child wants mental health services, and the parent says no, but they're 14 and can't drive. So, how do they get there? … I think that there's unique challenges in that age range 14 to 18, that maybe don't get met because of those intricacies."***

Participants in two groups raised concern about **instances of childhood neglect they have witnessed in their communities**:

- ***"What I'm noticing more in the community, with the substance abuse, is the neglect of children."***

Another participant recalled seeing children walking to the school bus stop without winter coats in cold weather.

The need for more afterschool activities and programs to help youth develop healthy lifestyles, such as sports, cooking classes, and basic financial literacy, was cited. Families also may need access to safe transportation options for children to get to and from afterschool programs, especially if parents or caregivers are working when programs are offered.

Older Adults

Social isolation during the pandemic has been harmful to older adults' mental and physical health, several participants said. A participant who works at a senior center mentioned recently seeing an older man whom her organization serves.

- During the pandemic, *"he stayed engaged in our virtual programs. … [But] when I saw him, he looked so old, and he looked isolated. He looked unkempt and disheveled. So, the isolation aspect is, I think, first and foremost. … What COVID did do is expose the need for social interaction--that it is important to be able to speak and touch and have those relationships."*

A top concern for older adults, discussed by multiple participants in the all groups, was **the challenge of affording health care and other essential services for those living on fixed incomes and reluctance for some to access services**.

- *"They're on the fixed income, and they're dealing with, can I continue to pay my taxes, even can I continue to stay in my house, or … can I get the medical attention that I need, so I have to learn now to sacrifice, and some of the sacrifice means going without, and [they] just find themselves in a desolate situation within their household that will impede on their health."*
- *"A lot of people that are in our community … cannot afford to buy a lot of things, especially when you get into the senior population [and] those that are on social security or disability. Their funding is limited, their food stamps are limited, things of that nature."*
- *"Sometimes, the seniors, they have to make a choice between getting their medication and/or food. And they'll choose to get the medication as opposed to the meal. They'll skip a meal [and] they'll have barely nothing, just so they can have that medication."*
- *"There are those who, because they're on the Main Line, and they're [in] the aging population, they don't want folks to know that they're struggling."*

For many older adults, another common challenge is affording or navigating Medicare and other health insurance. Lack of mental health and dental care coverage in many policies also was noted as a concern.

- *"That's the issue with my family, with the older adult, you know, older ones were like, 'I'm not gonna pay a co-pay,' especially if they have like, a $25, $35 co-pay."*
- A participant stated that many mental health providers do not accept Medicare, because of low reimbursement rates: *"What I'm hearing is … Medicare doesn't reimburse very well, so people [providers] have switched from accepting Medicare. And with the number of older individuals that we have in our population at this moment, that is a crisis in my mind."*
- *"For seniors who are on Medicare or whatever, the cost of co-pays prevent a lot of people from seeing different specialists and people that they need to see. … If you're not connected with the right health plan or supplemental plan, the co-pays can be prohibitive."*

The shift to telehealth during the pandemic has been especially challenging for many older adults, as noted by participants in all groups.

- An older participant shared: ***"It can be challenging for someone such as myself, who is not computer literate, to do these things online. We prefer speaking with a person, and you don't always have that ability to speak with the person and making appointments."***
- ***"I can think right now of three people I know that are 80s to 90s that are living by themselves, do not have internet services, wouldn't even have a clue how to get onto the internet."***
- ***"I live in a community where we have a number of old folks who just don't access the internet, and they live in isolation."***

Other barriers to health for older adults include lack of convenient, affordable transportation options and poor nutrition, due to difficulty affording, obtaining or preparing food.

"I think there's issues with nutrition," said a participant, who mentioned knowing an elderly couple where the wife struggles to get to the grocery store to buy food and lacks *"the stamina to cook it."* Another participant commented that for her elderly mother to get to doctor's appointments, *"she would have to get at least three buses."*

For older adults who lack English proficiency, challenges with accessing health care and other services are further increased.

- ***"Kids are resilient, so they can easily learn language, but when a person is older, it's very difficult to learn a new language,"*** said a participant whose family emigrated from another country.

Lack of support from family or community members can be a further barrier to care, the participant said, such as when adult children *"work a lot and they [their elderly parents] don't have somebody to assist them to go to the hospital. So, then, they are stuck at home. Even though they're sick, they don't know how to access these things … they don't know what to do or how to do it."*

Many older adults need assistance from family members or others, although some are reluctant to accept help.

- ***"Sometimes it takes us helping them go get what's necessary, [for example] going to pick up the food box at the pantry to make sure that they have what's necessary to eat, so that they're just not eating something that's quick, because they don't have the ener gy or ability to cook."***

However, another said:

- ***"There could also be an unwillingness sometimes among older adults to want to even go to the doctor or take their medication. Sometimes, they need help from their children, adult children, or you know, community members, or things of that nature, to help them stay healthy. And sometimes, in some cases, they could resist it."***

Other Groups

The needs of people reentering the community after incarceration were discussed. One participant stated: *"A lot of grown people in Delaware County, and specifically in Chester, do not even have valid identification cards,"* such as a current driver's license or other form of identification. People re-entering the community after incarceration often have no money or family support to pay for processing a valid ID, such as if their previous ID was lost, expired or never issued, the participant noted.

- ***"They have no family, they have no financial support. So, that's one of the barriers that I see on a regular basis in Delaware County and specifically in Chester."***

Immigrant communities. Several participants mentioned the **needs of immigrants living in the area who lack English proficiency, creating barriers to access health care and other services**. With a growing number of Asian and Latino/Hispanic immigrants, the area has greater need for more language services in health care settings and other services for these populations. Speaking from a patient's perspective, a participant noted that access to high-quality language interpretation services is important for *"empowering people to actually be part of what's happening to their lives and their treatment and their needs."*

- ***"Upper Darby, all those places are actually filled with immigrants from different countries. It could be language barrier that cause them to not have access to medical benefits and ... fear that they might not be understood."***
- An Asian American participant who speaks English fluently said that she accompanies her family members on medical appointments to ensure they understand health communications. ***"I just know for us, we obviously, we help them because [they're] family,"*** she said. ***"But if you didn't have family, what would you do, right? Are there even resources to help?"***

In the Upper Darby/Lansdowne group, participants emphasized the need for **more cultural competency among health providers** to serve the area's many immigrants.

- One cited the need for healthcare providers ***"who can understand what well-being is in the culture that they're dealing with. ... We're not just talking about language translation, but do they really understand what well-being means to West Africans as compared to even Somalians? [sic] Like, that's very different. They're not the same. So, around cultural competency and understanding sickness, health, recovery."***

Suggested Actions

Among their top priorities, participants in groups called for **more efforts to address mental health needs and substance use issues in their communities**. Among their suggestions:

Provide access to trained mental health professionals in all school districts countywide.

While existing school counselors are usually well-positioned to help identify and refer students in need of professional mental health services, school districts also should employ or contract with qualified mental health professionals who can provide therapeutic support for students in need.

Develop a stronger pipeline of mental health professionals, by creating career pathway programs to encourage students to enter the behavioral health field.

"Maybe behavioral health centers can go into colleges to offer signing bonuses to those – to you know, graduating students."

Participants in all groups noted the need to expand access to primary care services.

- **Establish community clinics that would serve as hubs for mental and physical health care, as well as social services.** One participant envisioned *"comprehensive health centers"* in communities that would provide "*physical, mental, [and dental care]… in a culturally competent way."* Another suggested a mobile clinic to bring health care services directly into the community and envisioned a "*one-stop shop*" for health services geared to community needs: *"Having a mobile unit in Chester to go to the different parts that will help, that would take away a lot of the barriers."* Creating a visiting nurse program or once-monthly clinic in an easily accessible community location to provide basic care for older adults who do not drive was also suggested.
- Advocate for passage of statewide legislation that would give nurse practitioners the ability to set up independent practices to provide primary care.

Raise awareness of local health and social service resources by conducting outreach directly in communities, in places that people are most likely to frequent.

While the internet can be an efficient way to provide information, more direct outreach into communities is needed:

- Hospitals can better publicize their community health services, such as free seminars, screenings, and health fairs.
- Create a centralized clearinghouse with easily accessible information about a wide range of health and social service resources in the area.
- *"There's definitely resources available, but people just are not aware. We have to go where they [people] are. And we have to be realistic about where they are, depending on the community."*
- *"In Philadelphia, where I go to get my hair done, is a community fridge right in front of the hair place. So, I actually get a lot of news through that community fridge. And I actually talk to [other people using] that fridge versus, you know, in Chester, I'm sort of isolated."*
- Another suggestion was sending trained outreach workers into the community to *"just hear from them what's going on and what services they need."* Another agreed, adding *"if we had multiple teams and volunteers that would go into the community to do it, we could solve a lot of these problems, and work together as a community to get that done."*

Suggested Actions

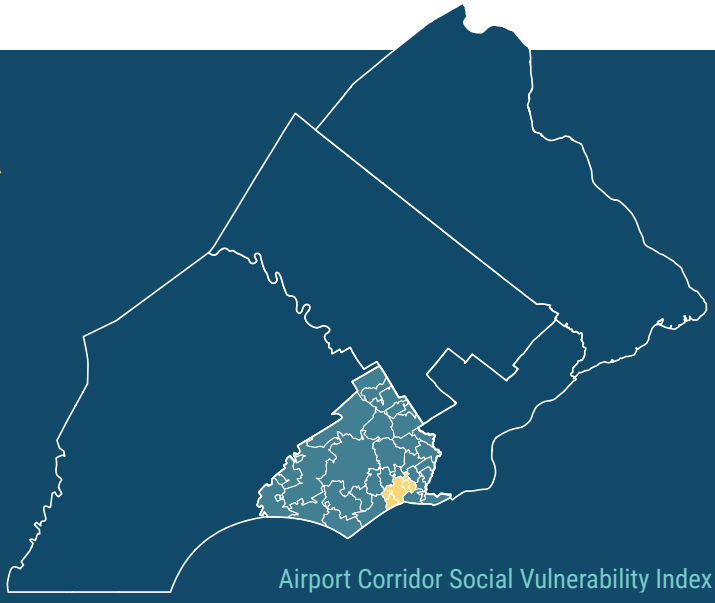
Increase collaboration and resource sharing among local nonprofits and other service agencies.	*"I have seen organizations doing a better job of sharing information,"* said a participant who works for a social services organization. *"Like my organization, we get information from other social service agencies hat we can distribute to our database of clients, so we tried to do that on a regular basis. So, sharing of resources would be good."*
Provide trained advocates to help people navigate health and social services.	• Providing **medical advocates to help those with financial needs access medical assistance programs**, such as programs to defray the cost of prescription drugs, was recommended. • A participant **described a program that's already working well in her church, which employs a nurse who helps members navigate a variety of health and social service needs.** *"She runs a caregiver support group, which was my lifeline, when I was going through a really difficult time. She welcomes you, when you join the church; she will accompany you to doctor appointments to serve as your advocate. She will help you with transportation. If you need to move into assisted living, she'll help you with that,"* the participant explained.
Develop new programs, or raise awareness of existing efforts, to educate youth and adults on healthy eating and other valuable skills, such as cooking, food shopping, and budgeting.	Participants mentioned several programs that already are working well to support families with developing healthy lifestyles and improving their welfare. For example, one participant mentioned his organization offers a program to *"show our clients how to cook healthy nutritious meals, [with] handed out samples for them right there."* Another program provides a community dinner for families, followed by homework help for youth while parents attend customer service training as part of a job training initiative.
Expand affordable transportation options for older adults and create a way to regularly check in on those who are socially isolated.	Free or inexpensive transportation options are needed to help older adults get to and from medical appointments and other community services, helping them to age in place. One participant also recommended creating a service, perhaps led by volunteers, to call on homebound adults to check in and assess their needs.
Expand access to affordable housing.	One participant, an attorney, suggested passing a local ordinance requiring that a certain percentage of units in new developments be offered at affordable prices for people living on fixed or limited incomes.
Expand efforts to close the digital divide.	Delaware County is conducting a survey to assess residents' access to broadband internet. In addition to affordable internet service, some residents need access to computer equipment and skills training, several said.
Increase assistance for returning citizens, especially those in need of valid IDs.	Compared with Philadelphia, which has several programs to help people with the application and fees to obtain an ID, similar programs in Chester are limited, with more support needed.

AIRPORT CORRIDOR

ZIP CODES: 19022, 19033, 19043, 19074, 19076, 19078

This community is served by:

- Children's Hospital of Philadelphia
- Magee Rehabilitation



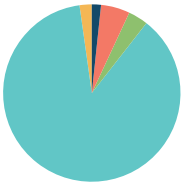
POPULATION

39,002

MEDIAN HOUSEHOLD INCOME

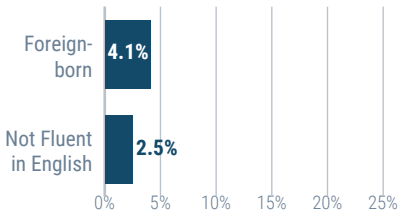
$70,019

RACE/ETHNICITY/LANGUAGE



1.7% | Asian*
5.4% | Black*
3.7% | Hispanic/Latino
87.0% | White*
2.1% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

1. Heart disease
2. Cancer
3. COVID-19
4. Chronic lower respiratory diseases
5. Cerebrovascular diseases

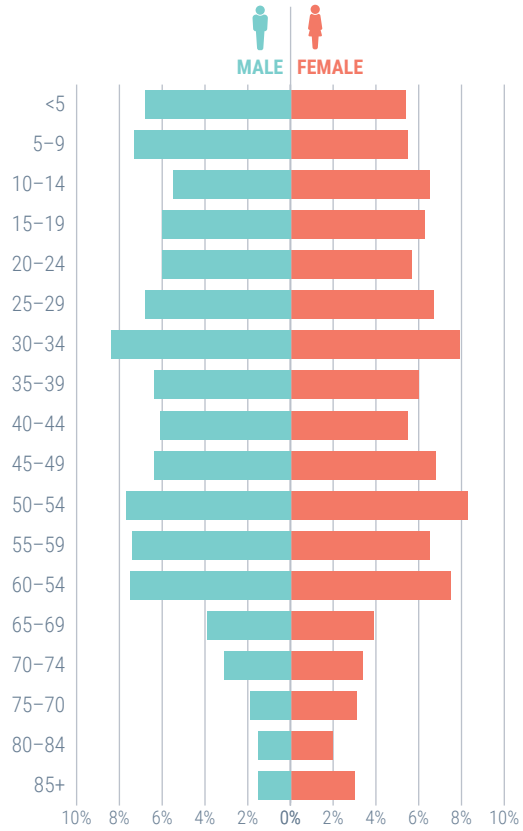
EDUCATIONAL ATTAINMENT

High school as highest education level **32.1%**

PEOPLE WITH DISABILITIES

12.8%

AGE DISTRIBUTION



summary health measures

		Airport Corridor		Delaware County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	974.3	1,130.7	973.2	1,139.5
	Life expectancy: Female (in years)	80.0	78.4	81.3	79.5
	Life expectancy: Male (in years)	73.4	73.0	76.0	73.9
	Years of potential life lost before 75	3,524	3,377	37,712	43,617
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	233.3	N/A	713.4
	COVID-related hospitalization rate (per 100,000)	N/A	530.7	N/A	564.8
Chronic Disease & Health Behaviors	Adult obesity prevalence	28.6%		29.1%	
	Diabetes prevalence	9.2%		10.0%	
	Diabetes-related hospitalization rate (per 100,000)	156.4	138.5	149.6	142.6
	Hypertension prevalence	28.5%		29.9%	
	Hypertension-related hospitalization rate (per 100,000)	341.0	325.6	439.5	394.0
	Potentially preventable hospitalization rate (per 100,000)	984.6	879.4	1,070.1	897.4
	Premature cardiovascular disease mortality rate (per 100,000)	51.3	43.6	36.5	36.0
	Major cancer incidence rate (per 100,000)	271.8		262.9	
	Major cancer mortality rate (per 100,000)	89.7		88.9	
	Colorectal cancer screening	63.8%		65.1%	
	Mammography screening	75.4%		77.4%	
	Physical inactivity (leisure time) prevalence	21.7%		21.6%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	--	--	14.1	7.0
	Infant mortality rate (per 1,000 live births)	--	--	6.9	6.2
	Percent low birthweight births out of live births	6.2%	8.2%	8.5%	9.2%
	Percent preterm births out of live births	8.2%	6.5%	9.2%	9.6%
Behavioral Health	Adult binge drinking	21.7%		19.6%	
	Adult smoking	19.7%		17.5%	
	Drug overdose mortality rate (per 100,000)	41.0	43.6	30.3	31.2
	Opioid-related hospitalization rate (per 100,000)	256.4	243.6	130.7	125.5
	Substance-related hospitalization rate (per 100,000)	889.7	876.9	557.7	504.3
	Poor mental health for 14+ days in past 30 days	14.8%		14.0%	
	Suicide mortality rate (per 100,000)	25.6	--	13.5	11.7
Injuries	Fall-related hospitalization rate (per 100,000)	8,941.2	9,921.6	3,869.3	3,988.7
	Gun-related emergency department utilization (per 100,000)	--	54.1	29.8	27.6
	Homicide mortality rate (per 100,000)	--	--	6.0	9.9
Access to Care	Adults 19-64 years with Medicaid	13.6%		13.4%	
	Children <19 years with public insurance	33.6%		33.0%	
	Population without insurance	4.8%		4.7%	
	Children <19 years without insurance	2.8%		2.3%	
	Emergency department utilization (per 100,000)	23,889.7	39,524.7	24,497.8	29,155.4
	High emergency department utilization (per 100,000)	530.6	1,239.9	475.3	795.4
Social & Economic Conditions	Population in poverty	9.6%		9.9%	
	Children <18 years in poverty	14.9%		13.5%	
	Adults 19-64 years unemployed	2.7%		2.5%	
	Householders living alone who are 65+ years	32.9%		37.2%	
	Households receiving SNAP benefits	12.8%		10.1%	
	Households that are housing cost-burdened	18.8%		15.8%	
	Housing with potential lead risk	83.9%		69.8%	
	Vacant housing units	9.2%		6.9%	

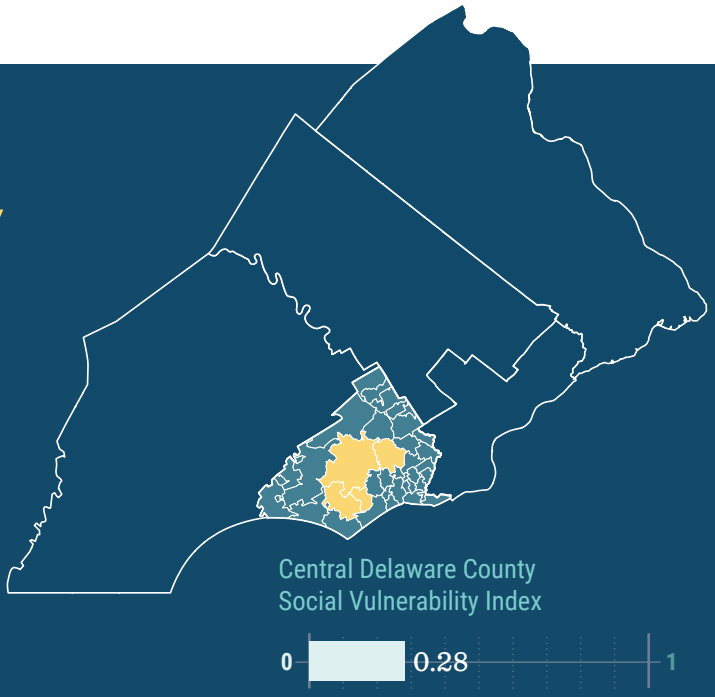
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

CENTRAL DELAWARE COUNTY

ZIP CODES: 19014, 19015, 19017, 19063, 19064, 19070, 19081, 19086

This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Magee Rehabilitation
- Main Line Health



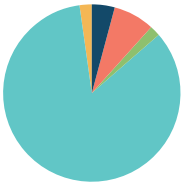
POPULATION

127,001

MEDIAN HOUSEHOLD INCOME

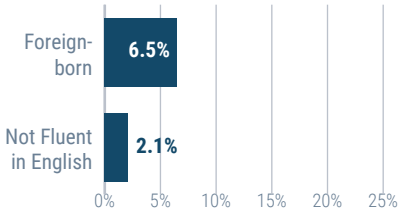
$91,378

RACE/ETHNICITY/LANGUAGE

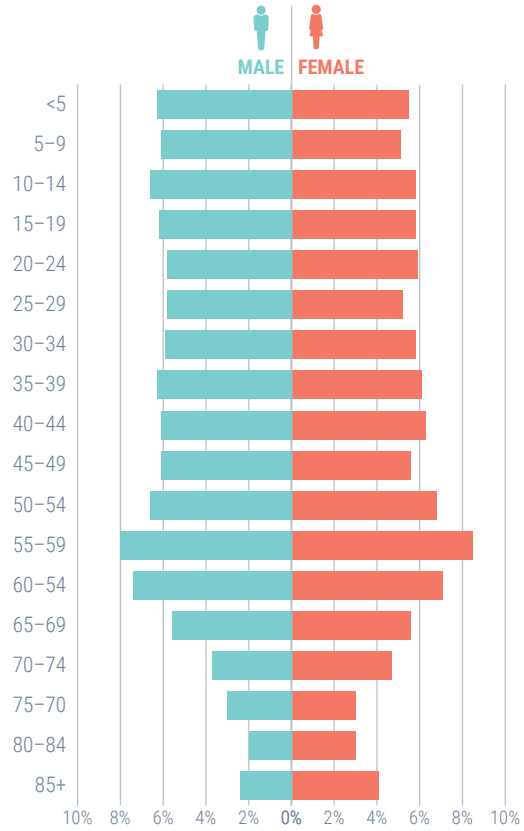


4.2% | Asian*
7.6% | Black*
1.8% | Hispanic/Latino
83.9% | White*
2.2% | Other*

* Non-Hispanic



AGE DISTRIBUTION



LEADING CAUSES OF DEATH

1. Heart disease
2. COVID-19
3. Cancer
4. Cerebrovascular diseases
5. Chronic lower respiratory diseases

EDUCATIONAL ATTAINMENT

High school as highest education level **20.2%**

PEOPLE WITH DISABILITIES

10.9%

summary health measures

		Central Delaware County		Delaware County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	1,103.9	1,232.3	973.2	1,139.5
	Life expectancy: Female (in years)	81.9	80.6	81.3	79.5
	Life expectancy: Male (in years)	78.0	76.6	76.0	73.9
	Years of potential life lost before 75	6,684	7,695	37,712	43,617
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	242.5	N/A	713.4
	COVID-related hospitalization rate (per 100,000)	N/A	503.1	N/A	564.8
Chronic Disease & Health Behaviors	Adult obesity prevalence	26.5%		29.1%	
	Diabetes prevalence	9.0%		10.0%	
	Diabetes-related hospitalization rate (per 100,000)	103.1	86.6	149.6	142.6
	Hypertension prevalence	28.8%		29.9%	
	Hypertension-related hospitalization rate (per 100,000)	366.1	352.8	439.5	394.0
	Potentially preventable hospitalization rate (per 100,000)	918.1	772.4	1,070.1	897.4
	Premature cardiovascular disease mortality rate (per 100,000)	28.3	26.0	36.5	36.0
	Major cancer incidence rate (per 100,000)	279.5		262.9	
	Major cancer mortality rate (per 100,000)	87.4		88.9	
	Colorectal cancer screening	67.6%		65.1%	
	Mammography screening	77.2%		77.4%	
	Physical inactivity (leisure time) prevalence	19.0%		21.6%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	--	--	14.1	7.0
	Infant mortality rate (per 1,000 live births)	5.8	--	6.9	6.2
	Percent low birthweight births out of live births	7.1%	6.8%	8.5%	9.2%
	Percent preterm births out of live births	6.3%	5.6%	9.2%	9.6%
Behavioral Health	Adult binge drinking	20.2%		19.6%	
	Adult smoking	15.1%		17.5%	
	Drug overdose mortality rate (per 100,000)	28.3	26.0	30.3	31.2
	Opioid-related hospitalization rate (per 100,000)	85.8	86.6	130.7	125.5
	Substance-related hospitalization rate (per 100,000)	348.0	339.4	557.7	504.3
	Poor mental health for 14+ days in past 30 days	12.5%		14.0%	
	Suicide mortality rate (per 100,000)	14.2	9.4	13.5	11.7
Injuries	Fall-related hospitalization rate (per 100,000)	7,729.5	8,212.6	3,869.3	3,988.7
	Gun-related emergency department utilization (per 100,000)	19.6	22.0	29.8	27.6
	Homicide mortality rate (per 100,000)	--	--	6.0	9.9
Access to Care	Adults 19-64 years with Medicaid	8.4%		13.4%	
	Children <19 years with public insurance	20.3%		33.0%	
	Population without insurance	2.6%		4.7%	
	Children <19 years without insurance	1.5%		2.3%	
	Emergency department utilization (per 100,000)	19,617.2	22,424.1	24,497.8	29,155.4
	High emergency department utilization (per 100,000)	299.6	474.1	475.3	795.4
Social & Economic Conditions	Population in poverty	5.2%		9.9%	
	Children <18 years in poverty	6.1%		13.5%	
	Adults 19-64 years unemployed	2.1%		2.5%	
	Householders living alone who are 65+ years	43.6%		37.2%	
	Households receiving SNAP benefits	5.6%		10.1%	
	Households that are housing cost-burdened	12.3%		15.8%	
	Housing with potential lead risk	68.5%		69.8%	
	Vacant housing units	4.3%		6.9%	

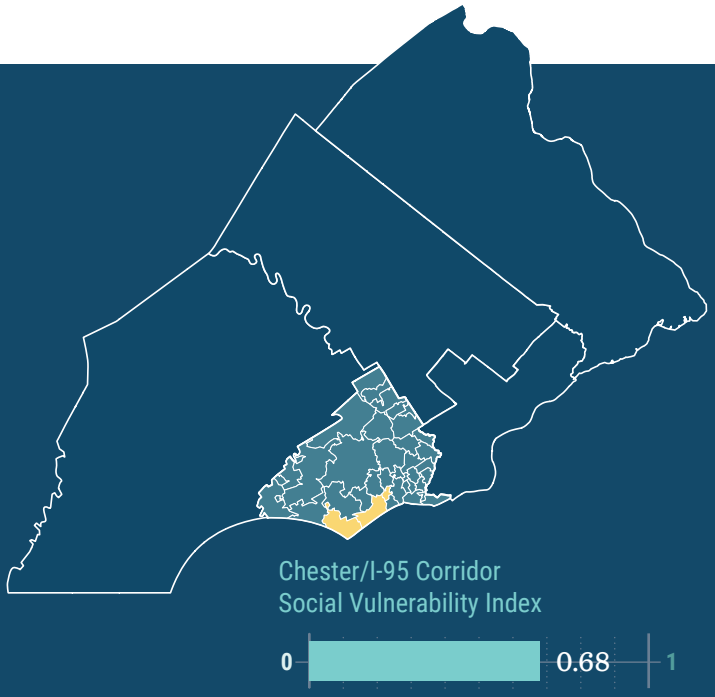
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

CHESTER/ I-95 CORRIDOR

ZIP CODES: 19013, 19061, 19094

This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Magee Rehabilitation
- Main Line Health



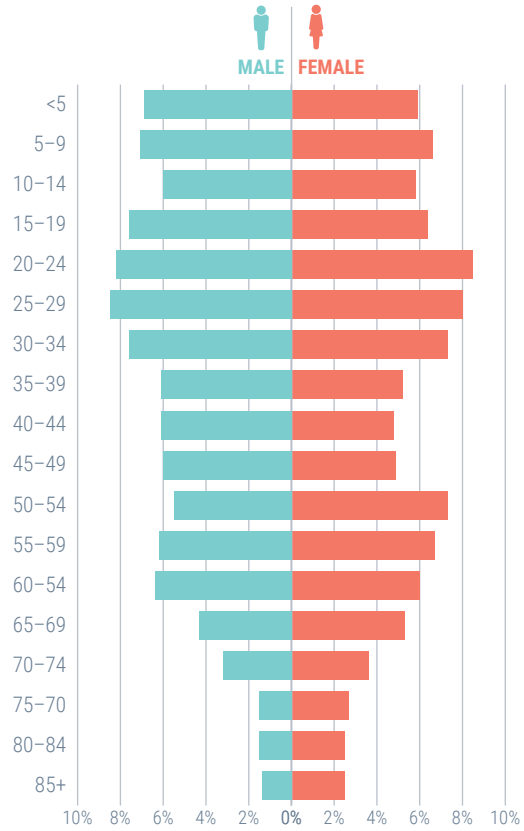
POPULATION

59,442

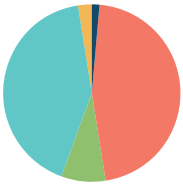
MEDIAN HOUSEHOLD INCOME

$54,784

AGE DISTRIBUTION

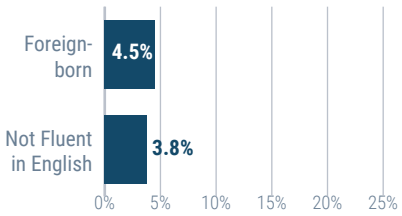


RACE/ETHNICITY/LANGUAGE



1.5% | Asian*
46.1% | Black*
8.1% | Hispanic/Latino
41.9% | White*
2.4% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

1. Heart disease
2. Cancer
3. COVID-19
4. Chronic lower respiratory diseases
5. Cerebrovascular diseases

EDUCATIONAL ATTAINMENT

High school as highest education level **36.9%**

PEOPLE WITH DISABILITIES

16.4%

summary health measures

		Chester/I-95 Corridor		Delaware County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	1,184.3	1,318.9	973.2	1,139.5
	Life expectancy: Female (in years)	75.7	74.7	81.3	79.5
	Life expectancy: Male (in years)	68.9	65.7	76.0	73.9
	Years of potential life lost before 75	7,512	9,107	37,712	43,617
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	282.6	N/A	713.4
	COVID-related hospitalization rate (per 100,000)	N/A	824.3	N/A	564.8
Chronic Disease & Health Behaviors	Adult obesity prevalence	36.9%		29.1%	
	Diabetes prevalence	14.4%		10.0%	
	Diabetes-related hospitalization rate (per 100,000)	277.6	301.1	149.6	142.6
	Hypertension prevalence	35.8%		29.9%	
	Hypertension-related hospitalization rate (per 100,000)	694.8	715.0	439.5	394.0
	Potentially preventable hospitalization rate (per 100,000)	1,552.8	1,472.0	1,070.1	897.4
	Premature cardiovascular disease mortality rate (per 100,000)	63.9	63.9	36.5	36.0
	Major cancer incidence rate (per 100,000)	277.6		262.9	
	Major cancer mortality rate (per 100,000)	100.9		88.9	
	Colorectal cancer screening	58.5%		65.1%	
	Mammography screening	78.4%		77.4%	
	Physical inactivity (leisure time) prevalence	30.4%		21.6%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	17.1	6.7	14.1	7.0
	Infant mortality rate (per 1,000 live births)	10.3	15.0	6.9	6.2
	Percent low birthweight births out of live births	12.1%	15.2%	8.5%	9.2%
	Percent preterm births out of live births	9.5%	10.0%	9.2%	9.6%
Behavioral Health	Adult binge drinking	17.6%		19.6%	
	Adult smoking	24.8%		17.5%	
	Drug overdose mortality rate (per 100,000)	60.6	47.1	30.3	31.2
	Opioid-related hospitalization rate (per 100,000)	316.3	321.3	130.7	125.5
	Substance-related hospitalization rate (per 100,000)	1,248.3	1,142.3	557.7	504.3
	Poor mental health for 14+ days in past 30 days	18.6%		14.0%	
	Suicide mortality rate (per 100,000)	15.1	--	13.5	11.7
Injuries	Fall-related hospitalization rate (per 100,000)	9,642.6	10,612.4	3,869.3	3,988.7
	Gun-related emergency department utilization (per 100,000)	207.8	90.6	29.8	27.6
	Homicide mortality rate (per 100,000)	26.9	42.1	6.0	9.9
Access to Care	Adults 19-64 years with Medicaid	26.8%		13.4%	
	Children <19 years with public insurance	65.6%		33.0%	
	Population without insurance	6.1%		4.7%	
	Children <19 years without insurance	2.7%		2.3%	
	Emergency department utilization (per 100,000)	37,778.9	54,970.0	24,497.8	29,155.4
	High emergency department utilization (per 100,000)	897.0	1,923.6	475.3	795.4
Social & Economic Conditions	Population in poverty	22.5%		9.9%	
	Children <18 years in poverty	32.7%		13.5%	
	Adults 19-64 years unemployed	3.7%		2.5%	
	Householders living alone who are 65+ years	37.9%		37.2%	
	Households receiving SNAP benefits	22.9%		10.1%	
	Households that are housing cost-burdened	29.2%		15.8%	
	Housing with potential lead risk	70.0%		69.8%	
	Vacant housing units	10.8%		6.9%	

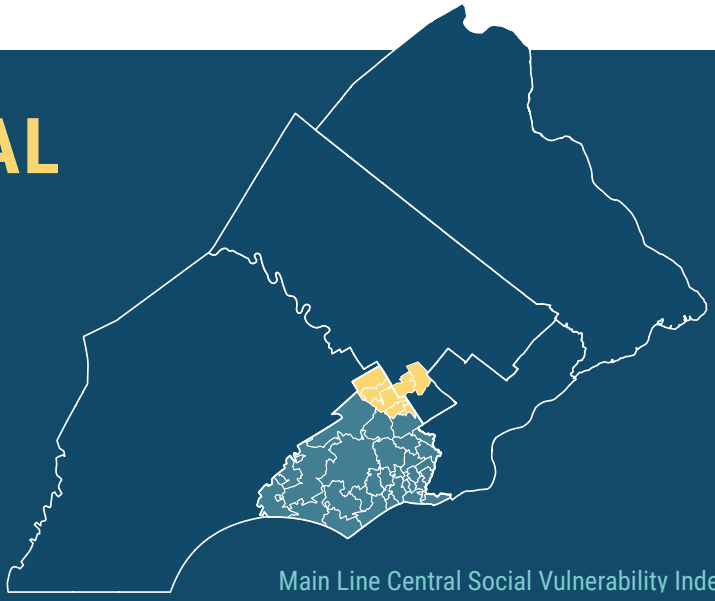
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

MAIN LINE CENTRAL

ZIP CODES: 19003, 19010, 19035, 19041, 19085, 19087

This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Magee Rehabilitation
- Main Line Health



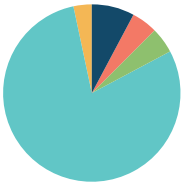
POPULATION

86,489

MEDIAN HOUSEHOLD INCOME

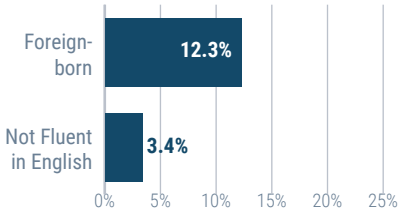
$141,377

RACE/ETHNICITY/LANGUAGE



7.8% | Asian*
4.9% | Black*
4.6% | Hispanic/Latino
79.3% | White*
3.3% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

1. Heart disease
2. Cancer
3. COVID-19
4. Cerebrovascular diseases
5. Chronic lower respiratory diseases

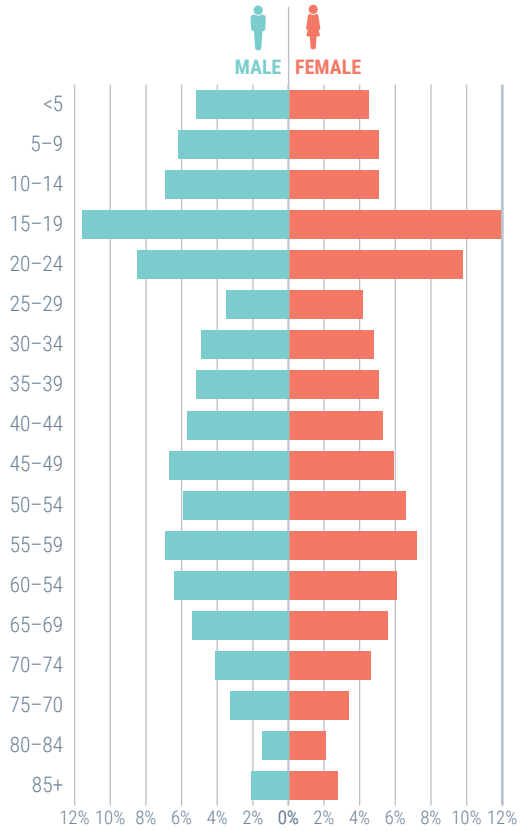
EDUCATIONAL ATTAINMENT

High school as highest education level: 6.4%

PEOPLE WITH DISABILITIES

7.1%

AGE DISTRIBUTION



summary health measures

		Main Line Central		Delaware County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	712.2	838.3	973.2	1,139.5
	Life expectancy: Female (in years)	85.3	84.4	81.3	79.5
	Life expectancy: Male (in years)	82.8	81.0	76.0	73.9
	Years of potential life lost before 75	2,229	2,500	37,712	43,617
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	355.0	N/A	713.4
	COVID-related hospitalization rate (per 100,000)	N/A	260.1	N/A	564.8
Chronic Disease & Health Behaviors	Adult obesity prevalence	23.9%		29.1%	
	Diabetes prevalence	7.4%		10.0%	
	Diabetes-related hospitalization rate (per 100,000)	41.6	76.3	149.6	142.6
	Hypertension prevalence	25.1%		29.9%	
	Hypertension-related hospitalization rate (per 100,000)	257.8	230.1	439.5	394.0
	Potentially preventable hospitalization rate (per 100,000)	633.6	573.5	1,070.1	897.4
	Premature cardiovascular disease mortality rate (per 100,000)	13.9	16.2	36.5	36.0
	Major cancer incidence rate (per 100,000)	218.5		262.9	
	Major cancer mortality rate (per 100,000)	70.5		88.9	
	Colorectal cancer screening	72.2%		65.1%	
	Mammography screening	78.7%		77.4%	
	Physical inactivity (leisure time) prevalence	15.4%		21.6%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	3.9	--	14.1	7.0
	Infant mortality rate (per 1,000 live births)	--	--	6.9	6.2
	Percent low birthweight births out of live births	5.9%	4.7%	8.5%	9.2%
	Percent preterm births out of live births	5.9%	4.7%	9.2%	9.6%
Behavioral Health	Adult binge drinking	19.9%		19.6%	
	Adult smoking	11.0%		17.5%	
	Drug overdose mortality rate (per 100,000)	6.9	12.7	30.3	31.2
	Opioid-related hospitalization rate (per 100,000)	8.1	10.4	130.7	125.5
	Substance-related hospitalization rate (per 100,000)	161.9	122.6	557.7	504.3
	Poor mental health for 14+ days in past 30 days	11.5%		14.0%	
	Suicide mortality rate (per 100,000)	10.4	8.1	13.5	11.7
Injuries	Fall-related hospitalization rate (per 100,000)	8,737.1	8,343.4	3,869.3	3,988.7
	Gun-related emergency department utilization (per 100,000)	--	9.0	29.8	27.6
	Homicide mortality rate (per 100,000)	--	--	6.0	9.9
Access to Care	Adults 19-64 years with Medicaid	4.5%		13.4%	
	Children <19 years with public insurance	12.6%		33.0%	
	Population without insurance	2.2%		4.7%	
	Children <19 years without insurance	1.7%		2.3%	
	Emergency department utilization (per 100,000)	15,965.6	12,449.6	24,497.8	29,155.4
	High emergency department utilization (per 100,000)	144.9	137.7	475.3	795.4
Social & Economic Conditions	Population in poverty	5.2%		9.9%	
	Children <18 years in poverty	3.5%		13.5%	
	Adults 19-64 years unemployed	1.7%		2.5%	
	Householders living alone who are 65+ years	43.8%		37.2%	
	Households receiving SNAP benefits	2.0%		10.1%	
	Households that are housing cost-burdened	10.9%		15.8%	
	Housing with potential lead risk	59.9%		69.8%	
	Vacant housing units	6.2%		6.9%	

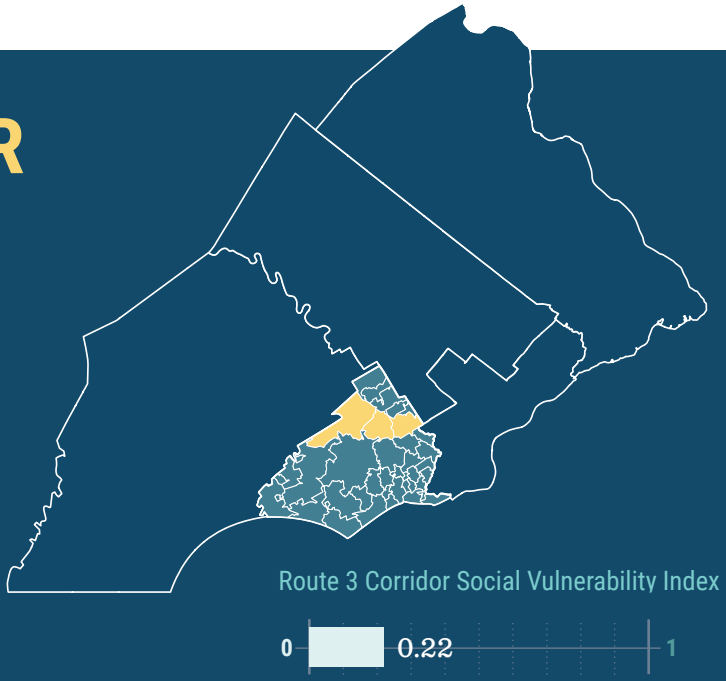
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

ROUTE 3 CORRIDOR

ZIP CODES: 19008, 19073, 19083

This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Magee Rehabilitation
- Main Line Health



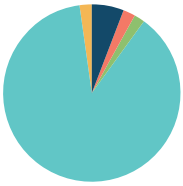
POPULATION

77,330

MEDIAN HOUSEHOLD INCOME

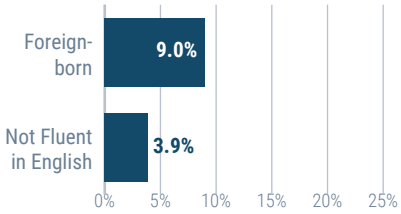
$106,842

RACE/ETHNICITY/LANGUAGE

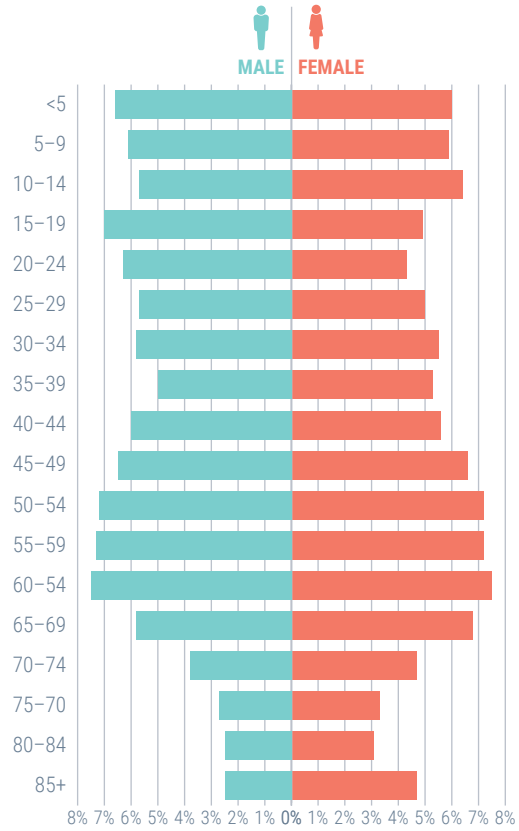


6.0% | Asian*
2.2% | Black*
1.8% | Hispanic/Latino
87.6% | White*
2.2% | Other*

* Non-Hispanic



AGE DISTRIBUTION



LEADING CAUSES OF DEATH

1. Heart disease
2. Cancer
3. COVID-19
4. Cerebrovascular diseases
5. Chronic lower respiratory diseases

EDUCATIONAL ATTAINMENT

High school as highest education level: 17.0%

PEOPLE WITH DISABILITIES

9.6%

summary health measures

		Route 3 Corridor		Delaware County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	963.4	1,184.5	973.2	1,139.5
	Life expectancy: Female (in years)	84.3	82.4	81.3	79.5
	Life expectancy: Male (in years)	81.6	77.9	76.0	73.9
	Years of potential life lost before 75	2,826	3,715	37,712	43,617
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	384.1	N/A	713.4
	COVID-related hospitalization rate (per 100,000)	N/A	386.7	N/A	564.8
Chronic Disease & Health Behaviors	Adult obesity prevalence	25.1%		29.1%	
	Diabetes prevalence	8.8%		10.0%	
	Diabetes-related hospitalization rate (per 100,000)	85.3	63.4	149.6	142.6
	Hypertension prevalence	28.9%		29.9%	
	Hypertension-related hospitalization rate (per 100,000)	380.2	301.3	439.5	394.0
	Potentially preventable hospitalization rate (per 100,000)	916.8	681.5	1,070.1	897.4
	Premature cardiovascular disease mortality rate (per 100,000)	18.1	22.0	36.5	36.0
	Major cancer incidence rate (per 100,000)	297.4		262.9	
	Major cancer mortality rate (per 100,000)	90.5		88.9	
	Colorectal cancer screening	68.7%		65.1%	
	Mammography screening	77.2%		77.4%	
	Physical inactivity (leisure time) prevalence	17.8%		21.6%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	4.6	--	14.1	7.0
	Infant mortality rate (per 1,000 live births)	--	--	6.9	6.2
	Percent low birthweight births out of live births	4.9%	4.4%	8.5%	9.2%
	Percent preterm births out of live births	5.5%	5.1%	9.2%	9.6%
Behavioral Health	Adult binge drinking	19.8%		19.6%	
	Adult smoking	13.7%		17.5%	
	Drug overdose mortality rate (per 100,000)	19.4	20.7	30.3	31.2
	Opioid-related hospitalization rate (per 100,000)	41.4	36.2	130.7	125.5
	Substance-related hospitalization rate (per 100,000)	269.0	239.2	557.7	504.3
	Poor mental health for 14+ days in past 30 days	11.4%		14.0%	
	Suicide mortality rate (per 100,000)	--	14.2	13.5	11.7
Injuries	Fall-related hospitalization rate (per 100,000)	8,569.1	8,624.0	3,869.3	3,988.7
	Gun-related emergency department utilization (per 100,000)	7.4	9.6	29.8	27.6
	Homicide mortality rate (per 100,000)	--	--	6.0	9.9
Access to Care	Adults 19-64 years with Medicaid	6.4%		13.4%	
	Children <19 years with public insurance	14.6%		33.0%	
	Population without insurance	2.4%		4.7%	
	Children <19 years without insurance	1.2%		2.3%	
	Emergency department utilization (per 100,000)	18,491.2	15,361.2	24,497.8	29,155.4
	High emergency department utilization (per 100,000)	201.3	169.7	475.3	795.4
Social & Economic Conditions	Population in poverty	4.0%		9.9%	
	Children <18 years in poverty	4.1%		13.5%	
	Adults 19-64 years unemployed	1.8%		2.5%	
	Householders living alone who are 65+ years	48.4%		37.2%	
	Households receiving SNAP benefits	3.6%		10.1%	
	Households that are housing cost-burdened	11.6%		15.8%	
	Housing with potential lead risk	72.6%		69.8%	
	Vacant housing units	4.3%		6.9%	

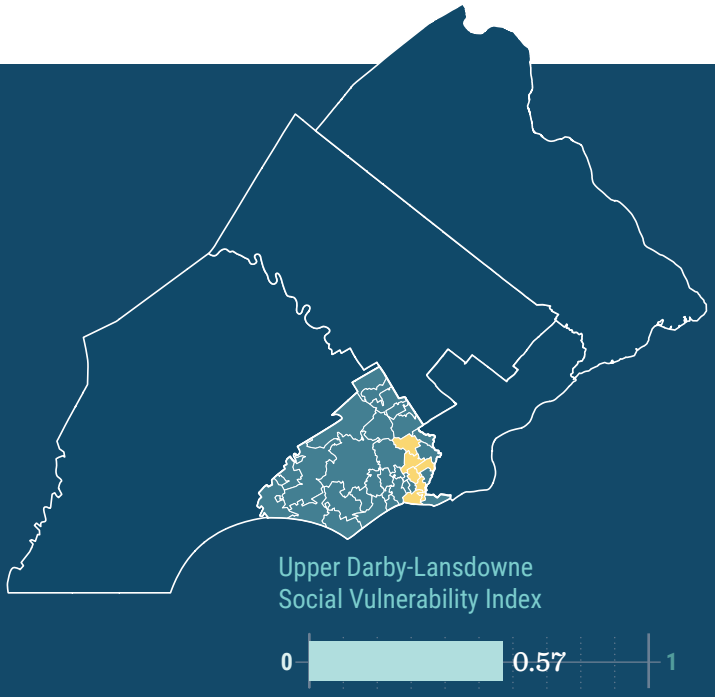
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

UPPER DARBY AND LANSDOWNE

ZIP CODES: 19018, 19023, 19026, 19029, 19032, 19036, 19050, 19079, 19082

This community is served by:

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



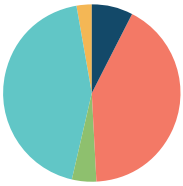
POPULATION

178,580

MEDIAN HOUSEHOLD INCOME

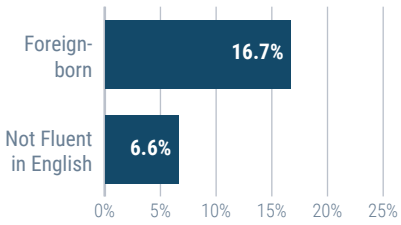
$56,454

RACE/ETHNICITY/LANGUAGE



7.7% | Asian*
41.6% | Black*
4.4% | Hispanic/Latino
43.7% | White*
2.6% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

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

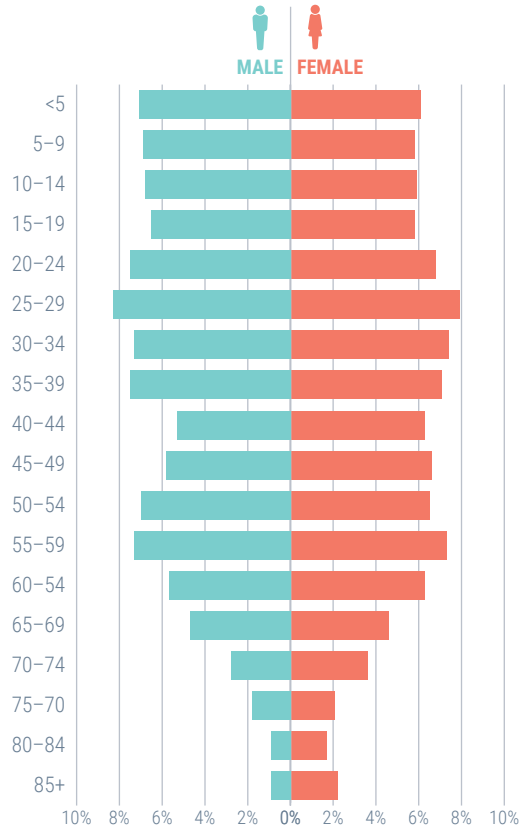
EDUCATIONAL ATTAINMENT

High school as highest education level **29.6%**

PEOPLE WITH DISABILITIES

13.2%

AGE DISTRIBUTION



summary health measures

		Upper Darby-Lansdowne		Delaware County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	846.7	1,011.9	973.2	1,139.5
	Life expectancy: Female (in years)	80.5	78.2	81.3	79.5
	Life expectancy: Male (in years)	73.2	71.2	76.0	73.9
	Years of potential life lost before 75	14,984	16,874	37,712	43,617
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	575.7	N/A	713.4
	COVID-related hospitalization rate (per 100,000)	N/A	705.6	N/A	564.8
Chronic Disease & Health Behaviors	Adult obesity prevalence	32.1%		29.1%	
	Diabetes prevalence	11.1%		10.0%	
	Diabetes-related hospitalization rate (per 100,000)	207.2	193.8	149.6	142.6
	Hypertension prevalence	31.3%		29.9%	
	Hypertension-related hospitalization rate (per 100,000)	514.1	427.3	439.5	394.0
	Potentially preventable hospitalization rate (per 100,000)	1,249.9	1,011.3	1,070.1	897.4
	Premature cardiovascular disease mortality rate (per 100,000)	48.7	46.5	36.5	36.0
	Major cancer incidence rate (per 100,000)	222.9		262.9	
	Major cancer mortality rate (per 100,000)	85.1		88.9	
	Colorectal cancer screening	61.8%		65.1%	
	Mammography screening	77.6%		77.4%	
	Physical inactivity (leisure time) prevalence	24.6%		21.6%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	20.7	9.8	14.1	7.0
	Infant mortality rate (per 1,000 live births)	9.1	6.9	6.9	6.2
	Percent low birthweight births out of live births	10.3%	10.7%	8.5%	9.2%
	Percent preterm births out of live births	8.6%	9.2%	9.2%	9.6%
Behavioral Health	Adult binge drinking	18.9%		19.6%	
	Adult smoking	20.5%		17.5%	
	Drug overdose mortality rate (per 100,000)	33.0	39.8	30.3	31.2
	Opioid-related hospitalization rate (per 100,000)	149.0	140.6	130.7	125.5
	Substance-related hospitalization rate (per 100,000)	684.3	586.3	557.7	504.3
	Poor mental health for 14+ days in past 30 days	15.6%		14.0%	
	Suicide mortality rate (per 100,000)	15.7	14.0	13.5	11.7
Injuries	Fall-related hospitalization rate (per 100,000)	10,622.5	10,919.5	3,869.3	3,988.7
	Gun-related emergency department utilization (per 100,000)	18.2	20.5	29.8	27.6
	Homicide mortality rate (per 100,000)	6.7	11.8	6.0	9.9
Access to Care	Adults 19-64 years with Medicaid	18.9%		13.4%	
	Children <19 years with public insurance	50.7%		33.0%	
	Population without insurance	7.9%		4.7%	
	Children <19 years without insurance	3.4%		2.3%	
	Emergency department utilization (per 100,000)	35,532.1	39,400.2	24,497.8	29,155.4
	High emergency department utilization (per 100,000)	770.3	1,151.3	475.3	795.4
Social & Economic Conditions	Population in poverty	14.2%		9.9%	
	Children <18 years in poverty	19.9%		13.5%	
	Adults 19-64 years unemployed	2.9%		2.5%	
	Householders living alone who are 65+ years	27.5%		37.2%	
	Households receiving SNAP benefits	16.8%		10.1%	
	Households that are housing cost-burdened	18.4%		15.8%	
	Housing with potential lead risk	82.8%		69.8%	
	Vacant housing units	9.5%		6.9%	

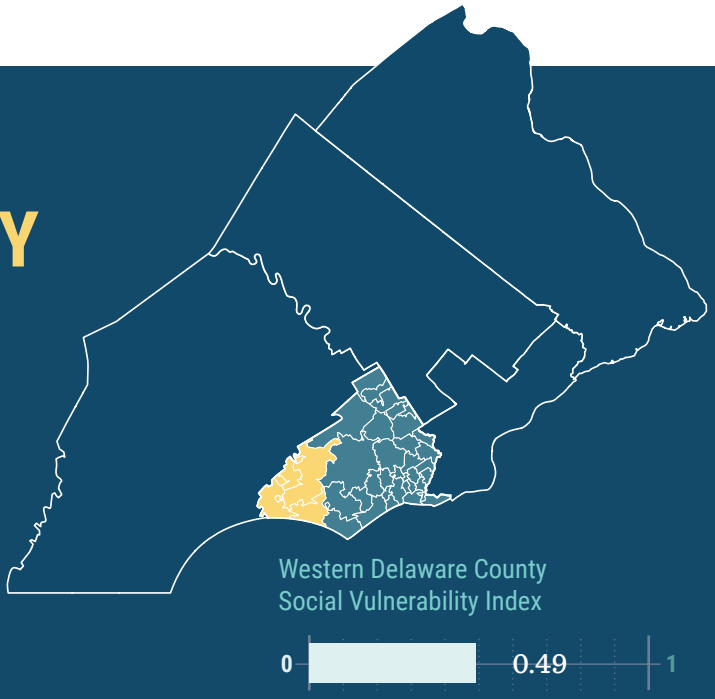
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

WESTERN DELAWARE COUNTY

ZIP CODES: 19060, 19317, 19319, 19342, 19373

This community is served by:

- Bryn Mawr Rehab Hospital
- Chester County Hospital
- Children's Hospital of Philadelphia
- Magee Rehabilitation
- Main Line Health



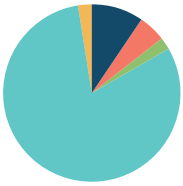
POPULATION

45,608

MEDIAN HOUSEHOLD INCOME

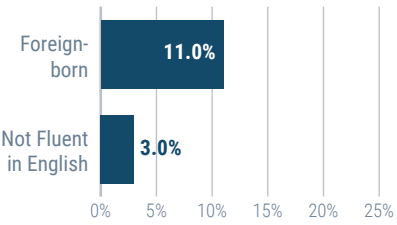
$161,983

RACE/ETHNICITY/LANGUAGE



9.5% | Asian*
5.0% | Black*
2.4% | Hispanic/Latino
80.7% | White*
2.3% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

1. Cancer
2. Heart disease
3. COVID-19
4. Cerebrovascular diseases
5. Chronic lower respiratory diseases

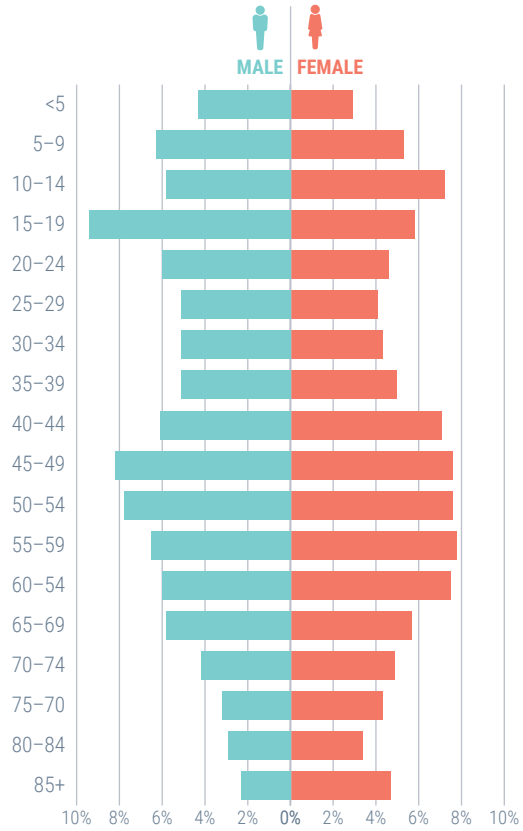
EDUCATIONAL ATTAINMENT

High school as highest education level **15.5%**

PEOPLE WITH DISABILITIES

8.8%

AGE DISTRIBUTION



summary health measures

		Western Delaware County		Delaware County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	916.5	1,133.6	973.2	1,139.5
	Life expectancy: Female (in years)	86.7	83.4	81.3	79.5
	Life expectancy: Male (in years)	81.6	78.9	76.0	73.9
	Years of potential life lost before 75	1,194	1,907	37,712	43,617
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	157.9	N/A	713.4
	COVID-related hospitalization rate (per 100,000)	N/A	339.9	N/A	564.8
Chronic Disease & Health Behaviors	Adult obesity prevalence	25.4%		29.1%	
	Diabetes prevalence	8.5%		10.0%	
	Diabetes-related hospitalization rate (per 100,000)	39.5	35.1	149.6	142.6
	Hypertension prevalence	28.1%		29.9%	
	Hypertension-related hospitalization rate (per 100,000)	265.3	239.0	439.5	394.0
	Potentially preventable hospitalization rate (per 100,000)	690.7	530.6	1,070.1	897.4
	Premature cardiovascular disease mortality rate (per 100,000)	13.2	19.7	36.5	36.0
	Major cancer incidence rate (per 100,000)	212.7		262.9	
	Major cancer mortality rate (per 100,000)	100.9		88.9	
	Colorectal cancer screening	69.1%		65.1%	
	Mammography screening	77.4%		77.4%	
	Physical inactivity (leisure time) prevalence	17.3%		21.6%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	--	--	14.1	7.0
	Infant mortality rate (per 1,000 live births)	--	--	6.9	6.2
	Percent low birthweight births out of live births	8.0%	6.7%	8.5%	9.2%
	Percent preterm births out of live births	3.8%	6.0%	9.2%	9.6%
Behavioral Health	Adult binge drinking	20.0%		19.6%	
	Adult smoking	13.5%		17.5%	
	Drug overdose mortality rate (per 100,000)	--	21.9	30.3	31.2
	Opioid-related hospitalization rate (per 100,000)	48.2	46.0	130.7	125.5
	Substance-related hospitalization rate (per 100,000)	254.3	208.3	557.7	504.3
	Poor mental health for 14+ days in past 30 days	11.3%		14.0%	
	Suicide mortality rate (per 100,000)	--	--	13.5	11.7
Injuries	Fall-related hospitalization rate (per 100,000)	6,816.7	6,900.9	3,869.3	3,988.7
	Gun-related emergency department utilization (per 100,000)	--	8.0	29.8	27.6
	Homicide mortality rate (per 100,000)	--	--	6.0	9.9
Access to Care	Adults 19-64 years with Medicaid	4.8%		13.4%	
	Children <19 years with public insurance	10.3%		33.0%	
	Population without insurance	2.0%		4.7%	
	Children <19 years without insurance	0.7%		2.3%	
	Emergency department utilization (per 100,000)	12,343.8	10,089.0	24,497.8	29,155.4
	High emergency department utilization (per 100,000)	214.7	131.0	475.3	795.4
Social & Economic Conditions	Population in poverty	2.9%		9.9%	
	Children <18 years in poverty	1.6%		13.5%	
	Adults 19-64 years unemployed	1.7%		2.5%	
	Householders living alone who are 65+ years	42.1%		37.2%	
	Households receiving SNAP benefits	2.4%		10.1%	
	Households that are housing cost-burdened	4.0%		15.8%	
	Housing with potential lead risk	23.4%		69.8%	
	Vacant housing units	1.7%		6.9%	

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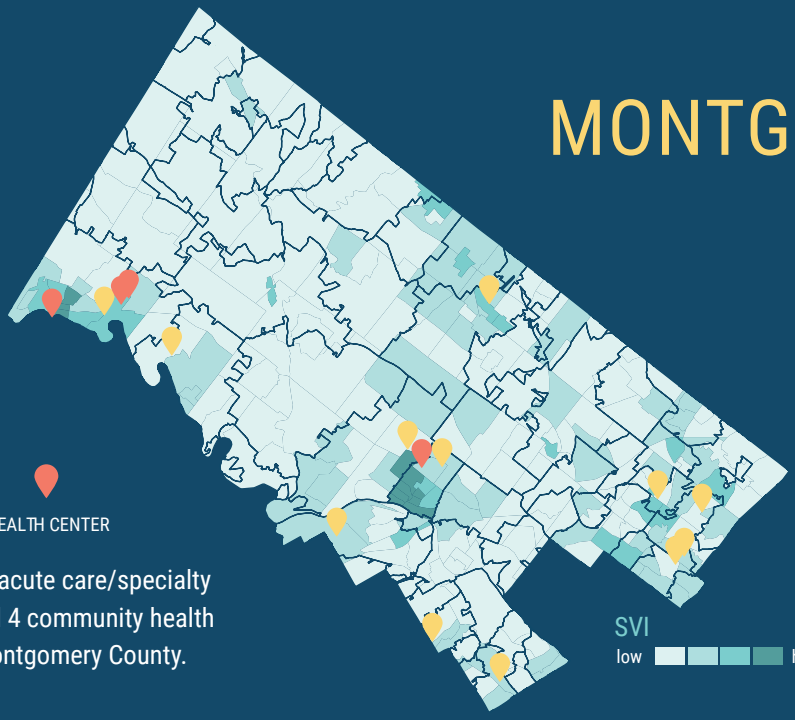
-- Estimates are unavailable or unreliable due to low sample size within a community.

MONTGOMERY COUNTY



There are 12 acute care/specialty hospitals and 4 community health centers in Montgomery County.

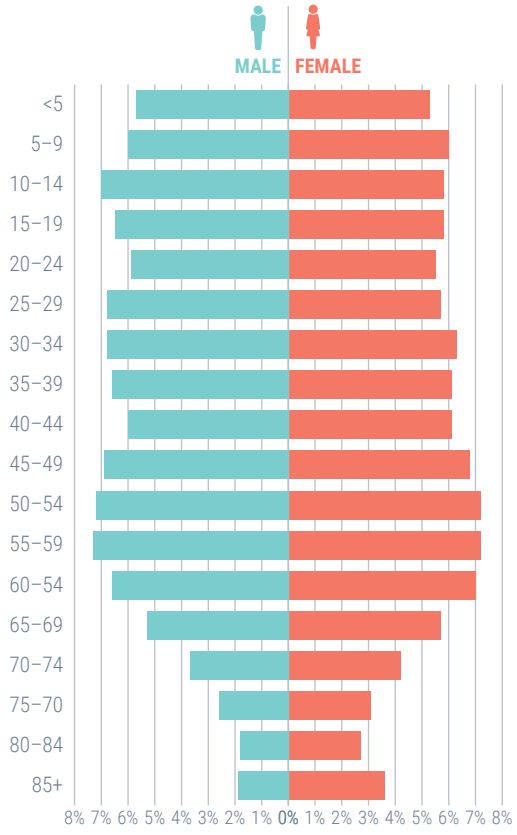
Social Vulnerability Index (SVI)

0 — 0.15 — 1

Median Income	$99,037
High school as highest education	19.6%
Food Insecurity	6.9%
With a Disability	10.0%
Violent Crime Rate	89.8 per 100,000

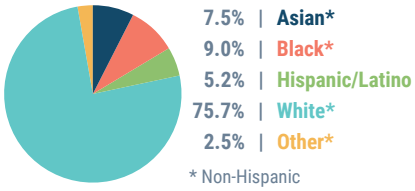
AGE DISTRIBUTION

Montgomery County has an estimated population of 799,143, with the largest proportion of residents between the ages of 45 and 59.

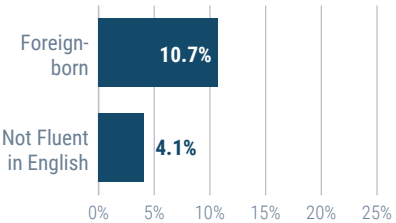


RACE/ETHNICITY/LANGUAGE

75.7% of residents are non-Hispanic White. Non-Hispanic Black residents make the next largest population, comprising 9% of the county's residents.



Nearly 11% of residents are foreign-born and about 4% speak English less than "very well."



COVID-19 | Rates per 100,000

Fully Vaccinated	56,857.4
COVID-related:	
• Emergency Department Use	853.5
• Hospitalization	394.6
• Mortality	144.2

MORTALITY

Leading Causes of Death

1. Heart disease
2. Cancer
3. COVID-19
4. Cerebrovascular diseases
5. Chronic lower respiratory diseases

YOUTH BEHAVIOR

Attempted Suicide	9.0%
Feeling Depressed/ Sad/Hopeless	37.8%
Binge Drinking	11.9%
Cigarette Smoking	2.6%
Vaping	25.2%

COMMUNITY PERSPECTIVES

This summarizes focus group-style community conversations conducted with residents of five geographic communities: one each in Main Line Central, North Penn/Lansdale, Norristown, Pottstown, and Willow Grove.**

Community Assets

Throughout Montgomery County, residents spoke highly of **local organizations serving the community**, providing a wide range of services for youth, older adults, immigrant communities, and others. Important organizations include **faith-based institutions, public schools, and emergency food providers**. Among the many groups mentioned:

- *"I think the senior centers are a wonderful source of information. … Through PALM [Center for Positive Aging in Ardmore], I was turned on to a diabetes prevention class that's offered by Montgomery County Aging and Adult Services, and I signed up for that."*
- *"I was thinking about the positives that we have in our faith community. Not only is there a church or synagogue or a mosque on every corner, they're really invested in the community."*

A Latina participant who attends Spanish mass at her church in Pottstown shared:

- *"When somebody is going through a rough time, I see people genuinely caring about the people that attend there. … It makes me feel like it's my happy place."*

A participant commented on social services and health and wellness programs for Latinos and other community members:

- *"The community has organizations like ACLAMO that provide good information for the people."*

A participant mentioned the Asian American Coalition for COVID-19, which includes members from Chinese, Vietnamese, Indian, Filipino, and other Asian American heritages.

In most groups, participants commented on the **strong sense of community** where they live.

- *"You have people in the community check up on you or checking in or making a phone call or dropping something off. They're very supportive here, which is the beauty of this town."*
- *"Abington's a pretty close-knit community. There's a lot of support groups within Abington, and there's a lot of services available. Our library is very good at posting information for residents to see what they have available. Our township website, our Abington township, they host a lot of classes."*

In Pottstown borough, community events and resources such as a local farmers market help to reinforce social connections and promote health.

- *"There's a lot of things that the town has to offer that focus around your well-being overall."*

In a majority of groups, participants mentioned the **value of local parks and other aspects of the built environment, such as playgrounds, walking trails, and YMCAs**.

- *"As a lifelong resident, Haverford College and their nature trail have been valuable for me. … Just a place to be able to … lift your spirits by experiencing the different seasons, walking through the woods, I love that."*
- *"Pottstown is very outdoors friendly … there's a lot of things to do, like the [Schuylkill River] trail, that's something that a lot of my friends do….It's a good opportunity to kind of stay healthy, like exercise or whatever, take walks with your children and stuff with your dogs."*
- *"In Lansdale [we have] a bunch of parks and public spaces, and it definitely helps me and my family stay healthy, and … that's what we [are] using mostly daily for … fun, just breathe fresh air and walk around and relax, and look at greens and trees."*

* There are several ZIP codes that span Delaware and Montgomery Counties. The Main Line Central group included participants from both counties. Therefore information from this discussion is included in both Delaware County and Montgomery County geographic community meeting summaries.

Key Challenges

Across Montgomery County, in every group, **multiple participants discussed a range of worsening behavioral health issues during the pandemic--from depression and anxiety to substance use disorders--as their top concern**. Amid this growing need for care, behavioral health clinics are increasingly short-staffed, leading to long wait times for treatment, especially for children.

- *"There's a lack of availability for mental services 100%, here in Pottstown. I've had a really rough time finding mental health services for children especially,"* noted a participant from a social services agency.
- *"So, we have all these people calling [our] 24-hour crisis hotline who need services, and can't get them, because either they don't have coverage [or] the provider doesn't take the insurance. The call volume has far exceeded anything we've ever experienced ever, to the point where we can't even accept any new cases for children at all,"* shared a participant from a social services agency.

Substance use issues are rising among youth and adults, multiple participants said.

- *"We have seen an uptick in substance use, like we've never seen, with the kids being home and isolated and with them having access to the internet where they could buy drugs online. There's been deaths in the community from kids that have been buying drugs that they thought were Percocet or Valium, but they're being made in somebody's basement and they have fentanyl. So, it's an epidemic inside a pandemic, to say the least."*
- *"It's across the board, and also pandemic-related, with alcohol, and with ... a lot of substances ... I don't see a lot of resources."*
- *"I would definitely say substance abuse is a big challenge,"* said a participant whose nonprofit organization provides behavioral health services, including care for people experiencing homelessness. *"Unfortunately, substance abuse is a big contributor to that [homelessness], and goes along with mental health."*

Stigma remains a common barrier to seeking mental health treatment, noted participants in two groups. *"They're afraid to come forward because they feel that they're already judged, or they already feel useless, they're not loved,"* shared one participant, who noted people need to be educated that mental health challenges are health problems, not a sign of personal failure.

Within Asian-American communities,

- *"there's such a big stigma around mental health counseling, that a lot of times, the Asian American community members will ignore it, or say it's something that 'I have to deal with,' or even if it's dealing with their kids, the parents may reject that idea, and not get the support that they may need."*

Social isolation during the pandemic has worsened mental health for many, as has grieving and bereavement due to lives lost to the pandemic. Some people who recovered have long-term complications and are unable to work, causing families to lose crucial income.

- *"We lost a lot of our clients, and the parents of our kids,"* said a participant who works at a social services organization. *"From March to May last year, we lost 15 parents, that so many of them got sick and they were in the hospital for three, four, five, six weeks. … it's just been very challenging."*
- *"One thing that's been really difficult is that they haven't really had an opportunity to grieve,"* said another participant, who noted that traditional funerals and bereavement support services have been curtailed or hard to access during the pandemic.

Heart disease, diabetes, asthma, and obesity are prevalent throughout the county, noted participants in four of the five groups. *"Diabetes is something that is huge. … that is something that it's really present in the community,"* said a participant who works with Hispanic/Latino communities. Another commented on the high prevalence of hypertension, which many do not take seriously:

- *"There's so many things that high blood pressure contributes to, and people take [it] for granted."*

As is the case for accessing behavioral health services, participants discussed **long delays in scheduling primary or specialty care visits, due to fear of going out during the pandemic and staffing shortages in many health care facilities**. A participant who works for a health care center spoke about the staffing shortage in her center:

- *"Recently, that has been a big issue for everyone, not having enough staff members to attend to the needs of everybody. And even the staff that you already have, and I say this openly, because it's something that everybody knows is going on,…we are understaffed. So what happens is that each staff member ends up taking up more roles and more responsibilities, and that is a burden. As an employee, as a provider for services, you want to be able to put your full attention and be there 100% for the client that you're assisting."*

Several participants also expressed **concern about the well-being of health care providers during the pandemic, as well as health system capacity to meet demand for services**.

- *"We are losing so many providers because of COVID. How are all the people in the area going to receive medical care? If you have to wait two or three months to get a doctor's appointment, what's that doing to your health?"*
- *"Clearly, the hospitals lack capacity to deal with things that are non-COVID, right? I think the ICUs are pretty much packed if not near packed with COVID. … I do wonder what is being done to care for the mental health of medical providers on the other side of COVID as well, because they're just dealing with it day in and day out."*

Access to affordable primary care has been further reduced by some physicians shifting into concierge practices, said participants in two groups. A participant shared:

- *"I just got a letter from my doctor saying that they're becoming concierge practice, so basically, they're opting to have less patients, and [now] I have to pay to be a member to access my primary care physician for $1,800 a year, on top of my regular insurance."*

She added: "*That's not going to impact me as much as somebody who is on Medicaid*" and others who cannot afford concierge services and would need to find another doctor.

High health care costs, such as co-pays and medication expenses, were mentioned as barriers to care in most groups.

- *"I'm a middle-class person with a decent job, and [health insurance] coverage, and you know what, I haven't been to a doctor since January 2019. Why? … I have resources, but I don't go, because I'm not going to make my deductible, everything's out of pocket."*
- *"It's also the fear of going to the doctors, and them telling you: 'You need a medication,' and then you can't afford it. So prescription costs as well."*

Just the fear of incurring medical expenses prevents some from seeking care. A participant who works for a local social services organization commented that her clients *"have told us 'well, you go to the hospital and they charge you whatever they want, they never have prices they will tell you, this is how much it's gonna cost you.' If they go to an appointment, they never know, people charge you whatever they want.' I don't understand why everywhere [else] prices are posted, except in medicine."* She added:

- *"That's one of the reasons why we had a lot of Latinos get very, very sick with COVID or die from COVID, because they were avoiding … going to the hospital."*

Another pandemic-related issue, mentioned by one participant, was **confusion and distress over COVID-related hospital bills**:

- *"A lot of people are getting stuck with bills that are related to COVID hospitalizations."*

The problem was attributed to patients' lack of awareness about emergency medical assistance and health system delays in processing assistance applications.

In every group, participants stressed **the need for better language services in healthcare settings, along with more culturally competent care for the region's diverse immigrant population**.

- *"More language services, because we know language access is also a big issue."*
- *"Speaking from the Asian American community, there's not enough bilingual and bicultural or even multicultural providers. We have mental health counseling services, but the demand is high, it's always been high for mental health counselors [but there are] not enough, [and] when you look for people who can speak different language, and have a cultural understanding, very, very few around."*
- *"This is not just in mental health service, I feel like it's the issue all across with physical therapists, OT, speech therapist, even nurses and doctors, there's shortage of people who speak multiple languages and understand the cultural background that affects people's mental and physical health. Language Line is not always a good solution. But sometimes, even the interpreting services that are put in place are not so easy to utilize from the community with language barrier, especially the seniors."*
- *"I think there are two therapists right in Norristown who speak Spanish and that's it--no more, that's it, and you have a waiting list like forever, so it's terrible."*
- *"Language barriers can be a significant challenge. … Whether that's the police department or the hospital, there's always some form of an element of a language barrier, for a variety of reasons I would say, can mean that maybe people are understaffed, or they don't have bilingual bicultural staff, [or] maybe not enough resources to pay for … a certified interpreter. I think it goes beyond Spanish speakers as well, I've encountered those who speak Chinese Mandarin, those who are Korean-speaking, and so I think language overall can be a challenge,"* said a participant who works for a victim services agency.

From a patient's perspective, access to high-quality language interpretation services is important for *"empowering people to actually be part of what's happening to their lives and their treatment and their needs."*

Participants throughout Montgomery County generally agreed that the **shift toward telehealth during the pandemic has had benefits and challenges**. On the plus side, the increase in telehealth visits has provided greater patient convenience and **enabled some providers to meet the demand for their services during the pandemic**. *"We have had a decrease in no-shows and cancellations of appointments, due to the use of telehealth. Small silver lining,"* said a participant whose organization provides health and social services. On the other hand, the shift to virtual services during the pandemic has created **new barriers for many older adults, people with limited English proficiency, and those who need or prefer in-person visits**.

Social Determinants of Health

Participants across Montgomery County discussed a number of social determinants that create barriers to health for some:

Transportation. In every group, participants commented on the lack of adequate and affordable transportation options to access health care and other essential services, especially for homebound older adults and others who do not drive or cannot easily use public transit.

- *"Lack of transportation makes it very difficult for them [seniors] to get food, or get to doctor's appointments."*
- Lack of transportation also *"contributes to social isolation -- if you're afraid to walk out your door, or you can't get anywhere."*
- *"Transportation is a big barrier for seniors. I know that you can get a bus pass; I think it's over 65 you ride the bus for free, which is great. Not everybody can get to the bus."*

With regard to the paratransit system:

- *"We also see people waiting for very long time, some days to be picked up. So, I do think transportation is an issue there. Even if there's a million programs to help, it's not helpful if they can't get there, so I do think that transportation is a real challenge."*

An older adult participant commented:

- *"The regional line that goes through Philadelphia-- good luck climbing up the stairs on that thing, you know? And even though we ride for free on SEPTA, it's – transportation is hard."*

Healthy food access. Lack of convenient access to affordable nutritious food, along with the need for nutrition education, was mentioned in most groups.

- *"Norristown is a what we call … a food desert; it's recognized as a food desert. [In local bodegas, the food] "is not really appealing to anyone. They normally have like [bananas with] black spots like they're not fresh, so people tend to eat bread and soda because it's less expensive too."*

Lack of knowledge about healthy food choices is another factor, the participant added:

- *"People don't always either … know how to use [healthy food], , they have no idea how to do it, so I think it's challenging."*

Another challenge for some, especially those without cars, is the ability to carry food home:

- *"I think that that's challenging when you can only go to one place [e.g., a pantry] to get one food, and you can only take two bags, because you cannot carry more."*

- *"There should be more places that have, you know, fresh produce at reasonable prices."*
- *"They have a farmer's market in Bryn Mawr, but the prices are pretty darn high."*
- *"One of the concerns for me is school food, which I... think it's super unhealthy."*

Chronic disease management may be difficult for people experiencing food insecurity who are also contending with diabetes or other diet-related conditions and rely on the emergency food system. A participant who works for a food pantry mentioned:

- *"I have more families asking for lower sugar items, which are difficult, because we don't normally get that stuff donated."*

Built environment. While participants in four groups view their local parks and green space as assets, Norristown was a notable exception, with participants expressing safety concerns about using outdoor recreation spaces.

- *"My concern in Norristown, many times, is that we don't have enough safe green spaces for people to exercise right or to go out ... We have trails, right, ... but this is the problem, the trails are [not marked], there're [no] spaces where people can park ...they are not safe...there are no lights, there are no signs, it's scary."*

Participants in several focus groups also commented that their **communities lack sufficient walkability, bike lanes, and public transit routes**.

- *"There's a bus stop right outside my house, [but] it'll only take me to Philadelphia, which is not the only – not nearly the only place I want to go,"* noted a participant who does not drive.
- *"In Lower Pottsgrove, there are few, if any, sidewalks. So, it makes some of the walking very difficult. You really have to drive someplace or take a bus someplace in order to utilize the outdoor space."*
- *"I used to ride my bike up Ardmore Avenue when I was younger, and last week, I tried to do the same thing, I almost got killed, you know? There's no bike lanes or anything."*

Cost of living, including housing. In most groups, participants commented on the high cost of living in many areas of Montgomery County, making it difficult for older adults and others with limited incomes to afford health care, housing, food, and other essential needs. Recent consumer price inflation also was noted.

- *"I definitely feel like I'm being priced out of my own home. The older neighbors are all passing on, and those of us who are left are really under the gun to try and keep our properties up to standard with a limited income."*
- *"Health insurance is a big thing too for them [older adults]. It's too expensive for them. Most of them are on fixed incomes."*
- *"The medication issue is a nightmare, how much people are asked to pay towards their medication ... it's an outrageous amount of money. And people are deciding [whether] to use less medication, or no medication, or less food or less heat."*
- *"I see a lot of people that live alone, and then they have to decide where their money goes, if it goes towards groceries, or if it goes towards medical bills, and so that's something that I don't think should happen, but that's the U.S. right, like, that's the way that the health insurance is set up for seniors."*
- *"The price of gas, the price of food, the price of everything has increased so much that it has put a strain on families, and it definitely has impacted the aging population."*

Violence. A recent increase in community violence was discussed in the Norristown group:

- *"In Norristown, we all kind of know that there's been a very big increase in violence, and especially gun violence, and so how are we going to address that? We can't just keep saying, 'oh, well that's a city thing.' It's moving into our areas, it's in Norristown, it's in Pottstown, all of these things are impacting it."*

Another added: *"We can build as many green spaces as we want, but...if those spaces aren't properly maintained, if they're not safe, and it's not a safe community to go out into, then that doesn't make a difference as to how we're helping the community."*

Children and Youth

In every group, the pandemic's impact on mental health among young people was a major concern, along with limited and delayed access to care.

- *"The wait right now for mental health treatment for children is three to five months or longer for us to be able to get them connected to somebody who is trained, who can actually work with them on a fee that is affordable for the families."*
- *"Having families that can't get the proper services that they need for their children is very distressing and puts a lot of responsibility on us as a community as to how we're going to help these children and these families, especially with the mental health needs increasing since COVID had started."*
- *"Montgomery County has a lot of good resources, and yet, right now, the accessibility to these resources is very, very limited, especially within the behavioral health system."*
- *"My daughter is in fifth grade, but some of her friends have talked about suicide. I mean, you're talking 11-years-old. Coming from the pandemic, from that social isolation, and also from parents trying to balance work, life, school, the pressure society puts on us is just – it's tough, and it's tough being a parent to manage."*

Several participants also raised concern about the **high rate of substance use among children and youth**, which they said has increased during the pandemic:

- *"We've had kids as young as 11, 12 on cocaine. I think it's a contribution of the high pressure of mental health, the need to numb themselves and escape. And I think alcohol is somewhat normalized to a point where it's like, is it normal or is it alcoholism, right?"*

Accessing mental health care for children and youth is especially difficult for families with limited English proficiency.

- *"A lot of times it requires us to do a lot of searching and like looking into things and calling different agencies, trying to figure out what services they provide, but when it comes to children and mental health issues, ... they never have availability for new patients. ... And when the family doesn't speak English, or doesn't have an interpreter, then they choose to move the child to a waitlist."*

Lack of physical activity and healthy eating, and the associated increased risk of childhood obesity, were raised as concerns in all groups:

- *"The lack of time they get to run around during the day, the recess. They're sitting, like so much, and their backpacks are like 35 pounds, and then they just sit all day. ... I always wish there was more movement, I guess that's my theme, movement."*

With virtual schooling, youth miss out on extracurricular activities, which compounds their social isolation and physical inactivity:

- *"That's what I see as one of the struggles for keeping the kids moving. I don't think it helped that they [students] were completely virtual all last year, and many are having a very hard time adjusting to get back into school, and a lot of students have opted to stay virtual."*
- *"I think a very big health issue in our community and nationwide is obesity, and the lack of education as far as healthy eating goes. I think maybe the lack of the ability to get healthy food, it's very, very cheap to eat unhealthy, but if you want to eat the healthy things, it's twice as much money to buy those things."*

Other barriers to physical activity for youth, discussed in one or more groups, include expensive fees to participate in local youth sports leagues, too few options for extracurricular activities outside of competitive sports, and lack of playgrounds and other recreational resources that are adapted for children with special needs. A participant also expressed concern about competitive pressures for youth to excel at one sport rather than learn to play many. *"They want you to be the best of the best,"* said the participant, adding that over-competitiveness in sports, plus pressure for youth to succeed in school can *"stress these kids out, and they don't think of their mental health behind it."*

Several participants noted the need for families to spend more time together – and away from their electronic devices. Concerns also were raised about children accessing adult websites, apps, and social media that are inappropriate or dangerous for them.

"Parents are not necessarily being educated [and] up to date on all these technological changes that are exposing their children to danger," said one participant, who cited an app that allows children to talk to random strangers. *"Kids are exposed to a lot that I think .., we could avoid with more education."*

Older Adults

In every group, multiple participants cited social isolation, which has greatly increased during the pandemic, as a major concern for the mental and physical well-being of older adults.

- *"For seniors, it's definitely a mental health issue that they're so isolated, and they are afraid to reach out sometimes. They used to come into our centers and connect with people and be active and do healthy things, and they just were cut off [by the pandemic],"* said a participant who works at a senior center.
- In Asian-American communities, fear of discrimination has further increased isolation. *"With anti-Asian sentiments ... and fear of COVID, seniors are limiting going out of their homes, they're staying home, which limits their movement, so physically, it's not good for them. Also, because they're staying isolated, it's not good for their mental health, either."*
- A participant who works at a senior center described seeing an elderly man she knows, who visited after a long absence: *"When I saw him, he looked so old, and he looked isolated. He looked unkempt and disheveled. So, the isolation aspect is, I think, first and foremost ...What COVID did do is expose the need for social interaction--that it is important to be able to speak and touch and have those relationships."*

Participants in all groups noted that social isolation has been worsened by lack of affordable transportation options, making it difficult for homebound adults to access essential services, such as groceries and health care.

- *"A lot of them are remaining independent for a long time, and either their families take away their cars, or they decide "I'm not comfortable driving anymore," and I don't think there's a lot of good, affordable transportation in this area. So, I see that just getting to doctor's appointments a lot of times and getting out and so forth."*
- *"The building I live in [has] a lot of seniors...they don't have transportation, and they don't have knowledge about what's going on in the community, or how the world is changing and becoming more computerized."*
- *"I have a population of older adults who walk here to get food. You know, and then you have to keep in mind that they have to figure out a way to get to doctor's appointments, and then they have to prioritize if I'm going to ask somebody for a ride, what's the most important thing, a doctor, or a food?"*

The shift to virtual services during the pandemic has further isolated some older adults:

- *"Technology is a huge barrier for seniors, as a whole world moving into virtual world, we need to make sure that we don't leave them behind. For low-income seniors, that technology can be an issue…especially if during COVID they couldn't get to libraries or senior centers."*
- *"I live in a community where we have a number of old folks who just don't access the internet, and they live in isolation."*

With fixed or limited incomes, many older adults also face challenges in affording health care and other essential services. Difficulty navigating the health care system, especially Medicare policies, also was mentioned several times.

- *"For seniors who are on Medicare or whatever, the cost of co-pays prevents a lot of people from seeing different specialists and people that they need to see. … If you're not connected with the right health plan or supplemental plan, the co-pays can be prohibitive."*
- *"I see a lot of seniors working part time at like Giant and Walmart and like different places that do minimum wage because they need the money…Because they won't qualify for Medicaid, because their Social Security income is too high already, and so they have to compensate by working. And when you're 75-80 years old, the last thing you want to do is be working at Walmart to make ends meet."*
- *"I was a social worker for years and years and years, and [choosing] the appropriate Medicare plan is very, very difficult. It's not just you look at a chart and say, oh, this one fits me. It doesn't work that way at all."*

More resources are needed to help older adults age in place, especially amid rising costs for housing and the need for convenient, affordable transportation, participants generally agreed.

- *"It's a big deal to be able to have … the resources in the community so that people can stay in their homes … I mean, I think that's crucial."*

Other Groups

Participants in all groups highlighted the **needs of immigrant communities living in the county, especially those who lack English proficiency**. With a growing number of Asian, Hispanic/Latino immigrants and refugees, participants cited the need for greater affordability and availability of health care that is culturally and linguistically competent, especially for mental health services.

The need for more community resources for LGBTQ+ individuals was also noted in one group.

Suggested Actions

Convene a coalition to increase communication and coordination among community groups to address common challenges.	A participant spoke to the need to "*get everyone in the same room so that those client needs can get addressed in like a more holistic sort of way.*" Another suggested reconvening the Tri County Network, which had previously met periodically to improve coordination among agencies. Creating a centralized clearinghouse with easily accessible information about a wide range of health and social service resources in the area was also recommended.
Strengthen partnerships between hospitals and community service providers.	Participants suggested increasing collaboration between senior living facilities and hospital discharge staff to better coordinate care when older adults are discharged from a hospital stay. Another noted the need for hospitals to better publicize their community health services, such as free seminars, screenings, and health fairs. Because many people lack digital access, hospitals need to include non-virtual communications to raise awareness of their services, another participant suggested. Smaller community organizations also could benefit from partnerships with hospitals that provide training, funding, or other support.
Expand access to primary care services	A participant advocated for passage of statewide legislation that would allow nurse practitioners to establish independent practices to provide primary care. Another suggested creating a visiting nurse program or a once-monthly clinic in an easily accessible community location to provide basic care for older adults. A community health clinic that offers a wider range of primary care services than an urgent care center was also envisioned by a participant.
Expand access to behavioral health services.	A participant suggested integrating screening for behavioral health issues as part of routine primary care exams. Another suggested training people with lived experience to provide peer support to others with behavioral health challenges, such as Certified Recovery Specialists and Certified Peer Specialists. Hospitals also could provide training to local social service organizations whose staff are often the first to encounter and support people experiencing behavioral health issues. As a longer-term solution, developing career pipelines to train more health and social service providers to address behavioral health staffing shortages was suggested. Similarly, a participant recommended *"investing in mental health structure and equitable pay for people that are working in that field, and also giving them things that are more valuable, in terms of [things] like more paid time off, more time off for them to spend and have family time with their children."*
Increase affordable transportation options for older adults and create a way to regularly check in on those who are socially isolated.	Free or inexpensive transportation options are needed to help older adults get to and from medical appointments and other community services. Creating a service, perhaps led by volunteers, to call on older and homebound adults to check in and assess their needs was suggested: "*An organized service where people could drop in on seniors to visit them in their homes, to help assess what they need, and care for them.*"
Provide more support services for older adults who wish to age in place.	A participant suggested passing a local ordinance requiring that a certain percentage of units in new developments be offered at affordable prices for people living on fixed or limited incomes. A related suggestion: provide exercise coaches who visit older adults in their homes to encourage physical activity.

Suggested Actions

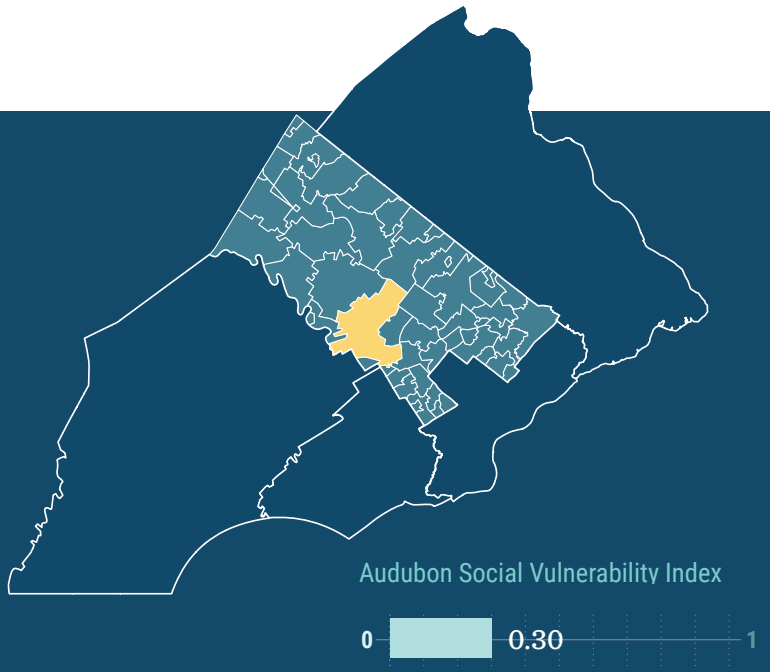
Increase community health education prevention programs to encourage healthy lifestyles for youth and adults.	Participants stressed the need for more education in schools on healthy eating, internet safety, and sexual health topics. Another mentioned the need for education on gun safety and violence prevention. Education for adults on home safety issues, such as preventing falls and mitigating mold, is needed, another participant noted. As one participant put it: *"I think the key is the power of education. Education versus opinion, though."*
Improve access to healthy food and safe spaces for physical activity for youth and adults.	Suggestions from participants included opening farmers markets and food co-ops, increasing public safety on trails and other open space, and providing more free or affordable access to recreation centers and other facilities for youth to play basketball or other activities.

AUDUBON

ZIP CODE: 19403

This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Einstein Medical Center Montgomery
- Fox Chase Cancer Center
- Main Line Health
- Rothman Orthopaedic Specialty Hospital



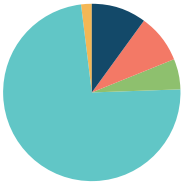
POPULATION

46,592

MEDIAN HOUSEHOLD INCOME

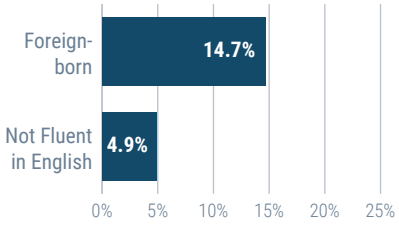
$86,787

RACE/ETHNICITY/LANGUAGE

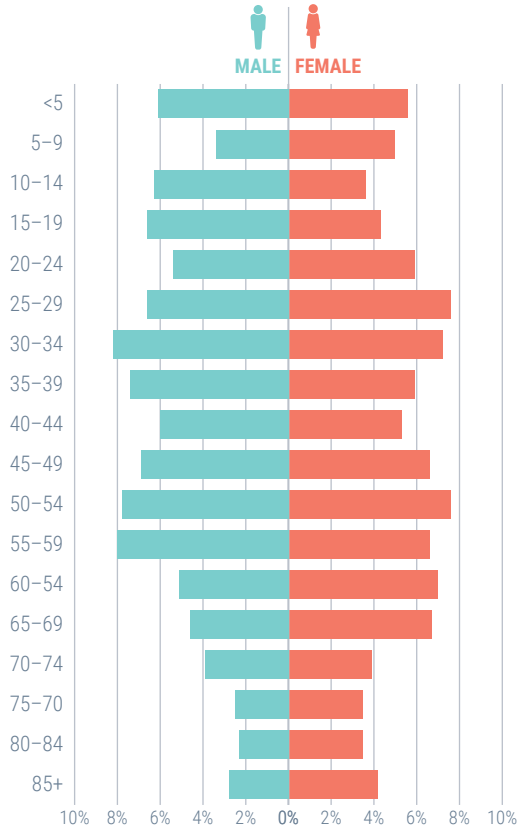


10.1% | Asian*
8.8% | Black*
5.7% | Hispanic/Latino
73.6% | White*
1.7% | Other*

* Non-Hispanic



AGE DISTRIBUTION



LEADING CAUSES OF DEATH

1. Cancer
2. Heart disease
3. Cerebrovascular diseases
4. COVID-19
5. Chronic lower respiratory diseases

EDUCATIONAL ATTAINMENT

High school as highest education level **21.3%**

PEOPLE WITH DISABILITIES

10.0%

summary health measures

		Audubon		Montgomery County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	963.7	1,077.4	939.0	1,072.8
	Life expectancy: Female (in years)	84.7	81.4	83.1	81.7
	Life expectancy: Male (in years)	79.6	79.3	78.3	77.0
	Years of potential life lost before 75	2,159	2,375	41,424	45,416
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	272.6	N/A	853.5
	COVID-related hospitalization rate (per 100,000)	N/A	354.1	N/A	394.6
Chronic Disease & Health Behaviors	Adult obesity prevalence	28.9%		29.1%	
	Diabetes prevalence	8.7%		8.9%	
	Diabetes-related hospitalization rate (per 100,000)	118.0	94.4	124.6	113.0
	Hypertension prevalence	27.5%		27.7%	
	Hypertension-related hospitalization rate (per 100,000)	452.9	375.6	380.9	328.6
	Potentially preventable hospitalization rate (per 100,000)	1,051.7	770.5	979.3	763.1
	Premature cardiovascular disease mortality rate (per 100,000)	27.9	36.5	26.3	30.1
	Major cancer incidence rate (per 100,000)	283.3		286.1	
	Major cancer mortality rate (per 100,000)	77.3		85.2	
	Colorectal cancer screening	71.4%		71.3%	
	Mammography screening	76.9%		77.4%	
	Physical inactivity (leisure time) prevalence	19.5%		19.6%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	8.1	--	10.0	2.9
	Infant mortality rate (per 1,000 live births)	--	--	4.1	2.7
	Percent low birthweight births out of live births	6.9%	7.7%	7.2%	6.9%
	Percent preterm births out of live births	6.7%	7.7%	8.7%	8.0%
Behavioral Health	Adult binge drinking	19.1%		18.8%	
	Adult smoking	14.5%		14.4%	
	Drug overdose mortality rate (per 100,000)	32.2	19.3	24.3	23.7
	Opioid-related hospitalization rate (per 100,000)	176.0	212.5	43.6	34.2
	Substance-related hospitalization rate (per 100,000)	480.8	532.3	265.9	223.8
	Poor mental health for 14+ days in past 30 days	12.3%		12.5%	
	Suicide mortality rate (per 100,000)	12.9	12.9	13.4	12.7
Injuries	Fall-related hospitalization rate (per 100,000)	7,117.0	7,117.0	3,146.4	3,083.5
	Gun-related emergency department utilization (per 100,000)	--	--	9.4	9.9
	Homicide mortality rate (per 100,000)	--	--	2.5	2.5
Access to Care	Adults 19-64 years with Medicaid	7.4%		8.0%	
	Children <19 years with public insurance	18.5%		21.5%	
	Population without insurance	2.7%		3.6%	
	Children <19 years without insurance	3.4%		2.3%	
	Emergency department utilization (per 100,000)	21,130.2	13,781.3	19,958.7	16,419.9
	High emergency department utilization (per 100,000)	513.0	225.4	319.9	247.5
Social & Economic Conditions	Population in poverty	5.8%		5.8%	
	Children <18 years in poverty	8.6%		6.9%	
	Adults 19-64 years unemployed	2.2%		2.0%	
	Householders living alone who are 65+ years	43.5%		43.5%	
	Households receiving SNAP benefits	3.6%		5.1%	
	Households that are housing cost-burdened	10.4%		12.7%	
	Housing with potential lead risk	40.6%		55.4%	
	Vacant housing units	5.1%		5.0%	

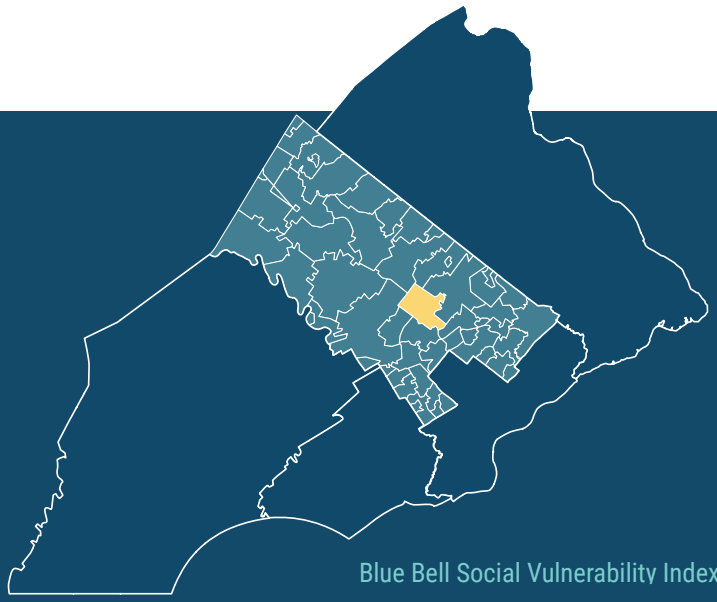
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

BLUE BELL

ZIP CODE: 19422

This community is served by:

- Children's Hospital of Philadelphia
- Einstein Medical Center Montgomery
- Fox Chase Cancer Center
- Jefferson Abington Hospital
- Jefferson Lansdale Hospital
- Rothman Orthopaedic Specialty Hospital



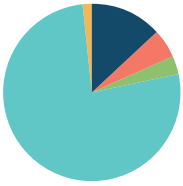
POPULATION

18,852

MEDIAN HOUSEHOLD INCOME

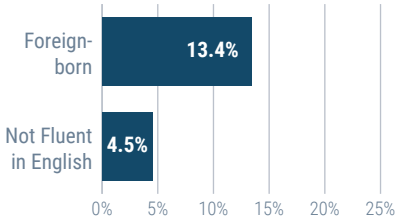
$125,561

RACE/ETHNICITY/LANGUAGE



13.1% | Asian*
5.5% | Black*
3.1% | Hispanic/Latino
76.7% | White*
1.6% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

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

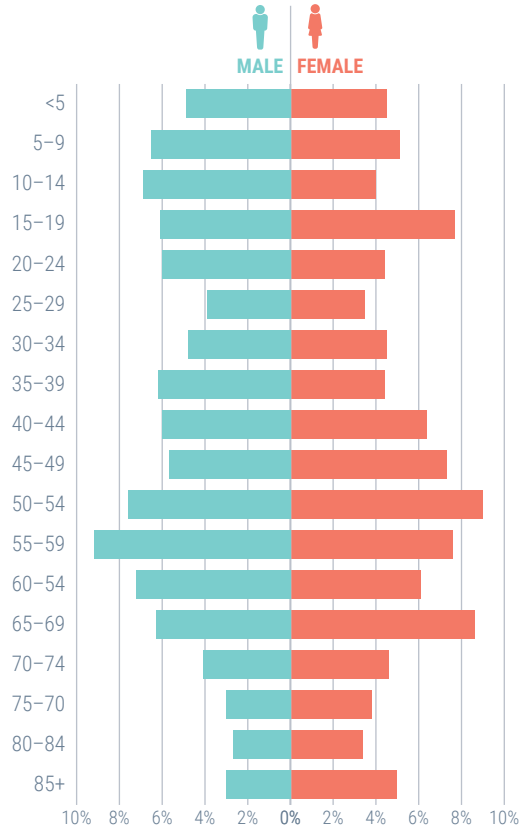
EDUCATIONAL ATTAINMENT

High school as highest education level **11.6%**

PEOPLE WITH DISABILITIES

8.5%

AGE DISTRIBUTION



summary health measures

		Blue Bell		Montgomery County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	976.0	1,167.0	939.0	1,072.8
	Life expectancy: Female (in years)	84.3	83.3	83.1	81.7
	Life expectancy: Male (in years)	83.0	81.3	78.3	77.0
	Years of potential life lost before 75	611	601	41,424	45,416
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	122.0	N/A	853.5
	COVID-related hospitalization rate (per 100,000)	N/A	366.0	N/A	394.6
Chronic Disease & Health Behaviors	Adult obesity prevalence	26.8%		29.1%	
	Diabetes prevalence	9.0%		8.9%	
	Diabetes-related hospitalization rate (per 100,000)	90.2	95.5	124.6	113.0
	Hypertension prevalence	28.7%		27.7%	
	Hypertension-related hospitalization rate (per 100,000)	403.1	307.7	380.9	328.6
	Potentially preventable hospitalization rate (per 100,000)	917.7	673.7	979.3	763.1
	Premature cardiovascular disease mortality rate (per 100,000)	--	--	26.3	30.1
	Major cancer incidence rate (per 100,000)	339.5		286.1	
	Major cancer mortality rate (per 100,000)	127.3		85.2	
	Colorectal cancer screening	73.9%		71.3%	
	Mammography screening	78.4%		77.4%	
	Physical inactivity (leisure time) prevalence	17.4%		19.6%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	--	--	10.0	2.9
	Infant mortality rate (per 1,000 live births)	--	--	4.1	2.7
	Percent low birthweight births out of live births	5.9%	5.4%	7.2%	6.9%
	Percent preterm births out of live births	8.3%	3.6%	8.7%	8.0%
Behavioral Health	Adult binge drinking	17.1%		18.8%	
	Adult smoking	11.1%		14.4%	
	Drug overdose mortality rate (per 100,000)	--	--	24.3	23.7
	Opioid-related hospitalization rate (per 100,000)	42.4	--	43.6	34.2
	Substance-related hospitalization rate (per 100,000)	233.4	175.0	265.9	223.8
	Poor mental health for 14+ days in past 30 days	10.4%		12.5%	
	Suicide mortality rate (per 100,000)	--	--	13.4	12.7
Injuries	Fall-related hospitalization rate (per 100,000)	5,071.0	6,440.2	3,146.4	3,083.5
	Gun-related emergency department utilization (per 100,000)	--	5.3	9.4	9.9
	Homicide mortality rate (per 100,000)	--	--	2.5	2.5
Access to Care	Adults 19-64 years with Medicaid	4.0%		8.0%	
	Children <19 years with public insurance	11.3%		21.5%	
	Population without insurance	1.6%		3.6%	
	Children <19 years without insurance	1.2%		2.3%	
	Emergency department utilization (per 100,000)	17,027.4	10,582.4	19,958.7	16,419.9
	High emergency department utilization (per 100,000)	244.0	116.7	319.9	247.5
Social & Economic Conditions	Population in poverty	2.4%		5.8%	
	Children <18 years in poverty	1.6%		6.9%	
	Adults 19-64 years unemployed	2.3%		2.0%	
	Householders living alone who are 65+ years	51.3%		43.5%	
	Households receiving SNAP benefits	1.8%		5.1%	
	Households that are housing cost-burdened	9.7%		12.7%	
	Housing with potential lead risk	29.8%		55.4%	
	Vacant housing units	6.9%		5.0%	

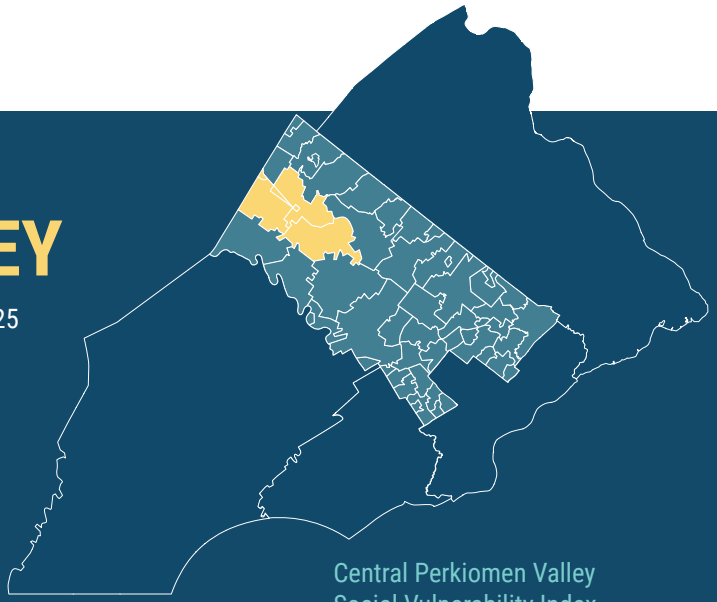
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

CENTRAL PERKIOMEN VALLEY

ZIP CODES: 18074, 19435, 19472, 19473, 19492, 19525

This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Einstein Medical Center Montgomery
- Fox Chase Cancer Center
- Grand View Health
- Main Line Health



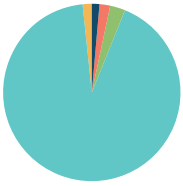
POPULATION

39,384

MEDIAN HOUSEHOLD INCOME

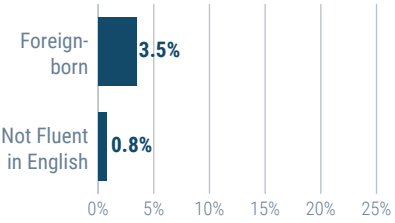
$91,668

RACE/ETHNICITY/LANGUAGE

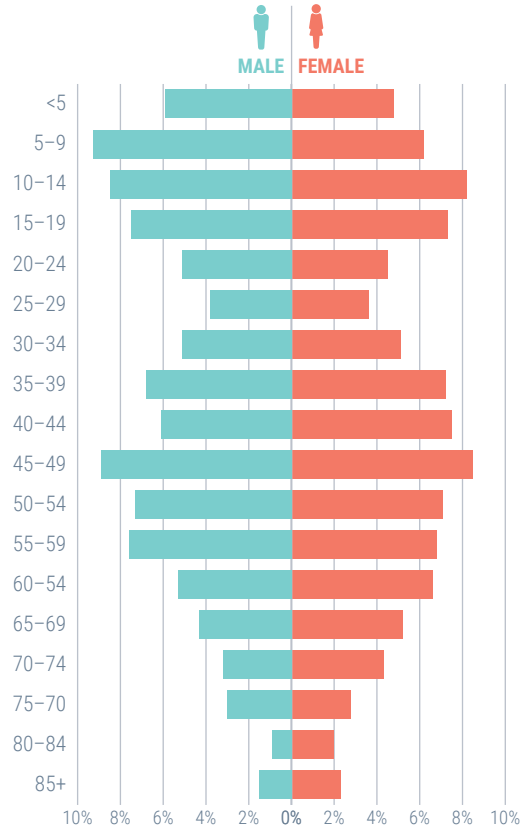


1.6% | Asian*
1.8% | Black*
3.0% | Hispanic/Latino
92.3% | White*
1.4% | Other*

* Non-Hispanic



AGE DISTRIBUTION



LEADING CAUSES OF DEATH

1. Heart disease
2. Cancer
3. COVID-19
4. Cerebrovascular diseases
5. Chronic kidney disease

EDUCATIONAL ATTAINMENT

High school as highest education level 21.0%

PEOPLE WITH DISABILITIES

8.7%

summary health measures

		Central Perkiomen Valley		Montgomery County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	716.0	708.4	939.0	1,072.8
	Life expectancy: Female (in years)	84.1	84.0	83.1	81.7
	Life expectancy: Male (in years)	78.8	79.1	78.3	77.0
	Years of potential life lost before 75	1,829	1,643	41,424	45,416
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	259.0	N/A	853.5
	COVID-related hospitalization rate (per 100,000)	N/A	147.3	N/A	394.6
Chronic Disease & Health Behaviors	Adult obesity prevalence	30.1%		29.1%	
	Diabetes prevalence	8.2%		8.9%	
	Diabetes-related hospitalization rate (per 100,000)	81.3	86.3	124.6	113.0
	Hypertension prevalence	26.3%		27.7%	
	Hypertension-related hospitalization rate (per 100,000)	226.0	193.0	380.9	328.6
	Potentially preventable hospitalization rate (per 100,000)	726.2	576.4	979.3	763.1
	Premature cardiovascular disease mortality rate (per 100,000)	33.0	30.5	26.3	30.1
	Major cancer incidence rate (per 100,000)	251.4		286.1	
	Major cancer mortality rate (per 100,000)	88.9		85.2	
	Colorectal cancer screening	70.7%		71.3%	
	Mammography screening	76.9%		77.4%	
	Physical inactivity (leisure time) prevalence	19.2%		19.6%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	--	--	10.0	2.9
	Infant mortality rate (per 1,000 live births)	--	--	4.1	2.7
	Percent low birthweight births out of live births	4.6%	8.5%	7.2%	6.9%
	Percent preterm births out of live births	6.1%	6.7%	8.7%	8.0%
Behavioral Health	Adult binge drinking	20.4%		18.8%	
	Adult smoking	15.9%		14.4%	
	Drug overdose mortality rate (per 100,000)	15.2	--	24.3	23.7
	Opioid-related hospitalization rate (per 100,000)	--	--	43.6	34.2
	Substance-related hospitalization rate (per 100,000)	187.9	132.0	265.9	223.8
	Poor mental health for 14+ days in past 30 days	13.2%		12.5%	
	Suicide mortality rate (per 100,000)	--	17.8	13.4	12.7
Injuries	Fall-related hospitalization rate (per 100,000)	5,668.8	5,261.0	3,146.4	3,083.5
	Gun-related emergency department utilization (per 100,000)	--	20.2	9.4	9.9
	Homicide mortality rate (per 100,000)	--	15.2	2.5	2.5
Access to Care	Adults 19-64 years with Medicaid	5.5%		8.0%	
	Children <19 years with public insurance	14.9%		21.5%	
	Population without insurance	2.4%		3.6%	
	Children <19 years without insurance	1.7%		2.3%	
	Emergency department utilization (per 100,000)	16,133.0	19,713.6	19,958.7	16,419.9
	High emergency department utilization (per 100,000)	127.3	523.7	319.9	247.5
Social & Economic Conditions	Population in poverty	4.5%		5.8%	
	Children <18 years in poverty	5.8%		6.9%	
	Adults 19-64 years unemployed	1.6%		2.0%	
	Householders living alone who are 65+ years	39.3%		43.5%	
	Households receiving SNAP benefits	1.8%		5.1%	
	Households that are housing cost-burdened	14.7%		12.7%	
	Housing with potential lead risk	51.1%		55.4%	
	Vacant housing units	4.5%		5.0%	

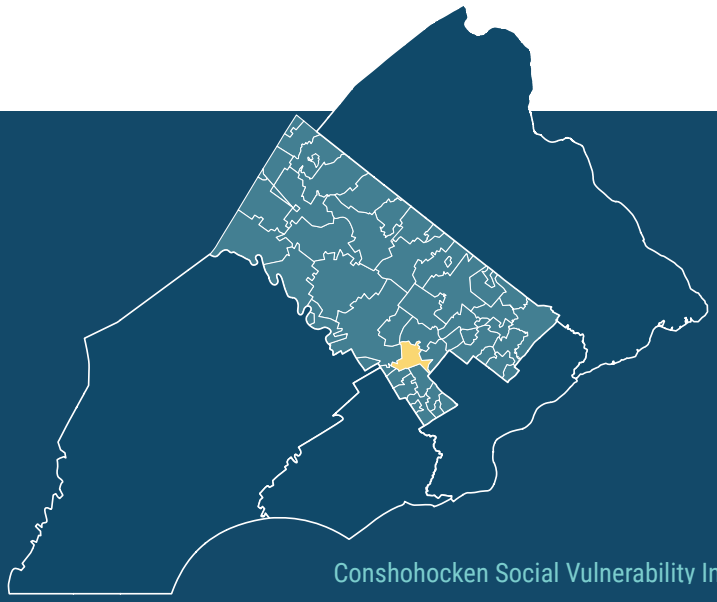
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

CONSHOHOCKEN

ZIP CODES: 19428, 19444, 19462

This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Einstein Medical Center Montgomery
- Fox Chase Cancer Center
- Main Line Health



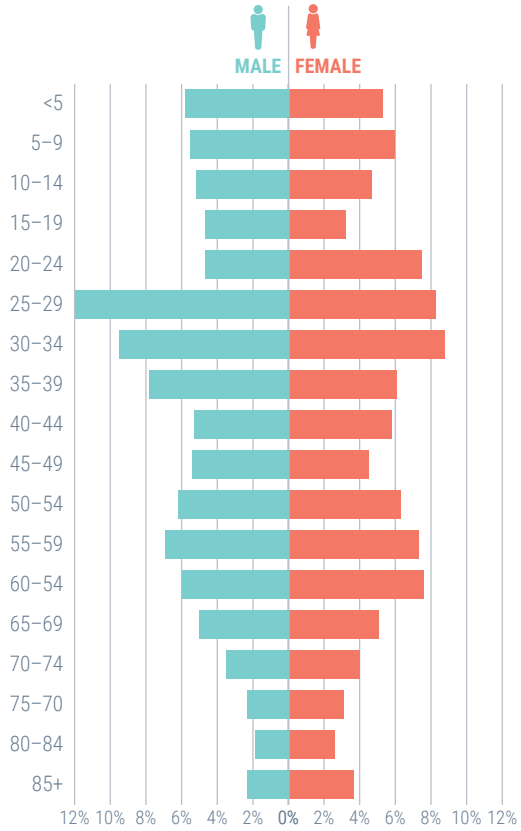
POPULATION

43,923

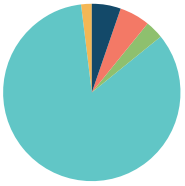
MEDIAN HOUSEHOLD INCOME

$102,218

AGE DISTRIBUTION

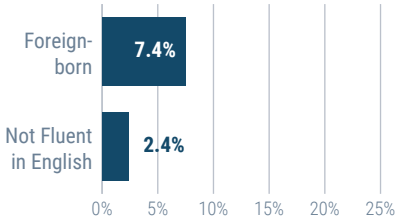


RACE/ETHNICITY/LANGUAGE



5.5% | Asian*
5.5% | Black*
3.3% | Hispanic/Latino
83.8% | White*
1.8% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

1. Heart disease
2. Cancer
3. COVID-19
4. Cerebrovascular diseases
5. Unintentional injuries (excluding drug overdoses)

EDUCATIONAL ATTAINMENT

High school as highest education level **17.2%**

PEOPLE WITH DISABILITIES

9.1%

summary health measures

		Conshohocken		Montgomery County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	997.2	1,097.4	939.0	1,072.8
	Life expectancy: Female (in years)	83.2	81.6	83.1	81.7
	Life expectancy: Male (in years)	79.0	77.3	78.3	77.0
	Years of potential life lost before 75	1,928	2,349	41,424	45,416
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	218.6	N/A	853.5
	COVID-related hospitalization rate (per 100,000)	N/A	296.0	N/A	394.6
Chronic Disease & Health Behaviors	Adult obesity prevalence	27.5%		29.1%	
	Diabetes prevalence	7.8%		8.9%	
	Diabetes-related hospitalization rate (per 100,000)	104.7	97.9	124.6	113.0
	Hypertension prevalence	25.8%		27.7%	
	Hypertension-related hospitalization rate (per 100,000)	441.7	302.8	380.9	328.6
	Potentially preventable hospitalization rate (per 100,000)	981.3	667.1	979.3	763.1
	Premature cardiovascular disease mortality rate (per 100,000)	15.9	25.0	26.3	30.1
	Major cancer incidence rate (per 100,000)	289.1		286.1	
	Major cancer mortality rate (per 100,000)	107.0		85.2	
	Colorectal cancer screening	73.0%		71.3%	
	Mammography screening	77.7%		77.4%	
	Physical inactivity (leisure time) prevalence	17.3%		19.6%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	--	--	10.0	2.9
	Infant mortality rate (per 1,000 live births)	--	--	4.1	2.7
	Percent low birthweight births out of live births	6.9%	6.3%	7.2%	6.9%
	Percent preterm births out of live births	4.6%	4.2%	8.7%	8.0%
Behavioral Health	Adult binge drinking	20.0%		18.8%	
	Adult smoking	12.8%		14.4%	
	Drug overdose mortality rate (per 100,000)	22.8	18.2	24.3	23.7
	Opioid-related hospitalization rate (per 100,000)	29.6	--	43.6	34.2
	Substance-related hospitalization rate (per 100,000)	200.4	191.2	265.9	223.8
	Poor mental health for 14+ days in past 30 days	11.7%		12.5%	
	Suicide mortality rate (per 100,000)	--	15.9	13.4	12.7
Injuries	Fall-related hospitalization rate (per 100,000)	8,456.7	7,687.9	3,146.4	3,083.5
	Gun-related emergency department utilization (per 100,000)	--	9.2	9.4	9.9
	Homicide mortality rate (per 100,000)	--	--	2.5	2.5
Access to Care	Adults 19-64 years with Medicaid	5.8%		8.0%	
	Children <19 years with public insurance	12.8%		21.5%	
	Population without insurance	2.0%		3.6%	
	Children <19 years without insurance	1.5%		2.3%	
	Emergency department utilization (per 100,000)	16,765.6	13,203.7	19,958.7	16,419.9
	High emergency department utilization (per 100,000)	281.2	208.9	319.9	247.5
Social & Economic Conditions	Population in poverty	5.0%		5.8%	
	Children <18 years in poverty	4.0%		6.9%	
	Adults 19-64 years unemployed	1.6%		2.0%	
	Householders living alone who are 65+ years	36.9%		43.5%	
	Households receiving SNAP benefits	3.6%		5.1%	
	Households that are housing cost-burdened	13.1%		12.7%	
	Housing with potential lead risk	52.8%		55.4%	
	Vacant housing units	4.9%		5.0%	

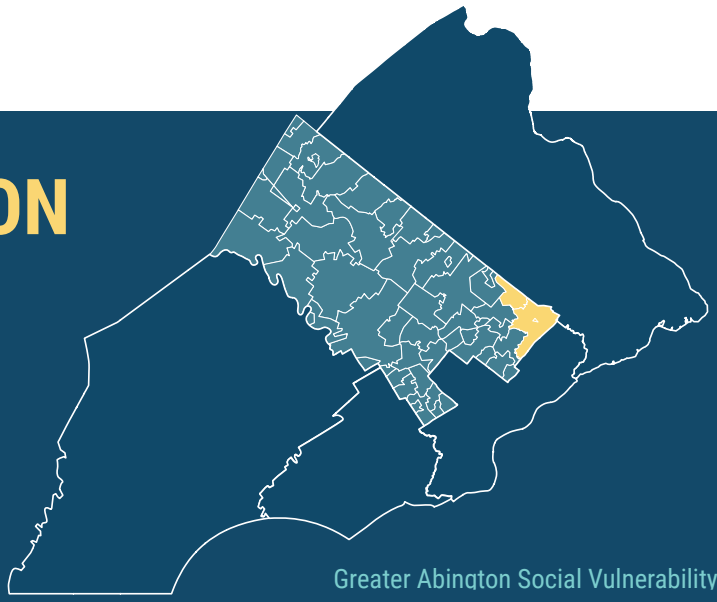
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

GREATER ABINGTON

ZIP CODES: 19006, 19009, 19040

This community is served by:

- Children's Hospital of Philadelphia
- Doylestown Health
- Fox Chase Cancer Center
- Jefferson Abington Hospital
- Magee Rehabilitation
- Redeemer Health
- Rothman Orthopaedic Specialty Hospital



Greater Abington Social Vulnerability Index

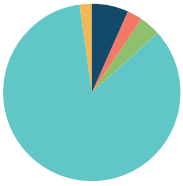
POPULATION

43,640

MEDIAN HOUSEHOLD INCOME

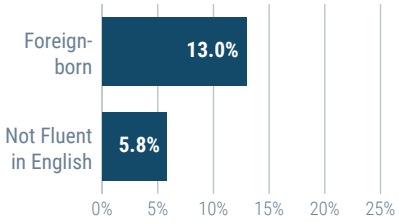
$93,238

RACE/ETHNICITY/LANGUAGE

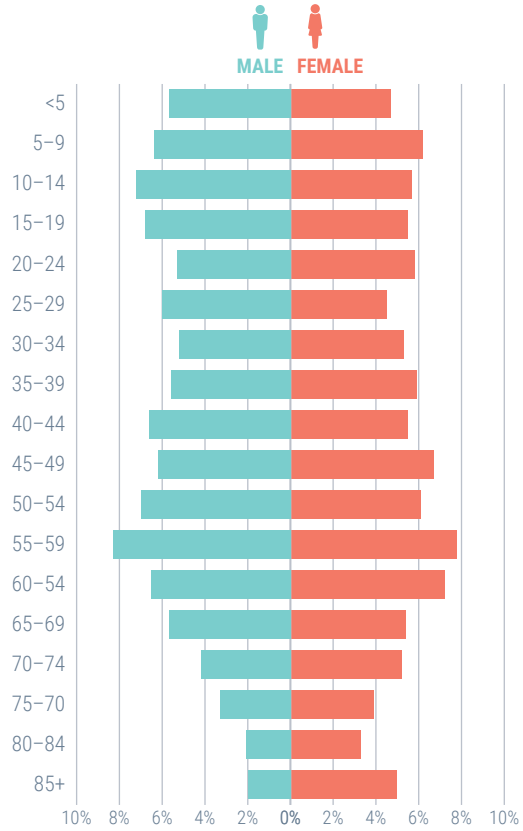


6.8% | Asian*
2.7% | Black*
3.9% | Hispanic/Latino
84.5% | White*
2.0% | Other*

* Non-Hispanic



AGE DISTRIBUTION



LEADING CAUSES OF DEATH

1. Cancer
2. Heart disease
3. COVID-19
4. Cerebrovascular diseases
5. Alzheimer's disease

EDUCATIONAL ATTAINMENT

High school as highest education level **20.5%**

PEOPLE WITH DISABILITIES

9.3%

summary health measures

		Greater Abington		Montgomery County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	1,120.5	1,182.4	939.0	1,072.8
	Life expectancy: Female (in years)	84.1	83.7	83.1	81.7
	Life expectancy: Male (in years)	77.1	76.5	78.3	77.0
	Years of potential life lost before 75	2,257	2,281	41,424	45,416
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	293.3	N/A	853.5
	COVID-related hospitalization rate (per 100,000)	N/A	515.6	N/A	394.6
Chronic Disease & Health Behaviors	Adult obesity prevalence	28.4%		29.1%	
	Diabetes prevalence	9.4%		8.9%	
	Diabetes-related hospitalization rate (per 100,000)	114.6	112.3	124.6	113.0
	Hypertension prevalence	29.3%		27.7%	
	Hypertension-related hospitalization rate (per 100,000)	421.6	325.4	380.9	328.6
	Potentially preventable hospitalization rate (per 100,000)	1,099.9	857.0	979.3	763.1
	Premature cardiovascular disease mortality rate (per 100,000)	29.8	20.6	26.3	30.1
	Major cancer incidence rate (per 100,000)	263.5		286.1	
	Major cancer mortality rate (per 100,000)	91.7		85.2	
	Colorectal cancer screening	71.5%		71.3%	
	Mammography screening	76.4%		77.4%	
	Physical inactivity (leisure time) prevalence	20.0%		19.6%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	--	--	10.0	2.9
	Infant mortality rate (per 1,000 live births)	--	--	4.1	2.7
	Percent low birthweight births out of live births	5.8%	6.2%	7.2%	6.9%
	Percent preterm births out of live births	4.4%	5.6%	8.7%	8.0%
Behavioral Health	Adult binge drinking	18.1%		18.8%	
	Adult smoking	13.9%		14.4%	
	Drug overdose mortality rate (per 100,000)	29.8	32.1	24.3	23.7
	Opioid-related hospitalization rate (per 100,000)	25.2	--	43.6	34.2
	Substance-related hospitalization rate (per 100,000)	203.9	169.6	265.9	223.8
	Poor mental health for 14+ days in past 30 days	12.2%		12.5%	
	Suicide mortality rate (per 100,000)	13.7	--	13.4	12.7
Injuries	Fall-related hospitalization rate (per 100,000)	8,179.7	7,350.2	3,146.4	3,083.5
	Gun-related emergency department utilization (per 100,000)	--	4.7	9.4	9.9
	Homicide mortality rate (per 100,000)	--	--	2.5	2.5
Access to Care	Adults 19-64 years with Medicaid	6.6%		8.0%	
	Children <19 years with public insurance	21.8%		21.5%	
	Population without insurance	3.1%		3.6%	
	Children <19 years without insurance	2.3%		2.3%	
	Emergency department utilization (per 100,000)	17,554.8	12,934.6	19,958.7	16,419.9
	High emergency department utilization (per 100,000)	242.3	186.9	319.9	247.5
Social & Economic Conditions	Population in poverty	5.4%		5.8%	
	Children <18 years in poverty	6.7%		6.9%	
	Adults 19-64 years unemployed	2.0%		2.0%	
	Householders living alone who are 65+ years	51.7%		43.5%	
	Households receiving SNAP benefits	4.4%		5.1%	
	Households that are housing cost-burdened	14.5%		12.7%	
	Housing with potential lead risk	66.5%		55.4%	
	Vacant housing units	5.8%		5.0%	

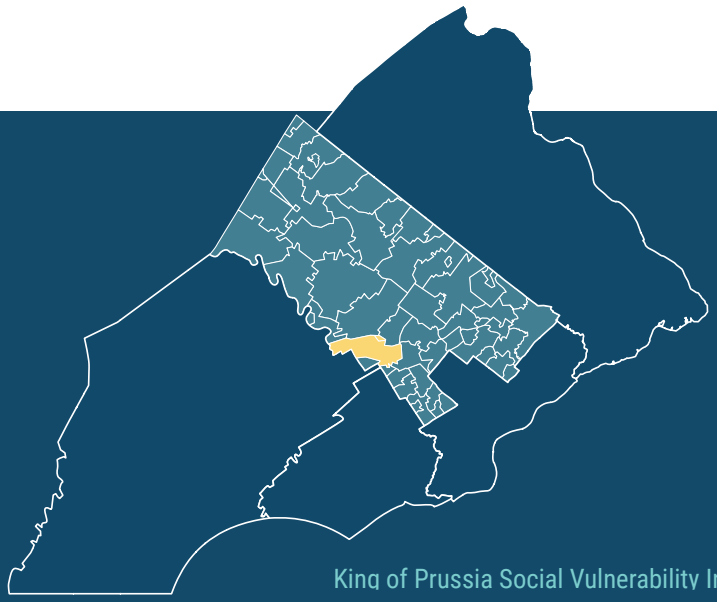
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

KING OF PRUSSIA

ZIP CODES: 19405, 19406

This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Einstein Medical Center Philadelphia
- Main Line Health



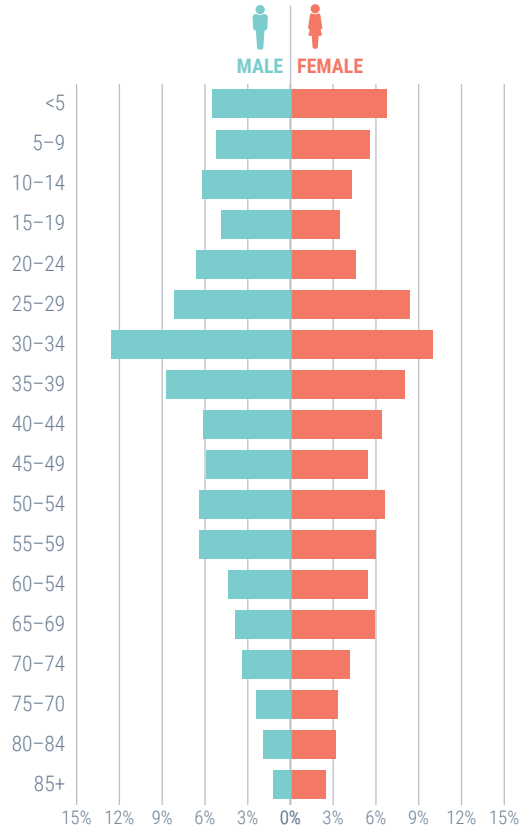
POPULATION

30,355

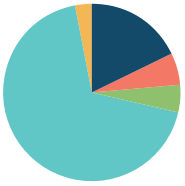
MEDIAN HOUSEHOLD INCOME

$76,964

AGE DISTRIBUTION

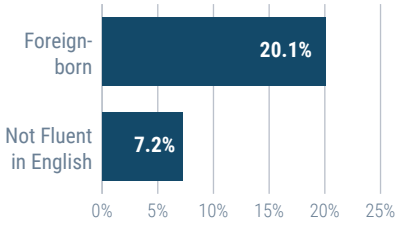


RACE/ETHNICITY/LANGUAGE



17.8% | Asian*
5.9% | Black*
5.1% | Hispanic/Latino
68.4% | White*
2.8% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

1. Cancer
2. Heart disease
3. COVID-19
4. Cerebrovascular diseases
5. Chronic lower respiratory diseases

EDUCATIONAL ATTAINMENT

High school as highest education level **18.1%**

PEOPLE WITH DISABILITIES

8.3%

summary health measures

		King of Prussia		Montgomery County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	777.5	833.5	939.0	1,072.8
	Life expectancy: Female (in years)	84.5	83.4	83.1	81.7
	Life expectancy: Male (in years)	78.0	78.3	78.3	77.0
	Years of potential life lost before 75	1,273	1,388	41,424	45,416
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	289.9	N/A	853.5
	COVID-related hospitalization rate (per 100,000)	N/A	316.3	N/A	394.6
Chronic Disease & Health Behaviors	Adult obesity prevalence	27.0%		29.1%	
	Diabetes prevalence	7.9%		8.9%	
	Diabetes-related hospitalization rate (per 100,000)	82.4	112.0	124.6	113.0
	Hypertension prevalence	25.1%		27.7%	
	Hypertension-related hospitalization rate (per 100,000)	451.3	303.1	380.9	328.6
	Potentially preventable hospitalization rate (per 100,000)	912.5	655.6	979.3	763.1
	Premature cardiovascular disease mortality rate (per 100,000)	23.1	29.6	26.3	30.1
	Major cancer incidence rate (per 100,000)	243.8		286.1	
	Major cancer mortality rate (per 100,000)	75.8		85.2	
	Colorectal cancer screening	72.2%		71.3%	
	Mammography screening	77.6%		77.4%	
	Physical inactivity (leisure time) prevalence	18.2%		19.6%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	--	--	10.0	2.9
	Infant mortality rate (per 1,000 live births)	--	--	4.1	2.7
	Percent low birthweight births out of live births	8.6%	8.2%	7.2%	6.9%
	Percent preterm births out of live births	6.3%	5.5%	8.7%	8.0%
Behavioral Health	Adult binge drinking	19.3%		18.8%	
	Adult smoking	13.4%		14.4%	
	Drug overdose mortality rate (per 100,000)	32.9	23.1	24.3	23.7
	Opioid-related hospitalization rate (per 100,000)	--	--	43.6	34.2
	Substance-related hospitalization rate (per 100,000)	253.7	230.6	265.9	223.8
	Poor mental health for 14+ days in past 30 days	11.9%		12.5%	
	Suicide mortality rate (per 100,000)	--	--	13.4	12.7
Injuries	Fall-related hospitalization rate (per 100,000)	8,908.2	7,400.6	3,146.4	3,083.5
	Gun-related emergency department utilization (per 100,000)	19.0	4.0	9.4	9.9
	Homicide mortality rate (per 100,000)	--	--	2.5	2.5
Access to Care	Adults 19-64 years with Medicaid	6.4%		8.0%	
	Children <19 years with public insurance	20.9%		21.5%	
	Population without insurance	4.0%		3.6%	
	Children <19 years without insurance	2.1%		2.3%	
	Emergency department utilization (per 100,000)	23,716.8	16,366.6	19,958.7	16,419.9
	High emergency department utilization (per 100,000)	469.2	279.7	319.9	247.5
Social & Economic Conditions	Population in poverty	5.7%		5.8%	
	Children <18 years in poverty	7.3%		6.9%	
	Adults 19-64 years unemployed	2.1%		2.0%	
	Householders living alone who are 65+ years	20.9%		43.5%	
	Households receiving SNAP benefits	8.0%		5.1%	
	Households that are housing cost-burdened	14.1%		12.7%	
	Housing with potential lead risk	60.4%		55.4%	
	Vacant housing units	7.5%		5.0%	

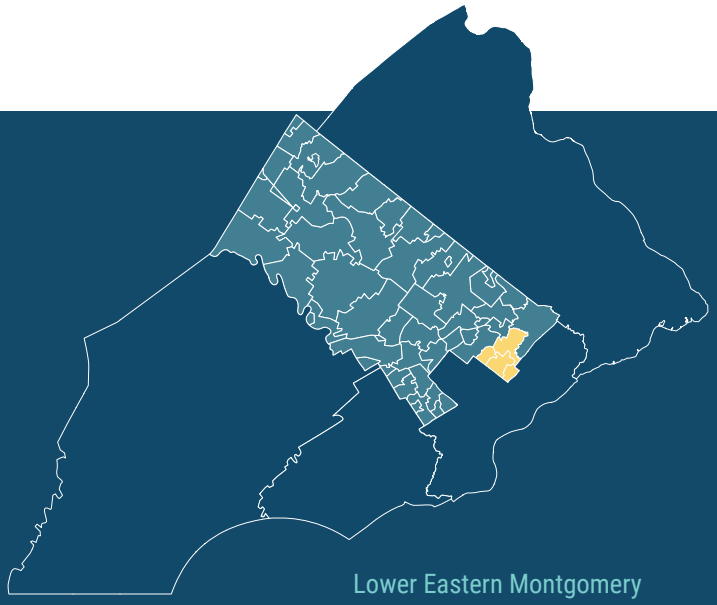
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

LOWER EASTERN
MONTGOMERY

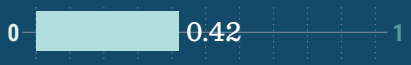
ZIP CODES: 19012, 19027, 19046, 19095

This community is served by:

- Children's Hospital of Philadelphia
- Einstein Medical Center Philadelphia
- Fox Chase Cancer Center
- Jefferson Abington Hospital
- Magee Rehabilitation
- Redeemer Health
- Rothman Orthopaedic Specialty Hospital



Lower Eastern Montgomery
Social Vulnerability Index



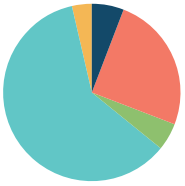
POPULATION

51,126

MEDIAN HOUSEHOLD INCOME

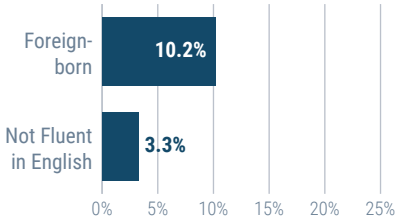
$90,439

RACE/ETHNICITY/LANGUAGE



5.9% | Asian*
25.0% | Black*
5.0% | Hispanic/Latino
60.4% | White*
3.5% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

1. Alzheimer's disease
2. Cerebrovascular diseases
3. COVID-19
4. Cancer
5. Heart disease

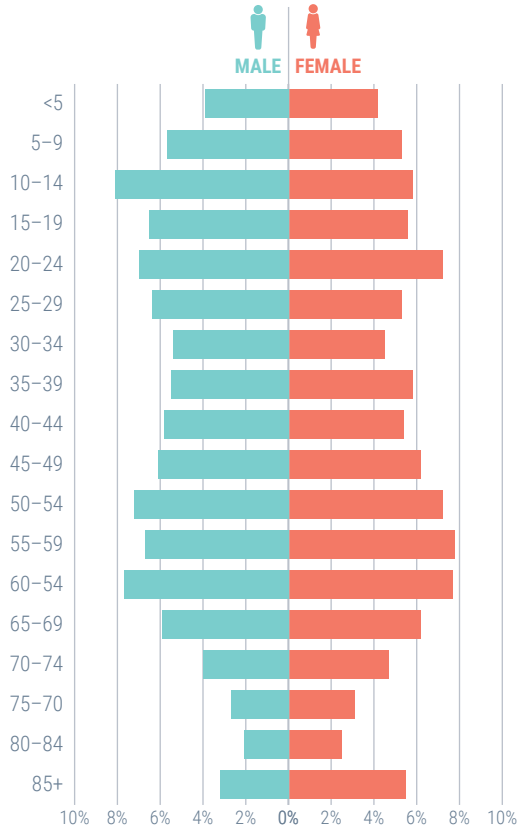
EDUCATIONAL ATTAINMENT

High school as highest education level **14.5%**

PEOPLE WITH DISABILITIES

12.3%

AGE DISTRIBUTION



summary health measures

		Lower Eastern Montgomery		Montgomery County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	1,118.8	1,328.1	939.0	1,072.8
	Life expectancy: Female (in years)	82.4	79.2	83.1	81.7
	Life expectancy: Male (in years)	79.5	78.1	78.3	77.0
	Years of potential life lost before 75	2,479	2,909	41,424	45,416
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	313.0	N/A	853.5
	COVID-related hospitalization rate (per 100,000)	N/A	588.7	N/A	394.6
Chronic Disease & Health Behaviors	Adult obesity prevalence	29.4%		29.1%	
	Diabetes prevalence	10.0%		8.9%	
	Diabetes-related hospitalization rate (per 100,000)	158.4	129.1	124.6	113.0
	Hypertension prevalence	30.8%		27.7%	
	Hypertension-related hospitalization rate (per 100,000)	545.7	434.2	380.9	328.6
	Potentially preventable hospitalization rate (per 100,000)	1,206.8	938.9	979.3	763.1
	Premature cardiovascular disease mortality rate (per 100,000)	25.4	23.5	26.3	30.1
	Major cancer incidence rate (per 100,000)	299.3		286.1	
	Major cancer mortality rate (per 100,000)	99.8		85.2	
	Colorectal cancer screening	72.7%		71.3%	
	Mammography screening	78.8%		77.4%	
	Physical inactivity (leisure time) prevalence	19.5%		19.6%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	5.7	--	10.0	2.9
	Infant mortality rate (per 1,000 live births)	--	--	4.1	2.7
	Percent low birthweight births out of live births	8.2%	7.5%	7.2%	6.9%
	Percent preterm births out of live births	7.3%	6.6%	8.7%	8.0%
Behavioral Health	Adult binge drinking	16.5%		18.8%	
	Adult smoking	12.3%		14.4%	
	Drug overdose mortality rate (per 100,000)	--	--	24.3	23.7
	Opioid-related hospitalization rate (per 100,000)	--	--	43.6	34.2
	Substance-related hospitalization rate (per 100,000)	168.2	152.6	265.9	223.8
	Poor mental health for 14+ days in past 30 days	11.5%		12.5%	
	Suicide mortality rate (per 100,000)	--	19.6	13.4	12.7
Injuries	Fall-related hospitalization rate (per 100,000)	7,286.8	7,144.3	3,146.4	3,083.5
	Gun-related emergency department utilization (per 100,000)	--	--	9.4	9.9
	Homicide mortality rate (per 100,000)	--	--	2.5	2.5
Access to Care	Adults 19-64 years with Medicaid	8.0%		8.0%	
	Children <19 years with public insurance	20.5%		21.5%	
	Population without insurance	3.1%		3.6%	
	Children <19 years without insurance	2.4%		2.3%	
	Emergency department utilization (per 100,000)	24,093.7	19,122.7	19,958.7	16,419.9
	High emergency department utilization (per 100,000)	409.2	332.6	319.9	247.5
Social & Economic Conditions	Population in poverty	7.1%		5.8%	
	Children <18 years in poverty	7.1%		6.9%	
	Adults 19-64 years unemployed	1.8%		2.0%	
	Householders living alone who are 65+ years	42.8%		43.5%	
	Households receiving SNAP benefits	5.7%		5.1%	
	Households that are housing cost-burdened	20.2%		12.7%	
	Housing with potential lead risk	78.0%		55.4%	
	Vacant housing units	8.9%		5.0%	

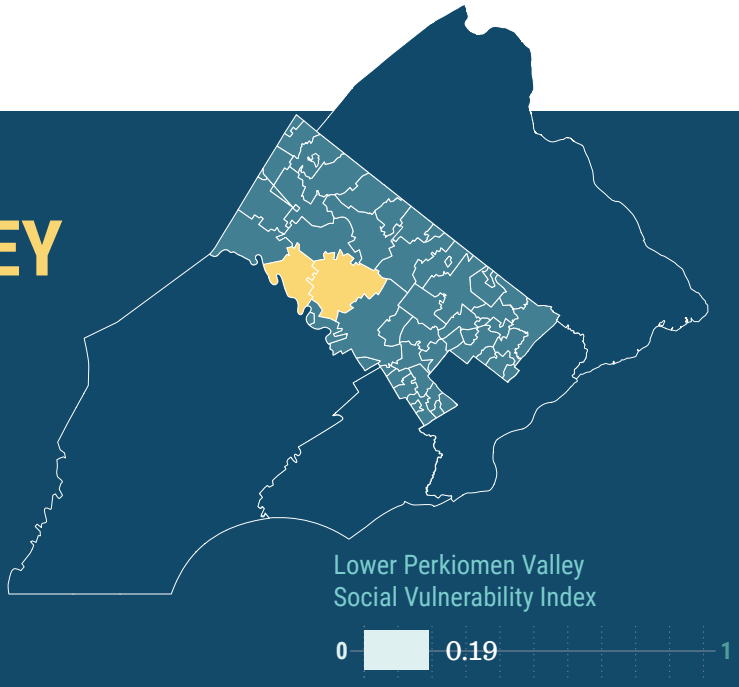
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

LOWER PERKIOMEN VALLEY

ZIP CODES: 19426, 19468

This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Einstein Medical Center Montgomery
- Fox Chase Cancer Center
- Grand View Health
- Main Line Health



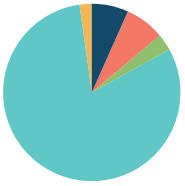
POPULATION

66,728

MEDIAN HOUSEHOLD INCOME

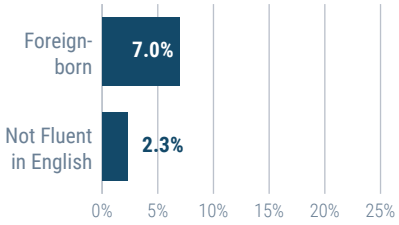
$105,961

RACE/ETHNICITY/LANGUAGE

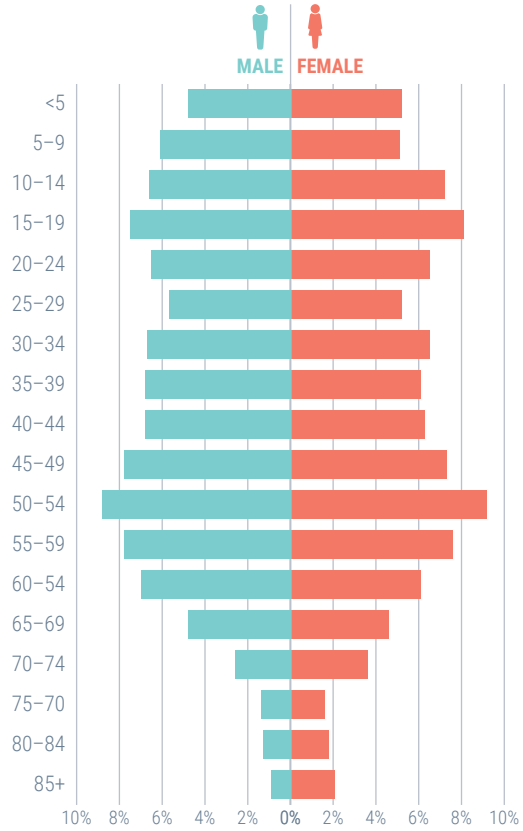


6.7% | Asian*
7.4% | Black*
3.0% | Hispanic/Latino
80.7% | White*
2.2% | Other*

* Non-Hispanic



AGE DISTRIBUTION



LEADING CAUSES OF DEATH

1. Cancer
2. Heart disease
3. COVID-19
4. Cerebrovascular diseases
5. Chronic lower respiratory diseases

EDUCATIONAL ATTAINMENT

High school as highest education level **15.9%**

PEOPLE WITH DISABILITIES

7.6%

summary health measures

		Lower Perkiomen Valley		Montgomery County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	675.9	750.8	939.0	1,072.8
	Life expectancy: Female (in years)	81.7	80.5	83.1	81.7
	Life expectancy: Male (in years)	78.8	77.9	78.3	77.0
	Years of potential life lost before 75	2,894	3,367	41,424	45,416
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	461.6	N/A	853.5
	COVID-related hospitalization rate (per 100,000)	N/A	298.2	N/A	394.6
Chronic Disease & Health Behaviors	Adult obesity prevalence	29.2%		29.1%	
	Diabetes prevalence	7.5%		8.9%	
	Diabetes-related hospitalization rate (per 100,000)	116.9	83.9	124.6	113.0
	Hypertension prevalence	24.4%		27.7%	
	Hypertension-related hospitalization rate (per 100,000)	296.7	286.2	380.9	328.6
	Potentially preventable hospitalization rate (per 100,000)	791.3	678.9	979.3	763.1
	Premature cardiovascular disease mortality rate (per 100,000)	28.5	25.5	26.3	30.1
	Major cancer incidence rate (per 100,000)	236.8		286.1	
	Major cancer mortality rate (per 100,000)	62.9		85.2	
	Colorectal cancer screening	71.2%		71.3%	
	Mammography screening	77.4%		77.4%	
	Physical inactivity (leisure time) prevalence	17.9%		19.6%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	--	--	10.0	2.9
	Infant mortality rate (per 1,000 live births)	--	--	4.1	2.7
	Percent low birthweight births out of live births	6.6%	4.9%	7.2%	6.9%
	Percent preterm births out of live births	6.4%	5.9%	8.7%	8.0%
Behavioral Health	Adult binge drinking	21.3%		18.8%	
	Adult smoking	15.0%		14.4%	
	Drug overdose mortality rate (per 100,000)	15.0	21.0	24.3	23.7
	Opioid-related hospitalization rate (per 100,000)	37.5	--	43.6	34.2
	Substance-related hospitalization rate (per 100,000)	251.8	178.3	265.9	223.8
	Poor mental health for 14+ days in past 30 days	12.8%		12.5%	
	Suicide mortality rate (per 100,000)	18.0	21.0	13.4	12.7
Injuries	Fall-related hospitalization rate (per 100,000)	9,348.3	8,887.4	3,146.4	3,083.5
	Gun-related emergency department utilization (per 100,000)	--	--	9.4	9.9
	Homicide mortality rate (per 100,000)	--	--	2.5	2.5
Access to Care	Adults 19-64 years with Medicaid	6.9%		8.0%	
	Children <19 years with public insurance	16.3%		21.5%	
	Population without insurance	2.4%		3.6%	
	Children <19 years without insurance	1.7%		2.3%	
	Emergency department utilization (per 100,000)	11,948.9	13,545.7	19,958.7	16,419.9
	High emergency department utilization (per 100,000)	165.7	156.8	319.9	247.5
Social & Economic Conditions	Population in poverty	4.0%		5.8%	
	Children <18 years in poverty	3.9%		6.9%	
	Adults 19-64 years unemployed	2.0%		2.0%	
	Householders living alone who are 65+ years	37.2%		43.5%	
	Households receiving SNAP benefits	4.4%		5.1%	
	Households that are housing cost-burdened	8.9%		12.7%	
	Housing with potential lead risk	26.4%		55.4%	
	Vacant housing units	3.4%		5.0%	

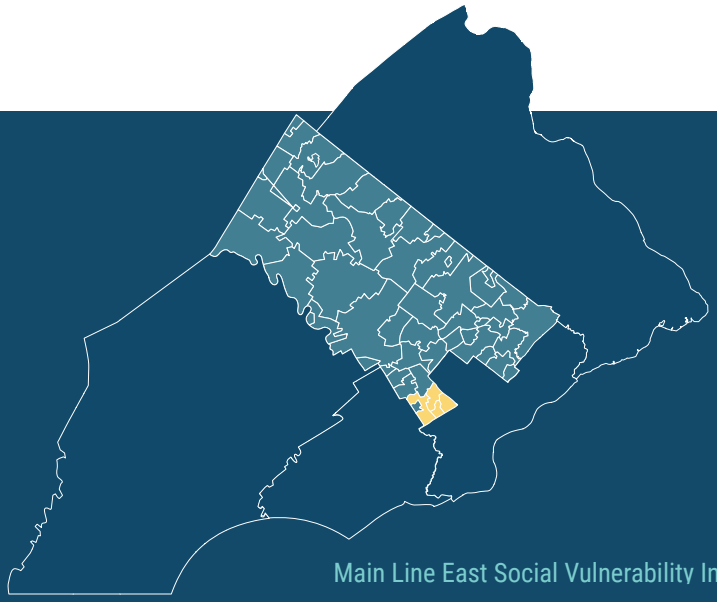
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

MAIN LINE EAST

ZIP CODES: 19004, 19066, 19072, 19096

This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Magee Rehabilitation
- Main Line Health



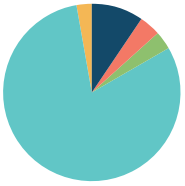
POPULATION

38,683

MEDIAN HOUSEHOLD INCOME

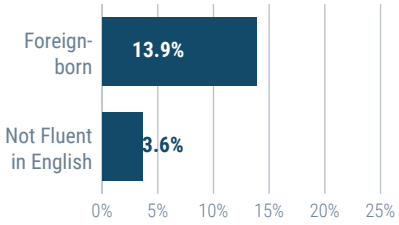
$146,995

RACE/ETHNICITY/LANGUAGE



9.6% | Asian*
3.9% | Black*
3.3% | Hispanic/Latino
80.6% | White*
2.6% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

1. Heart disease
2. Cancer
3. COVID-19
4. Cerebrovascular diseases
5. Parkinson's disease

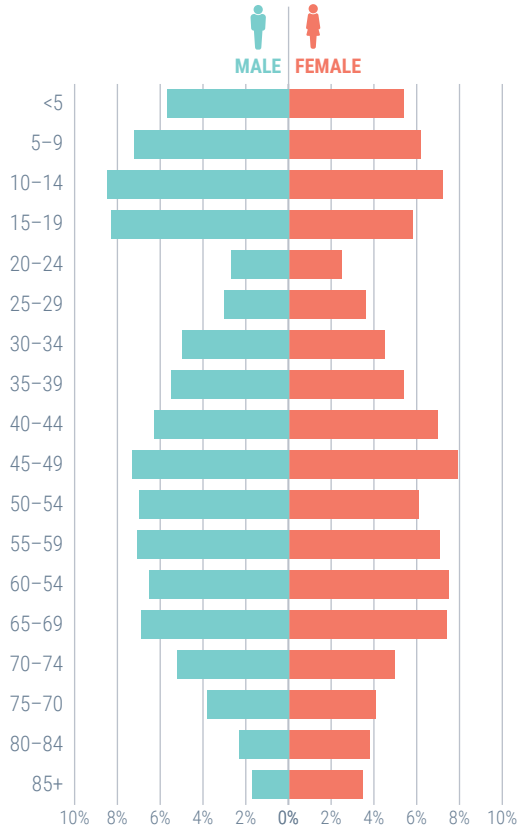
EDUCATIONAL ATTAINMENT

High school as highest education level **6.1%**

PEOPLE WITH DISABILITIES

7.4%

AGE DISTRIBUTION



summary health measures

		Main Line East		Montgomery County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	770.4	974.6	939.0	1,072.8
	Life expectancy: Female (in years)	87.8	85.3	83.1	81.7
	Life expectancy: Male (in years)	81.7	79.9	78.3	77.0
	Years of potential life lost before 75	1,002	1,176	41,424	45,416
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	429.1	N/A	853.5
	COVID-related hospitalization rate (per 100,000)	N/A	286.9	N/A	394.6
Chronic Disease & Health Behaviors	Adult obesity prevalence	25.6%		29.1%	
	Diabetes prevalence	7.9%		8.9%	
	Diabetes-related hospitalization rate (per 100,000)	25.9	--	124.6	113.0
	Hypertension prevalence	27.1%		27.7%	
	Hypertension-related hospitalization rate (per 100,000)	328.3	292.1	380.9	328.6
	Potentially preventable hospitalization rate (per 100,000)	687.6	579.1	979.3	763.1
	Premature cardiovascular disease mortality rate (per 100,000)	--	--	26.3	30.1
	Major cancer incidence rate (per 100,000)	305.0		286.1	
	Major cancer mortality rate (per 100,000)	80.1		85.2	
	Colorectal cancer screening	76.0%		71.3%	
	Mammography screening	79.1%		77.4%	
	Physical inactivity (leisure time) prevalence	14.8%		19.6%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	--	--	10.0	2.9
	Infant mortality rate (per 1,000 live births)	--	--	4.1	2.7
	Percent low birthweight births out of live births	3.9%	7.9%	7.2%	6.9%
	Percent preterm births out of live births	3.6%	5.7%	8.7%	8.0%
Behavioral Health	Adult binge drinking	17.8%		18.8%	
	Adult smoking	9.1%		14.4%	
	Drug overdose mortality rate (per 100,000)	--	--	24.3	23.7
	Opioid-related hospitalization rate (per 100,000)	--	--	43.6	34.2
	Substance-related hospitalization rate (per 100,000)	121.5	62.0	265.9	223.8
	Poor mental health for 14+ days in past 30 days	9.6%		12.5%	
	Suicide mortality rate (per 100,000)	--	--	13.4	12.7
Injuries	Fall-related hospitalization rate (per 100,000)	8,116.7	8,355.4	3,146.4	3,083.5
	Gun-related emergency department utilization (per 100,000)	--	14.1	9.4	9.9
	Homicide mortality rate (per 100,000)	--	--	2.5	2.5
Access to Care	Adults 19-64 years with Medicaid	4.1%		8.0%	
	Children <19 years with public insurance	8.4%		21.5%	
	Population without insurance	1.8%		3.6%	
	Children <19 years without insurance	2.1%		2.3%	
	Emergency department utilization (per 100,000)	17,857.9	14,083.7	19,958.7	16,419.9
	High emergency department utilization (per 100,000)	203.1	155.2	319.9	247.5
Social & Economic Conditions	Population in poverty	4.3%		5.8%	
	Children <18 years in poverty	3.7%		6.9%	
	Adults 19-64 years unemployed	1.5%		2.0%	
	Householders living alone who are 65+ years	51.8%		43.5%	
	Households receiving SNAP benefits	1.6%		5.1%	
	Households that are housing cost-burdened	9.3%		12.7%	
	Housing with potential lead risk	84.6%		55.4%	
	Vacant housing units	4.1%		5.0%	

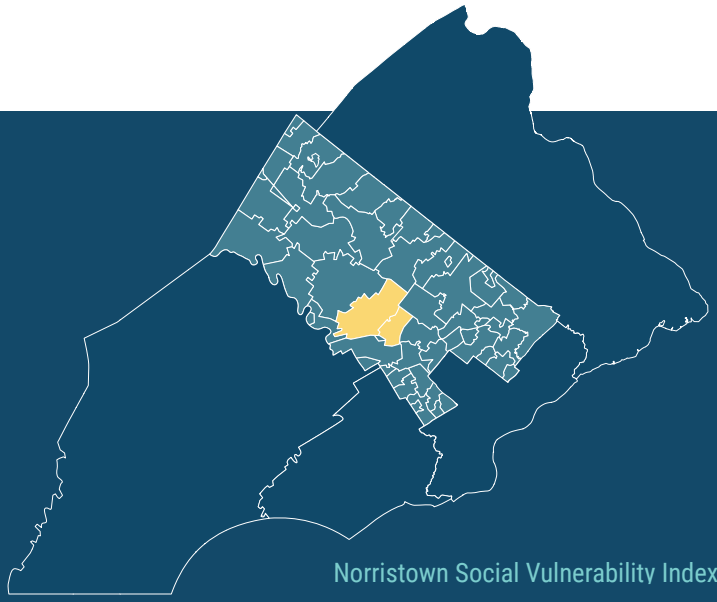
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

NORRISTOWN

ZIP CODE: 19401

This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Einstein Medical Center Montgomery
- Fox Chase Cancer Center
- Main Line Health



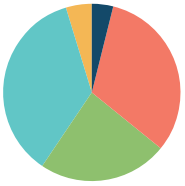
POPULATION

41,897

MEDIAN HOUSEHOLD INCOME

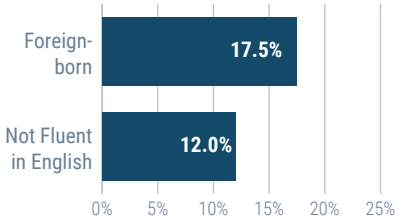
$53,696

RACE/ETHNICITY/LANGUAGE

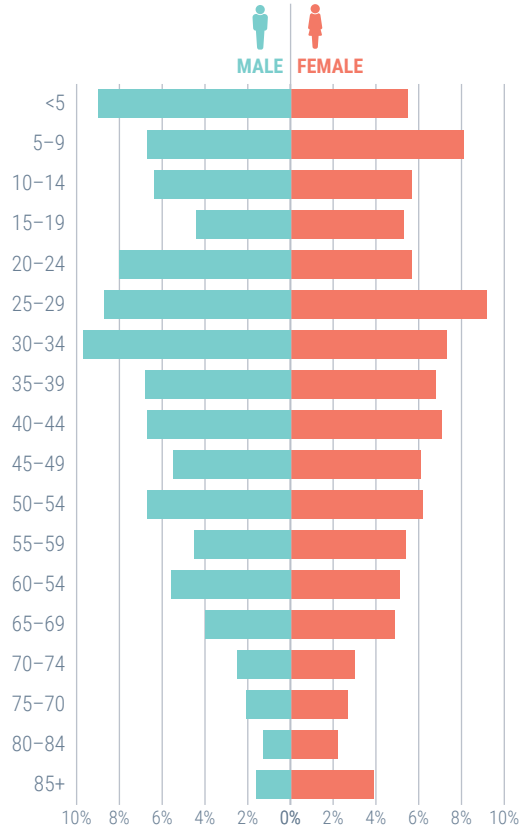


3.9% | Asian*
32.1% | Black*
23.4% | Hispanic/Latino
36.0% | White*
4.5% | Other*

* Non-Hispanic



AGE DISTRIBUTION



LEADING CAUSES OF DEATH

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

EDUCATIONAL ATTAINMENT

High school as highest education level **32.9%**

PEOPLE WITH DISABILITIES

15.3%

summary health measures

		Norristown		Montgomery County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	1,066.9	1,324.7	939.0	1,072.8
	Life expectancy: Female (in years)	80.7	76.7	83.1	81.7
	Life expectancy: Male (in years)	70.7	67.0	78.3	77.0
	Years of potential life lost before 75	3,879	5,351	41,424	45,416
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	475.0	N/A	853.5
	COVID-related hospitalization rate (per 100,000)	N/A	954.7	N/A	394.6
Chronic Disease & Health Behaviors	Adult obesity prevalence	36.5%		29.1%	
	Diabetes prevalence	11.8%		8.9%	
	Diabetes-related hospitalization rate (per 100,000)	255.4	236.3	124.6	113.0
	Hypertension prevalence	30.5%		27.7%	
	Hypertension-related hospitalization rate (per 100,000)	689.8	608.6	380.9	328.6
	Potentially preventable hospitalization rate (per 100,000)	1,558.6	1,329.5	979.3	763.1
	Premature cardiovascular disease mortality rate (per 100,000)	57.3	69.2	26.3	30.1
	Major cancer incidence rate (per 100,000)	245.8		286.1	
	Major cancer mortality rate (per 100,000)	81.2		85.2	
	Colorectal cancer screening	64.7%		71.3%	
	Mammography screening	77.5%		77.4%	
	Physical inactivity (leisure time) prevalence	28.4%		19.6%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	17.3	10.2	10.0	2.9
	Infant mortality rate (per 1,000 live births)	--	--	4.1	2.7
	Percent low birthweight births out of live births	9.6%	9.7%	7.2%	6.9%
	Percent preterm births out of live births	7.2%	7.8%	8.7%	8.0%
Behavioral Health	Adult binge drinking	17.4%		18.8%	
	Adult smoking	20.5%		14.4%	
	Drug overdose mortality rate (per 100,000)	54.9	81.2	24.3	23.7
	Opioid-related hospitalization rate (per 100,000)	131.3	74.0	43.6	34.2
	Substance-related hospitalization rate (per 100,000)	649.2	503.6	265.9	223.8
	Poor mental health for 14+ days in past 30 days	16.8%		12.5%	
	Suicide mortality rate (per 100,000)	14.3	--	13.4	12.7
Injuries	Fall-related hospitalization rate (per 100,000)	9,934.7	7,734.6	3,146.4	3,083.5
	Gun-related emergency department utilization (per 100,000)	4.8	7.2	9.4	9.9
	Homicide mortality rate (per 100,000)	--	--	2.5	2.5
Access to Care	Adults 19-64 years with Medicaid	20.9%		8.0%	
	Children <19 years with public insurance	62.4%		21.5%	
	Population without insurance	13.0%		3.6%	
	Children <19 years without insurance	3.7%		2.3%	
	Emergency department utilization (per 100,000)	37,375.0	25,794.2	19,958.7	16,419.9
	High emergency department utilization (per 100,000)	1,136.1	680.2	319.9	247.5
Social & Economic Conditions	Population in poverty	17.2%		5.8%	
	Children <18 years in poverty	23.8%		6.9%	
	Adults 19-64 years unemployed	3.1%		2.0%	
	Householders living alone who are 65+ years	28.8%		43.5%	
	Households receiving SNAP benefits	24.2%		5.1%	
	Households that are housing cost-burdened	19.0%		12.7%	
	Housing with potential lead risk	70.9%		55.4%	
	Vacant housing units	11.6%		5.0%	

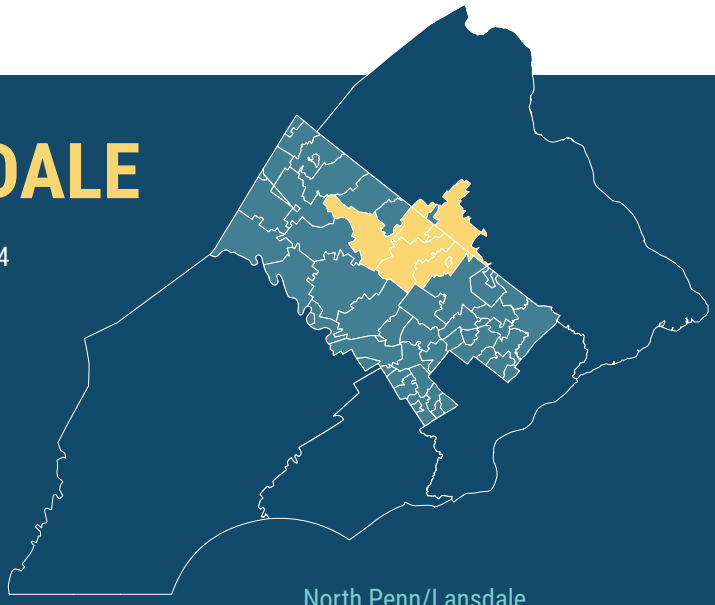
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

NORTH PENN/LANSDALE

ZIP CODE: 18915, 18932, 18936, 19438, 19440, 19446, 19454

This community is served by:

- Children's Hospital of Philadelphia
- Doylestown Health
- Einstein Medical Center Montgomery
- Fox Chase Cancer Center
- Grand View Health
- Jefferson Abington Hospital
- Jefferson Lansdale Hospital
- Rothman Orthopaedic Specialty Hospital



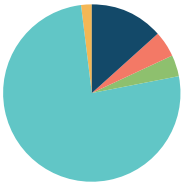
POPULATION

131,122

MEDIAN HOUSEHOLD INCOME

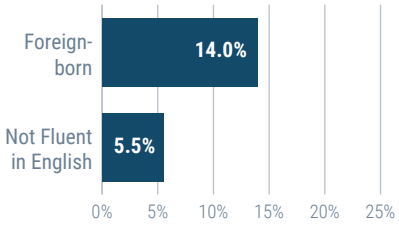
$94,899

RACE/ETHNICITY/LANGUAGE



13.4% | Asian*
4.9% | Black*
3.8% | Hispanic/Latino
76.0% | White*
1.9% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

1. Heart disease
2. Cancer
3. COVID-19
4. Cerebrovascular diseases
5. Unintentional injuries (excluding drug overdoses)

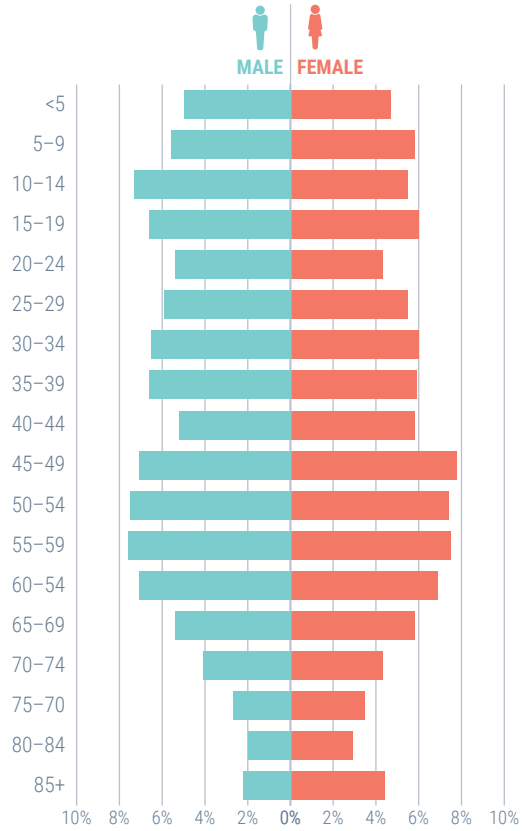
EDUCATIONAL ATTAINMENT

High school as highest education level **19.7%**

PEOPLE WITH DISABILITIES

9.6%

AGE DISTRIBUTION



summary health measures

		North Penn/Lansdale		Montgomery County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	1,007.5	1,153.9	939.0	1,072.8
	Life expectancy: Female (in years)	83.6	82.4	83.1	81.7
	Life expectancy: Male (in years)	78.9	78.5	78.3	77.0
	Years of potential life lost before 75	6,210	5,984	41,424	45,416
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	151.0	N/A	853.5
	COVID-related hospitalization rate (per 100,000)	N/A	398.1	N/A	394.6
Chronic Disease & Health Behaviors	Adult obesity prevalence	27.7%		29.1%	
	Diabetes prevalence	8.8%		8.9%	
	Diabetes-related hospitalization rate (per 100,000)	117.4	109.1	124.6	113.0
	Hypertension prevalence	27.1%		27.7%	
	Hypertension-related hospitalization rate (per 100,000)	353.1	292.9	380.9	328.6
	Potentially preventable hospitalization rate (per 100,000)	1,039.5	760.4	979.3	763.1
	Premature cardiovascular disease mortality rate (per 100,000)	19.8	22.1	26.3	30.1
	Major cancer incidence rate (per 100,000)	263.1		286.1	
	Major cancer mortality rate (per 100,000)	77.8		85.2	
	Colorectal cancer screening	71.2%		71.3%	
	Mammography screening	77.3%		77.4%	
	Physical inactivity (leisure time) prevalence	19.3%		19.6%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	17.8	--	10.0	2.9
	Infant mortality rate (per 1,000 live births)	5.9	--	4.1	2.7
	Percent low birthweight births out of live births	6.0%	6.3%	7.2%	6.9%
	Percent preterm births out of live births	5.9%	5.9%	8.7%	8.0%
Behavioral Health	Adult binge drinking	18.4%		18.8%	
	Adult smoking	13.7%		14.4%	
	Drug overdose mortality rate (per 100,000)	22.1	18.3	24.3	23.7
	Opioid-related hospitalization rate (per 100,000)	20.6	19.8	43.6	34.2
	Substance-related hospitalization rate (per 100,000)	178.5	160.9	265.9	223.8
	Poor mental health for 14+ days in past 30 days	12.0%		12.5%	
	Suicide mortality rate (per 100,000)	14.5	9.9	13.4	12.7
Injuries	Fall-related hospitalization rate (per 100,000)	6,375.2	6,571.2	3,146.4	3,083.5
	Gun-related emergency department utilization (per 100,000)	--	5.2	9.4	9.9
	Homicide mortality rate (per 100,000)	--	--	2.5	2.5
Access to Care	Adults 19-64 years with Medicaid	5.9%		8.0%	
	Children <19 years with public insurance	16.4%		21.5%	
	Population without insurance	3.3%		3.6%	
	Children <19 years without insurance	1.9%		2.3%	
	Emergency department utilization (per 100,000)	27,151.8	20,267.4	19,958.7	16,419.9
	High emergency department utilization (per 100,000)	329.5	190.8	319.9	247.5
Social & Economic Conditions	Population in poverty	3.9%		5.8%	
	Children <18 years in poverty	3.4%		6.9%	
	Adults 19-64 years unemployed	1.7%		2.0%	
	Householders living alone who are 65+ years	36.2%		43.5%	
	Households receiving SNAP benefits	5.6%		5.1%	
	Households that are housing cost-burdened	9.6%		12.7%	
	Housing with potential lead risk	32.0%		55.4%	
	Vacant housing units	2.1%		5.0%	

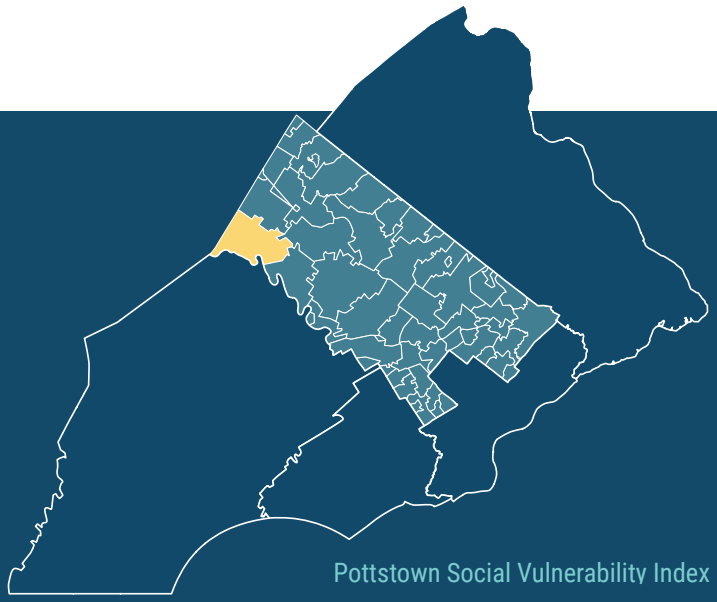
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

POTTSTOWN

ZIP CODE: 19464

This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Einstein Medical Center Montgomery
- Fox Chase Cancer Center
- Main Line Health



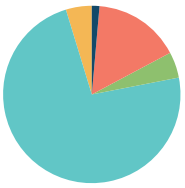
POPULATION

46,904

MEDIAN HOUSEHOLD INCOME

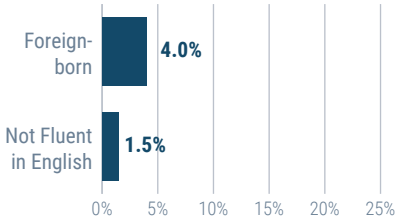
$62,956

RACE/ETHNICITY/LANGUAGE

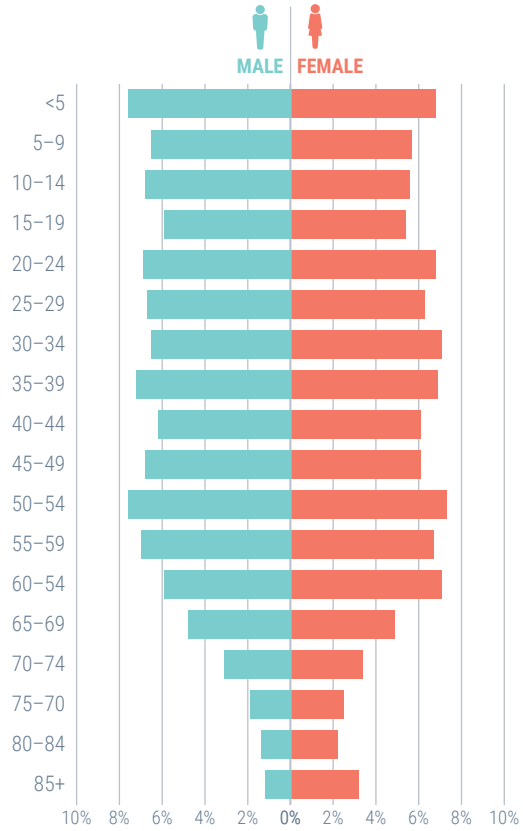


1.6% | Asian*
15.7% | Black*
4.8% | Hispanic/Latino
73.2% | White*
4.6% | Other*

* Non-Hispanic



AGE DISTRIBUTION



LEADING CAUSES OF DEATH

1. Heart disease
2. Cancer
3. COVID-19
4. Drug overdose
5. Chronic lower respiratory diseases

EDUCATIONAL ATTAINMENT

High school as highest education level **31.0%**

PEOPLE WITH DISABILITIES

13.8%

summary health measures

		Pottstown		Montgomery County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	1,059.6	1,066.0	939.0	1,072.8
	Life expectancy: Female (in years)	79.4	80.6	83.1	81.7
	Life expectancy: Male (in years)	72.7	70.8	78.3	77.0
	Years of potential life lost before 75	4,190	4,603	41,424	45,416
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	880.5	N/A	853.5
	COVID-related hospitalization rate (per 100,000)	N/A	373.1	N/A	394.6
Chronic Disease & Health Behaviors	Adult obesity prevalence	33.1%		29.1%	
	Diabetes prevalence	9.9%		8.9%	
	Diabetes-related hospitalization rate (per 100,000)	270.8	266.5	124.6	113.0
	Hypertension prevalence	29.3%		27.7%	
	Hypertension-related hospitalization rate (per 100,000)	452.0	545.8	380.9	328.6
	Potentially preventable hospitalization rate (per 100,000)	1,601.1	1,353.8	979.3	763.1
	Premature cardiovascular disease mortality rate (per 100,000)	51.2	61.8	26.3	30.1
	Major cancer incidence rate (per 100,000)	226.0		286.1	
	Major cancer mortality rate (per 100,000)	85.3		85.2	
	Colorectal cancer screening	67.5%		71.3%	
	Mammography screening	75.9%		77.4%	
	Physical inactivity (leisure time) prevalence	23.9%		19.6%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	--	--	10.0	2.9
	Infant mortality rate (per 1,000 live births)	--	--	4.1	2.7
	Percent low birthweight births out of live births	10.0%	8.6%	7.2%	6.9%
	Percent preterm births out of live births	7.3%	9.0%	8.7%	8.0%
Behavioral Health	Adult binge drinking	19.2%		18.8%	
	Adult smoking	19.5%		14.4%	
	Drug overdose mortality rate (per 100,000)	49.0	55.4	24.3	23.7
	Opioid-related hospitalization rate (per 100,000)	95.9	44.8	43.6	34.2
	Substance-related hospitalization rate (per 100,000)	748.3	458.4	265.9	223.8
	Poor mental health for 14+ days in past 30 days	15.7%		12.5%	
	Suicide mortality rate (per 100,000)	23.5	14.9	13.4	12.7
Injuries	Fall-related hospitalization rate (per 100,000)	7,614.2	8,764.8	3,146.4	3,083.5
	Gun-related emergency department utilization (per 100,000)	4.3	17.1	9.4	9.9
	Homicide mortality rate (per 100,000)	--	--	2.5	2.5
Access to Care	Adults 19-64 years with Medicaid	17.6%		8.0%	
	Children <19 years with public insurance	43.3%		21.5%	
	Population without insurance	4.4%		3.6%	
	Children <19 years without insurance	1.8%		2.3%	
	Emergency department utilization (per 100,000)	15,271.6	32,839.4	19,958.7	16,419.9
	High emergency department utilization (per 100,000)	204.7	699.3	319.9	247.5
Social & Economic Conditions	Population in poverty	12.0%		5.8%	
	Children <18 years in poverty	17.6%		6.9%	
	Adults 19-64 years unemployed	2.9%		2.0%	
	Householders living alone who are 65+ years	34.0%		43.5%	
	Households receiving SNAP benefits	14.6%		5.1%	
	Households that are housing cost-burdened	22.2%		12.7%	
	Housing with potential lead risk	60.1%		55.4%	
	Vacant housing units	9.4%		5.0%	

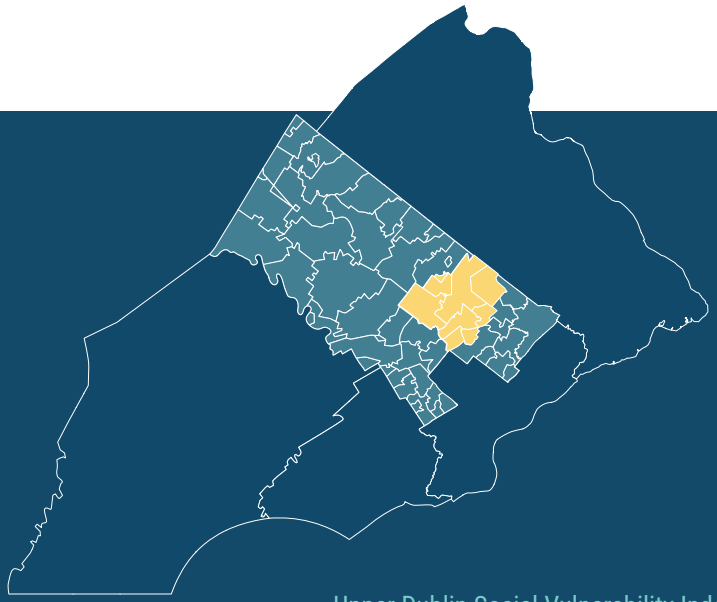
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

UPPER DUBLIN

ZIP CODES: 19002, 19025, 19031, 19034, 19044, 19075, 19436, 19437, 19477

This community is served by:

- Children's Hospital of Philadelphia
- Doylestown Health
- Fox Chase Cancer Center
- Jefferson Abington Hospital
- Jefferson Lansdale Hospital
- Magee Rehabilitation
- Rothman Orthopaedic Specialty Hospital



Upper Dublin Social Vulnerability Index

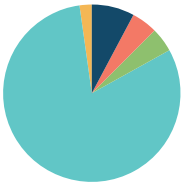
POPULATION

74,371

MEDIAN HOUSEHOLD INCOME

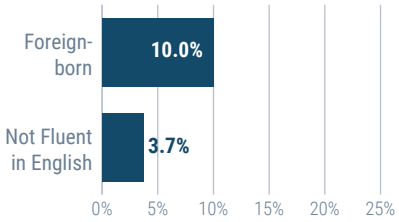
$112,285

RACE/ETHNICITY/LANGUAGE



7.8% | Asian*
4.7% | Black*
4.5% | Hispanic/Latino
80.9% | White*
2.1% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

1. Heart disease
2. Cancer
3. COVID-19
4. Cerebrovascular diseases
5. Alzheimer's disease

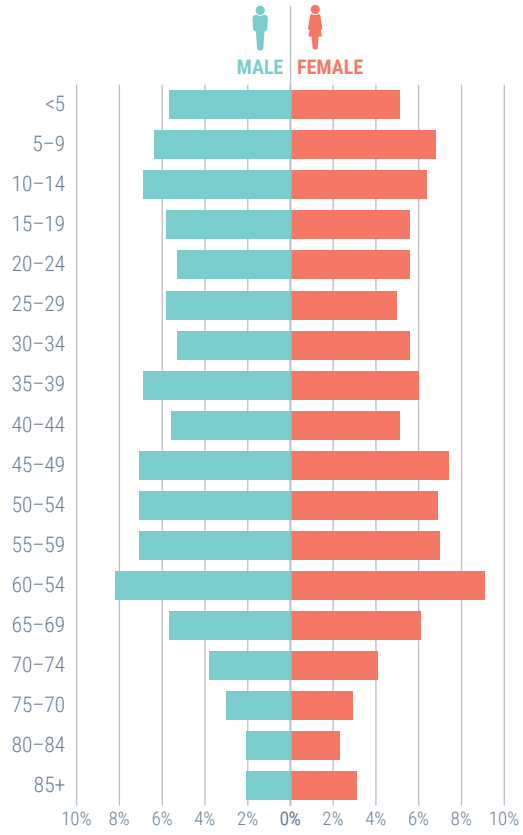
EDUCATIONAL ATTAINMENT

High school as highest education level **14.4%**

PEOPLE WITH DISABILITIES

8.2%

AGE DISTRIBUTION



summary health measures

		Upper Dublin		Montgomery County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	938.5	1,118.7	939.0	1,072.8
	Life expectancy: Female (in years)	83.7	82.4	83.1	81.7
	Life expectancy: Male (in years)	79.5	78.6	78.3	77.0
	Years of potential life lost before 75	2,969	2,961	41,424	45,416
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	217.8	N/A	853.5
	COVID-related hospitalization rate (per 100,000)	N/A	372.5	N/A	394.6
Chronic Disease & Health Behaviors	Adult obesity prevalence	27.8%		29.1%	
	Diabetes prevalence	8.5%		8.9%	
	Diabetes-related hospitalization rate (per 100,000)	94.1	87.4	124.6	113.0
	Hypertension prevalence	27.4%		27.7%	
	Hypertension-related hospitalization rate (per 100,000)	325.4	260.9	380.9	328.6
	Potentially preventable hospitalization rate (per 100,000)	890.1	650.8	979.3	763.1
	Premature cardiovascular disease mortality rate (per 100,000)	20.2	16.1	26.3	30.1
	Major cancer incidence rate (per 100,000)	255.5		286.1	
	Major cancer mortality rate (per 100,000)	82.0		85.2	
	Colorectal cancer screening	72.6%		71.3%	
	Mammography screening	77.9%		77.4%	
	Physical inactivity (leisure time) prevalence	17.8%		19.6%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	--	--	10.0	2.9
	Infant mortality rate (per 1,000 live births)	--	--	4.1	2.7
	Percent low birthweight births out of live births	6.9%	6.1%	7.2%	6.9%
	Percent preterm births out of live births	5.2%	5.3%	8.7%	8.0%
Behavioral Health	Adult binge drinking	18.5%		18.8%	
	Adult smoking	12.5%		14.4%	
	Drug overdose mortality rate (per 100,000)	18.8	20.2	24.3	23.7
	Opioid-related hospitalization rate (per 100,000)	8.1	8.1	43.6	34.2
	Substance-related hospitalization rate (per 100,000)	215.1	158.7	265.9	223.8
	Poor mental health for 14+ days in past 30 days	11.4%		12.5%	
	Suicide mortality rate (per 100,000)	14.8	8.1	13.4	12.7
Injuries	Fall-related hospitalization rate (per 100,000)	7,972.4	7,679.0	3,146.4	3,083.5
	Gun-related emergency department utilization (per 100,000)	--	--	9.4	9.9
	Homicide mortality rate (per 100,000)	--	--	2.5	2.5
Access to Care	Adults 19-64 years with Medicaid	6.0%		8.0%	
	Children <19 years with public insurance	14.9%		21.5%	
	Population without insurance	3.0%		3.6%	
	Children <19 years without insurance	2.5%		2.3%	
	Emergency department utilization (per 100,000)	21,068.4	15,895.1	19,958.7	16,419.9
	High emergency department utilization (per 100,000)	489.7	169.5	319.9	247.5
Social & Economic Conditions	Population in poverty	3.7%		5.8%	
	Children <18 years in poverty	4.0%		6.9%	
	Adults 19-64 years unemployed	1.8%		2.0%	
	Householders living alone who are 65+ years	59.9%		43.5%	
	Households receiving SNAP benefits	3.0%		5.1%	
	Households that are housing cost-burdened	7.7%		12.7%	
	Housing with potential lead risk	52.6%		55.4%	
	Vacant housing units	3.4%		5.0%	

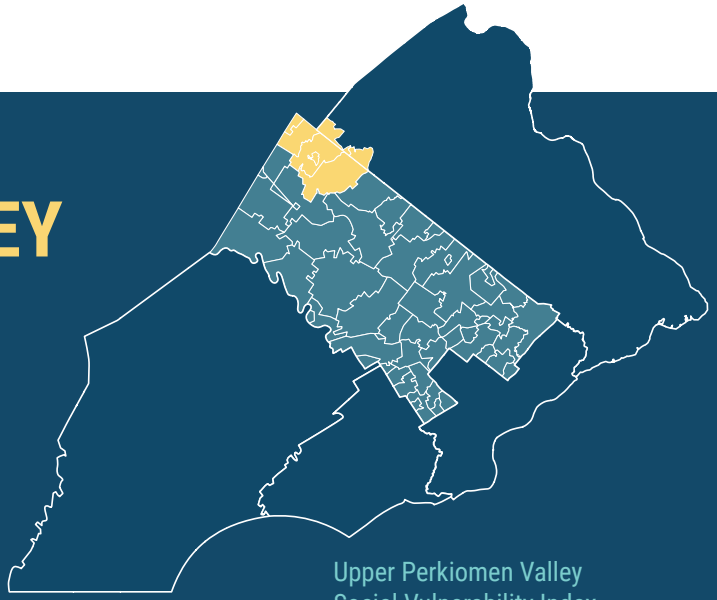
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

UPPER PERKIOMEN VALLEY

ZIP CODES: 18041, 18054, 18070, 18073, 18076

This community is served by:

- Children's Hospital of Philadelphia
- Doylestown Health
- Grand View Health



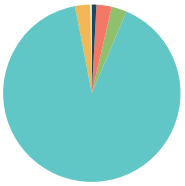
POPULATION

24,454

MEDIAN HOUSEHOLD INCOME

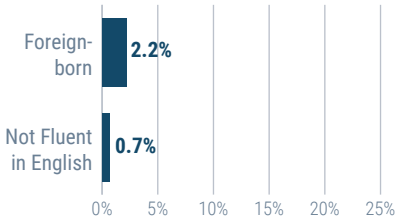
$78,759

RACE/ETHNICITY/LANGUAGE



0.9% | Asian*
2.8% | Black*
2.8% | Hispanic/Latino
90.7% | White*
2.9% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

1. Cancer
2. Heart disease
3. COVID-19
4. Cerebrovascular diseases
5. Chronic lower respiratory diseases

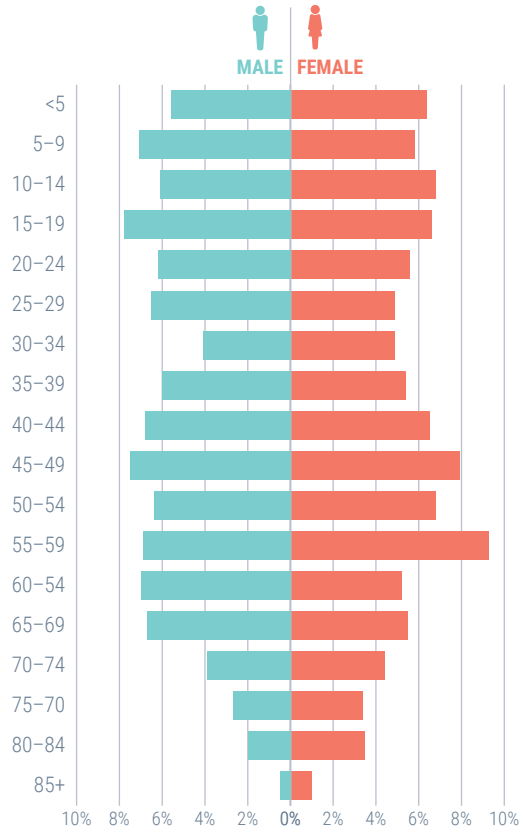
EDUCATIONAL ATTAINMENT

High school as highest education level **30.1%**

PEOPLE WITH DISABILITIES

10.6%

AGE DISTRIBUTION



summary health measures

		Upper Perkiomen Valley		Montgomery County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	809.7	940.5	939.0	1,072.8
	Life expectancy: Female (in years)	79.3	79.6	83.1	81.7
	Life expectancy: Male (in years)	78.0	76.7	78.3	77.0
	Years of potential life lost before 75	1,373	1,240	41,424	45,416
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	32.7	N/A	853.5
	COVID-related hospitalization rate (per 100,000)	N/A	184.0	N/A	394.6
Chronic Disease & Health Behaviors	Adult obesity prevalence	31.0%		29.1%	
	Diabetes prevalence	9.2%		8.9%	
	Diabetes-related hospitalization rate (per 100,000)	28.6	73.6	124.6	113.0
	Hypertension prevalence	28.6%		27.7%	
	Hypertension-related hospitalization rate (per 100,000)	269.9	265.8	380.9	328.6
	Potentially preventable hospitalization rate (per 100,000)	633.8	580.7	979.3	763.1
	Premature cardiovascular disease mortality rate (per 100,000)	--	24.5	26.3	30.1
	Major cancer incidence rate (per 100,000)	204.5		286.1	
	Major cancer mortality rate (per 100,000)	77.7		85.2	
	Colorectal cancer screening	70.1%		71.3%	
	Mammography screening	75.8%		77.4%	
	Physical inactivity (leisure time) prevalence	21.6%		19.6%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	--	--	10.0	2.9
	Infant mortality rate (per 1,000 live births)	--	--	4.1	2.7
	Percent low birthweight births out of live births	7.0%	5.1%	7.2%	6.9%
	Percent preterm births out of live births	5.7%	8.1%	8.7%	8.0%
Behavioral Health	Adult binge drinking	19.9%		18.8%	
	Adult smoking	17.9%		14.4%	
	Drug overdose mortality rate (per 100,000)	24.5	--	24.3	23.7
	Opioid-related hospitalization rate (per 100,000)	--	--	43.6	34.2
	Substance-related hospitalization rate (per 100,000)	159.5	175.8	265.9	223.8
	Poor mental health for 14+ days in past 30 days	14.2%		12.5%	
	Suicide mortality rate (per 100,000)	24.5	--	13.4	12.7
Injuries	Fall-related hospitalization rate (per 100,000)	3,497.8	5,121.8	3,146.4	3,083.5
	Gun-related emergency department utilization (per 100,000)	--	--	9.4	9.9
	Homicide mortality rate (per 100,000)	--	--	2.5	2.5
Access to Care	Adults 19-64 years with Medicaid	7.9%		8.0%	
	Children <19 years with public insurance	32.8%		21.5%	
	Population without insurance	3.9%		3.6%	
	Children <19 years without insurance	4.1%		2.3%	
	Emergency department utilization (per 100,000)	11,245.2	7,938.4	19,958.7	16,419.9
	High emergency department utilization (per 100,000)	132.9	46.7	319.9	247.5
Social & Economic Conditions	Population in poverty	5.2%		5.8%	
	Children <18 years in poverty	6.7%		6.9%	
	Adults 19-64 years unemployed	1.5%		2.0%	
	Householders living alone who are 65+ years	36.6%		43.5%	
	Households receiving SNAP benefits	6.1%		5.1%	
	Households that are housing cost-burdened	11.6%		12.7%	
	Housing with potential lead risk	50.4%		55.4%	
	Vacant housing units	6.5%		5.0%	

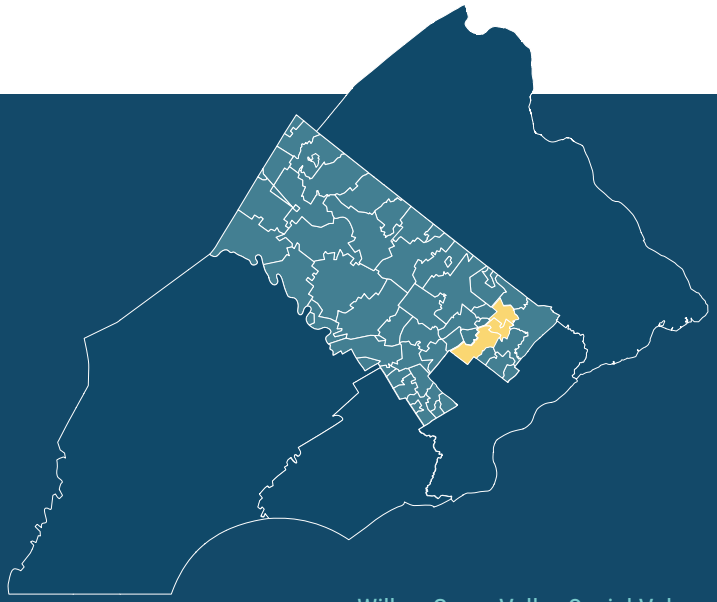
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

WILLOW GROVE

ZIP CODES: 19001, 19038, 19090

This community is served by:

- Children's Hospital of Philadelphia
- Doylestown Health
- Fox Chase Cancer Center
- Jefferson Abington Hospital
- Magee Rehabilitation
- Rothman Orthopaedic Specialty Hospital



Willow Grove Valley Social Vulnerability Index

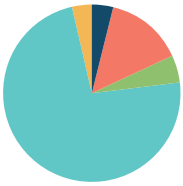
POPULATION

66,911

MEDIAN HOUSEHOLD INCOME

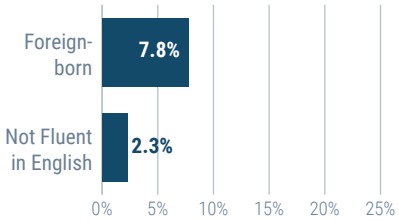
$88,858

RACE/ETHNICITY/LANGUAGE



3.9% | Asian*
14.4% | Black*
4.9% | Hispanic/Latino
73.4% | White*
3.4% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

1. Heart disease
2. Cancer
3. COVID-19
4. Cerebrovascular diseases
5. Alzheimer's disease

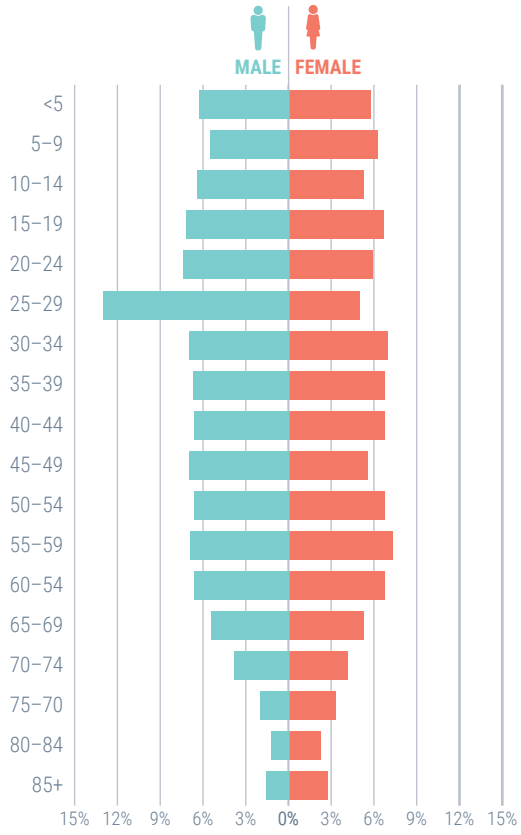
EDUCATIONAL ATTAINMENT

High school as highest education level **17.5%**

PEOPLE WITH DISABILITIES

11.4%

AGE DISTRIBUTION



summary health measures

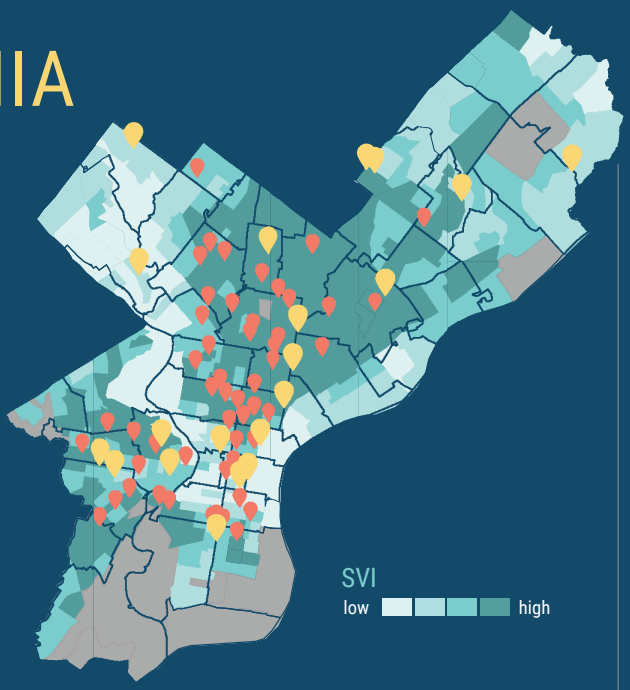
		Willow Grove		Montgomery County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	916.1	1,088.0	939.0	1,072.8
	Life expectancy: Female (in years)	81.9	80.5	83.1	81.7
	Life expectancy: Male (in years)	76.7	73.9	78.3	77.0
	Years of potential life lost before 75	3,760	4,571	41,424	45,416
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	248.1	N/A	853.5
	COVID-related hospitalization rate (per 100,000)	N/A	572.4	N/A	394.6
Chronic Disease & Health Behaviors	Adult obesity prevalence	29.5%		29.1%	
	Diabetes prevalence	8.9%		8.9%	
	Diabetes-related hospitalization rate (per 100,000)	142.0	109.1	124.6	113.0
	Hypertension prevalence	28.0%		27.7%	
	Hypertension-related hospitalization rate (per 100,000)	403.5	375.1	380.9	328.6
	Potentially preventable hospitalization rate (per 100,000)	1,001.3	787.6	979.3	763.1
	Premature cardiovascular disease mortality rate (per 100,000)	26.9	44.8	26.3	30.1
	Major cancer incidence rate (per 100,000)	331.8		286.1	
	Major cancer mortality rate (per 100,000)	103.1		85.2	
	Colorectal cancer screening	71.7%		71.3%	
	Mammography screening	78.2%		77.4%	
	Physical inactivity (leisure time) prevalence	19.0%		19.6%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	--	--	10.0	2.9
	Infant mortality rate (per 1,000 live births)	--	--	4.1	2.7
	Percent low birthweight births out of live births	8.8%	5.6%	7.2%	6.9%
	Percent preterm births out of live births	9.1%	6.1%	8.7%	8.0%
Behavioral Health	Adult binge drinking	19.0%		18.8%	
	Adult smoking	13.9%		14.4%	
	Drug overdose mortality rate (per 100,000)	29.9	23.9	24.3	23.7
	Opioid-related hospitalization rate (per 100,000)	37.4	37.4	43.6	34.2
	Substance-related hospitalization rate (per 100,000)	258.6	291.4	265.9	223.8
	Poor mental health for 14+ days in past 30 days	12.7%		12.5%	
	Suicide mortality rate (per 100,000)	12.0	13.5	13.4	12.7
Injuries	Fall-related hospitalization rate (per 100,000)	9,474.9	8,938.5	3,146.4	3,083.5
	Gun-related emergency department utilization (per 100,000)	--	3.2	9.4	9.9
	Homicide mortality rate (per 100,000)	--	--	2.5	2.5
Access to Care	Adults 19-64 years with Medicaid	9.4%		8.0%	
	Children <19 years with public insurance	24.5%		21.5%	
	Population without insurance	3.2%		3.6%	
	Children <19 years without insurance	2.5%		2.3%	
	Emergency department utilization (per 100,000)	22,508.1	19,407.8	19,958.7	16,419.9
	High emergency department utilization (per 100,000)	300.6	336.4	319.9	247.5
Social & Economic Conditions	Population in poverty	6.4%		5.8%	
	Children <18 years in poverty	5.6%		6.9%	
	Adults 19-64 years unemployed	2.1%		2.0%	
	Householders living alone who are 65+ years	35.7%		43.5%	
	Households receiving SNAP benefits	7.9%		5.1%	
	Households that are housing cost-burdened	15.1%		12.7%	
	Housing with potential lead risk	81.5%		55.4%	
	Vacant housing units	5.2%		5.0%	

* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

PHILADELPHIA COUNTY

HOSPITAL HEALTH CENTER

Philadelphia's residents are served by 20 acute care/ specialty hospitals and 52 community health centers.



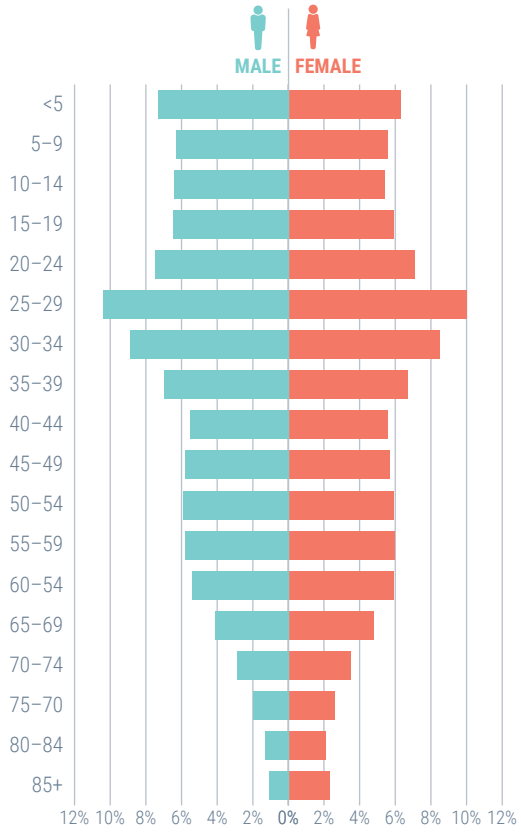
Social Vulnerability Index (SVI)

0 — 1.0 — 1

Median Income	$52,866
High school as highest education	31.3%
Food Insecurity	14.4%
With a Disability	16.6%
Violent Crime Rate	2,360 per 100,000

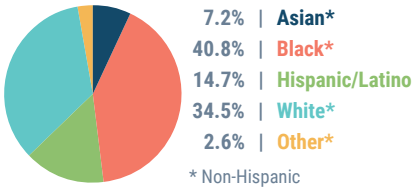
AGE DISTRIBUTION

Philadelphia County has an estimated population of 1,579,305, with the largest proportion of residents between the ages of 20 and 39.

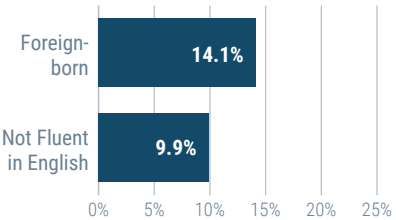


RACE/ETHNICITY/LANGUAGE

40.8% of residents are non-Hispanic Black. Non-Hispanic White residents make the next largest population, comprising 34.5% of the county's residents.



About 14% of residents are foreign-born and nearly 10% speak English less than "very well."



COVID-19 | Rates per 100,000

Fully Vaccinated	58,072.7
COVID-related:	
• Emergency Department Use	701.4
• Hospitalization	851.0
• Mortality	164.5

MORTALITY

Leading Causes of Death

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

YOUTH BEHAVIOR

Attempted Suicide	14.6%
Feeling Depressed/ Sad/Hopeless	40.3%
Binge Drinking	5.2%
Cigarette Smoking	2.1%
Vaping	7.1%

Far North Philadelphia and Northwest Philadelphia

COMMUNITY PERSPECTIVES

This summarizes focus group-style community conversations conducted with residents of two geographic communities: one each in Far North Philadelphia and Northwest Philadelphia.

Community Assets

The built environment, including access to green space, recreational facilities, and transportation, were valued as community assets in both groups. Green space and recreational programs promote well-being through opportunities for safe physical activity and stress management.

- *"We are totally surrounded by trees, and I find that just the beauty of the neighborhood ... and the fresh air ... and the fact that people enter our neighborhood garden a lot is very healthy for all of us."*
- *"Access to parks and to other recreational programs is great ... the Wissahickon Trail and Friends of the Wissahickon ... it's important to have a clean space and access to those hiking trails."*
- *"The Salvation Army Kroc Center is the bomb ... they have everything from yoga, Zumba, biking, treadmill ... I feel great, I'm back in the game." Another said: "they have wonderful health-focused programs for seniors."*

Another participant added that some centers need financial assistance:

- *"We have several recreation centers ... they need some support and help, but they're there and available."*

The built environment is enhanced by **easy access to public transit** for many. With the Olney Transportation Center for bus and subway transit, *"you can get anywhere in the city from that hub."* The community also is seen as walkable, particularly along the Germantown Avenue commercial corridor.

Access to quality, affordable food was cited as a community asset in both groups.

- *"We are very blessed to fight for and get the Save A Lot store ... because we really needed a place to get us fresh fruit, vegetables ... they've got good prices and very good products."*

Another shared that **available food markets reflect community cultural preferences**:

- *"We have good grocery stores, as well as corner stores of all different varieties. ... Certainly, the smaller stores are reflective of a lot of the cultural traditions of the community and neighborhood. ... They're contributing factors to the health and wellness."*

However, **grocery stores are not easily accessible for everyone, while corner and dollar stores generally sell mostly processed rather than fresh food.** *"Supermarkets are only on Germantown Avenue and may not be accessible for those who live farther away,"* said a participant from the Northwest Philadelphia group. Another participant noted that local organizations are donating fresh produce and other food, but information to help people find such resources can be challenging.

- *"The problem is finding out the information, but there's plenty of [food]. If you're hungry in this area, it's because you don't know where to go."*

Several participants highlighted the **availability of health care** in the neighborhood including primary care and physical therapy, and pharmacies that provide home delivery.

Key Challenges

The **availability of services and programs for older adults**, such as those provided at Center in the Park, **was cited as "*an excellent contribution*" to the community**. Programs include health promotion, social services, opportunities for socialization, and help for older adults to become more comfortable using technology.

- *"[There are] a lot of different resources within the community that are addressing the aging population…and making sure that their voices are being heard within the community."*

Community engagement, by both informal social groups (e.g., neighborhood blocks) and formal community organizations (e.g., East Mount Airy Neighbors), **was seen as a mechanism for inclusion of the collective community voice in addressing issues**.

Chronic conditions, including obesity, diabetes, heart disease, kidney disease, COPD, and chronic pain, were identified as key health problems. The need to raise awareness about and increase participation in healthy lifestyle classes and disease self-management programs was noted.

- *"One of the programs we were trying to run was a healthy lifestyle class. It's for people who are prediabetic, but everyone we reached was already diabetic. So, diabetes is huge in the community."*

Mental and behavioral health was a priority concern in both communities.

"I do think that our biggest issue, not just in our community but I think in all neighborhoods across the city, is mental health--whether it's individuals within our communities that are facing acute crises, or individuals that are suffering from chronic ongoing issues, such as depression and anxiety."

Drug and alcohol addiction are *"a scourge right now in all of our communities, whether it's hidden, like in my community, or if it's more in your face, like it is in other communities."*

Better access to affordable, convenient health care is a need in both communities, particularly for working families and older adults. Possible over-utilization of emergency services was cited, as was the need for mental health facilities providing high quality, affordable care within a reasonable distance.

A participant shared concern that 911 emergency services in her neighborhood are overutilized:

- *"It seems that in our community, at least where I am, 911 gets used as the healthcare system. From the amount of fire engines and medic trucks that are constantly in and out on the street … people use that as a medical system, as opposed to going to a doctor or a hospital."*

Another noted the need for increased access to urgent care centers, particularly at convenient times for working adults and families, and the use of mobile health outreach units to improve access to care for older adults.

- *"There's an opportunity for more mobile outreach units … to help seniors, to help people that are not available during the day."*

Challenges with navigating the health care system were discussed by most participants in both communities. Issues include ease of appointment making, the need for accurate lists of available providers, access to providers who accept new patients, and improved care coordination between primary and specialty care providers.

- *"Navigating the health care field is not the easiest thing in general with referrals … and making sure you know what information needs to be on the referral. You are told you need to go to this doctor but not specifically what testing, what needs to be done. Then you call and the appointment date is two months out … and you weren't sure that you may need x-rays before the appointment. So just making sure that providers are providing you with a clear understanding of what the next steps truly are."*
- *"I don't think it's just older seniors. I find myself having to manage all of my health concerns, and I can't get in to see my primary. I have to wait … and sometimes when I decide which specialist I'm going to, I'm not sure if it's the correct specialist."*
- *"A lot of times my primary care is not talking to my cardiologist, who's not talking to my pulmonologist, and I'm running around like 'Oh, I have to do this, and I have to do that' … and then they're like 'Well, I don't know anything about that.' "*

She added:

- *"It's just all these … hoops you have to jump through. … It just really gets way complicated sometimes, and they don't sometimes give you the respect that I think you deserve as a patient."*

Navigation challenges with online health portals also were mentioned, especially for those who see providers at multiple institutions that use different portals.

"There are numbers of university [health] systems across the city, and the patchwork ability that they all have to connect with their patients is very poor, and, actually, quite shocking. The platforms require certain levels of technical capacity, and hardware equipment that most of us don't have."

Lack of affordable care due to high co-pays and uncovered expenses was identified as a barrier to care, as was the need to assist individuals in understanding insurance coverage, such as deductible limits for Medicare policies.

- *"Even though you have the insurance, but you go see four doctors and you've got a $60 co-pay for a doctor – you know, who can afford that?"*

In both groups, participants mentioned reluctance to seek care for physical or behavioral health issues due to lack of cultural competence and empathy among healthcare providers and other professionals.

- *"One of the biggest challenges in our community is accessing mental health support that is culturally relevant and accessible."*
- *"How people are treated is essential. I'm talking about the genuine care that medical providers and medical institutions are providing to their patients. … I will go so far as to say that is the main barrier for people to access health and wellness in the community. I think that it's one of the reasons why a lot of people are reluctant to go get checked on a regular basis, because they're so badly treated, and so indifferently treated by the medical institutions across the city."*

Outreach services by trained professionals are needed to increase access to behavioral health care.

- *"There are people that are not willing to enter these programs. There needs to be some community outreach where someone will come out and try to assist, and coach, and coax and get these folks to understand that there is help. … I mean there's resistance. But it has to be available, and hands-on … and the help needs to be at their location, and oftentimes that's on the street."*

- *"They [people experiencing homelessness] don't have anywhere to go, they [facilities] put them out during the day … they aren't allowed to stay in these facilities in the rain, sleet or snow – they're out there,"* said a participant who suggested *"hospitals should provide more outreach to help them."*

Participants stressed that behavioral health programs need to be high-quality, evidence-based, and well-supervised.

- *"We also have many programs unfortunately that are not well supervised. We need … programs that are successful, and that work, and that ensure the health of clients as well as the community. … It doesn't make sense to have programs that just warehouse people, as opposed to helping them."*

Efforts are needed to address the stigma associated with mental health, such as media campaigns and community service announcements.

"There's not a time if I'm watching TV or looking at a magazine that I don't see something about breast cancer, diabetes, heart issues. So, I think people are very aware of that and that's because there's been a campaign. … I love that young people are talking about their therapy, you see it on the media - and I think it needs to be spread out, so it becomes the same conversation you have about diabetes we're now having about anxiety and the issues related to other mental health issues."

Social Determinants of Health

Built environment concerns were noted by most participants. Challenges include lack of walkability due to damaged sidewalks and speeding traffic, community cleanliness, and the poor condition of the *"wonderful green spaces and trees."*

In terms of **walkability and pedestrian safety**, one participant shared:

- *"It makes the city less walkable if people have to go around a hole in the sidewalk. So that's one of the things that makes being healthy a little bit difficult."* Others commented: *"We've had a number of people, seniors, who are not able to walk in their immediate neighborhood because of streets and the speeding traffic in our residential areas"* and *"Drivers run red lights regularly and don't look for people."*

Lack of community cleanliness was raised by several participants, who cited trash dumping, not leashing or curbing dogs, the need for additional trash collection and trash receptacles, and the need to educate businesses and residents on reducing trash.

- *"Our guys are out there every single day cleaning the Ave, that trash still comes back the next day. … You can put trash cans out there, but there's still going to be trash on the ground. That means that people are actually throwing trash on the ground, and they don't do that in other neighborhoods, but they do it in Germantown. So that's a health concern, especially during the pandemic. We saw gloves, masks, everything on the ground. … That's what I am trying to change."*

Safety concerns related to community violence were cited.

- *"There was greater violence in public spaces that used to be safe [parks, basketball courts]; this past summer there was a significant decline in use of outdoor space due to fear of violence."* Exposure to violence has had a toll on the mental health of Black boys and men, especially. *"Black boys and men, even if they are not involved in street culture, the constant toll of knowing that you can potentially be shot or knowing family or friends who have been, dealing with policing—there are a lot of those issues that we're ignoring."*

Improving access to healthy, affordable food (a high priority) and reducing access to less healthy products, such as tobacco, were recommended by several participants.

- *"What is sold in corner stores, the selection could be a whole lot more improved, and less tobacco, and unhealthy products, sodas and chips, in favor of fresh fruit and vegetables, and healthier choices that will improve people's outlook."*
- *"We do have some very limited farmers markets. ... Having healthy fruits and vegetables readily available and affordable in our community makes a significant difference for health, and that continues to be an opportunity."*
- *"Everything is fast food and greasy fried whatever ... people need healthy restaurant choices."*

The need for increased access to information and resources was raised. A participant involved with a faith-based organization noted:

- *"We have close to a thousand followers and we send out information ... because a lot of people do not know these places and services exist in our area, and that's one of the downfalls. Germantown is not a place that really advertises what they have and that it's positive. ... We need other groups and all of us to join together to spread the good news, to encourage all people, all ages and color, that we do have good things in Germantown, and the only way we can keep it going is by spreading the word."*

Children and Youth

Most participants discussed the need for safe places for physical activity and structured opportunities for youth during non-school hours. More community awareness of existing programs is needed, along with less screen time to encourage youth participation in recreational and physical activities.

- *"The lack of playgrounds, and the lack of recreational activities, or group sponsored activities as outlets for young children, middle [school] children and teenagers is very seriously lacking, and I think that affects health as well as our children being able to thrive."*
- *"When I was young, I was outside all of the time. With these video games, and TVs now, a lot of kids are inside. So, I don't think they're getting the exercise [they need]. And the other thing with the internet, you don't have face-to-face discussions. They're on the internet all the time, so they're not learning how to deal with a person face-to-face."*

Several participants emphasized the need to help children develop healthy eating habits.

- *"When I grew up, we had breakfast, lunch, and dinner, and it was in the house. The generation that's under me … they weren't raised to know what a balanced diet is. … If we can raise the children to eat healthier, then maybe they can teach the parents."*
- *"If we introduce the healthy food choices earlier on, then eating healthy should become a habit. … The sooner that we expose the kids to healthy food choices, I think that will help."*

More schools should offer the School District of Philadelphia's Eat Right Philly program, which one participant highly praised:

- *"It was wonderful because my daughter … would come home every week knowing another fruit or vegetable, and it taught me, taught the whole family, and she was excited about it."*

Housing-related health issues for children were mentioned, such as lead poisoning and childhood asthma from exposure to mold or other indoor air contaminants in aging houses.

Behavioral health issues, recognized by both communities as a top concern, included bullying and low self-esteem. The need for more volunteers to serve as mentors and role models, and to supervise youth was highlighted.

- *"There need to be volunteers that monitor what goes on. … They need supervision and role models that will show them the right path to take, as opposed to all of the negative role models that are everywhere in our community and jeopardize and put them at risk."*

Improved coordination of mental health services for students between school guidance counselors and community mental health resources also was recommended.

Older Adults

Social isolation and loneliness were cited as top issues for older adults by several participants.

- "*We have a lot of seniors [who aren't] sick or anything, but they don't have family, and there's no gathering places for them … like at the recreation centers. I know there's senior centers in different areas of the city, but I don't see a lot of people participating, especially since the pandemic."*

Chronic conditions. such as diabetes, heart disease, and chronic pain, were mentioned as common among older adults, as was asthma from exposure to mold and other pollutants in aging homes.

A participant who provides disease self-management programs for older adults cited the need to raise awareness about existing programs and coordinate care between hospitals, clinics, and the community:

- *"If they [a clinic] have a patient with diabetes, they refer them to a trusted organization that has a self-management program … they [the organization] can follow-up with them … it can reassure someone to stay on the right track to manage themselves."*

- *"Hospital social workers could work with senior centers to provide check-ins, or something that keeps the seniors on their radar screen."*
- *"At-home services that are well organized and do not require a lot of coordination and facilitation by the senior" are needed.*

Home delivery (e.g., food, medicines) and other home-based services for older adults are lacking – as is knowledge and support to help them find available resources, said several participants. One stated:

- *"My biggest concern is that there aren't enough advocates out there for seniors. … There is food out there, there are health services out there, but they don't know about them, and so there aren't enough advocates getting the word out." Furthermore, "we have things around here, but people don't know about them. So, they would need access through knowledge about them, and they would need access through just getting there physically, or having things delivered to them."*

Many aging homes are in disrepair, posing risks to older adults' mental and physical health. Especially for older adults on fixed or limited incomes, *"they don't have any way to address all these repairs … and they're like stuck in a cycle. Because if they fix the mold, now they can't pay the electricity, and they can't pay the gas, and that then does nothing but it adds to their stress."*

Transportation and other mobility issues are barriers for some older adults in both communities. A participant said about mobility issues:

- *"I think there could be a fear factor because of the different neighborhoods that we live in, where the seniors could be afraid to venture out because of what they feel may happen, or the type of neighborhood that you may live in."* Another person shared that CCT Connect (Customized Community Transportation) could be *"unreliable."*

Use of technology poses challenges for many older adults.

- *"A lot of older adults were forced into the virtual space because of the pandemic."*

Initially, *"some people had a lot of hesitation"* but now *"in the middle of the pandemic, people are connecting with providers online, or via phone."* One added that *"hospitals have to do computer literacy for elders,"* so that they can access their online medical records. Another suggested that hospitals coordinate with and refer to community resources that provide access to technology and training, such as Center in the Park and the Salvation Army's Kroc Center.

Predatory scams that target older adults add to their stress and vulnerability. For example, aggressive advertising of reverse mortgages was mentioned by one participant.

"The elderly are fearful because there are a lot of predators…I've seen people lose their house."

Other Groups

One participant noted an influx of immigrants in the Olney area, many of whom may lack knowledge about, or fear using, support services and resources.

- *The "neighborhood is very populated with new immigrants, new folks coming in that don't know the system yet, or are afraid of the system, or are outside of the system, who aren't able to access the health benefits that others of us can enjoy. … How do we work to make sure that they know about the services available to them?"*

Pandemic Impacts

Participants in both groups had **mixed views on the shift toward telehealth during the pandemic.** As discussed above, technology poses challenges for some older adults; however, some shared that use of telehealth during the pandemic was positive, especially for certain types of visits.

- *"People didn't have to worry about physically going to their provider. They could just call in or do a Zoom. I think it made access a little easier, so it's nice to continue that when applicable."*
- *"I found [telehealth] easier with some of my doctors. However, for some things, it was nearly impossible. … You can't see a cardiologist over the phone, it just doesn't work as well. But in general, [with] my GP [and] the diabetes educator, that stuff was all fantastic. It actually made it easier to set up also … I didn't have to walk out the door, I could pretty much be in my house in sweatpants."*
- *"With regard to accessing medical care in the pandemic … I experienced a range of different medical providers, some have capacity to do tele-visits and phone visits, others have no capacity."*

Delays in getting care during the pandemic were discussed.

- *"People have been very timid about going to doctors and the hospital because of COVID."*

Another issue was long wait times for appointments, particularly with specialists. One participant, who helped her brother make medical appointments, said he has to wait months for scheduled visits.

- *"It's hard. I mean, it's very difficult. … We've been waiting since September for one, the earliest appointment is December 3rd."*

Another appointment for her brother was more than six months away.

Participants also shared that access to testing and vaccinations, particularly early in the pandemic, was lacking and people were unaware of where they could get vaccinated. They highlighted outreach efforts led by Dr. Ala Stanford (founder of the Black Doctors COVID-19 Consortium) and availability at local pharmacies.

- *"It wasn't until Dr. Stanford came into communities of color that we had access for vaccinations, and it wasn't until our major pharmacies like CVS and Walgreens, and we have a limited number in our community, made this available."*
- Another shared that the pandemic *"opened up the void and gap in services, it made it more visible, particularly for people with chronic illness."*

Suggested Actions

Engage city council members and state representatives in efforts to improve community health.	More government funding is needed and allocated appropriately. *"We need to stay on our city council and state reps. They've got to step up. … It starts with them."*
Increase access to culturally competent behavioral health care.	Many participants cited getting more help for people with mental or behavioral health issues as a key priority.
Increase public awareness about community resources and services that support health.	*"There are a lot of great programs and community initiatives out there but people just don't know about them."* Several participants suggested the use of advocates to help vulnerable residents, such as older adults, obtain needed information, and support. *"I just think more information needs to be disseminated to people in the community so that they know what they can access,"* one said. Others encouraged "*more effective advocacy; getting the word out about available services"* and *"increasing knowledge of available resources."*
Expand out-of-school time programs to help children develop healthy eating habits and other life skills.	*"It would go a long way toward developing citizens who understand the bigger picture of health and community,"* said one participant. Another mentioned the need for programs to help young people develop stronger social connections to help reduce interpersonal conflicts and bullying. Other suggestions included increasing the availability of structured, supervised activities for youth and working with the community to expand programs, such as those offered by Weavers Way, which provide healthy afterschool snacks and encourage youth to eat fresh fruits and vegetables.
Provide youth with career pipelines to help increase diversity of the healthcare workforce.	For example, develop ambassador programs with hospitals or other health care facilities to educate youth about health professions.
Hospitals could invest in patient advocates based in the community and provide more services in the neighborhoods where people live and work.	Increased access to primary care services in the community also is needed. *"Critical care centers, cancer centers have social services and patient advocates as well as resources available. We need more of that for our community so we're not using 911 or other avenues to reach medical facilities."*

Suggested Actions

Coordinate healthcare/ clinic services with community services to support healthy aging, disease management, and access to technology for older adults.

Areas of focus include:

- Expand mobile health outreach for older adults and working families.
- Increase coordination between hospital social workers and senior centers.
- Expand activities and socialization opportunities for older adults.
- Provide more help for older adults to age in place, including better access to home-repair assistance programs, more accessible and affordable home care services, and greater support for navigating services.

Expand assistance for the "near poor."

That is, provide help for vulnerable older adults and others with incomes that are limited but above the cut-off to receive various subsidies and services. For example, one participant talked about her father's inability to afford a stairlift, because his pension income put him above the threshold to qualify for financial assistance for this major purchase.

"You know, it's almost like he's punished for giving 41 years to a job, and … he's not rich by any means, but he's not, I guess, what they would call income poor. But he is, in the sense that he can't afford a stairlift."

Engage the business community in improving community health.

- Expand Germantown United CDC's Taking Care of Business program to address community cleanliness.
- Bring together area businesses, such as corner stores, and community organizations to work together to improve the community. For example, create opportunities for neighborhood corner store owners to learn about healthier products that residents desire.

  "We need to get them [store owners] on a meeting so they can learn what the neighborhood would like to see in their stores, or taken out of their stores, and brighten up their stores so all age groups can feel safer going into their stores."

Increase neighborhood parks and playgrounds by cleaning and greening vacant lots, particularly those that are tax delinquent.

Far Northeast Philadelphia and Lower Northeast Philadelphia

COMMUNITY PERSPECTIVES

This summarizes focus group-style community conversations conducted with residentsof two geographic communities: one each in Far Northeast Philadelphia and Lower Northeast Philadelphia.

Community Assets

A safe environment and sense of community were noted as keys to a healthy community in both groups. One participant shared:

- *"I think what makes a healthy community is a community where you feel safe … and where you can have the complete healthy lifestyle — healthy food choices along with healthy places to get free outdoor activity."*

The built environment, including parks, playgrounds, schools, and recreational facilities, provides opportunities for physical activity and socialization. In addition, the community was noted as "walkable," particularly along Germantown Avenue, providing access to food, pharmacies, and other basic needs. The Riverwalk and access to outside parks, particularly in the Lower Northeast, were noted as safe, free resources that support physical activity. A local civic association organizes volunteers to clean local playgrounds.

- *"I was just thinking about all the pharmacies that are popping up in the area, which is a good thing, people can get their medication, vitamins. Anything that's going to help them with their health or hygiene."*
- *"We're not in a food desert. We have the Acme, so we have access to fresh food and produce."*
- *"There's the neighborhood playground, we have a track. A lot of parents and kids when they're up there for different activities, take time to walk the track."*

Community involvement and volunteerism support health in the neighborhoods. One participant shared:

- *"Volunteerism is very important to keep the community healthy."*

Another commented:

- *"If you make the neighborhood something that you're proud of, you don't mind getting involved."*

Participants in both communities underscored the important role of community volunteers and organizations in helping people access food and other resources.

Organizations, including schools, libraries, and faith-based institutions, were cited as community hubs that help those in need and enable people to come together for physical activity and socialization.

- *"The YMCA is a great community hub for people to maintain a healthy lifestyle, both mentally and physically, where people can have an active social life."*
- *"Caring for Friends donates meals to people that are isolated in their homes. You have your local churches that have senior programs and you have your libraries."*

Due to the efforts of two older adults, more than 200 older adults and immigrants are more physically active:

- *"Every day they take the kids to school and then they gather in the park nearby, and they dance together and exercise."*

The Pentecostal Church provides resources for those who are experiencing homelessness or need resources.

- *"I go and find out what they need … and they tell me what's happening so I can find them the resources."*

The Salvation Army and other groups distribute food to those in need.

- *"Just within a few blocks they give out food on different days of the week … and a group of senior citizen volunteers made a community garden in Lawncrest Park."*
- *"At the school, especially during COVID, they had meal programs that were set up by the government through the Archdiocese. We also offer snacks for the children after school. I believe the YMCA also offers a meal program for their children."*

Health services such as mobile mammography and Emergency Medical Services (EMS) community education programs including CPR, First Aid, and Narcan training are provided at community facilities.

Key Challenges

Major health concerns identified include heart disease, cancer, high blood pressure, and diabetes. Lack of proper nutrition and physical activity as well as stress were identified as contributing factors. Access to care issues impacting health outcomes include a shortage of free clinics and limited access to dental care.

- *"Heart disease, high blood pressure, and overwhelming stress. Diabetes definitely … with lack of movement, lack of proper nutrition, eating too much food on the go."*
- *"This [pandemic] was the rainy day that you need to save for, and for some families unfortunately, it put a lot of stress on them. And individuals not taking time for themselves, and just being too busy and overwhelmed with family, and maybe not having enough resources to help them out with all the things on their plate."*

Most participants from both communities cited behavioral health challenges as priority concerns for both adults and youth. Lack of available providers, cost of care, and stigma were noted as barriers to care. Increasing awareness about the availability of local mental health providers was recommended.

- *"In my opinion, it [the pandemic] has raised the depression rate and suicide rate. … If you are in the house by yourself, if you're a widow or widower, and you can't go out … you can't see your children or grandchildren … it has affected everybody. And family problems as well, because you got people living in the same house for a year."*
- *"During the pandemic, many people stay home all the time, adults and children, and they cannot go anywhere. It creates a lot of stress on people, mentally. Physical health and healthcare are important, but spiritual, mental health is something we should explore more … because when people get depressed … they get into anger, bickering and fighting in the family."*
- *"Just breaking the stigma of mental health, treating it just like you would diabetes, or high blood pressure, or heart disease. I think people are more reluctant to ask for help because of the stigma, they're ashamed or embarrassed. We need to make them understand that there's nothing to be ashamed about. We need to make it feel more normal to have those things."*

Several participants discussed the negative impact of substance use on the community and its association with increased homelessness and crime.

- *"If you walk into my neighborhood, you see this daily, when you go out the door. People just walking, homeless, standing there with needles in their hand … Families need the park back."*

A participant trained in Narcan administration carries it during community outreach and has revived several people: "

- *You can have all the spiritual prayer, but sometimes they don't wake up. Sometimes they get angry because you took their high away, but others may be thankful. I have a couple of people that went into rehab after they had that experience."*
- *"I think it's substance as well as mental health, because people who are on drugs often also have some type of mental health issues."*
- *"The drug epidemic is something that we should definitely be concerned about on the street. The guns, you know, we're starting to work on anti-gun violence."*

Access to healthcare issues include transportation barriers, inability to afford healthcare costs (including out-of-pocket expenses), long wait times for appointments, and delayed care. These issues are particularly acute for those who are new immigrants, uninsured, or have lower incomes.

In terms of **transportation and affordable care**, one participant said:

- *"Some people just can't get there … you might be taking a bus there at seven in the morning and coming back at 6:60 at night, because that's the only time slot they have. … I'm on the edge of the Northeast and there's no free clinic – there's nothing like that for something minor. Everything is pay as you go."*

Social Determinants of Health

Another noted the impact of the pandemic:

- *"During COVID, getting rides to doctor's appointment and social services was hard."*

Obtaining timely primary and specialty care is problematic and made worse during the pandemic: *"There's help, but it's very difficult to get help. There are not enough doctors, counselors, to see people who are suffering and then the cost of healthcare. Because of COVID, there's so many more cases of depression and anxiety and the suicide rate has increased, because they can't get in to see anybody. There's such a backlog of patients."*

Another noted: *"The health center is overbooked. … A patient can wait 6 months to see the doctor…that's a real need, you know, more healthcare for low-income people."* Another participant stated that *"getting an appointment with a specialist was a three month wait."*

People are delaying preventive care due to perceived backlog of services. *"I put off a procedure because of COVID, because I figure I could wait another year because they're so backed up, and I figure some other person needs it more than I do. So, I put it off for a year."*

Healthcare navigation services are needed, particularly by older adults and immigrants with limited English proficiency. Assistance with scheduling appointments is needed for those who lack access or skills to use technology, speak another language, or have visual or other impairments.

- *"Older people, seniors, you know newcomers, they don't have that ability and there's nobody to work for them or with them."*

In both communities, participants noted that community assets were not universally accessible, leading to challenges related to the built environment, poverty, food access, and homelessness:

- *"When I moved in, there was nothing really healthy about the whole area … too much poverty, too much homelessness, too much drugs going on."*

Housing quality and increasing homelessness in the community were areas of concern.

- *"We're seeing more people out and about with homelessness now."* Another participant noted the impact of the pandemic: *"Too many living on the streets even with COVID 19."*
- *"There's a lot more renters popping up in the area. And in some, the houses are not kept up, and the property is not kept up. Then there's also a number of houses that are empty. And that can lead to problems in the community, for example, in terms of safety."*

While parks are available, one person shared that some are little used or unavailable due to safety concerns.

- *"There's no place for the kids … there's a park but they fenced it up because of all the drugs, things that are going on, all of the homelessness. People are practically pushing their needles in front of your face, and you have to tell them to stop when you're walking with the children."*

Access to food was seen as a community asset; however, for some individuals, available food resources may not be affordable, especially during the pandemic. In addition, healthier food in the community is needed, particularly in daycare facilities and schools:

- *"Even just to get daily food, a lot of times you can go to different food banks or shelters if you set it up right … and some of them just aren't available. … It's harder to find them open, and have any extended hours [since the pandemic]."*
- *"There's a restaurant that's like two blocks away that feeds you greasy food and I don't think that's healthy. I think we need a nutritional program for our daycares."* Another participant shared that school food is *"still not what it should be."*
- *"So, access to healthy foods for one. We have our supermarkets, but we don't have any type of co-op for people that have financial issues, and maybe can't afford to shop in the local supermarket, so we probably could have more of that."*

Access to resources for those experiencing economic distress was cited as a priority. Several participants voiced concerns about the ability of the working poor and individuals with disabilities to get assistance when needed.

Some people "*are on the cusp*" of being poor and do not qualify for government support services, such as SNAP (food stamps) and Medicaid.

- *"You know it really does make a difference what they're able to get food-wise … just not food stamps but even Medicaid as opposed to Medicare … that keep them from going through with doctor's appointments or getting their medication, all those little things that pile on and make a difference. If you make just $25 more, nothing's available to you. … I think that's something that has to be addressed somehow for those people that are just on the margin all the time."*
- *"The working poor, whatever term you want to use, or the disabled that are right on the cusp… if you take a job then you are losing that [benefit assistance]."*
- *"One of the real problems is that there has to be someone or somebody that can bridge that gap between the poor and almost poor. The person who's almost poor is still poor, because the difference could be $2 where they didn't make the cut."*

Knowledge about healthy lifestyles is important to maintaining health throughout the life cycle. Access to this information is lacking or may be from sources that promote misinformation. Increased awareness of community resources and service options is needed.

- *"Living a healthy lifestyle is getting adequate sleep, adequate nutrition, hydration, vitamin D, getting outside, and movement. Whatever we have that contributes to that is good, and whatever we're missing, we need more of. There's a lot of misinformation out there."*
- *"There's not a lot of options in the Northeast, or if there are, people don't know about them."*

Use of technology and telehealth visits have expanded during the pandemic. Access and ability to use technology can vary based on factors such as socioeconomic status and age. Preferences for using technology versus human interaction also varies.

- *"Who was able to use technology during COVID? So many people lost their jobs, so where's the income coming to pay for the internet … or access to the equipment?"*
- One person shared that utilization of telehealth during COVID was positive: *"It saved me time, you know, waiting in the clinic – telehealth saves a lot of time and is efficient. My clinic put the patient records in a digital system, so we can go and access our health record our self. It works pretty well for most healthy people and who understand English."*
- *"It's hard to get people on the phone anymore when you want a doctor. Everything's always done through these portals, where you have to message everybody. Sometimes it's nice just to talk to a human, interact that way, instead of doing everything through the computer. … If you don't know your passwords, then everything else is hard to get a hold of and access."*

Children and Youth

Participants from both communities expressed concerns about mental health and substance use among youth, particularly the increasing rates of anxiety, depression, and suicide. Use of substances, chiefly marijuana, alcohol, and vaping, was highlighted as a major health concern as was the impact of social media on the mental wellness of youth. Lack of resources, including behavioral health professionals, was also cited.

- *"There were children that were very fearful coming back to school. School anxiety was through the roof."*
- *These kids are experiencing more depression, more anxiety. The suicide rate is climbing, drug use is climbing, especially with marijuana. They feel it's legal, everyone's doing it, the government's allowed it. … They're trying to run away from their problems and using drugs. I don't see enough resources, there's not enough doctors around to handle this problem. With parents, I don't think there's enough information on where you can get help."*
- *"Those who are 18 or younger are able to get their hands on vapes, or tobacco products, which is causing a problem with our youth right now. … My daughter, she's a freshman in high school, said the vaping is terrible in school. They can't even go to the bathrooms without the girls vaping. Whether they're vaping tobacco, or marijuana, the vaping is unbelievable."*
- *"I believe social media plays a huge part. Teenagers, especially the females, are in constant contact with people. If it's bullying, if it's trying to keep up with the others, it's 24-7, they're up in the middle of the night, they're just literally addicted to this. … Social media draws them in … how many likes you get, that's what keeps them going. They keep trying to do these videos, so they get more and more likes. They feel like they're winning, and if they don't get their likes, they're losing, so they get depressed."*

Participants linked the lack of positive opportunities for youth to stress, depression, and substance use. They stressed that to effectively engage youth, they need to be involved in planning and implementing the activities they desire. Opportunities to volunteer and gain work experience are needed.

- *"Kids here basically stay inside. There's too much violence in the surroundings. The park needs to be recreational instead of closed to families … it very much helps with depression and stress."*
- *"There's nothing for them, that's why kids are going into the drugs."*

One individual who worked with youth shared: "

- *"You know it was when we volunteer, we cooked at MANNA, we did the Red Cross, we did all of these things. But, you know, the kids wanted to do it, you've got to get the kids involved."*
- *"There's a number of sports that have started up again - soccer, basketball, track, swimming. When COVID hit, a lot of children were in the house and there were no activities for them to be involved in. That's started up again, and we're seeing children becoming more healthy."*

More preventive education and school-based counseling services are needed, as well as healthier food in schools.

- *"Professional mental health advocates are needed in the schools so youth can feel safe and go to that person and talk. These kids don't know where to go to for help. It's hard for parents - working maybe a full-time-and-a-half job, they're not there for the kids, because they're trying to put food on the table. Teachers are overwhelmed trying to teach, and do test scores, and state testing. They don't have time to counsel these kids."*

Prevention education, on topics such as nutrition, sexuality, and substance use, is effective and needed. According to a participant who teaches and whose students received education about vaping: "*I think it was eye-opening, because they received information like a pack of cigarettes is equivalent to one vaping.*"

- *"We need more workshops in schools and parents to really stand up."*

A participant who works with immigrant communities spoke about the stress created in immigrant families related to cultural transitions across generations and the need to support these families.

"When they (youth) go out of the house, they're exposed to a totally different culture, but when they come home, the parents expect them to be traditional Chinese... this causes a problem. And the kids are really stressed out and the parents are also stressed out, so more help for the immigrant community is needed."

Older Adults

Mental health and needs related to transportation, access to healthy affordable food, and affordability of health care and medications are concerns for older adults, especially those living on a fixed income.

- *"If they are already low income, and now they're retired and they're not bringing in any income, a lot are afraid to go to the doctors because they're afraid to get that bill, they're afraid to spend money on medication. Is it medication, or is it food, or heat in the house? They have to make these decisions, it's awful, they shouldn't have to go through this."*
- *"The concern would be financial. Being able to afford the medications they need and not trying to cut corners like breaking medications in half or taking them every other day. Or being able to get to a doctor, or hospital...as they get older, a lot stop driving, or should."*

One person who works with immigrants shared that for older adult immigrants who live just above the poverty line, but do not have a green card or have not been in the United States for at least five years, access to services may be limited due to lack of eligibility.

Understanding Medicare, telehealth, and how to access services and resources that promote aging-in-place were described as challenging for some older adults.

- *"My husband is reaching 65 and looking for Medicare and supplemental insurance. He's an intelligent gentleman, but he found it to be extremely confusing trying to figure out the right supplemental insurance to go with it. What was needed, what wasn't needed, based on his health problems, or his medications? One person would tell him one thing, somebody else would tell him something else. So that was a little confusing."*
- *"Knowing they could stay in their homes, that they don't have to go to a nursing home if they don't need to. That they could have a service that will come in and help them age in place, that's important. That helps a senior citizen in their journey as they're aging, knowing that they can stay in their own home. It alleviates a lot of anxiety and stress of having to go to a nursing home, if it can be avoided. More services are needed to assist with that."*

The need for socialization is paramount for mental health. Participants from the Lower Northeast noted a need for more senior centers as the few that exist are overcrowded. One mentioned that while the Veterans Center provides a variety of programs and services for retired veterans, more funding is needed to assist in obtaining necessary resources and to promote socialization.

- *"My mother is 88-years-old and she has a lot of friends that are in that range and some of them have not come out of the house. They don't go out anywhere, they're afraid. It's mentally not good."*

A participant said about the YMCA:

- *"The first thing for older adults is definitely keeping the mind healthy with social interaction. Sometimes they come in and they don't even touch a piece of equipment. They're there just for social interaction and their mental health. Movement is important - definitely keeping them moving in some way."*
- *"My mother lives over in Christ the King Parish...Recently, she started going with a friend to Christ the King. They play bingo, and they had dinners, and it's a social event every week. It's just with women. She has been so happy lately. I just think that's a positive. Other parishes or community centers might have that as well."*

Telehealth and the use of technology were seen as helpful but also challenging. While it improves access to care, access to the technology and knowing how to use it are barriers for some older adults.

- *"As far as seniors, I think telehealth is good, because if they can't get out to the doctor, at least they could talk to somebody, and I think a lot of seniors, just want to talk to somebody for a little while about their health, or their conditions."*
- *"Speaking personally, it's not good because they don't have access to a computer, or don't know how to use a computer. So, it wouldn't work."*
- *"Most of our seniors were okay with the access, they just were confused with how to use it. And they weren't crazy about, having a virtual call with their doctor as opposed to a physical one. We did have a few ask us to show them on their phone different ways to take a video call, so yes, we did help them with simple steps."*

Other Groups

Individuals with special needs were cited in one group as a population that faces social isolation and needs assistance in accessing resources and services.

- *"We see many folks with special needs that are living in group homes or other arrangements. They are receiving services but they feel disconnected in a lot of ways from the community. We see them on the healthcare side, but you know, 80% of what we do is emotional support and 20% is medical support. I think a lot of the special needs population living in our communities in residential homes could do better as far as feeling ... more integrated into our community."*
- *"I have a child with special needs. I know what it is to be in hardship and feeling like there's nobody there to reach out to. There has to be a different form to reach out to people, even if it's leaving something on their doorstep with some kind of brochure on how to get in touch with someone if they need help."*

Suggested Actions

Expand preventive education and school-based counseling services that also use peer supports.	*"A lot of stuff that youth are getting on social media is false information. They need to hear from a professional, and it doesn't have to be in person. They could do large Zoom classes, and listen to other kids, or people their age about what they went through. I did a couple seminars with young teenagers, girls who were caught in domestic abuse, and the girls who watched this, they connected, and they were able to open up and speak more freely about what they endured and to seek help."*
Increase volunteerism.	For example, civic organizations could increase resources to meet community needs by expanding programs that incentivize students to volunteer as well as adults. For youth, incentives might include free standardized test preparation courses and opportunities to fulfill graduation requirements for community service. Opportunities for volunteerism that appear to work well include bilingual interpretation, food distribution, tree-planting, community clean-ups, and visiting the elderly.
Increase awareness of community resources and service options, including health education programs, among health professionals, community organizations, and residents.	*"You have all of these resources, but the problem is, a lot of people don't know about them."*
Increase access to affordable, fresh produce through the creation of food co-ops and local farmers markets.	
Increase awareness about the availability of local mental health providers to reduce barriers to care.	*"Maybe hospitals or pharmacies could have a display of mental health facilitators [available] in the area because we have a lot more low-income people [living in] the neighborhood. If they can't travel because they have no car, but there's somebody in the neighborhood they could walk to, or maybe take a short bus ride to for help, because no one wants to travel miles just to see a doctor."*
Support the mental health needs of health care and mental health professionals to retain professionals in hospitals and the community.	
Increase engagement of civic organizations, policymakers, and city government in community-led solutions.	
Develop "bridging" strategies to improve access to healthcare and social services for individuals who have lower incomes but do not qualify for public assistance.	*"There needs to be something put in place to bridge that gap for those [near-poor] folks who don't meet certain criteria."*

North Philadelphia-East, North Philadelphia-West, and River Wards

COMMUNITY PERSPECTIVES

This summarizes focus group-style community conversations conducted with residents of three geographic communities: one each in North Philadelphia-East, North Philadelphia-West, and the River Wards.

Community Assets

A number of participants praised the work of local organizations serving the community, such as **nonprofits that have increased donations of fresh produce and pantry staples during the pandemic.**

- *"I think the food giveaways were excellent for the community. That was something that could help everybody,"* said one.

Another shared that during the pandemic:

- *"Our church continues with the farmer's market, and that made it more accessible for a lot of the residents … so that was a blessing."*

The built environment, specifically walkability, was mentioned as an important community asset.

- *"Walkability – just being able to get out, take a break or a breath of fresh air, it's really nice to be able to just walk places and be able to get my needs met within a pretty good square radius."*

Access to greenspace was cited as a valued resource.

- *"The proximity to Fairmount Park is something that promotes health in our neighborhoods, because you can spend time outside, and it also gives shade in the summer."*

A strong sense of community and neighborhood social capital were discussed in two groups. Multiple participants highlighted social connectedness with neighbors and family as an important asset. One shared:

- *"Seeing people around and just getting to talk with people is really good for mental health. My neighbors and people around me are really helping." Another said: "Seniors are the most civically-engaged folks in the community. Most block captains are older folks."*

Key Challenges

Cancer and other chronic conditions, such as heart disease, hypertension, obesity, and diabetes, are common in these three communities. In the River Wards group, several participants raised concern about **high rates of cancer and chronic obstructive pulmonary disease (COPD) having possible links to local environmental contamination**.

- *"There's a high rate of cancer in our area. It was reported nationally at one point, because of previous manufacturers that used to be here. And now, it's all hush-hush. … And now, the grounds that were contaminated, they're building houses on and digging up the dirt. And all of this is being re-exposed even more so than it was 40 years ago… there's no one overseeing the health of the people while all this is being dug up."*

In all three groups, behavioral health issues, including substance use, were a top concern. Increased social isolation during the pandemic, as well as trauma from exposure to violence and substance use, have worsened behavioral health. These problems are compounded by limited access to resources and reluctance to discuss or report illegal activities in the neighborhood. More police, political support, and other services are needed to address underlying issues of violence and drug dealing, several participants said.

- *"I think the mental health component is really a big thing. We have added to our church a mental health component where we have mental health professionals on call, for our congregation, and for people that may call in. People have gotten so stagnated since the pandemic, it's like they're so isolated."*
- *"At least for me in my neighborhood, there's an added layer of high crime and high drug use. So, you're adding the pandemic that isolated everybody, we have our seniors who are even more isolated because of that, and then we have a bunch of individuals who are running around the neighborhood kind of like inducing fear."*

Access to behavioral health services is lacking, both in the community and surrounding areas, several participants emphasized.

- *"You have to get accessibility outside the neighborhood, and then it's very limited."*
- *"It's frustrating to see people who have been there for decades and who are impacted by drug use and mental health. Instead of setting up places that are going to help those people, like behavioral health or counseling centers, we're getting restaurants and small businesses. It's been really sad to see people who are really desperate for help. We could be using that space for better uses. … I think it would be cool to see a community where there's both. It feels really unfair to push people out just to make the neighborhood look nicer."*

During the pandemic, people delayed routine screenings and other health care visits, noted several participants. Fear of going out in public was a deterrent, one noted:

- *"During the pandemic, people put their routine mammograms, or the men for their prostate checks … on hold, because they [were like] 'I'm not going to go out.'"*

The same participant commented on the impact of delayed care on health outcomes:

- *"I understand that they're seeing such an uptick [in] cancer in the community, because people are coming in and their cancer has been active for 18 or 19 months, and now … things are worse than it would have been if they [had] gone a year and a half ago."*

Insurance was cited as a major challenge to accessing health care by several participants. Difficulties include access to services based on type of insurance, perceived inequities in the quality of care based on insurance, navigating health insurance plans, and affording out-of-pocket costs. Stigma also came up again in relation to the type or lack of insurance coverage.

- *"Lack of medical coverage is one thing, but a lot of times it's the stereotypes and the stigmas that people experience because they don't have that coverage," said one participant. Another added: "Some people feel embarrassed or [feel] as if where they're going, they don't care about them because they don't have the money or the type of insurance they accept, so they are pretty much put on the back burner. And they can't receive the help they need quality wise."*

Several participants commented that while urgent care centers are supposed to reduce emergency department use for non-emergent health issues, **access to urgent care is challenging due to insurance eligibility and out of pocket expenses**:

- *"I think the urgent care centers were something that was supposed to kind of help in our communities. But then when you actually need to go to them, there's some kind of criteria that you must meet in order to be seen."*

In the North Philadelphia, West of Broad area, a participant noted that several health care centers are located near each other, **but for individuals who don't live in proximity to these centers, access to care can be challenging**.

Insufficient time during medical appointments to discuss health issues and care plans was raised as an issue in one group.

- *"Doctors are limited to a certain time frame [and] if it's over a half hour, then they're running into somebody else's time. So, you have to write down or know what you need from the doctor and give it to them and ask them to explain it in that time period, because the doctor only has a certain time period with you."*

Stigma around behavioral health issues is another barrier to care. As one participant put it:

- *"People don't like to admit to it, I guess because it's being judged or them feeling that they're inadequate. People are afraid to speak up and say, 'I need help' or 'Something's wrong.'"*

Social Determinants of Health

Participants discussed a range of social determinants of health that lead to or worsen health disparities in their communities, with **poverty and racism** cited by several as root causes of these health inequities.

- *"I think racism is the underlying disease that causes many of the health issues – especially given that the life expectancy here can be 20 years less than in other parts of the city," noted one participant.*

Other key issues in these communities include:

Transportation barriers were cited in all groups, especially for seniors who don't drive and others with mobility issues.

"People that are on walkers or wheelchairs, there's a fear factor of the community. So, they do need transportation, so they don't have to try to walk to get where ... they're going, because we know the crime level, they prey upon the seniors."

Other participants noted that, while public transportation and paratransit are available, **concerns about safety and long wait times discourage use**, creating barriers to travel to health care and other services, such as pharmacies and supermarkets. One person shared that *"SEPTA transit is supposed to come pick them up – But they end up waiting an hour, like sometimes on the curb and it's cold. And sometimes they don't make their appointments on time because SEPTA was late."*

Lack of affordable, safe housing was cited as an issue in several groups. Inability to afford home repairs, such as to mitigate mold, was seen as a risk factor for respiratory ailments, such as chronic obstructive pulmonary disease (COPD).

- *"COPD, a lot of seniors suffer with it. ... And I feel like in homes, sometimes the air quality isn't right. ... A lot of people in my community live in old houses, and they're unable to have the money to fix it up. It's a real big issue."*

Other habitability issues highlighted include lack of essential kitchen equipment (working stove or refrigerator), leaky roofs, and confusion over a home's legal ownership title:

- *"Many people need to have their homes repaired but there are lot of tangled title issues, which prevent people from accessing resources to repair their homes."*

Access to healthy, affordable food and nutrition education was a concern among multiple participants and groups. Several participants cited the area's limited access to fresh produce, with an overabundance of less healthy fast-food options. One participant commented, *"We really don't have access to healthy eating, fresh produce. The accessibility for a hoagie, cheese steaks, french fries and pizza is on every corner."* Other participants spoke about the need for more nutrition education.

- *"Grass [roots]-level programs that teach the community and people about healthy eating and healthy lifestyles would be very beneficial."*

Children and Youth

Lack of awareness of available community resources, especially during the pandemic, was cited as an issue in all three groups.

- *"I think if people aren't getting out of their homes, especially now with COVID, or like seniors being homebound or folks with disabilities, just letting them know what is out there, especially if they're not able to look it up on a computer. If they don't know it's there, they're not going to go."*

Language and cultural barriers hinder access to health care and other services for many immigrants and refugees:

"Language is an extreme barrier. ... I cannot count, I cannot tell you how many times I've heard stories of people who speak Spanish or any other language, just facing so many difficulties that are unnecessary that could just be easily improved if there was an advocate."

Another noted the need to address *"not only language, but custom and culture and all that together."*

Lack of digital access or skills.

- *"Certain populations, especially like low-income individuals that I work with at my nonprofit, they can't afford to have internet, they can't afford to buy a computer or an iPad,"* said one participant. *"It's opened my eyes that not everyone has equal access to the resources, and the assumption that they do is, is just wrong."*

Participants in all three groups discussed the need for **more programs to help youth develop knowledge and skills for a healthy lifestyle and a path to employment**.

- *"It's a challenge for the neighborhood, because when there's too much time on their hands, they're likely to get in trouble," observed a participant. Another commented: "I watched the kids during COVID, they were in the streets playing basketball, but they needed more to do, it wasn't enough, you know."*

With fewer youth programs open during the pandemic, some areas have seen an uptick in juvenile misbehavior and law-breaking. One participant noted:

- *"We're seeing problems that we didn't see before. And so younger kids breaking into houses and stuff like that. It's not like it didn't happen, but it's much more of a plague now than it was before. And I think it's probably, because there may not be things for them to do, to occupy them."*

For youth with behavioral health issues, including those exposed to trauma or violence, more resources and support are needed.

- *"There's a lot of murders committed in our area, and it's trauma there. Children experience it, they see it. ... But there's no resources out there for them. But generally in their families, it's just something that you go through and you keep quiet about it. So a lot of them go through this trauma and they feel like they can't speak up."*

Other efforts needed to support healthy youth development, cited by participants, include:

Programs to encourage physical activity and healthy eating, as well as reduce screen time, including social media use. During the pandemic, youth have been less physically active due to reduced access to recreation centers and more time on digital devices playing, socializing, and attending virtual school.

- *"What I'm noticing is a lot of the kids now are not being active because they are playing those video games, where they used to go out and play, now most of them got their heads down in their phones or either on the computers or their Xboxes,"* commented a participant. Another said: *"I think that just how much kids are on these devices ... especially at such young ages, it can have a detrimental effect on their mental health, which can affect their physical health as well."*

Sexual health education:

- *"They don't need to be 15 and pregnant. ... That's a healthcare issue that needs to be addressed in our community."*

Safe, academically challenging schools:

- *"Schools, making sure they are safe, and that they're doing everything that they possibly can to challenge them academically."*

More career-pipeline programs, especially for employable skills such as carpentry, home repairs, or careers in exercise instruction or other health professions.

Several participants discussed **issues with access to recreation centers in their communities, such as closures or limited hours and the need for expanded hours**. In the River Wards group, a participant commented that four of the community's recreation centers had closed or were about to be closed due to needed renovations and environmental lead exposure. Concerns were shared about the impact of these closures on youth.

- *"To me the timing was terrible. Someone from a political office told me, 'Well, we can bus them [children] to another one'. That doesn't work for a child that wants to be able to walk two blocks and get on the swings or run in the field or have access to the inside after school. They're not thinking of the children in many ways. ... Children need accessibility in order to interact."*

Older Adults

Across the three groups, top concerns for older adults included **transportation barriers to accessing necessities like food and health care, social isolation, and challenges with using digital technology**. Financial strain to pay for food, medicine, and other essential needs also affects many.

- *"I sort of live in what we call a food desert, and there's a lot of seniors who are on walkers and wheelchairs and canes, and right now, it's hard for them to get from point A to point B, because of the distance of the food markets."*
- *"I really think the pandemic has isolated a lot of the seniors. The seniors are the largest population that have been vaccinated, I am aware of that, but I think a lot of them are still fearful to come out. ... The food desert is really an issue, they can't get around for transportation ... and then we know that the cost of everything has gone up. ... It's financially a strain upon them to try to get food and pay for medication."*
- *"I think when a lot of seniors can no longer get around like they used to because they are having health challenges or they don't have the correct accessible means of transportation, then they start to stay in the house more often. I think that this can cause them to decline faster than they usually would."*

Amid the pandemic, **many senior centers have closed or reduced hours of operation**, limiting opportunities for older adults to socialize and engage in physical activity programs: "*They seem to be cutting the days (at the senior center), it's not as many as it used to be.*" The pandemic also has heightened concerns about the **digital divide for older adults**, including using technology to schedule appointments and communicate with healthcare providers. Having to use a computer to schedule an appointment, being placed "*on hold*" for extended periods of time, and complicated telephone directions are among these challenges.

- *"A lot of seniors are not up to date with the technology, digital technology. A lot of us need some kind of computer training or digital training on how to push buttons and what to use and what not to use."*

Even phone systems can be "*extremely difficult*" for older adults, especially if dementia is present.

- *"It's not a simple process – press this or do this – and then they wait on hold, and they get confused, 'Did I miss something?' Then end up giving up. And then days go by before they try to call again, then they miss their appointments. ... They cannot just call and leave a message for the doctor. It's not simple anymore. So they obviously need help with something as simple as that or the technology."*

- *"They expect for senior citizens to use the computer to make their appointments, to make a phone call to speak to someone in the doctor's office, and you're on the line for like an hour-and-a-half or more. And, of course, the senior citizen then forgets what they wanted by the time they answer the phone. And then they have to redirect them to where they want to be. So it's very difficult for them to communicate with their doctor."*

Multiple participants discussed **concerns with social support and home care for seniors, such as from family members or home health workers**.

- *"A lot of seniors are alone and don't have that family support. So, there's a big gap … in getting the right support to assist seniors to their doctors' and medical appointments or even knowing about the different health plans."*

Several participants discussed **concerns about the quality of care provided by caregivers who are family or friends**, as well as workers from home healthcare agencies.

A participant who works in community health said:

- *"I went to a senior's home who receives health aides. Each time I go, the health aide is sitting there on their phone and this is also true for others that I've seen."*

Concerns also were shared about inadequate or spoiled food in some homes, as well as possible misappropriation of food by caregivers.

- *"It's very strange that there's no money left on the food stamp card and yet their refrigerator and cabinets are bare and no one checked the refrigerator, but they [caregivers] take a lot from the older adults too, sadly."*

Pandemic Impacts

Low rates of COVID vaccination in the community were a source of concern and frustration for some. One participant said: "*I'm concerned about the ones that don't have the shots yet. I mean, this pandemic should have been long gone and over with, if people would just do their research, and read and understand that the vaccination is important. Some people are still not vaccinated, and that's horrible. When is it going to stop?*" Another mentioned **distrust of health care as a factor for low vaccination rates**, especially in the Black community.

Others discussed the **negative impact of mandated vaccination on employment**.

- *I know people that are on the verge of losing their job that they've been at for 20 years – it's horrible. Who is going to ask who is vaccinated [at large gatherings where] it's going to be thousands of people? But yet they're interfering with businesses and people working, their livelihood, really makes no sense."*

Others noted the **stigma associated with being unvaccinated, and the growing divisiveness in communities about vaccination issues**:

- *"For the ones that choose not to be vaccinated, they're kind of cast out against the ones that are vaccinated. I've seen it right in my own church as well, so that's been a big issue and problem. And when you say it's your choice, it should be your choice."*
- *"It's causing a lot of division throughout the city, and let alone in neighborhoods with neighbors, which causes stress and stress is – it's just so unnecessary and so harmful to all."*

Suggested Actions

Increase outreach to raise awareness of community resources and services.	Participants in all three groups called for more robust communications about available health and social services. Suggestions included sending periodic flyers and mailings to homes to increase awareness of local resources and holding more job fairs to promote employment opportunities. Local health fairs also could help connect people with needed services, beyond just handing out information and providing screenings.
Provide more accessible transportation to health care and other essential services, especially for homebound seniors and others with limited mobility.	*"I wish all medical facilities would provide some kind of transportation for some of the seniors. … You know, it doesn't have to be everyone, but there are some that really do need it and they are alone,"* said one participant. Another suggested creating opportunities for small transportation businesses to work with larger companies to provide transport to health care and related errands, such as trips to pharmacies for medications. A related suggestion: more home-based services, including food delivery and other forms of assistance, to better enable seniors to age in place.
Expand treatment services for people with behavioral health issues.	One suggestion was to create a large centrally located intake center to help those with mental health or addiction issues as well as those experiencing homelessness: *"All these people need to and should have a path to getting a roof over their head and getting medical attention… It would solve so much."*
Expand school, community, and home-based educational programs on healthy lifestyles.	Include culturally appropriate nutrition education, physical activity, and stress management for youth and adults. *"We need programs for once they are sick, but there are certain things we can do to help prevent them from getting there in the first place. I think a big part of that is education,"* a participant commented. Others added: *"We have to have the parents involved in order to ensure some of this stuff is implemented,"* and *"Sometimes it's the kids who influence the parents to have healthier lifestyles, to eat more vegetables, and to recycle their garbage."* .
Develop career pipeline programs to introduce youth to careers in different occupations, including health care.	A participant suggested scholarships to encourage high school students to go into health-related professions. *"So that, someday, our kids in North Philly and West Philly don't just become the object of researchers … no, that they become the doctors, they become the health professionals, they become the researchers and the policymakers."*
Provide more education and support to address the digital divide for older adults and others, such as *"free workshops for digital literacy."*	

Suggested Actions

Develop more collaborations between hospitals and community-based organizations serving local residents.	*"I think that it's necessary for the [health care] institutions to collaborate, like an effective partnership with the community organizations that are rooted in the community, to be able to connect the people to the resources appropriately,"* shared a participant. Another noted the need for more funding and resources to support community organizations, including sharing of relevant professional expertise and job creation.
Train advocates to help people navigate health services and understand their care plans.	*"We need people in the communities to assist the youth and the elderly, help them with their appointments, make sure that they get to their appointments,"* said a participant. Another suggested: *"Medical students or interns from the various hospitals [could] come into the communities and advocate, and talk to the youth and the seniors, and sort of guide them, and advocate [for] them, and navigate them into the right resources, or to the right places they can go to get help."*
Increase bilingual, culturally competent health care providers.	*"I would say definitely having more bilingual staff. For example, someone like a Spanish-speaking patient sitting in a room, I've seen so many times where like they're waiting a half hour or more just to get an interpreter on the line,"* commented a participant. Another remarked: *"I think we have to meet the challenge of not only the differences in culture and ethnicity, but also the differences in religion, when we're going to deal with our Muslim community, or the Buddhist community that are coming into the facility with different kinds of beliefs. And we have to we have to honor their belief and present it in a way that will be acceptable."*
Expand access to COVID testing.	*"We need to also have access to the testing if you've been exposed. So, that's another issue that I would like to see addressed, I really would."*

South Philadelphia-East and South Philadelphia-West

COMMUNITY PERSPECTIVES

This summarizes focus group-style community conversations conducted with residents of two geographic communities: one each in South Philadelphia-East and South Philadelphia-West.

Community Assets

The **built environment** was discussed as an important asset in both communities, supporting **health through opportunities for safe physical activity**:

- *"One thing that helps me stay healthy is having parks in the area and green infrastructure. … Just being able to go on walks and bike rides safely."*
- *"I can walk to the health center. I can walk to the [hospital]. So, that keeps me healthy and my baby, too."*

A strong sense of community and local organizations that serve those in need were cited as community assets by multiple participants. Several participants said they use the services of SEAMAAC, a nonprofit organization that serves immigrants, refugees, and other under-represented communities. Neighborhood clean-up efforts and community gardens were mentioned, as were local wellness programs, such as meditation and yoga. Local health centers that serve people in need, such as those who lack health insurance, also were cited as an asset.

The majority of participants spoke of the **social connectedness of their neighborhoods** as a key asset. For example, while Grays Ferry was once a racially divided neighborhood, that is changing.

As one participant put it:

- *"My community is really working together, and not believing in the stereotypes. … What makes us healthy is understanding the kind of vision we want as a community … if our children are together playing, how about them having the same recreation, how about the same park? How about the same library in the school? So what makes us healthy is understanding that communication, what is bringing us together as one body."*

Another participant shared:

- *"I see the diversity of the community changing where I live, and it's changing rapidly, and I say acceptance, because a lot of faces are different now, but that doesn't mean we all still cannot be a community. … I'm African American and Muslim, he's Caucasian, but we speak, we talk, we get to know each another, and accepting each other as neighbors."*

Public transportation was mentioned as an asset: *"We have a lot of public transportation options, meaning there's fewer cars on the road, which means fewer chances to get hit by one and less pollution."* Access to groceries and healthy food was cited as an asset in some, but not all, neighborhoods.

Key Challenges

Behavioral health issues, including substance use, were cited as top health concerns in both groups, as well as lack of access to behavioral health care, especially for youth and immigrants who lack English proficiency.

- *"Mental health seems to me to be a big crisis as well as the lack of services in other languages and the difficulty in getting therapists that are available even with insurance, especially Medicaid."*

The **need to address substance use** and associated issues was discussed in both groups:

- *"I agree with what [was] said about drug use; it's a very big problem, as is prostitution."*
- *"99% of problems related to drugs would vanish overnight were they not, you know, criminalized. … There'd be no need for turf wars, there'd be no need for gun violence … how long are we going to do this dance?"*

South Philadelphia is a diverse community with many immigrant and refugee populations, particularly those from Southeast Asia, Mexico, and Africa. **Both language and cultural barriers pose challenges for immigrants to access health care:**

- *"Many doctors don't use [the] language line. Some interpreters are not very good at English. There's interpreters, but there's also that fear of them just not fully understanding, especially cultural wise."*
- *"There's actually a big stigma with [health care providers who] believe that Hispanics are overdramatic when it comes to their pain."*

A participant who works with immigrants and refugees said:

- *"The feedback that we have received from our clients is that, even if they provide translators in the hospital, they … want to show and describe to the doctor their pain by themselves, instead of using the translator. They say that the translator … doesn't understand our pain or what we are feeling."*

Participants also pointed out that, in some cultures, women want to be seen by a female doctor and may be reluctant or ashamed to see a male provider. In addition, religious dietary principles can impede medication use; for example, those who practice the Muslim faith need to check that their medications do not contain pork-derived substances, a participant said.

Other concerns about health care quality and access were brought up, including:

Mistrust of healthcare.

"There's a great deal of people who don't believe that it [hospitals/ health systems] actually helps. We go in with one thing and we come out with five other things wrong with us."

Cursory physical exams.

"No one is being checked out the way you used to get checked out. They might ask you to breathe, but that's about it. They take your weight with your clothes and shoes on … you don't take your clothes off … you don't get your reflexes checked anymore, they don't do your eyes, they didn't do my ears. You just go in there, they ask how you feel. The physicals are not true physicals."

Navigating health system barriers.

"There's a provider I go to that's an FQHC [federally qualified health center] that is very culturally competent, but it is hard to get an appointment with them. Their phone tree is horrendous. I had a friend with syphilis and needed to get treated. … He was given the runaround until I actually had to intervene and say …'there's somebody who is 19 years old … who's a sex worker, who is going to be transmitting the disease.' "

Need for support of integrative medicine, such as increased insurance coverage and provider openness to discussing alternative therapies.

"There needs to be more [support for] natural healing. … I spent hundreds of dollars in natural healing because there's no access to any financial assistance."

Attitudes towards health.

"[People] just give up a lot of times … they give up because they are inundated by too much information, or they feel powerless. And so they … don't maintain [care for their] conditions, whether it be diabetes, whether it be depression. I think one of the biggest health issues … affecting my community is a [lack] of personal ownership of health, and actually feeling self-determined in that regard."

Social Determinants of Health

Access to nutritious, affordable food and nutrition education were discussed by multiple participants in both groups.

- *"Having fresh produce, you know, I don't think there are any farmer's markets in our area."*
- *"Certain neighborhoods will have fresh fruit that's not molded, that you don't need to pick through, and other neighborhoods may have the bottom of the barrel. … We feel as though we are overlooked and not as important or needed as other community members."*
- *"We don't even know how to check the nutrition facts in … foods. A lot of people don't know how to eat healthy food, [make] healthy meals to take care of health. Lack of education on nutrition and other ways to be healthy seems to be lacking."*

Excessive trash and lack of neighborhood cleanliness impacts health and quality of life, several participants said.

- *"Walking tonight, I literally saw somebody bend down on the sidewalk, take out a container and shove it into the sewer. It's the little things that build upon larger systemic issues. You're in a spiral of just like, 'Well, everyone else is sick around this neighborhood. Everyone else is living in filth. Why would you care?' "*

Exposure to air pollution, especially in neighborhoods close to major highways, was noted as a health risk.

- *"Rates of asthma are dramatically higher in this neighborhood [Grey's Ferry] for children … and we're basically poisoning children with car exhausts,"* said one participant, noting that air quality improved during the pandemic, as vehicular traffic decreased. Another shared: *"the air quality from the highways and refineries worry me as well."*

Parks are not always convenient to reach. While sidewalks increase walkability in the area, one participant cited the need for more green space.

- *"In my neighborhood, there's no green space that you can access. … You have to walk a few more block away [from] your neighborhood to find a green space. It's quite a challenge."*

Equitable access to quality education.

- *"We need adequate public schools that everyone can send their kid to because right now, in this city and in this neighborhood, there's a bifurcation between people who can and cannot afford quality education, and it has an untold amount of effects on everybody."*

Increased access to information and resources is needed.

- *"I feel most of the time that I hear about outreach in South Philadelphia, I see it on Facebook, and that's not enough."*

Children and Youth

Multiple participants cited **mental health issues and trauma** as priority health concerns for children and youth. As a participant who attends high school put it:

- *"I would say a lot of people talk about mental health because of the pandemic. Because last year, we were online school--it was a virtual school. And then a lot of peoples' grades were dropping, [they] couldn't get access of internet or computer. … They were panicking. Until now, they still have a lot of mental health. Not all of them will have access to someone to talk to, or someone that they trust to release their problems or mental wise."*

Participants discussed the **high rate of trauma among youth, stemming from poverty, the pandemic, and other factors**.

- *"I think one of the worst things that's affecting most children, at least in the neighborhood, and LGBTQ community is trauma. Lived experience of trauma as well as the vicarious trauma one experiences by just seeing things on a daily basis has really warped our sense of what is normal. … Guys on the corner every day, in the bars, just hurt people. … Children are being traumatized, and poverty is traumatic … going with hunger is traumatic, having your parents argue over the light bill is traumatic."*
- *"Helping youth through trauma, grief and mental health issues. They're our future."*

Older Adults

Lack of behavioral health counselors for youth, resulting in care delays, also was discussed.

- *"There's limited counseling for youth. … I can count on one hand those that I actually know about for youth."*
- *"There's at least a six to eight week wait for the intake, not the service, just the intake. … [There is] so much trauma and grief going on that even the counselors … cannot keep up with the caseloads."*

Several participants cited the need for **more health education for youth as well as funding for programs to develop them as leaders and build bridges across diverse cultures**.

- *"Young people need a lot of support. They are thinkers, they are leaders. … We just need enough support for them, and [with] a program to … guide them, we'll be able to build a better community here."*

A lack of safe recreational spaces for children also was noted.

- *"I've seen a lot of kids grow up on my block. And of course, where they play is in the street because … there's not a lot of other places to go, where there's not green space or parks. … But the streets are filled with broken glass and trash and cars go too fast."*

The constraints of living on a fixed income for many older adults, including finding affordable help for their needs at home, was discussed in both groups.

- *"I do give young people that help me a few dollars and sometimes I think that's why they keep coming back. But what about those that are on a fixed income … and can't afford to pay anyone anything … or don't have a youth group with young adults that can come over and assist them? That's a real concern for me, for older adults."*
- *"Our home care system is a big problem. I went through this with my mom for many years. It's hard to get home care, it's expensive, [and] home care aides are hard to find."*
- *"Some seniors do not want non-family members coming into their homes. Sometimes they have a hard time trusting people in their home. I just know that whenever I have clients who desperately need care, I'll try. They'll say, 'No, no. You're not family. We don't want these strangers in our home.' "*

Immigrant seniors with limited incomes are especially vulnerable.

"I know a lot of immigrant elders are working until their late 70s, and they're working in factory situations and in pain a lot. They feel they have to because they don't feel like they can survive on their social security checks … [and] some don't have that. There's quite a few elderlies who are actually undocumented and are forced to work."

Concerns were raised about the **impact of aging on overall health, as well as the ability to access services and stay physically active and socially connected**:

- *"The physical issues impact me mentally, spiritually, anxiety-wise, because the pain and the lack of being able to move about to the extent that you were, to do what you did. Even the way that the furniture is arranged in my home … because when I get up at night, I may bump into it. I'm blessed because I still have people to aid and assist me in many instances, but what about those that are isolated?"*

An older adult with mobility challenges shared safety concerns about walking in the neighborhood.

- *"When I come home, I have to ride around 20, 25 minutes to find a parking space, sometimes it may be 2 or 3 blocks from my home. I'm looking over my shoulders and behind my back. I've walked these streets for 14 years without a thought of being harmed, and now I'm fretful when I walk the streets, particularly if the sun goes down."*

Social connectedness was discussed in terms of valuing older adults as productive, contributing members of the community.

- *"It's like making sure that people that are older, as well as people that are younger, feel that they have something to contribute to the conversation – that society isn't just 18-55...I think a lot of times they retire and it's 'Okay, bye, see you soon'. Well, you know life doesn't just end if you stop working. And so it's just like creating spaces where that's safe to do ... where people feel welcomed."*

Other Groups

Participants in one group commented briefly on **special issues for immigrants, especially those who are undocumented, and the LGBQT+ community**:

- *"There's a lack of security when you're an immigrant, as well. You're always questioning your status. Yeah, my family are immigrants, so they question their status sometimes, just like, 'Do I deserve to be here? Let me prove myself.' Unfortunately, that's not actually the case legally, but mentally that can be the case."*
- *"Something to also take into consideration is support for the LGBTQ+ community in South Philly. In my experience there are less resources here than in other areas."*

Pandemic Impacts

Participants discussed the pandemic's wide-ranging impacts on health in their communities, including the impacts of the pandemic on immigrant communities and Asian Americans:

Difficulty providing outreach and education for immigrant communities. When COVID-19 vaccine clinics were first announced, local organizations serving immigrants struggled to find educational materials and conduct outreach in other languages.

Increased discrimination and violence against Asian Americans.

- *"I think safety is a biggest concern for my community," said a participant who is an Asian American. "Many people are concerned as Asian; many people are concerned as Chinese. There's increase of anti-Asian violence. ... It's still going on. Everywhere, small things happen. Now, students are going back to school. I hear a few cases around the school. Like now students getting bullied if they're Asian or if they are Chinese."*

Participants commented on the **pros and cons of using telehealth** during the pandemic. While one participant said, "*I love telehealth, I love not having to go to the office*," others were less enthusiastic. An older adult shared:

- *"Well, I did it once ... and it didn't work, so we had to reschedule it. ... I don't mind texting or emailing, but that's after I make the initial phone call – I like that human interaction."*

A participant who works with immigrants and refugees noted that accessing online COVID information and virtual services such as Zoom are difficult for many people, such as those with limited English proficiency and older adults.

The pandemic also raised awareness about income-related disparities that existed prior to COVID and "*humbled the community*," as more people lost income and experienced a lower standard of living or poverty.

- *"I think before the pandemic, what people thought of poor as [was] someone who was receiving food stamps, or you wore certain types of attire. I believe that this COVID pandemic has humbled our community in some ways - for us to be on the same page. And now it's alright, we all don't have any. So how do we build each other up collectively so there's not a fight for the little that we will have coming in?"*

Suggested Actions

Increase health literacy and reduce language barriers, especially in immigrant and refugee communities.	For example, hospitals can work with community organizations to improve health literacy of resources and raise awareness about the availability of interpreters.
Provide more programs to help people find jobs paying a living wage.	While not yet a formal program, a participant noted that SEAMAAC works with an English-speaking community liaison who helps connect immigrants with jobs at area businesses. With more funding, this effort could expand into a structured program, the participant said, helping to connect immigrants with "*employers who are willing to take people whose English isn't quite so good yet, or to find ways to employ them. I think that's important, and that's a solution.*"
Build trust and understanding among people from different cultures, especially youth.	For example, multicultural programs could bring together immigrant youth with other young people, such as in programs to grow food together in community gardens. *"A lot of times in mainstream society, they tell us what's the different between us. They never teach us what is similar … and why we need to be humble and learn from each other. We need a program to identify each other's identity, how beautiful each other's culture [is]."*
Strengthen support for local organizations serving the community.	The importance of faith-based organizations in providing outreach and support services was also mentioned. Participants also suggested engaging community organizations and other trusted messengers to increase outreach about local resources and services. *"Those leaders can reach out to the community because they are close to the community."*
Improve neighborhood cleanliness and the safety of streets and play spaces.	*"More could be done to think of our streets as play places and keep them safe, traffic calming, more cleanups. I know there's play streets programs in other parts of the city. … More opportunities for kids to be able to play outside the front [of their] house without worrying about getting injured, could be really important."*
Increase timely access to mental health and trauma resources and services, particularly for youth.	One suggestion: expand the use of peer counseling models, using people with lived experience, which one participant described as *"a peer-based model … like a bipolar buddy program. … I used to sell drugs, I was homeless. … Unless you did those things, I don't want your opinion on them. … I don't trust people that haven't been through what I've been through."* Another suggestion was to evaluate the efficacy of current substance use treatment programs, then restructure services to improve effectiveness.

Suggested Actions

Improve access to equitable, quality education for youth.	*"One of the most positive things we can do for youth is an adequate public school system,"* a participant said. Others pointed to the need for more youth education on sexual health, good nutrition, and substance use prevention.
Provide incentives for students to volunteer to help older adults or others in need.	A young adult participant commented: *"I can't tell you the number of students that I work with [who] want to help older adults, but they [students] don't have the funds. They don't have the time. … Anything that could help them a little bit, so they can do what they want to do, which is actually benefit [a] person's life."*
Regulate social media to reduce its impact on mental health, youth sexuality, violence, and related concerns.	*"The kind of problems we see with social media, some of it can be alleviated with actual regulation … that's low hanging fruit that Congress could easily do."*
Expand the use of community advisory councils.	Include youth, parents, police, city government agencies, and other community-based organizations to ensure all voices are heard and to foster community ownership. *"Having an advisory council, or, you know, just some people that need to be at the table … should be there."* Another said: *"Community boards are really vital – they give people a sense of self-determination and ownership that will improve everything."*

Southwest Philadelphia and West Philadelphia

COMMUNITY PERSPECTIVES

This summarizes focus group-style community conversations conducted with residents of two geographic communities: one each in Southwest Philadelphia and West Philadelphia.

Community Assets

Participants in both groups cited **proximity to green space and recreational facilities** as valued community assets.

- *"I'm a walker, so I love that I live in the area that [has]a lot of trees, and parks, and that's what makes it healthier for me."*
- *"I think part of what helps to keep our community healthy, we have a lot of open green space,"* said a participant who noted the proximity to the John Heinz National Wildlife Refuge.
- *"I like the fact that there's a playground in our area, and I think throughout West Philly, there are other playgrounds that people could go to, and I think that can help give clarity, especially to our kids who are going through so much right now."*
- *"I think green spaces and park areas really, really are a boost to your mental, physical, and emotional health."*

Another participant commented on the recreation center in her community, as a place for residents to stay active with *"lighting to make sure it's safe for everybody to utilize"* and a new *"beautiful mural on the outside."*

In both communities, participants commented on the **value of community engagement**, such as joining in local clean-up efforts or serving as a block captain.

- *"I'm starting to see neighbors come out and clean their own fronts and sweep up, have some pride in the neighborhood that they live in, that we all live in. Because the statistics tell us that [if] you feel good about where you live, crime goes down, people feel better about themselves, better about the community."*
- *"Block captains were very instrumental in my neighborhood's growth and development. My grandfather was a block captain for over 50 years."*

Participants had mixed views on **healthy food access**. While West Philadelphia has the Clark Park Farmer's Market and a few other produce vendors, participants pointed to the need for easier access to fresh produce in other areas and their desire for fewer fast food outlets and convenience stores that mostly sell processed food. Also, getting to a local grocery store typically requires a car or public transit, which limits access for some.

Access to public transit was cited as an asset in West Philadelphia, such as the LUCY bus (Loop through University City). In Southwest Philadelphia, participants noted that the nearby airport and heavy vehicle traffic can detract from health, because of **noise and air pollution** as well as **pedestrian safety issues**.

One Southwest Philadelphia participant said:

- *"We have blessings and curses. We are a community of contradiction. But I think that the open green space is a good attribute to our emotional health."*

Key Challenges

Behavioral health issues, such as substance use and trauma, and violence are top concerns in both communities.

- *"We have an unprecedented mental health crisis with the pandemic, and also the violence that's going on in the city."*
- Lack of diagnosis and treatment for mental illness is associated with increased risks of homelessness, violence, and other adverse outcomes. *"We could help people, if we could get them access at an earlier point, but the standard is to wait until they self-harm or harm someone else."*

"Drug and alcohol abuse [are] prevalent," said a participant who voiced concern about the proliferation of "*stop-and-go takeout places for alcohol in the neighborhood*" along Lancaster Avenue, as well as numerous small delis and corner stores where drug dealers and others gather.

- *"What we can do to stop all of these bars and delis from coming into our neighborhoods?"*

Stigma associated with mental illness prevents many from seeking care.

- *"People think that there's a stigma when you go for mental health treatment, and it doesn't necessarily mean that you're off your rocker, but we all need a healing, let's just say, and there's nothing wrong with seeking it."*

Widespread divisiveness about COVID vaccination and masks has taken a toll on mental health and community cohesion.

- *"You know, we had the anti-vaxxers versus the vaxxers, the masked versus the unmasked, the parents that want the schools open, versus virtual. So it just created – it became political, COVID became political, it became a mental health issue, and it also affected the Black community, the hardest hit, because we still see the disparity that has affected us in our community."*

Accessing health care during the pandemic has been difficult, leading to delayed care for both mental and physical health concerns, multiple participants said.

- *"The COVID pandemic has made it really difficult to access health care. I had some medical appointments cancelled/ rescheduled during the pandemic. Think about patients who are being managed for chronic illnesses but can't get regular appointments with their healthcare provider due to the COVID pandemic."*
- *"More and more people are putting off annual visits and everything, because people are, like, scared,"* said a participant who also noted longer wait times for appointments. *"I had to put off a surgery for over a year because of the COVID, and everything."*
- *"Because of the overload of the COVID cases, other people with other ailments got pushed to the backburner because there weren't enough supplies, doctors, beds."*

Access to convenient medical care was cited as a particular challenge in the Eastwick area of Southwest Philadelphia.

- *"We have no medical facilities back here. You always have to go over the county line (to Delaware County) for medical treatment. We have a few dentists and maybe one or two doctors' offices. And that's it."*

Participants cited pros and cons regarding the shift to telehealth and other online services, such as home delivery of groceries and medicine. One praised the convenience of telehealth visits:

- *"We are leaps and bounds ahead with telemedicine."*

However, others noted that the shift toward virtual services has created barriers for some, especially older adults and others who lack digital capability or simply prefer in-person appointments. One commented:

- *"I also think that using phones or smart devices to access health care is not as effective or productive as physical meetings."*

Social Determinants of Health

In Southwest Philadelphia, participants discussed the impact of environmental hazards, such as flooding and pollution, on mental and physical well-being in the community.

- With some areas of Eastwick being flood-prone, those living near creeks that can overflow during storms may experience extreme stress. *"Every time it rains, these people go crazy. It's sad."*

Several participants noted high rates of cancer and asthma, which they attributed to pollution. One participant, who noted that Eastwick is the site of a former Super Fund site (the Clearview Landfill), said:

- *"We have a very, very high rate of cancer back here because of the landfills, [for] which EPA recently has done clean up."*

Asthma is another common ailment, a participant said, which she associated with *"air quality where we live, with the airport and carbon from cars and all sorts of stuff."*

Poverty.

- *"Poverty lies at the heart of community health issues. It's a big issue that spans everything, right? You can't be healthy if you are being displaced from your home. You can't be healthy if, you know, you have triple pandemics happening at one time ... if you're fighting COVID, but people in your family have been shot, it's really hard to go to the dentist, or think about preventative care, or you having access to the medicines, life-saving medicines that you may need. ... So, these are major, major, major issues. You have issues with trauma and compounded trauma. We've just witnessed and are continuing to witness a mass death event [from the pandemic], and it's being exacerbated by poverty."*

Bias and discrimination.

Participants discussed distrust of health care providers, vaccine hesitancy, and other barriers to health care, especially in the Black community. In communities of color, *"our voices aren't always heard in health care,"* a participant shared. Based on demographics, healthcare providers *"always think we automatically have to smoke, have heart disease, we're exposed to alcoholism. So when we don't fit this demographic, healthcare providers don't know how to treat us."*

The same participant commented on mistrust of health care:

- *"A lot of people are still hesitant to get the vaccine ... studies show that African Americans and people of color get lower priority treatment when we go to hospitals for care. ... So there is a lot of distrust in the African American community with the health care, and that was before COVID. Now COVID just exacerbated that, that people are putting off, again, priority and annual appointments, check-ups, prostate exams, even physical exams."*

Housing issues. Participants shared two main housing-related issues their communities experience:

Cost.

"Cost of housing is really expensive in Southwest [Philadelphia] now. And if you had to put all your money, all your income on housing, then that would take away from you being able to buy fresh fruits and vegetables and healthy food. And that happens a lot. A three-bedroom home or a two-bedroom home might cost you $1,400 to live in Southwest in a row home. So, that takes up the majority of your monthly income. So, that's definitely, I believe, a factor in having a healthy lifestyle."

Habitability. Aging homes in disrepair pose a risk to occupants' health, including for many older adults. Demand for home repair assistance programs far exceeds supply, a participant said.

- *"Mold, asbestos, lead in older homes, without enough supports to repair."*
- *"You're healthy if you have a healthy home, if your home is making you sick, then – and you can't go outside because people are shooting. You know, it's kind of – you're stuck between a rock and a hard place."*

Access to fresh, affordable food.

- *"Our community has a lot of fast, casual, and high-fat, high-salt kind of convenience spots, and very little access to really fresh foods."*

Another participant said:

- *"We have ... seven bodegas in a two-block radius. But they are all instant food. None of them are quality food, none of them are fruits and vegetables."*

Rising food costs were mentioned by several participants.

- *"The price for the food is just ridiculous. The quantity of the food is less, but you're paying so much more. You can't even go to the market and get what you would normally get, say for a $100, it's costing you way more."*

Digital divide.

- *"We have to consider that even though we are the fifth largest city, we are in the top [rate of] poverty. We ... have technology inequalities that still exist, despite the low income internet programs."*

Built environment issues. Participants in both communities cited concerns related to the built environment, including illegal dumping and pedestrian safety issues, such as poorly maintained sidewalks and lack of traffic-calming speed bumps or school crossing guards on some roads.

- *"If one person dumps a bag anywhere, then that's the dumping target. And the city is doing nothing about it [because] come trash day, because it's not in front of a residential home ... the trash just keeps pilling in. ... And that is unsafe, unhealthy."*
- *"A lot of areas in Overbrook Park going down City Avenue, the sidewalks are not clean. ... If they're able to kind of clean up those areas, I think that you would find more people ... wanting to walk more in the community."*

Children and Youth

In both communities, the pandemic has amplified pre-existing issues such as gun violence and substance use, worsening behavioral health issues for young people.

One participant, a mother with two sons, said:

- *"I just try to keep them in the house–it's the same prayer that I say when every parent sends their child off to school, 'Please let my sons walk back through this door this afternoon.' You know, we just saw a school shooting the other day that – an innocent bystander just was murdered, just driving by. Like, this is heartbreaking, so mental health is definitely, definitely, definitely needed at a time like this, because it can only get worse. Remember, these affected children grow up to be affected adults."*
- *"We are in an ongoing health pandemic, but we're also in the middle of an epidemic of gun violence across the city,"* said a participant who emphasized the traumatic impact on children. *"The need for mental health is dire."*
- *"And now, look at the gun violence, these poor kids don't stand a chance, and a lot of them are afraid. They're afraid to go to school."*

A participant said that because of social isolation during the pandemic, children are at greater risk of suicide *"because they didn't know how to deal with not being able to go out and play and interact with other kids."*

- *"The pandemic has created perhaps a lack of access to healthy outlets for emotions/mental health."*

Many young people are processing grief from losing friends or other loved ones who died from COVID-19 or other causes.

- *"In the last school board meeting that I was at with the superintendent, one parent said her daughter ... has lost six friends, teenagers. ... The young are supposed to bury the old. But now these children don't even have a chance, and we have an unprecedented mental health crisis with the pandemic, and also the violence that's going on in the city, and also the things that are happening in our world right now, with the civil and racial unrest, and also, natural disasters, that can affect your mental health as well."*

Accessing behavioral health care for youth is very difficult. *"I do want to say as a mother of three teenagers that mental health services for adolescents is poor at best,"* said a participant who cited long wait lists for an open appointment and not getting returned calls about availability.

- *"The only way I could get services for my child was to pay out of pocket, to pay someone who did not accept insurance that was outside of the city. And this person, you know, took a sliding scale, so that was great, but I had resources and people around me who were able to refer me to this person who was able to have a lower out of pocket rate. But it's just ... a lot of the problems that we're having in our community are because these kids need mental health services for a variety of reasons, and I think that's impacting them well into their future."*

Participants in both communities brought up the **need for more extracurricular and out-of-school time programs for youth**.

- *"Even before the pandemic, they began taking away programs that were really conducive to children ... providing an outlet, the arts and various other types of programs which will contribute to helping to balance a kid and [provide] somewhere for them to just act out their energy, place their energy in a constructive manner."*
- *"The schools have cut so many sports programs and don't offer enough variety. Not everyone wants to run track [or play] basketball or football."*
- *"Aside from academics, youth especially need to engage in extracurricular and social activities to stay healthy, both physically and mentally healthy. This is constrained by the restrictions caused by the COVID pandemic and is a challenge."*

Older Adults

Social isolation due to the pandemic and fear of violence are key issues affecting older adults in both communities.

- *"We have a community that's heavily senior citizens, and that's the one prevailing theme from all of them; they're afraid to come out of their house now. It doesn't matter what time of day it is, they're mourning the loss of their independence, because they used to be able to jump on the bus. It's one bus to get to the supermarket, and pick up their medications, and things of that nature, that's all kind of convenient, but now they're afraid to do that."*
- *"I would say most of them [are] fearful coming out. … They [older adults] really fear for their lives, getting robbed. …. And when you're confined in the house because you're afraid to come out, that's not good for you. Your limbs don't move like they used to, you're not getting the fresh air that you need to stay healthy."*

Many older adults face navigation challenges to access health care, which have worsened during the pandemic, several participants said. Those who lack computer technology or skills have been especially challenged to access both health care and other basic services. Another major issue is difficulty understanding Medicare policies.

- *"Trying to navigate their way through this whole Medicare system. Really, that is a maze, that is a maze."*

Lack of awareness about eligibility for Medicare (or Medicaid) is another issue. A participant who works for a social services organization said:

- "*When we do an assessment, and we find out that [they are eligible for health insurance], they're really happy, because they may have had, or are having, issues, and … for some, they don't want to go to the doctor because of the expense."*

Limited transportation for older adults is an issue in both communities:

- *"I'm speaking on behalf of a lot of my neighbors who are senior citizens … [and] there are some people on the block who do not have public transportation to get to areas … where they can receive fresh vegetables or fruits."*
- For those who walk or take public transit for food shopping, it's difficult if *"you have a lot of packages, unless you want to use Uber, now you're talking about expensive."*

Several participants commented on the need for a **stronger support system for older adults**, such as from younger family members or others to check on them.

- *"For the older adult to stay healthy, I think they really need a strong support system from the younger adults. By support, I mean, financial, physical support for those who may not be able to walk themselves, to see health care facilities."*

Suggested Actions

Participants in both groups highlighted efforts that are working well to improve health in their communities:

"The Black Doctors [COVID-19] Consortium has been a very helpful resource for the African American community," said one participant, who added that *"Dr. Stanford is in the process of opening health centers for the community across the city."*

A participant noted that faith-based institutions are working with the city to provide COVID-19 education and vaccination. *"The city has come out, had its mobile testing unit on site at our faith-based organizations. We've had a number of vaccine clinics back here to help people as well as [provide] COVID education."* The participant added that she had received training [from a city program, Network of Neighbors] *"to help counsel people, and just form that warm, fuzzy community network, where people can come to us as a resource, until we can refer them out to more qualified individuals or organizations to address their concerns."*

In Southwest Philadelphia, a closed school building is being renovated to become a health clinic and facility to provide job training and career development. Career development activities will focus on STEAM, as well as training for tourism and hospitality. *"Sometimes, if you expose a child to something that they wouldn't ordinarily be exposed to, it could change their trajectory of what they do, and choices that they make moving forward. So, that's what we would like to see happen in our community. And we are aggressively working toward that."*

Participants offered suggestions for additional actions to address health needs in their communities:

Increase free out-of-school-time activities for children and youth, participants in both communities recommended.	Provide young people with safe outlets for their energy, opportunities to socialize, and activities to foster knowledge and skills for healthy, productive lives. *"Open the doors for volunteer programs within the hospitals for the youth. We can train them [to work] in the cafeteria, patient transportation, environmental services, to give these young people something to do."*
Increase hospital and business investment in the community, especially in local grassroots organizations that directly serve residents and programs that address social determinants of health.	Several participants noted that in lieu of taxes, which nonprofit hospitals do not pay, they wished to see further investment in community initiatives. *"I would say more money, and resources, and support, comprehensive support around things like rental assistance, mortgage assistance, and access to healthy foods, and job trainings, and things like that, it will help and trickle down into health."*
Activate more Neighborhood Advisory Committees (NACs) and reinvigorate the block captain system.	Use NACs to inform residents about local resources, mobilize community advocacy for change, and provide peer support for mental health. *"We have to start utilizing our block captains and spreading the word. Then we need to get involved with the NACs and get these NACs to start hosting these mental health meetings."*

Suggested Actions

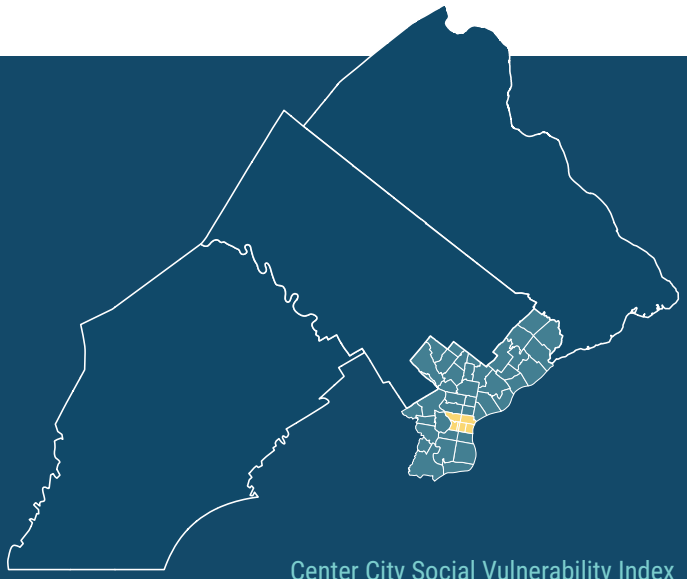
Develop partnerships to increase primary care and mental health services in the community.	Suggestions included deploying nurses or other health professionals to provide home health visits and embedding more doctors in the community. Other suggestions: develop a way for hospitals or behavioral health professionals to help provide mental health care in schools, such as by using professionals-in-training. A related idea: *"Scholarships that you could provide to get more training of Black and Brown folks to do the real work within the community."* Another participant suggested working with community members to *"help train each other to be responsive to people who may have mental health issues and to be able to refer them to other sources that can deal with your specific issues."*
Increase support for older adults to access and navigate health care and other basic services.	*"This is a new day, weird paradigm we're living in and things have changed significantly. And they just need help learning how to navigate those systems."* Better transportation options for older adults also were recommended, such as expanding the LUCY bus route to provide easier access to supermarkets.
Increase city support and neighborhood initiatives to clean up litter and trash in the community.	*"It's something that we do, we can organize our own blocks. The city will give you bags and rooms, and things of that nature. But we have to start it ourselves."*
Engage the community in initiatives to improve health and social services.	A participant stressed the need for taking action with the community's involvement; doing with the community, not to the community.

CENTER CITY

ZIP CODES: 19102, 19103, 19106, 19107, 19123, 19130

This community is served by:

- Children's Hospital of Philadelphia
- Jefferson Health - Center City
- Magee Rehabilitation
- Penn Medicine



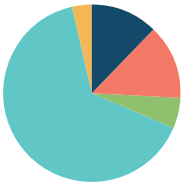
POPULATION

100,923

MEDIAN HOUSEHOLD INCOME

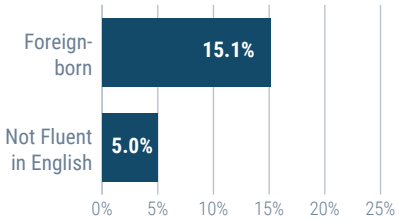
$83,489

RACE/ETHNICITY/LANGUAGE



12.2% | Asian*
13.7% | Black*
5.7% | Hispanic/Latino
64.8% | White*
3.4% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

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

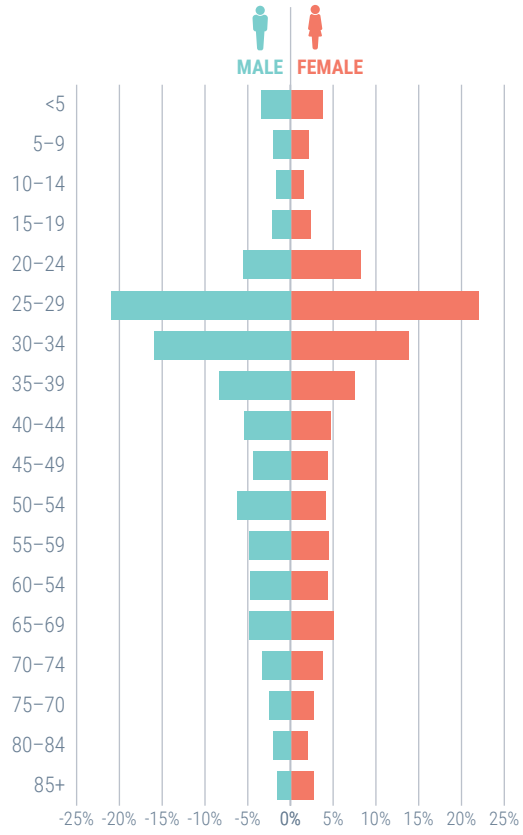
EDUCATIONAL ATTAINMENT

High school as highest education level **11.3%**

PEOPLE WITH DISABILITIES

9.9%

AGE DISTRIBUTION



summary health measures

		Center City		Philadelphia County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	631.2	792.7	879.3	1,121.3
	Life expectancy: Female (in years)	85.6	83.4	80.0	77.5
	Life expectancy: Male (in years)	79.4	78.3	73.0	69.1
	Years of potential life lost before 75	4,827	4,556	146,900	175,443
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	376.5	N/A	701.4
	COVID-related hospitalization rate (per 100,000)	N/A	577.7	N/A	851.0
Chronic Disease & Health Behaviors	Adult obesity prevalence	22.8%		32.3%	
	Diabetes prevalence	7.1%		13.1%	
	Diabetes-related hospitalization rate (per 100,000)	142.7	113.0	259.6	249.7
	Hypertension prevalence	23.4%		34.1%	
	Hypertension-related hospitalization rate (per 100,000)	341.8	292.3	660.5	596.3
	Potentially preventable hospitalization rate (per 100,000)	835.3	681.7	1,521.5	1,270.8
	Premature cardiovascular disease mortality rate (per 100,000)	23.8	20.8	57.1	60.7
	Major cancer incidence rate (per 100,000)	171.4		242.5	
	Major cancer mortality rate (per 100,000)	51.5		80.3	
	Colorectal cancer screening	72.4%		63.5%	
	Mammography screening	79.5%		78.3%	
	Physical inactivity (leisure time) prevalence	15.4%		27.4%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	10.3	--	42.0	17.8
	Infant mortality rate (per 1,000 live births)	--	--	7.0	5.8
	Percent low birthweight births out of live births	9.7%	7.3%	11.5%	11.0%
	Percent preterm births out of live births	6.0%	5.6%	11.4%	11.1%
Behavioral Health	Adult binge drinking	25.4%		19.9%	
	Adult smoking	13.1%		22.1%	
	Drug overdose mortality rate (per 100,000)	35.7	31.7	60.4	65.9
	Opioid-related hospitalization rate (per 100,000)	53.5	50.5	106.2	99.5
	Substance-related hospitalization rate (per 100,000)	720.4	547.0	738.7	598.5
	Poor mental health for 14+ days in past 30 days	13.1%		18.5%	
	Suicide mortality rate (per 100,000)	12.9	13.9	9.9	10.3
Injuries	Fall-related hospitalization rate (per 100,000)	7,721.1	6,743.4	3,583.0	3,430.3
	Gun-related emergency department utilization (per 100,000)	30.0	35.1	25.1	44.2
	Homicide mortality rate (per 100,000)	--	5.9	21.9	31.0
Access to Care	Adults 19-64 years with Medicaid	7.5%		26.0%	
	Children <19 years with public insurance	27.6%		61.0%	
	Population without insurance	3.9%		8.1%	
	Children <19 years without insurance	1.7%		3.8%	
	Emergency department utilization (per 100,000)	40,958.4	33,992.1	53,146.1	40,478.1
	High emergency department utilization (per 100,000)	1,078.9	889.6	1,668.3	1,145.9
Social & Economic Conditions	Population in poverty	12.9%		23.1%	
	Children <18 years in poverty	14.8%		32.2%	
	Adults 19-64 years unemployed	2.2%		4.0%	
	Householders living alone who are 65+ years	17.6%		27.1%	
	Households receiving SNAP benefits	6.7%		23.4%	
	Households that are housing cost-burdened	12.6%		23.2%	
	Housing with potential lead risk	61.3%		78.2%	
	Vacant housing units	12.6%		11.9%	

* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

FAR NORTH PHILADELPHIA

ZIP CODES: 19120, 19126, 19138, 19141, 19150

This community is served by:

- Children's Hospital of Philadelphia
- Einstein Medical Center Philadelphia
- Fox Chase Cancer Center
- Magee Rehabilitation
- Temple University Hospital

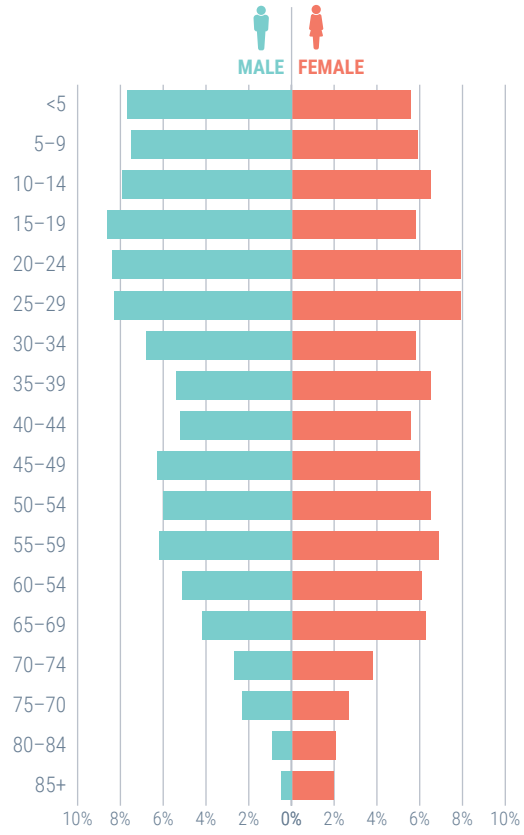
POPULATION

179,482

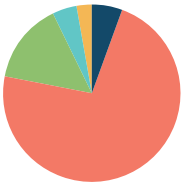
MEDIAN HOUSEHOLD INCOME

$40,565

AGE DISTRIBUTION

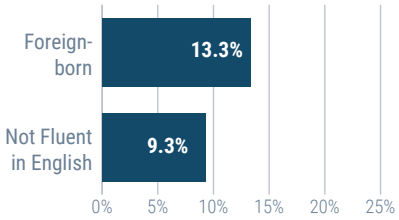


RACE/ETHNICITY/LANGUAGE



5.7% | Asian*
72.4% | Black*
14.6% | Hispanic/Latino
4.6% | White*
2.6% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

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

EDUCATIONAL ATTAINMENT

High school as highest education level **33.1%**

PEOPLE WITH DISABILITIES

18.2%

summary health measures

		Far North Philadelphia		Philadelphia County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	859.7	1,212.4	879.3	1,121.3
	Life expectancy: Female (in years)	80.9	76.6	80.0	77.5
	Life expectancy: Male (in years)	70.9	66.5	73.0	69.1
	Years of potential life lost before 75	16,656	21,860	146,900	175,443
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	804.5	N/A	701.4
	COVID-related hospitalization rate (per 100,000)	N/A	1,070.9	N/A	851.0
Chronic Disease & Health Behaviors	Adult obesity prevalence	36.7%		32.3%	
	Diabetes prevalence	16.1%		13.1%	
	Diabetes-related hospitalization rate (per 100,000)	343.8	315.9	259.6	249.7
	Hypertension prevalence	40.2%		34.1%	
	Hypertension-related hospitalization rate (per 100,000)	887.0	786.7	660.5	596.3
	Potentially preventable hospitalization rate (per 100,000)	1,853.1	1,542.8	1,521.5	1,270.8
	Premature cardiovascular disease mortality rate (per 100,000)	69.1	69.1	57.1	60.7
	Major cancer incidence rate (per 100,000)	256.3		242.5	
	Major cancer mortality rate (per 100,000)	86.4		80.3	
	Colorectal cancer screening	62.7%		63.5%	
	Mammography screening	80.3%		78.3%	
	Physical inactivity (leisure time) prevalence	30.6%		27.4%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	42.8	19.6	42.0	17.8
	Infant mortality rate (per 1,000 live births)	6.6	7.7	7.0	5.8
	Percent low birthweight births out of live births	13.3%	12.7%	11.5%	11.0%
	Percent preterm births out of live births	11.1%	10.9%	11.4%	11.1%
Behavioral Health	Adult binge drinking	16.8%		19.9%	
	Adult smoking	22.9%		22.1%	
	Drug overdose mortality rate (per 100,000)	43.5	55.2	60.4	65.9
	Opioid-related hospitalization rate (per 100,000)	69.1	69.1	106.2	99.5
	Substance-related hospitalization rate (per 100,000)	574.4	484.2	738.7	598.5
	Poor mental health for 14+ days in past 30 days	18.8%		18.5%	
	Suicide mortality rate (per 100,000)	8.4	5.0	9.9	10.3
Injuries	Fall-related hospitalization rate (per 100,000)	7,937.8	8,282.0	3,583.0	3,430.3
	Gun-related emergency department utilization (per 100,000)	13.6	28.3	25.1	44.2
	Homicide mortality rate (per 100,000)	30.1	44.6	21.9	31.0
Access to Care	Adults 19-64 years with Medicaid	30.2%		26.0%	
	Children <19 years with public insurance	70.5%		61.0%	
	Population without insurance	9.8%		8.1%	
	Children <19 years without insurance	4.2%		3.8%	
	Emergency department utilization (per 100,000)	60,219.0	46,345.3	53,146.1	40,478.1
	High emergency department utilization (per 100,000)	1,978.8	1,376.2	1,668.3	1,145.9
Social & Economic Conditions	Population in poverty	25.7%		23.1%	
	Children <18 years in poverty	37.6%		32.2%	
	Adults 19-64 years unemployed	5.5%		4.0%	
	Householders living alone who are 65+ years	33.4%		27.1%	
	Households receiving SNAP benefits	29.1%		23.4%	
	Households that are housing cost-burdened	27.3%		23.2%	
	Housing with potential lead risk	91.0%		78.2%	
	Vacant housing units	10.8%		11.9%	

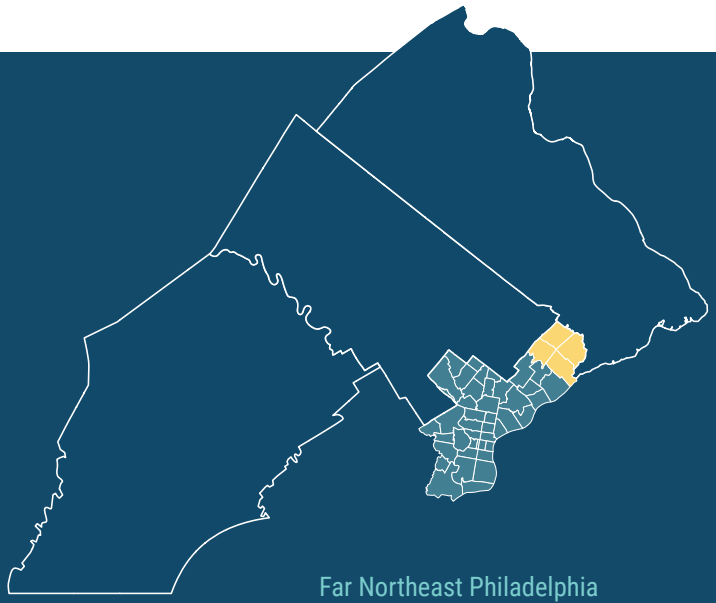
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

FAR NORTHEAST PHILADELPHIA

ZIP CODES: 19114, 19115, 19116, 19154

This community is served by:

- Children's Hospital of Philadelphia
- Einstein Medical Center Philadelphia
- Fox Chase Cancer Center
- Jefferson Health - Northeast
- Magee Rehabilitation
- Redeemer Health
- Rothman Orthopaedic Specialty Hospital
- Trinity Health Mid-Atlantic



Far Northeast Philadelphia
Social Vulnerability Index

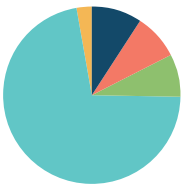
POPULATION

136,859

MEDIAN HOUSEHOLD INCOME

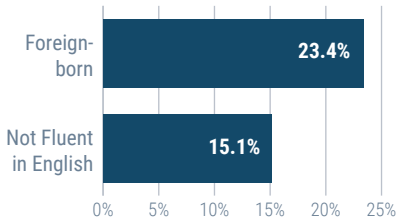
$60,277

RACE/ETHNICITY/LANGUAGE



9.4% | Asian*
8.1% | Black*
8.0% | Hispanic/Latino
71.9% | White*
2.5% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

1. Cancer
2. Heart disease
3. COVID-19
4. Cerebrovascular diseases
5. Chronic lower respiratory diseases

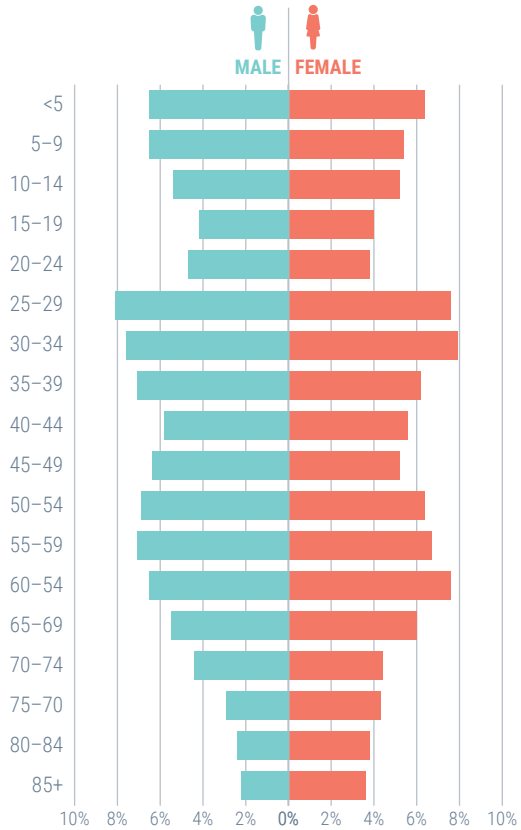
EDUCATIONAL ATTAINMENT

High school as highest education level **33.2%**

PEOPLE WITH DISABILITIES

15.3%

AGE DISTRIBUTION



summary health measures

		Far Northeast Philadelphia		Philadelphia County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	1,082.1	1,331.3	879.3	1,121.3
	Life expectancy: Female (in years)	82.6	80.7	80.0	77.5
	Life expectancy: Male (in years)	76.3	73.4	73.0	69.1
	Years of potential life lost before 75	9,377	10,637	146,900	175,443
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	406.3	N/A	701.4
	COVID-related hospitalization rate (per 100,000)	N/A	735.1	N/A	851.0
Chronic Disease & Health Behaviors	Adult obesity prevalence	25.9%		32.3%	
	Diabetes prevalence	10.4%		13.1%	
	Diabetes-related hospitalization rate (per 100,000)	154.9	152.0	259.6	249.7
	Hypertension prevalence	31.7%		34.1%	
	Hypertension-related hospitalization rate (per 100,000)	534.9	483.7	660.5	596.3
	Potentially preventable hospitalization rate (per 100,000)	1,290.4	1,020.8	1,521.5	1,270.8
	Premature cardiovascular disease mortality rate (per 100,000)	38.0	28.5	57.1	60.7
	Major cancer incidence rate (per 100,000)	291.5		242.5	
	Major cancer mortality rate (per 100,000)	100.8		80.3	
	Colorectal cancer screening	69.0%		63.5%	
	Mammography screening	75.0%		78.3%	
	Physical inactivity (leisure time) prevalence	22.1%		27.4%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	13.7	--	42.0	17.8
	Infant mortality rate (per 1,000 live births)	--	--	7.0	5.8
	Percent low birthweight births out of live births	8.1%	6.9%	11.5%	11.0%
	Percent preterm births out of live births	6.9%	7.0%	11.4%	11.1%
Behavioral Health	Adult binge drinking	21.4%		19.9%	
	Adult smoking	18.5%		22.1%	
	Drug overdose mortality rate (per 100,000)	46.8	42.4	60.4	65.9
	Opioid-related hospitalization rate (per 100,000)	77.5	73.1	106.2	99.5
	Substance-related hospitalization rate (per 100,000)	433.3	347.1	738.7	598.5
	Poor mental health for 14+ days in past 30 days	15.1%		18.5%	
	Suicide mortality rate (per 100,000)	9.5	13.2	9.9	10.3
Injuries	Fall-related hospitalization rate (per 100,000)	7,036.8	7,014.2	3,583.0	3,430.3
	Gun-related emergency department utilization (per 100,000)	4.3	5.1	25.1	44.2
	Homicide mortality rate (per 100,000)	--	--	21.9	31.0
Access to Care	Adults 19-64 years with Medicaid	15.4%		26.0%	
	Children <19 years with public insurance	43.7%		61.0%	
	Population without insurance	6.5%		8.1%	
	Children <19 years without insurance	3.1%		3.8%	
	Emergency department utilization (per 100,000)	31,596.5	24,211.8	53,146.1	40,478.1
	High emergency department utilization (per 100,000)	549.1	425.7	1,668.3	1,145.9
Social & Economic Conditions	Population in poverty	11.3%		23.1%	
	Children <18 years in poverty	14.6%		32.2%	
	Adults 19-64 years unemployed	2.8%		4.0%	
	Householders living alone who are 65+ years	41.6%		27.1%	
	Households receiving SNAP benefits	16.1%		23.4%	
	Households that are housing cost-burdened	20.5%		23.2%	
	Housing with potential lead risk	60.7%		78.2%	
	Vacant housing units	5.8%		11.9%	

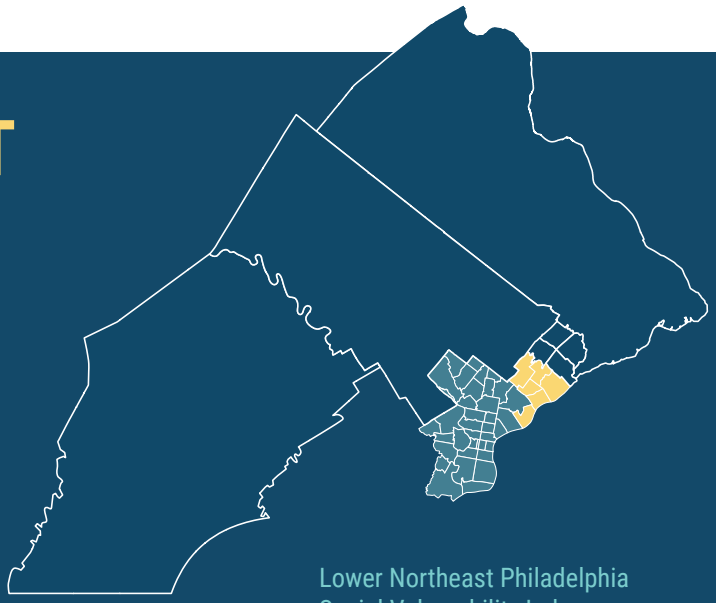
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

LOWER NORTHEAST PHILADELPHIA

ZIP CODES: 19111, 19135, 19136, 19137, 19149, 19152

This community is served by:

- Children's Hospital of Philadelphia
- Einstein Medical Center Philadelphia
- Fox Chase Cancer Center
- Jefferson Health - Northeast
- Magee Rehabilitation
- Redeemer Health
- Rothman Orthopaedic Specialty Hospital
- Temple University Hospital
- Trinity Health Mid-Atlantic



Lower Northeast Philadelphia
Social Vulnerability Index

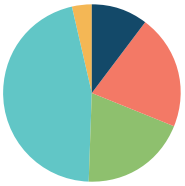
POPULATION

241,062

MEDIAN HOUSEHOLD INCOME

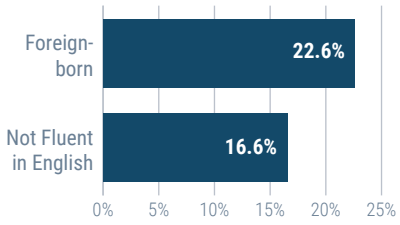
$49,762

RACE/ETHNICITY/LANGUAGE



10.3% | Asian*
20.8% | Black*
19.5% | Hispanic/Latino
45.8% | White*
3.4% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

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

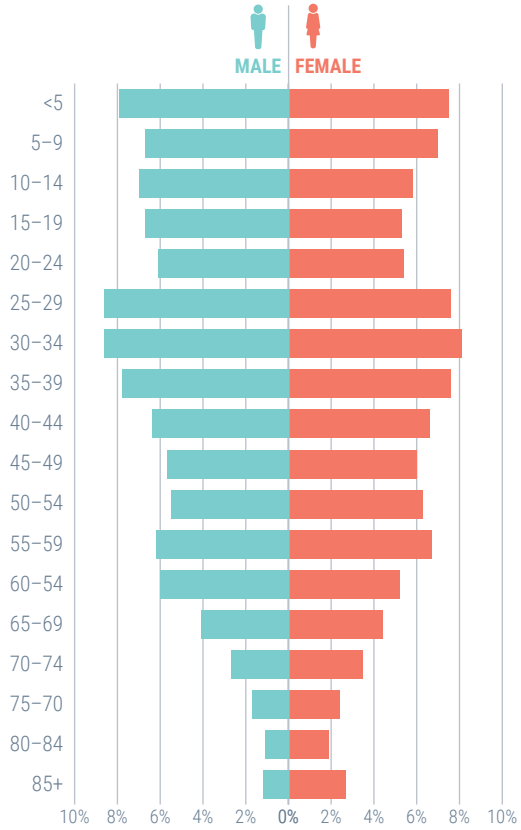
EDUCATIONAL ATTAINMENT

High school as highest education level **35.9%**

PEOPLE WITH DISABILITIES

14.6%

AGE DISTRIBUTION



summary health measures

		Lower Northeast Philadelphia		Philadelphia County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	834.6	1,061.1	879.3	1,121.3
	Life expectancy: Female (in years)	80.5	78.0	80.0	77.5
	Life expectancy: Male (in years)	74.5	71.2	73.0	69.1
	Years of potential life lost before 75	20,224	23,048	146,900	175,443
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	488.3	N/A	701.4
	COVID-related hospitalization rate (per 100,000)	N/A	815.6	N/A	851.0
Chronic Disease & Health Behaviors	Adult obesity prevalence	29.8%		32.3%	
	Diabetes prevalence	11.3%		13.1%	
	Diabetes-related hospitalization rate (per 100,000)	215.7	209.9	259.6	249.7
	Hypertension prevalence	31.8%		34.1%	
	Hypertension-related hospitalization rate (per 100,000)	523.9	436.4	660.5	596.3
	Potentially preventable hospitalization rate (per 100,000)	1,334.1	1,065.3	1,521.5	1,270.8
	Premature cardiovascular disease mortality rate (per 100,000)	48.1	48.5	57.1	60.7
	Major cancer incidence rate (per 100,000)	199.5		242.5	
	Major cancer mortality rate (per 100,000)	73.8		80.3	
	Colorectal cancer screening	62.9%		63.5%	
	Mammography screening	75.0%		78.3%	
	Physical inactivity (leisure time) prevalence	27.0%		27.4%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	28.1	8.8	42.0	17.8
	Infant mortality rate (per 1,000 live births)	8.2	3.8	7.0	5.8
	Percent low birthweight births out of live births	9.3%	9.5%	11.5%	11.0%
	Percent preterm births out of live births	7.5%	7.9%	11.4%	11.1%
Behavioral Health	Adult binge drinking	21.1%		19.9%	
	Adult smoking	23.6%		22.1%	
	Drug overdose mortality rate (per 100,000)	58.5	59.7	60.4	65.9
	Opioid-related hospitalization rate (per 100,000)	109.9	107.4	106.2	99.5
	Substance-related hospitalization rate (per 100,000)	548.4	422.3	738.7	598.5
	Poor mental health for 14+ days in past 30 days	18.5%		18.5%	
	Suicide mortality rate (per 100,000)	12.0	8.3	9.9	10.3
Injuries	Fall-related hospitalization rate (per 100,000)	10,108.0	8,998.2	3,583.0	3,430.3
	Gun-related emergency department utilization (per 100,000)	8.9	13.3	25.1	44.2
	Homicide mortality rate (per 100,000)	14.9	15.3	21.9	31.0
Access to Care	Adults 19-64 years with Medicaid	24.7%		26.0%	
	Children <19 years with public insurance	59.5%		61.0%	
	Population without insurance	9.9%		8.1%	
	Children <19 years without insurance	5.5%		3.8%	
	Emergency department utilization (per 100,000)	48,286.3	37,795.2	53,146.1	40,478.1
	High emergency department utilization (per 100,000)	1,151.3	925.8	1,668.3	1,145.9
Social & Economic Conditions	Population in poverty	18.6%		23.1%	
	Children <18 years in poverty	26.3%		32.2%	
	Adults 19-64 years unemployed	3.8%		4.0%	
	Householders living alone who are 65+ years	32.8%		27.1%	
	Households receiving SNAP benefits	23.2%		23.4%	
	Households that are housing cost-burdened	22.8%		23.2%	
	Housing with potential lead risk	85.2%		78.2%	
	Vacant housing units	8.4%		11.9%	

* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

NORTH PHILADELPHIA-EAST

ZIP CODES: 19122, 19133, 19140

This community is served by:

- Children's Hospital of Philadelphia
- Einstein Medical Center Philadelphia
- Fox Chase Cancer Center
- Jefferson Health - Center City
- Magee Rehabilitation
- Temple University Hospital

North Philadelphia-East
Social Vulnerability Index

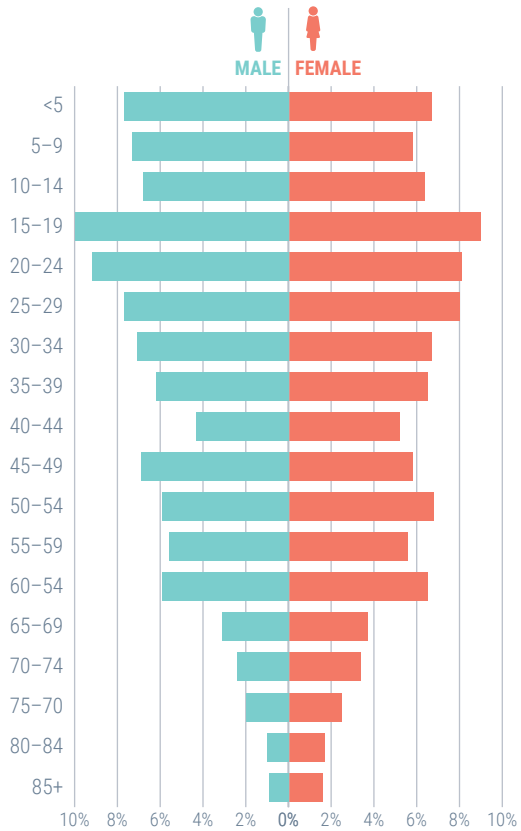
POPULATION

100,534

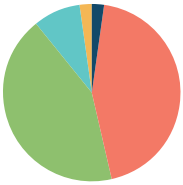
MEDIAN HOUSEHOLD INCOME

$26,780

AGE DISTRIBUTION

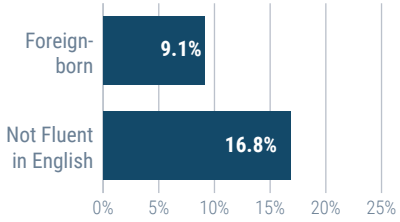


RACE/ETHNICITY/LANGUAGE



2.3% | Asian*
44.1% | Black*
42.7% | Hispanic/Latino
8.8% | White*
2.0% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

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

EDUCATIONAL ATTAINMENT

High school as highest education level **41.3%**

PEOPLE WITH DISABILITIES

25.2%

summary health measures

		North Philadelphia-East		Philadelphia County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	900.2	1,239.4	879.3	1,121.3
	Life expectancy: Female (in years)	77.7	74.9	80.0	77.5
	Life expectancy: Male (in years)	69.2	63.1	73.0	69.1
	Years of potential life lost before 75	13,162	16,148	146,900	175,443
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	636.6	N/A	701.4
	COVID-related hospitalization rate (per 100,000)	N/A	1,420.4	N/A	851.0
Chronic Disease & Health Behaviors	Adult obesity prevalence	39.3%		32.3%	
	Diabetes prevalence	17.9%		13.1%	
	Diabetes-related hospitalization rate (per 100,000)	385.9	373.0	259.6	249.7
	Hypertension prevalence	37.8%		34.1%	
	Hypertension-related hospitalization rate (per 100,000)	1,004.6	994.7	660.5	596.3
	Potentially preventable hospitalization rate (per 100,000)	2,197.3	1,960.5	1,521.5	1,270.8
	Premature cardiovascular disease mortality rate (per 100,000)	69.6	84.5	57.1	60.7
	Major cancer incidence rate (per 100,000)	238.7		242.5	
	Major cancer mortality rate (per 100,000)	66.6		80.3	
	Colorectal cancer screening	54.4%		63.5%	
	Mammography screening	78.9%		78.3%	
	Physical inactivity (leisure time) prevalence	37.2%		27.4%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	74.3	30.5	42.0	17.8
	Infant mortality rate (per 1,000 live births)	6.1	7.6	7.0	5.8
	Percent low birthweight births out of live births	13.8%	13.1%	11.5%	11.0%
	Percent preterm births out of live births	11.1%	12.2%	11.4%	11.1%
Behavioral Health	Adult binge drinking	17.6%		19.9%	
	Adult smoking	26.9%		22.1%	
	Drug overdose mortality rate (per 100,000)	104.4	110.4	60.4	65.9
	Opioid-related hospitalization rate (per 100,000)	100.5	120.4	106.2	99.5
	Substance-related hospitalization rate (per 100,000)	1,029.5	904.2	738.7	598.5
	Poor mental health for 14+ days in past 30 days	22.8%		18.5%	
	Suicide mortality rate (per 100,000)	7.0	9.9	9.9	10.3
Injuries	Fall-related hospitalization rate (per 100,000)	10,313.9	10,456.6	3,583.0	3,430.3
	Gun-related emergency department utilization (per 100,000)	19.8	66.9	25.1	44.2
	Homicide mortality rate (per 100,000)	43.8	55.7	21.9	31.0
Access to Care	Adults 19-64 years with Medicaid	45.0%		26.0%	
	Children <19 years with public insurance	83.8%		61.0%	
	Population without insurance	10.7%		8.1%	
	Children <19 years without insurance	3.8%		3.8%	
	Emergency department utilization (per 100,000)	100,535.5	71,037.6	53,146.1	40,478.1
	High emergency department utilization (per 100,000)	4,256.8	2,557.8	1,668.3	1,145.9
Social & Economic Conditions	Population in poverty	40.8%		23.1%	
	Children <18 years in poverty	53.1%		32.2%	
	Adults 19-64 years unemployed	5.4%		4.0%	
	Householders living alone who are 65+ years	27.6%		27.1%	
	Households receiving SNAP benefits	47.5%		23.4%	
	Households that are housing cost-burdened	37.8%		23.2%	
	Housing with potential lead risk	77.1%		78.2%	
	Vacant housing units	15.4%		11.9%	

* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

NORTH PHILADELPHIA-WEST

ZIP CODES: 19121, 19132

This community is served by:

- Children's Hospital of Philadelphia
- Einstein Medical Center Philadelphia
- Fox Chase Cancer Center
- Jefferson Health - Center City
- Magee Rehabilitation
- Main Line Health
- Temple University Hospital

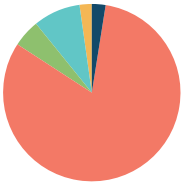
POPULATION

63,763

MEDIAN HOUSEHOLD INCOME

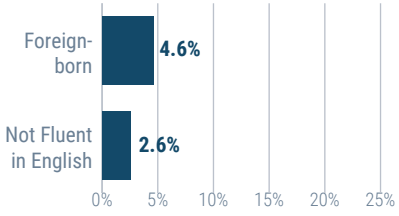
$21,401

RACE/ETHNICITY/LANGUAGE



2.7% | Asian*
81.5% | Black*
4.9% | Hispanic/Latino
8.5% | White*
2.2% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

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

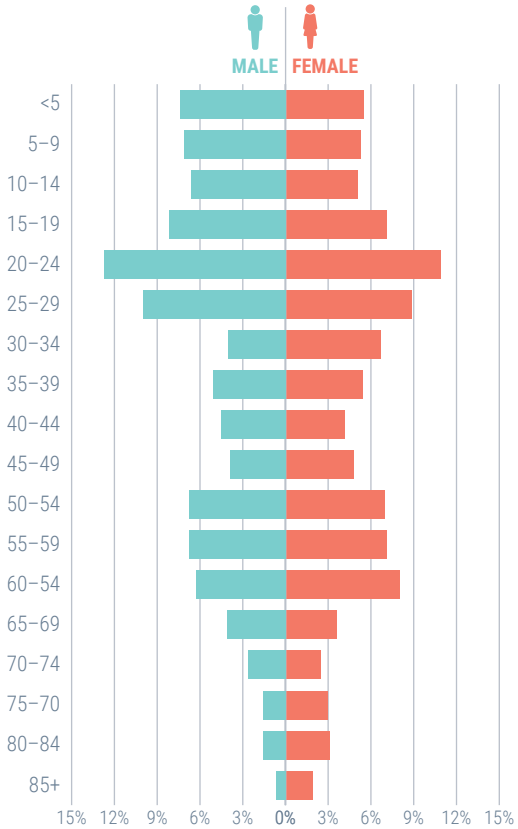
EDUCATIONAL ATTAINMENT

High school as highest education level **37.6%**

PEOPLE WITH DISABILITIES

20.3%

AGE DISTRIBUTION



summary health measures

		North Philadelphia-West		Philadelphia County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	1,257.8	1,664.0	879.3	1,121.3
	Life expectancy: Female (in years)	73.9	71.6	80.0	77.5
	Life expectancy: Male (in years)	64.3	57.9	73.0	69.1
	Years of potential life lost before 75	10,309	13,709	146,900	175,443
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	870.4	N/A	701.4
	COVID-related hospitalization rate (per 100,000)	N/A	1,303.3	N/A	851.0
Chronic Disease & Health Behaviors	Adult obesity prevalence	40.6%		32.3%	
	Diabetes prevalence	18.2%		13.1%	
	Diabetes-related hospitalization rate (per 100,000)	468.9	527.0	259.6	249.7
	Hypertension prevalence	42.5%		34.1%	
	Hypertension-related hospitalization rate (per 100,000)	1,358.2	1,318.9	660.5	596.3
	Potentially preventable hospitalization rate (per 100,000)	2,686.5	2,470.1	1,521.5	1,270.8
	Premature cardiovascular disease mortality rate (per 100,000)	116.1	123.9	57.1	60.7
	Major cancer incidence rate (per 100,000)	240.0		242.5	
	Major cancer mortality rate (per 100,000)	106.6		80.3	
	Colorectal cancer screening	58.9%		63.5%	
	Mammography screening	81.2%		78.3%	
	Physical inactivity (leisure time) prevalence	34.5%		27.4%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	86.6	38.7	42.0	17.8
	Infant mortality rate (per 1,000 live births)	10.9	11.6	7.0	5.8
	Percent low birthweight births out of live births	16.5%	16.0%	11.5%	11.0%
	Percent preterm births out of live births	12.0%	12.4%	11.4%	11.1%
Behavioral Health	Adult binge drinking	16.4%		19.9%	
	Adult smoking	27.5%		22.1%	
	Drug overdose mortality rate (per 100,000)	95.7	117.6	60.4	65.9
	Opioid-related hospitalization rate (per 100,000)	95.7	100.4	106.2	99.5
	Substance-related hospitalization rate (per 100,000)	1,347.2	1,137.0	738.7	598.5
	Poor mental health for 14+ days in past 30 days	23.2%		18.5%	
	Suicide mortality rate (per 100,000)	9.4	--	9.9	10.3
Injuries	Fall-related hospitalization rate (per 100,000)	9,684.0	8,579.5	3,583.0	3,430.3
	Gun-related emergency department utilization (per 100,000)	23.6	108.5	25.1	44.2
	Homicide mortality rate (per 100,000)	53.3	97.2	21.9	31.0
Access to Care	Adults 19-64 years with Medicaid	41.8%		26.0%	
	Children <19 years with public insurance	81.1%		61.0%	
	Population without insurance	8.3%		8.1%	
	Children <19 years without insurance	3.2%		3.8%	
	Emergency department utilization (per 100,000)	116,724.0	87,300.7	53,146.1	40,478.1
	High emergency department utilization (per 100,000)	5,159.8	3,415.8	1,668.3	1,145.9
Social & Economic Conditions	Population in poverty	43.5%		23.1%	
	Children <18 years in poverty	57.4%		32.2%	
	Adults 19-64 years unemployed	5.1%		4.0%	
	Householders living alone who are 65+ years	24.6%		27.1%	
	Households receiving SNAP benefits	40.1%		23.4%	
	Households that are housing cost-burdened	37.2%		23.2%	
	Housing with potential lead risk	83.0%		78.2%	
	Vacant housing units	23.4%		11.9%	

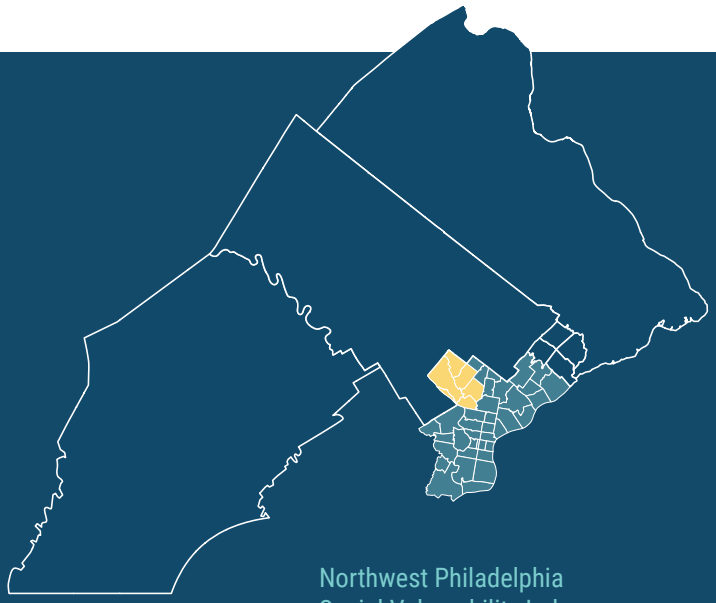
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

NORTHWEST PHILADELPHIA

ZIP CODES: 19118, 19119, 19127, 19128, 19129, 19144

This community is served by:

- Children's Hospital of Philadelphia
- Einstein Medical Center Philadelphia
- Fox Chase Cancer Center
- Magee Rehabilitation
- Main Line Health
- Rothman Orthopaedic Specialty Hospital



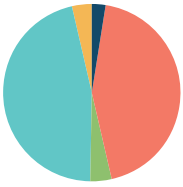
POPULATION

137,639

MEDIAN HOUSEHOLD INCOME

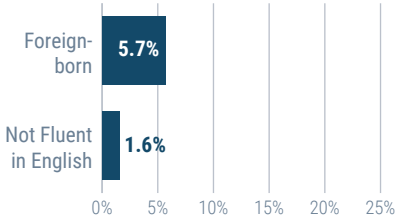
$69,497

RACE/ETHNICITY/LANGUAGE



2.7% | Asian*
43.7% | Black*
3.9% | Hispanic/Latino
45.9% | White*
3.5% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

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

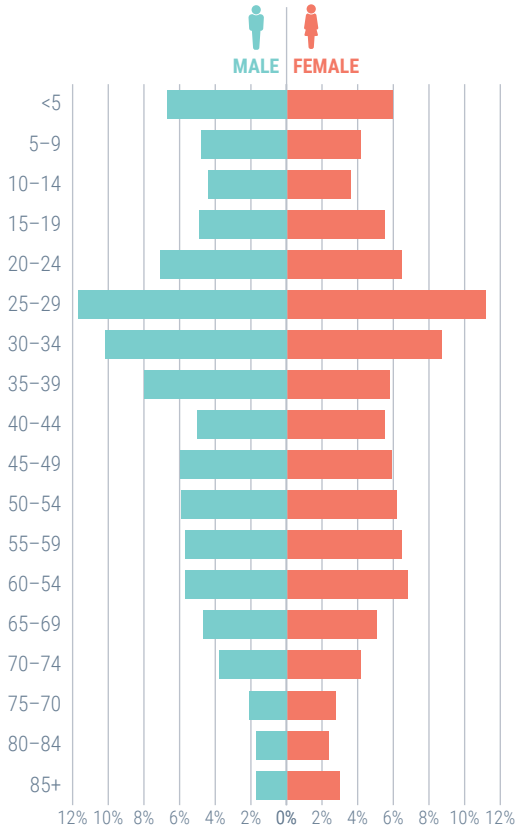
EDUCATIONAL ATTAINMENT

High school as highest education level **21.2%**

PEOPLE WITH DISABILITIES

14.0%

AGE DISTRIBUTION



summary health measures

		Northwest Philadelphia		Philadelphia County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	930.7	1,172.6	879.3	1,121.3
	Life expectancy: Female (in years)	81.3	78.0	80.0	77.5
	Life expectancy: Male (in years)	75.6	71.6	73.0	69.1
	Years of potential life lost before 75	10,094	13,459	146,900	175,443
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	571.1	N/A	701.4
	COVID-related hospitalization rate (per 100,000)	N/A	717.1	N/A	851.0
Chronic Disease & Health Behaviors	Adult obesity prevalence	29.8%		32.3%	
	Diabetes prevalence	11.4%		13.1%	
	Diabetes-related hospitalization rate (per 100,000)	252.1	231.0	259.6	249.7
	Hypertension prevalence	32.9%		34.1%	
	Hypertension-related hospitalization rate (per 100,000)	658.2	613.9	660.5	596.3
	Potentially preventable hospitalization rate (per 100,000)	1,412.4	1,189.3	1,521.5	1,270.8
	Premature cardiovascular disease mortality rate (per 100,000)	49.4	61.0	57.1	60.7
	Major cancer incidence rate (per 100,000)	236.1		242.5	
	Major cancer mortality rate (per 100,000)	86.5		80.3	
	Colorectal cancer screening	69.4%		63.5%	
	Mammography screening	79.9%		78.3%	
	Physical inactivity (leisure time) prevalence	21.7%		27.4%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	23.9	10.3	42.0	17.8
	Infant mortality rate (per 1,000 live births)	3.8	8.3	7.0	5.8
	Percent low birthweight births out of live births	9.6%	10.1%	11.5%	11.0%
	Percent preterm births out of live births	7.7%	7.8%	11.4%	11.1%
Behavioral Health	Adult binge drinking	21.4%		19.9%	
	Adult smoking	17.7%		22.1%	
	Drug overdose mortality rate (per 100,000)	34.1	50.9	60.4	65.9
	Opioid-related hospitalization rate (per 100,000)	86.5	58.8	106.2	99.5
	Substance-related hospitalization rate (per 100,000)	580.5	423.6	738.7	598.5
	Poor mental health for 14+ days in past 30 days	15.9%		18.5%	
	Suicide mortality rate (per 100,000)	13.1	14.5	9.9	10.3
Injuries	Fall-related hospitalization rate (per 100,000)	8,089.6	7,602.2	3,583.0	3,430.3
	Gun-related emergency department utilization (per 100,000)	7.9	18.2	25.1	44.2
	Homicide mortality rate (per 100,000)	16.7	21.8	21.9	31.0
Access to Care	Adults 19-64 years with Medicaid	17.4%		26.0%	
	Children <19 years with public insurance	43.6%		61.0%	
	Population without insurance	4.7%		8.1%	
	Children <19 years without insurance	2.4%		3.8%	
	Emergency department utilization (per 100,000)	26,353.2	23,555.2	53,146.1	40,478.1
	High emergency department utilization (per 100,000)	808.6	651.1	1,668.3	1,145.9
Social & Economic Conditions	Population in poverty	16.9%		23.1%	
	Children <18 years in poverty	19.2%		32.2%	
	Adults 19-64 years unemployed	3.3%		4.0%	
	Householders living alone who are 65+ years	25.0%		27.1%	
	Households receiving SNAP benefits	12.9%		23.4%	
	Households that are housing cost-burdened	15.5%		23.2%	
	Housing with potential lead risk	79.4%		78.2%	
	Vacant housing units	10.1%		11.9%	

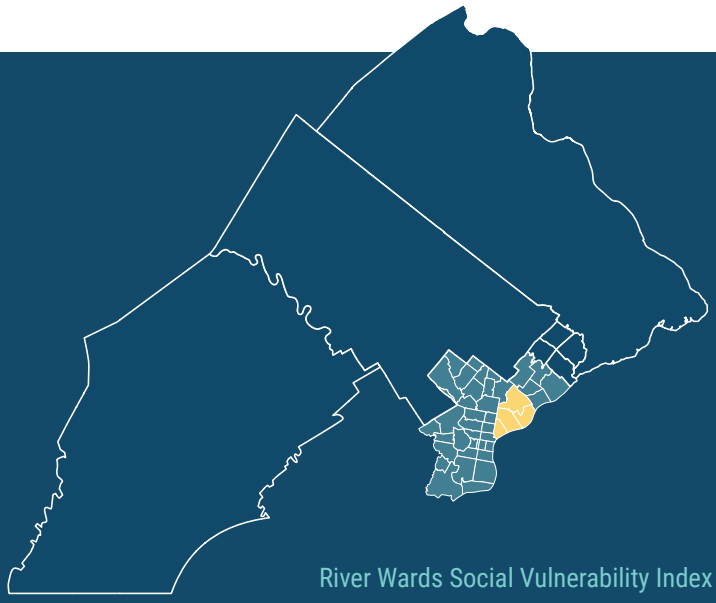
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

RIVER WARDS

ZIP CODES: 19124, 19125, 19134

This community is served by:

- Children's Hospital of Philadelphia
- Einstein Medical Center Philadelphia
- Fox Chase Cancer Center
- Jefferson Health - Center City
- Jefferson Health - Northeast
- Magee Rehabilitation
- Rothman Orthopaedic Specialty Hospital
- Temple University Hospital



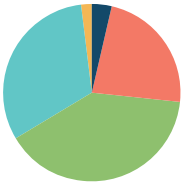
POPULATION

158,241

MEDIAN HOUSEHOLD INCOME

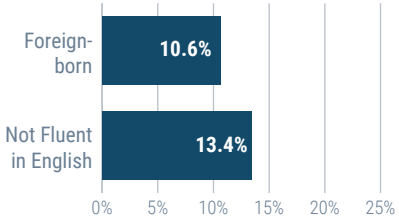
$46,045

RACE/ETHNICITY/LANGUAGE

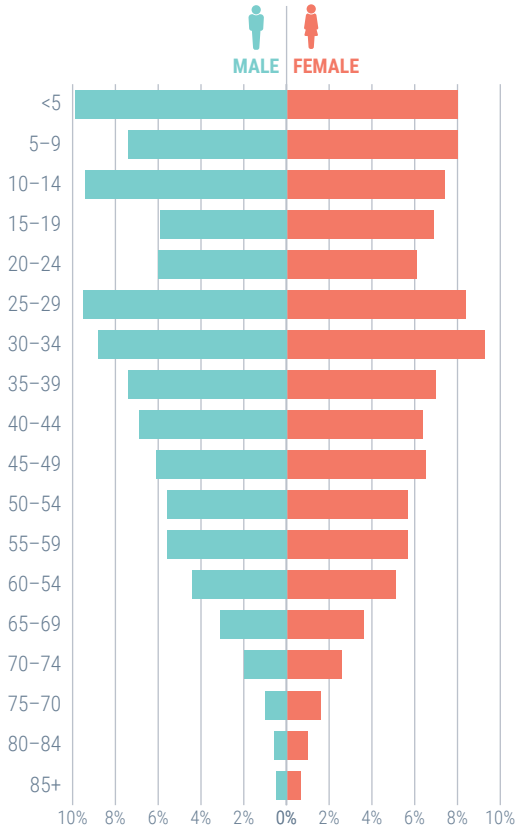


3.8% | Asian*
22.9% | Black*
39.7% | Hispanic/Latino
31.7% | White*
1.7% | Other*

* Non-Hispanic



AGE DISTRIBUTION



LEADING CAUSES OF DEATH

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

EDUCATIONAL ATTAINMENT

High school as highest education level **38.5%**

PEOPLE WITH DISABILITIES

21.4%

summary health measures

		River Wards		Philadelphia County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	772.9	930.9	879.3	1,121.3
	Life expectancy: Female (in years)	76.7	74.8	80.0	77.5
	Life expectancy: Male (in years)	68.6	65.6	73.0	69.1
	Years of potential life lost before 75	19,451	21,962	146,900	175,443
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	461.3	N/A	701.4
	COVID-related hospitalization rate (per 100,000)	N/A	846.2	N/A	851.0
Chronic Disease & Health Behaviors	Adult obesity prevalence	34.8%		32.3%	
	Diabetes prevalence	13.0%		13.1%	
	Diabetes-related hospitalization rate (per 100,000)	257.8	274.3	259.6	249.7
	Hypertension prevalence	31.7%		34.1%	
	Hypertension-related hospitalization rate (per 100,000)	486.0	512.5	660.5	596.3
	Potentially preventable hospitalization rate (per 100,000)	1,385.9	1,266.4	1,521.5	1,270.8
	Premature cardiovascular disease mortality rate (per 100,000)	67.6	71.4	57.1	60.7
	Major cancer incidence rate (per 100,000)	177.6		242.5	
	Major cancer mortality rate (per 100,000)	66.4		80.3	
	Colorectal cancer screening	56.9%		63.5%	
	Mammography screening	75.9%		78.3%	
	Physical inactivity (leisure time) prevalence	32.1%		27.4%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	53.1	22.4	42.0	17.8
	Infant mortality rate (per 1,000 live births)	8.9	6.6	7.0	5.8
	Percent low birthweight births out of live births	12.8%	11.1%	11.5%	11.0%
	Percent preterm births out of live births	10.0%	10.1%	11.4%	11.1%
Behavioral Health	Adult binge drinking	20.6%		19.9%	
	Adult smoking	26.8%		22.1%	
	Drug overdose mortality rate (per 100,000)	118.2	111.2	60.4	65.9
	Opioid-related hospitalization rate (per 100,000)	211.7	197.8	106.2	99.5
	Substance-related hospitalization rate (per 100,000)	1,164.0	923.9	738.7	598.5
	Poor mental health for 14+ days in past 30 days	21.6%		18.5%	
	Suicide mortality rate (per 100,000)	10.1	13.3	9.9	10.3
Injuries	Fall-related hospitalization rate (per 100,000)	15,561.2	14,895.6	3,583.0	3,430.3
	Gun-related emergency department utilization (per 100,000)	15.5	33.8	25.1	44.2
	Homicide mortality rate (per 100,000)	22.8	37.9	21.9	31.0
Access to Care	Adults 19-64 years with Medicaid	38.6%		26.0%	
	Children <19 years with public insurance	77.8%		61.0%	
	Population without insurance	9.5%		8.1%	
	Children <19 years without insurance	3.2%		3.8%	
	Emergency department utilization (per 100,000)	66,710.3	48,650.3	53,146.1	40,478.1
	High emergency department utilization (per 100,000)	2,224.4	1,460.7	1,668.3	1,145.9
Social & Economic Conditions	Population in poverty	34.0%		23.1%	
	Children <18 years in poverty	48.9%		32.2%	
	Adults 19-64 years unemployed	4.6%		4.0%	
	Householders living alone who are 65+ years	18.3%		27.1%	
	Households receiving SNAP benefits	35.4%		23.4%	
	Households that are housing cost-burdened	29.4%		23.2%	
	Housing with potential lead risk	87.8%		78.2%	
	Vacant housing units	11.5%		11.9%	

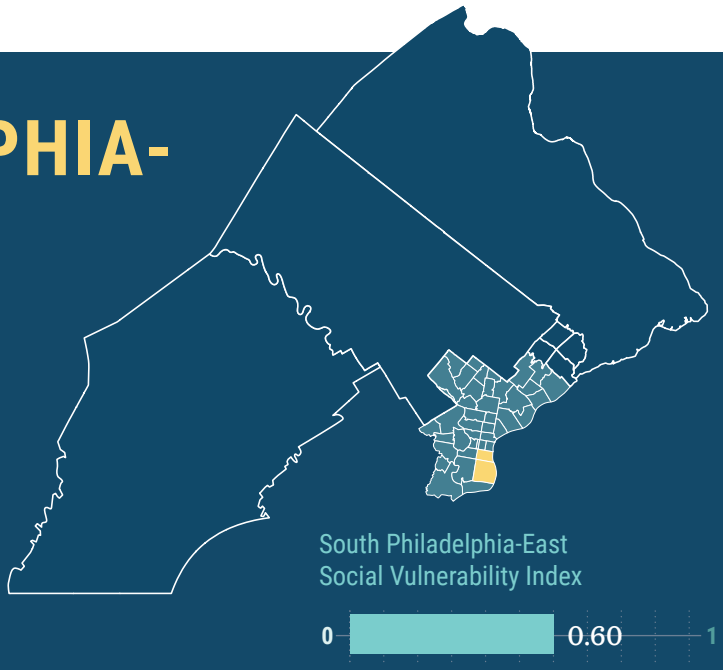
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

SOUTH PHILADELPHIA-EAST

ZIP CODES: 19147, 19148

This community is served by:

- Children's Hospital of Philadelphia
- Jefferson Health - Center City
- Magee Rehabilitation
- Penn Medicine
- Rothman Orthopaedic Specialty Hospital



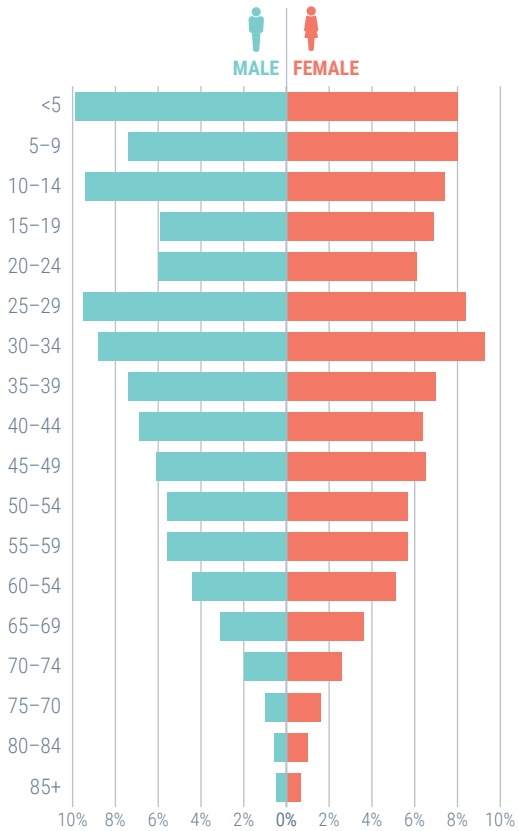
POPULATION

90,731

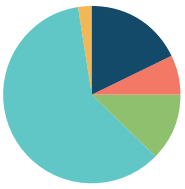
MEDIAN HOUSEHOLD INCOME

$66,760

AGE DISTRIBUTION

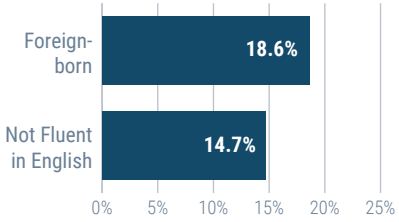


RACE/ETHNICITY/LANGUAGE



17.9% | Asian*
7.1% | Black*
12.3% | Hispanic/Latino
60.2% | White*
2.5% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

1. Cancer
2. Heart disease
3. COVID-19
4. Drug overdose
5. Chronic lower respiratory diseases

EDUCATIONAL ATTAINMENT

High school as highest education level **32.0%**

PEOPLE WITH DISABILITIES

13.1%

summary health measures

		South Philadelphia-East		Philadelphia County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	758.3	882.8	879.3	1,121.3
	Life expectancy: Female (in years)	82.2	80.5	80.0	77.5
	Life expectancy: Male (in years)	77.2	74.1	73.0	69.1
	Years of potential life lost before 75	5,764	6,508	146,900	175,443
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	1,041.5	N/A	701.4
	COVID-related hospitalization rate (per 100,000)	N/A	662.4	N/A	851.0
Chronic Disease & Health Behaviors	Adult obesity prevalence	25.6%		32.3%	
	Diabetes prevalence	9.7%		13.1%	
	Diabetes-related hospitalization rate (per 100,000)	179.7	143.3	259.6	249.7
	Hypertension prevalence	27.4%		34.1%	
	Hypertension-related hospitalization rate (per 100,000)	359.3	311.9	660.5	596.3
	Potentially preventable hospitalization rate (per 100,000)	962.2	710.9	1,521.5	1,270.8
	Premature cardiovascular disease mortality rate (per 100,000)	28.7	41.9	57.1	60.7
	Major cancer incidence rate (per 100,000)	187.4		242.5	
	Major cancer mortality rate (per 100,000)	87.1		80.3	
	Colorectal cancer screening	65.9%		63.5%	
	Mammography screening	76.2%		78.3%	
	Physical inactivity (leisure time) prevalence	22.8%		27.4%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	19.6	5.3	42.0	17.8
	Infant mortality rate (per 1,000 live births)	--	--	7.0	5.8
	Percent low birthweight births out of live births	8.1%	8.2%	11.5%	11.0%
	Percent preterm births out of live births	4.9%	5.7%	11.4%	11.1%
Behavioral Health	Adult binge drinking	22.8%		19.9%	
	Adult smoking	19.6%		22.1%	
	Drug overdose mortality rate (per 100,000)	60.6	55.1	60.4	65.9
	Opioid-related hospitalization rate (per 100,000)	106.9	101.4	106.2	99.5
	Substance-related hospitalization rate (per 100,000)	547.8	513.6	738.7	598.5
	Poor mental health for 14+ days in past 30 days	16.2%		18.5%	
	Suicide mortality rate (per 100,000)	8.8	18.7	9.9	10.3
Injuries	Fall-related hospitalization rate (per 100,000)	7,901.8	6,530.8	3,583.0	3,430.3
	Gun-related emergency department utilization (per 100,000)	16.2	11.2	25.1	44.2
	Homicide mortality rate (per 100,000)	--	--	21.9	31.0
Access to Care	Adults 19-64 years with Medicaid	18.0%		26.0%	
	Children <19 years with public insurance	50.5%		61.0%	
	Population without insurance	8.5%		8.1%	
	Children <19 years without insurance	2.5%		3.8%	
	Emergency department utilization (per 100,000)	34,441.5	26,816.2	53,146.1	40,478.1
	High emergency department utilization (per 100,000)	812.0	614.2	1,668.3	1,145.9
Social & Economic Conditions	Population in poverty	16.8%		23.1%	
	Children <18 years in poverty	28.0%		32.2%	
	Adults 19-64 years unemployed	3.2%		4.0%	
	Householders living alone who are 65+ years	21.7%		27.1%	
	Households receiving SNAP benefits	17.3%		23.4%	
	Households that are housing cost-burdened	15.2%		23.2%	
	Housing with potential lead risk	81.5%		78.2%	
	Vacant housing units	10.9%		11.9%	

* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

SOUTH PHILADELPHIA-WEST

ZIP CODES: 19145, 19146

This community is served by:

- Children's Hospital of Philadelphia
- Jefferson Health - Center City
- Magee Rehabilitation
- Penn Medicine
- Rothman Orthopaedic Specialty Hospital

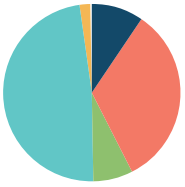
POPULATION

85,334

MEDIAN HOUSEHOLD INCOME

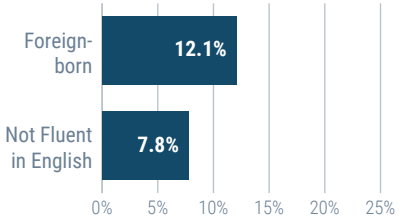
$57,923

RACE/ETHNICITY/LANGUAGE



9.6% | Asian*
33.0% | Black*
7.2% | Hispanic/Latino
47.6% | White*
2.2% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

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

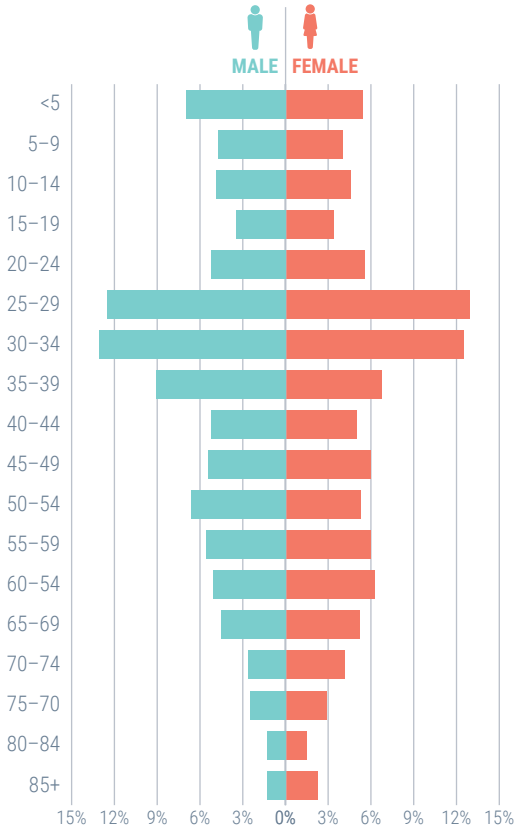
EDUCATIONAL ATTAINMENT

High school as highest education level **31.7%**

PEOPLE WITH DISABILITIES

15.2%

AGE DISTRIBUTION



summary health measures

		South Philadelphia-West		Philadelphia County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	836.7	1,094.5	879.3	1,121.3
	Life expectancy: Female (in years)	79.7	76.9	80.0	77.5
	Life expectancy: Male (in years)	76.2	71.5	73.0	69.1
	Years of potential life lost before 75	7,165	8,685	146,900	175,443
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	1,027.7	N/A	701.4
	COVID-related hospitalization rate (per 100,000)	N/A	632.8	N/A	851.0
Chronic Disease & Health Behaviors	Adult obesity prevalence	29.9%		32.3%	
	Diabetes prevalence	12.0%		13.1%	
	Diabetes-related hospitalization rate (per 100,000)	239.1	219.1	259.6	249.7
	Hypertension prevalence	32.8%		34.1%	
	Hypertension-related hospitalization rate (per 100,000)	543.7	467.6	660.5	596.3
	Potentially preventable hospitalization rate (per 100,000)	1,306.6	1,118.0	1,521.5	1,270.8
	Premature cardiovascular disease mortality rate (per 100,000)	55.1	38.7	57.1	60.7
	Major cancer incidence rate (per 100,000)	225.0		242.5	
	Major cancer mortality rate (per 100,000)	87.9		80.3	
	Colorectal cancer screening	65.9%		63.5%	
	Mammography screening	78.9%		78.3%	
	Physical inactivity (leisure time) prevalence	24.6%		27.4%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	44.3	12.8	42.0	17.8
	Infant mortality rate (per 1,000 live births)	6.5	--	7.0	5.8
	Percent low birthweight births out of live births	9.2%	7.7%	11.5%	11.0%
	Percent preterm births out of live births	6.7%	7.1%	11.4%	11.1%
Behavioral Health	Adult binge drinking	20.6%		19.9%	
	Adult smoking	20.3%		22.1%	
	Drug overdose mortality rate (per 100,000)	62.1	60.9	60.4	65.9
	Opioid-related hospitalization rate (per 100,000)	150.0	130.1	106.2	99.5
	Substance-related hospitalization rate (per 100,000)	690.2	605.9	738.7	598.5
	Poor mental health for 14+ days in past 30 days	16.9%		18.5%	
	Suicide mortality rate (per 100,000)	11.7	10.5	9.9	10.3
Injuries	Fall-related hospitalization rate (per 100,000)	7,537.4	7,178.5	3,583.0	3,430.3
	Gun-related emergency department utilization (per 100,000)	38.1	61.0	25.1	44.2
	Homicide mortality rate (per 100,000)	11.7	23.4	21.9	31.0
Access to Care	Adults 19-64 years with Medicaid	18.9%		26.0%	
	Children <19 years with public insurance	55.0%		61.0%	
	Population without insurance	7.4%		8.1%	
	Children <19 years without insurance	4.6%		3.8%	
	Emergency department utilization (per 100,000)	48,946.3	37,109.4	53,146.1	40,478.1
	High emergency department utilization (per 100,000)	1,410.1	960.2	1,668.3	1,145.9
Social & Economic Conditions	Population in poverty	17.9%		23.1%	
	Children <18 years in poverty	24.9%		32.2%	
	Adults 19-64 years unemployed	3.9%		4.0%	
	Householders living alone who are 65+ years	23.2%		27.1%	
	Households receiving SNAP benefits	20.2%		23.4%	
	Households that are housing cost-burdened	18.3%		23.2%	
	Housing with potential lead risk	79.9%		78.2%	
	Vacant housing units	12.4%		11.9%	

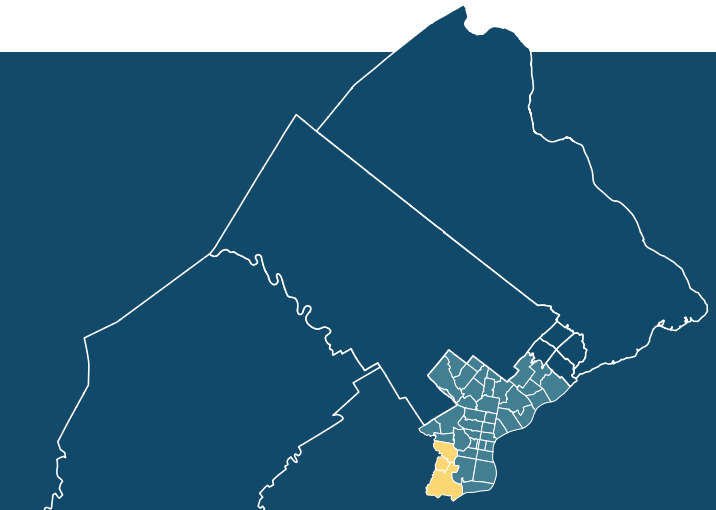
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

SOUTHWEST PHILADELPHIA

ZIP CODES: 19142, 19143, 19153

This community is served by:

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



Southwest Philadelphia
Social Vulnerability Index

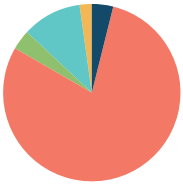
POPULATION

106,714

MEDIAN HOUSEHOLD INCOME

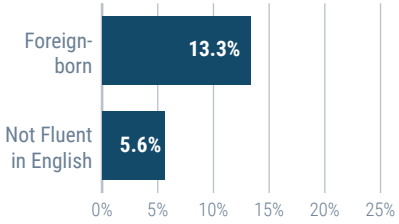
$38,674

RACE/ETHNICITY/LANGUAGE



4.1% | Asian*
79.0% | Black*
3.5% | Hispanic/Latino
10.8% | White*
2.2% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

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

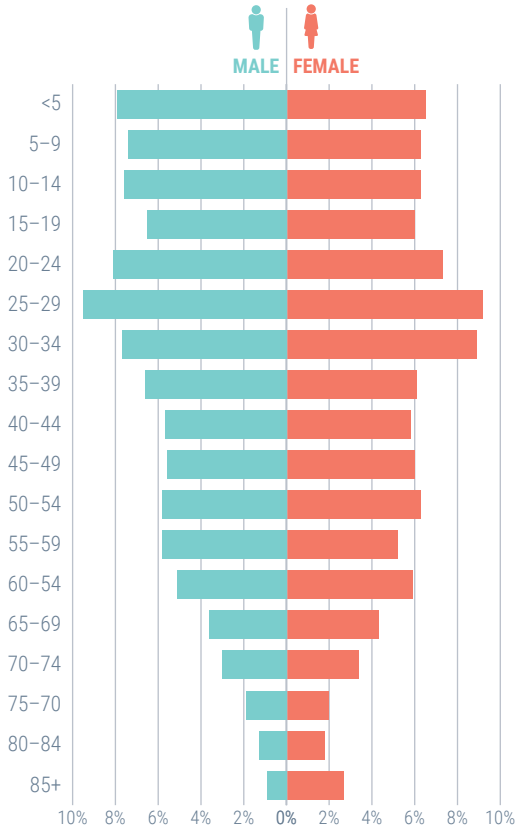
EDUCATIONAL ATTAINMENT

High school as highest education level **33.0%**

PEOPLE WITH DISABILITIES

16.5%

AGE DISTRIBUTION



summary health measures

		Southwest Philadelphia		Philadelphia County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
General	All-cause mortality rate (per 100,000)	955.8	1,174.2	879.3	1,121.3
	Life expectancy: Female (in years)	78.2	76.9	80.0	77.5
	Life expectancy: Male (in years)	69.7	65.5	73.0	69.1
	Years of potential life lost before 75	12,421	14,496	146,900	175,443
COVID-19	COVID-related emergency department utilization (per 100,000)	N/A	1,081.4	N/A	701.4
	COVID-related hospitalization rate (per 100,000)	N/A	864.0	N/A	851.0
Chronic Disease & Health Behaviors	Adult obesity prevalence	37.9%		32.3%	
	Diabetes prevalence	16.4%		13.1%	
	Diabetes-related hospitalization rate (per 100,000)	298.9	303.6	259.6	249.7
	Hypertension prevalence	40.7%		34.1%	
	Hypertension-related hospitalization rate (per 100,000)	834.0	631.6	660.5	596.3
	Potentially preventable hospitalization rate (per 100,000)	1,844.2	1,412.2	1,521.5	1,270.8
	Premature cardiovascular disease mortality rate (per 100,000)	74.0	98.4	57.1	60.7
	Major cancer incidence rate (per 100,000)	231.5		242.5	
	Major cancer mortality rate (per 100,000)	74.0		80.3	
	Colorectal cancer screening	62.5%		63.5%	
	Mammography screening	80.7%		78.3%	
	Physical inactivity (leisure time) prevalence	31.0%		27.4%	
Infant & Child Health	Asthma hospitalization rate <18 years (per 100,000 <18)	50.0	19.8	42.0	17.8
	Infant mortality rate (per 1,000 live births)	13.8	--	7.0	5.8
	Percent low birthweight births out of live births	15.2%	14.2%	11.5%	11.0%
	Percent preterm births out of live births	11.4%	10.1%	11.4%	11.1%
Behavioral Health	Adult binge drinking	17.1%		19.9%	
	Adult smoking	24.7%		22.1%	
	Drug overdose mortality rate (per 100,000)	46.9	49.7	60.4	65.9
	Opioid-related hospitalization rate (per 100,000)	114.3	90.9	106.2	99.5
	Substance-related hospitalization rate (per 100,000)	926.8	727.2	738.7	598.5
	Poor mental health for 14+ days in past 30 days	19.9%		18.5%	
	Suicide mortality rate (per 100,000)	8.4	10.3	9.9	10.3
Injuries	Fall-related hospitalization rate (per 100,000)	7,119.3	6,841.5	3,583.0	3,430.3
	Gun-related emergency department utilization (per 100,000)	62.3	115.7	25.1	44.2
	Homicide mortality rate (per 100,000)	45.0	63.7	21.9	31.0
Access to Care	Adults 19-64 years with Medicaid	35.3%		26.0%	
	Children <19 years with public insurance	73.7%		61.0%	
	Population without insurance	8.4%		8.1%	
	Children <19 years without insurance	3.2%		3.8%	
	Emergency department utilization (per 100,000)	62,594.9	42,658.5	53,146.1	40,478.1
	High emergency department utilization (per 100,000)	1,781.0	997.5	1,668.3	1,145.9
Social & Economic Conditions	Population in poverty	29.6%		23.1%	
	Children <18 years in poverty	38.2%		32.2%	
	Adults 19-64 years unemployed	5.1%		4.0%	
	Householders living alone who are 65+ years	25.0%		27.1%	
	Households receiving SNAP benefits	32.1%		23.4%	
	Households that are housing cost-burdened	28.4%		23.2%	
	Housing with potential lead risk	78.3%		78.2%	
	Vacant housing units	14.1%		11.9%	

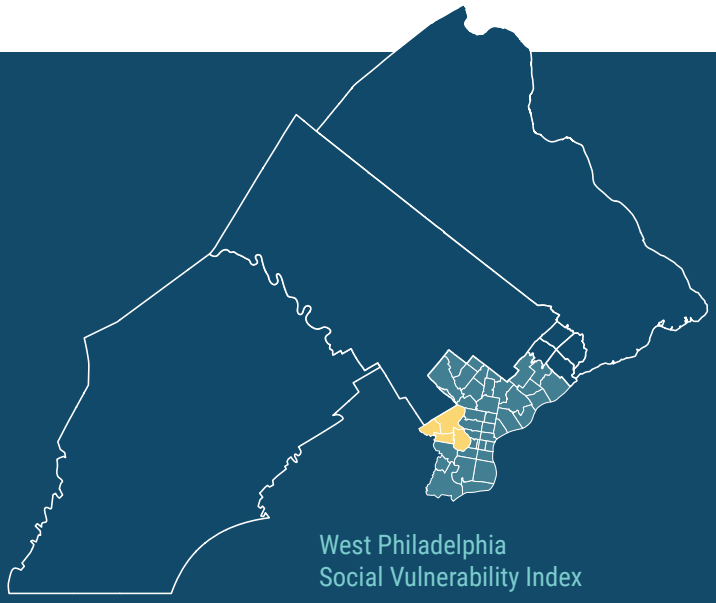
* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.
-- Estimates are unavailable or unreliable due to low sample size within a community.

WEST PHILADELPHIA

ZIP CODES: 19104, 19131, 19139, 19151

This community is served by:

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



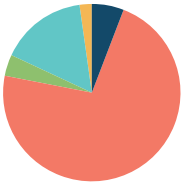
POPULATION

178,023

MEDIAN HOUSEHOLD INCOME

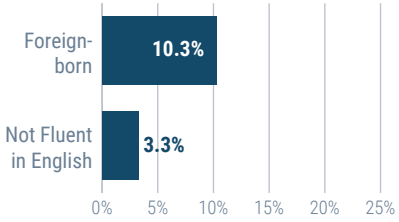
$36,186

RACE/ETHNICITY/LANGUAGE



6.0% | Asian*
71.9% | Black*
4.0% | Hispanic/Latino
15.6% | White*
2.2% | Other*

* Non-Hispanic



LEADING CAUSES OF DEATH

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

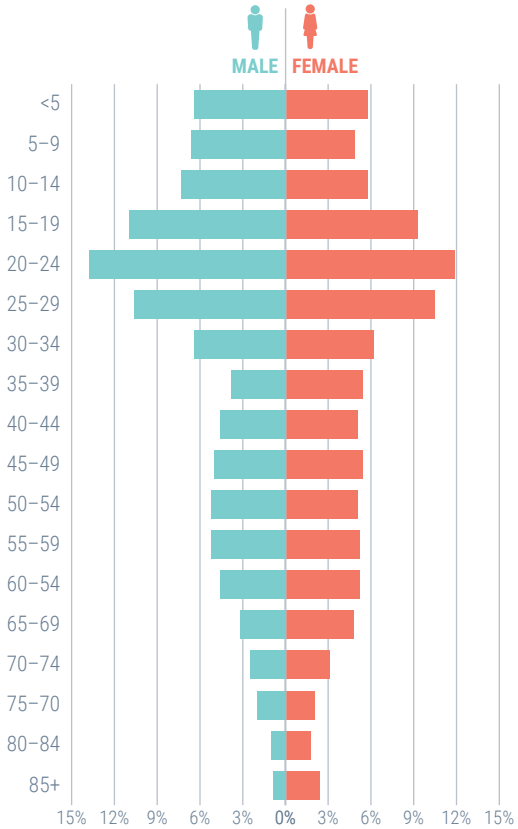
EDUCATIONAL ATTAINMENT

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

PEOPLE WITH DISABILITIES

16.2%

AGE DISTRIBUTION



summary health measures

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

COVID-19 PANDEMIC

The breadth, depth, and diversity of the impacts of the COVID-19 pandemic on the U.S. and the rest of the world are unprecedented.

While its effects have yet to be fully documented and understood, analyses of available U.S. data conducted over the past two years show:

- Significant negative impacts on excess mortality and life expectancy;
- Widespread hardship affecting food access, housing, and employment; and
- Persistent racial/ethnic disparities in infections, deaths, disease severity, vaccination, and experience of economic distress.

Local pandemic-related data for the five-county southeastern Pennsylvania (SEPA) region show patterns similar to national trends. For each of the five counties, COVID-19 is the third leading cause of death for 2020, following heart disease and cancer. Rates of COVID-19 mortality, health care utilization, and vaccination (see table below, which aggregates data featured in the county profiles; data for COVID-related health care utilization also available in tables for each geographic community[1]) are comparable to that of other metropolitan areas in the Northeast U.S.

	Bucks	Chester	Delaware	Montgomery	Philadelphia
COVID-19 fully covered vaccination rate (as of 11/30/21) (per 100,000)	55,875.8	61,756.4	55,860.1	56,857.4	58,072.7
COVID-related emergency department utilization (per 100,000)	190.2	445.0	713.4	853.5	701.4
COVID-related hospitalization rate (per 100,000)	398.9	274.1	564.8	394.6	851.0
COVID-related mortality rate (per 100,000)	145.1	110.2	177.9	144.2	165.4

[1] Due to the ongoing nature of the pandemic, these data are ever-changing so data incorporated into the report therefore represent snapshots at specific points in time. For more up-to-date information, please visit the CDC COVID Data Tracker, the COVID-19 Dashboard maintained by the Pennsylvania Department of Health, or county health department resources (see Bucks, Chester, Delaware, Montgomery, Philadelphia).

As in other parts of the country, communities of color have been hardest hit by the pandemic, with Black/African American communities and Hispanic/Latino communities experiencing the highest rates of COVID-19 infections, hospitalization, and death, as compared to other groups.

- An analysis of "interlocking systems of racism" encompassing employment, housing, neighborhoods, and transportation underscores the role of residential segregation in increasing risk of COVID-19 exposure and mortality for Black communities in Philadelphia
- Though gaps have reduced over time, COVID-19 vaccination rates among African Americans continue to lag behind other racial/ethnic groups for every age group, especially among children aged 11 years and under. While vaccine hesitancy has often been cited as driving lower vaccination rates in communities of color, building trust through community engagement and addressing barriers to access are also important factors.
- Beyond COVID-19-related metrics, evidence is growing that racial disparities in other health outcomes (for example, opioid overdose) and health care access (such as cancer care) deepened during early phases of the pandemic.
- Directly contributing to and exacerbating such disparities are pandemic-related job losses, experienced disproportionately by Black and Hispanic workers at all levels of educational attainment (but most starkly among those with less than a high school level of education, who are more likely to be in lower wage jobs in retail or hospitality). The cascading impacts of lost wages can be seen in hardships related to critical needs such as housing, as local renters express challenges with keeping up with rent and avoiding eviction during the pandemic.

The qualitative data collected for the rCHNA (see summaries of community conversations, spotlight discussions, and data collected for focus areas and communities) shed light on the lived experience of the pandemic on SEPA communities. Adults and youth alike experienced major disruptions to their lives, leading to negative impacts on mental health and physical health changes such as weight gain and sleep loss. For some communities, financial stress resulting from job loss contributed to experiencing higher levels of anxiety and depression.

Remote schooling was particularly challenging for youth, with many reporting difficulties with learning, lack of contact with peers, and feeling unprepared to socialize upon returning to in-person school. Impacts on older adults across the region were particularly acute, as heightened risks of COVID-19 morbidity and mortality contributed directly to significant social isolation. This had profound negative effects on their physical and behavioral health (e.g., reduced physical activity, food access challenges, delays in seeking health care, increased rates of depression and substance use).

A persistent theme across all rCHNA qualitative data collection efforts was the pronounced impact of the "digital divide," reflecting increased awareness of disparities in digital access as a result of the pandemic. Lack of access to broadband internet services was universally viewed as a major barrier to employment (i.e., ability to telecommute), education (i.e., participation in remote schooling), and health care access (i.e., telehealth). Discussion participants particularly noted older adults as having the biggest challenges with digital access, owing to technology access issues (both broadband and device-related), as well as lower levels of digital literacy and comfort with using digital devices.

Local reports have delved into better understanding the digital divide in the region. One regional analysis mapped census tracts with below-average household broadband subscription rates for the region and found a positive association between higher COVID-19 infection rates and below-average household broadband subscription rates at the census tract level. A recent report of the findings from a Philadelphia survey identify other groups, in addition to older adults, with lower access to broadband or a working device, including Black communities, Hispanic/Latino communities, and households with lower incomes. Thirty-three percent of Philadelphians are considered to be "subscription vulnerable," which is characterized by experiencing service interruption during the pandemic or having difficulty keeping internet service without a discount. Four in ten survey respondents cited affordability as a major reason for not having high-speed internet service, and 75 percent of residents with low incomes expressed that they are unable to afford paying $20/month for access. A recently released Digital Equity Plan outlines potential strategies for addressing these issues.

SPOTLIGHT TOPICS

Focus group discussions centered on "spotlight" topics were conducted with community organization and local government agency representatives in each county. A set of topics were selected for each county by Steering Committee members based in that county, taking into account prior CHNA priorities and key areas for input from community partners. (See "Our Collaborative Approach" section for details on topic selection by county.) Some topics were selected as a particular area of focus for a single county, while others were chosen by multiple counties. For topics discussed in multiple counties, discussions revealed a great deal of overlap in common themes across counties. To minimize redundancy in the report and highlight areas for potential shared regional action, summaries were written to aggregate insights across counties for a given topic.

The summaries included in this section are the following:

- **Access to care** *(Delaware County)*
- **Behavioral health** (including substance use*) *(All Five Counties)*
- **Chronic disease** *(All Five Counties)*
- **Food insecurity** *(Delaware, Chester, Montgomery Counties)*
- **Housing and homelessness** *(Philadelphia County)*
- **Older adults and care** *(Bucks County)*
- **Racism and discrimination in health care** *(Philadelphia County)*
- **Violence** *(Philadelphia County)*

* Given the significant overlap between the themes discussed in behavioral health and substance use discussions, these topics were combined in the summary.

ACCESS TO CARE

DELAWARE COUNTY

OVERVIEW

Until recently, Delaware County was the only county in the Philadelphia metropolitan area without a health department. In mid-2020, County officials initiated plans to start a health department, which became operational in early 2022. As part of planning for the new department, Johns Hopkins Bloomberg School of Public Health conducted an assessment of the delivery of health and public health services in Delaware County in 2019-2020. The assessment report noted that Delaware County has six hospitals, the largest of which is Crozer-Chester Medical Center. As of this writing, Crozer-Chester has made plans to close or suspend a number of its services, including those focused on substance use and mental health treatment. The County also is served by seven free and low-cost local health clinics, including two clinics run by ChesPenn Health Services in Chester and Upper Darby as well as the Delaware County State Health Center in Chester and the Mercy Fitzgerald Hospital Ambulatory Clinic in Darby.

In a survey conducted for the Johns Hopkins assessment report, community members were asked to list up to five public health issues of greatest concern to them personally. The most frequently reported concern in the county was access to health care, chosen as the top issue by 51% of respondents. The report noted, based on feedback from interviews with a cross-section of leaders, that *"the County's racial and socioeconomic diversity must be acknowledged and prioritized when working to improve community health for all county residents."*

Indeed, Delaware County has considerable racial, cultural, and socioeconomic diversity. According to the U.S. Census Bureau, 5 percent of Delaware County residents lack health insurance, but uninsured rates are much higher among Hispanics or Latinos (15%), foreign-born individuals who lack citizenship (18%) and those who are unemployed (20%). Foreign-born individuals make up 10 percent of the population, and 12 percent speak a language other than English, with Spanish being the most common. In some communities, immigrants make up a much larger share of the population. For example, in Upper Darby, which borders West Philadelphia, foreign-born individuals are 21 percent of the population, with 70 languages spoken in the area.

To understand needs and identify opportunities to improve access to health care in Delaware County, a focus group was conducted with representatives from local organizations with knowledge of local healthcare access needs. Healthcare access was also discussed in geographic community discussions with Delaware County residents; where relevant, comments from those discussions are included below. [Please see the summary of Delaware County geographic community discussions for further details.]

BARRIERS TO HEALTHCARE ACCESS

Participants discussed a number of barriers to healthcare access in the county, with pandemic-related obstacles as a top concern.

During the pandemic, delays in patients seeking or scheduling care have surged, due to fear of COVID-19 exposure and a lack of provider capacity, causing long waits for many medical appointments. With care delayed for many patients, several participants said, diseases, such as cancer, are being diagnosed in more advanced stages.

"We have great health facilities and great mental health facilities that do quality services all throughout the county. The issue is staff; staffing is a huge issue right now. There's more people to serve than there are people to serve them. ... It's a very skeletal crew for many of the hospitals right now and, trying to serve everybody is the issue right now."

"There is also a huge issue right now with providers not taking on new patients during COVID. This is a huge issue with specialists from dermatology to psychiatry. It can be a 6 month wait or simply not possible to get an appointment with a specialist at all."

"Also, adults who were not able to see doctors during COVID and then trying to get appointments ... and had to wait 6-8 months for an appointment."

Even prior to the pandemic, signing up for or navigating health insurance policies posed challenges to care for some. County residents who participated in community focus groups shared their firsthand perspectives:

"Sometimes, people just do not know or not aware that they can apply for Medicaid or Medicare ... And then, we have the health [insurance]markets where people can purchase health care, different packages for you know, however they can afford. So, I will say lack of knowledge of resources."

"I have a hard time accessing different providers for my children, because either the provider doesn't take the health care that I have for my children, or the provider is so booked up they're not taking new clients. So, I'm forced to go back into Philadelphia, and not my local provider."

Participants from local organizations and residents alike emphasized the dire need for more behavioral and mental health services throughout Delaware County—a need that existed before the pandemic and since has become increasingly urgent, with more children and adults in need of care.

"There are more people seeking mental health services than before. I think the pandemic just has had a huge impact on so many people."

"The only example I can really give is in mental health, because that's where I work. And we have over 100 people waiting for services ourselves, and when people call in, they tell us that [there is a] six months to a year waitlist everywhere. So, I know we're not the only ones that are short, and I know in nursing and hospitals as well, it's a problem."

"Mental health resources ... there's not a lot available currently, or the wait lists are super long, people aren't being seen."

–a school-based social worker, commenting on wait times for behavioral health care for children and youth.

Another barrier: insurance for mental health may not be adequate, such as insufficient coverage for the intensity or duration of treatment needed.

"I don't care how your child, your grandchild, your spouse is, there's nothing that can be done other than what that insurance carrier will approve. And that is the sad part, it depends on your insurance, it depends on the company, it depends on the benefit. ... I can say 'I'm going to jump off the roof.' They're going to 302 me [i.e., involuntary commitment for an acute psychiatric issue] for three days. They're going to give me medicine to keep me calm and make me sleep. And I can come back out on day five and jump off the roof and I'm dead."

SOCIAL DETERMINANTS OF HEALTH AND HEALTHCARE ACCESS

Beyond the COVID-19 pandemic, participants discussed a number of **social and economic disparities** that limit access to care for some populations in Delaware County.

Lack of transportation.

For those without access to a car or someone to drive them, getting to medical appointments is often an obstacle. Some residents also are fearful or reluctant to leave their immediate neighborhoods:

"We do live in an area that has good facilities but it's getting to them for appointments and etc. … Transportation, that is a huge barrier to getting to appointments, not having enough public transportation."

"Some individuals are fearful or reluctant to seek care much beyond their immediate neighborhood. The care needs to be accessible to them and I mean transportation-wise, because a lot of them don't go out of their very immediate area like a two to three-mile radius. … And if it was someone [a provider] five miles outside of the radius, they may not go to that, even if that's where the care is for them because of that trust issue and that familiarity."

Low health literacy.

Several participants expressed concern about patients who are not able to fully understand or act on health information due to health literacy issues, such as language barriers, and difficulty with comprehension or insufficient time with a provider to explain what's needed.

"We see them coming away from an appointment and not understanding the directions that were given or not understanding the scripts [prescriptions] that were given to them or not being able to fill the scripts that were given to them."

Bias and discrimination in health care.

Several participants commented on distrust of the healthcare system among Black and other racial or ethnic groups. Instances of bias and discrimination by healthcare staff toward people of color also were cited.

"We've heard from some of our specifically African-American clients, just feeling like they were receiving some bias based on their color and age sometimes, as well. And I think that's something that is just pervasive in Delaware County and something that needs to be addressed wholeheartedly and not just little bits here and there. But I think that's really important, because care is not care [if it] is not care for everyone--if it's not something that you feel is being done in a in a non-biased, supportive way."

CHILDREN AND YOUTH

A top concern noted by several participants is the **need to increase child and adolescent mental and behavioral health services** throughout the county.

More **trauma-informed and culturally competent care** is also needed. Young people of all ages are struggling with mental health issues stemming from the pandemic, overwhelming health system capacity, multiple participants said.

"We're talking about probably hundreds of children that are just broke, beaten down right now."

"Trauma-informed care I think is just so needed for these kids. They're really struggling. All these high schoolers … there's lots of fights occurring, there's lots of police involved. Like it's just been a really hard year already for a lot of the [school] district."

"Just having more availability, right now, the waitlist for kids to get into counseling … [is] like three to six to seven months waiting list – for the kids to actually get into like a therapy. … that's the number one thing we're experiencing now. A lot of newly identified students, some because of the pandemic, and just having the resources available for them and their families."

Participants also expressed concern about the **lack of inpatient behavioral health services for children and youth in the county.**

"They used to have inpatient beds in Delaware County [for children] and that stopped prior COVID … a few years prior. So, that's just been a hard thing … to have these kids not have inpatient beds in Delaware County. That's why we're sending them out."

Families who need inpatient hospitalization for their children must travel outside the county, participants said, creating further stress and strain for the child, parents, and other family members.

"They're going really far. … Once you get an inpatient [bed], then you're saying, okay, now, we're gonna take your kid like 45 minutes to an hour away. And, you know, it's hard. Because then that comes to the other problems of transportation. Getting your kid there, you know, there's lots of things that come up."

While partial hospitalization services are available in the county, these providers are inundated with requests for care.

"We have two [partial hospitalization services for youth] in Delaware County: Horsham Clinic and the Mirmont [Treatment Center]. And they are, again, I think it's hard because they're inundated … but the waiting lists are long too. So, we just try to help navigate, get them on the waiting list so they can be seen there, but it's hard.

The same participant stated that **these centers also have become more selective about which pediatric patients they'll take**, making placements even more difficult.

An Upper Darby resident also emphasized the **need for culturally competent care for youth with mental or behavioral health issues,** with *"therapists who are appropriate for the kind of culturally ethnic groups that we have"* in the area.

While the need for child and adolescent mental health services was a dominant theme among focus group participants, the increase in childhood obesity during the pandemic also was briefly mentioned, along with the need for **greater access to physical activity and nutrition education programs for youth**.

OLDER ADULTS

For older adults, participants focused on two particular barriers to healthcare access in the county: the **digital divide** and **lack of care coordination**. The need for **more education and support to prevent and manage chronic disease**, such as diabetes management and smoking cessation programs, also was noted.

Many older adults **lack computer technology or skills**, making it difficult for them to use online health portals and telehealth services.

"With the pandemic, we saw accessing vaccinations was really difficult for older adults. That's probably across the board when we're looking at any kind of appointments or anything that requires technology."

A health educator who works with older adults with low incomes added that providing health education over the phone is similarly suboptimal:

""I feel like a lot of people don't get the true message through over the phone. And then I would love to give them handouts, because they're not really retaining information over the phone; like you need things to read."

For older people with multiple ailments and complex treatment needs, **lack of care coordination** is another challenge.

"For older adults, it's the fragmentation of care. ... A lot of older adults have a lot of different health needs and a lot of different conditions. And if their care isn't being managed by, say, a nurse navigator--someone that can help them figure everything out--I think it can be really difficult."

One participant also commented on **the growing number of grandparents who have become primary caregivers for their grandchildren.**

She noted the need for

"getting more support for some of the grandparents that are raising kids and making sure they know what they're doing."

OTHER GROUPS

Several participants emphasized the need to **improve healthcare access for underserved populations in the county, such as communities of color, Spanish speakers, and recent immigrants**, including those who are undocumented.

A participant who works for a clinic that provides free or low-cost care for people in need said:

"When we're speaking with our Spanish population, some may be undocumented and so they were afraid to reach out for that help. So, we're trying to really let them know that ... your status is not what we're looking for. Your care is what we're looking for [and] we're looking to help there. So, underserved areas and women of color – we're trying to really ... penetrate [those] areas, so that they can get the care that they need."

In addition to the need for language interpretation and translation services for people who lack English proficiency, participants commented on **the need for care that is more culturally appropriate**.

"When you're looking at care for, you know, African American and immigrant populations, if the care's not culturally appropriate ... that's a huge barrier. It doesn't mean you can't access the care, it means that the care's not meeting your needs, right? That's a huge, a huge issue, I think, in our county."

"The other thing that comes into play, too, [is] some immigrant communities have different cultural ways of handling and interacting with health care and needs from a cultural perspective. And, lack of trust, not only from the immigrant community, but from the African American community, and the LGBTQ community. ... Oftentimes, I think the community is educating health care, and that's not really why they're going to the clinician's office."

"Cultural competency is very important in this community of Upper Darby [and] in Lansdowne area."

SUGGESTED ACTIONS

When asked "what's working well?," several participants highlighted the **availability of free and low-cost health clinics** in the county, such as the ChesPenn Health clinics in Chester and Upper Darby.

"Everything can be improved on, but that's important that we have that available … for those who are not insured or underinsured."

Opening the new Delaware County Health Department was hailed by several participants.

They emphasized the need for the new department to assess and prioritize county health needs and serve as a centralized resource for health communication and education. "*It would be very helpful and beneficial for Delaware County to have their own board set up, their own Health Department set up, and I think it'd be a better flow of information through the county,*" commented one participant.

Participants offered these suggestions for other actions to address health needs in the county:

Increase mental and behavioral healthcare services in the county. Also, establish inpatient care for children and youth in crisis.

One person commented on the need for more *"mental health care for adolescents and trauma-informed care for adolescents."* Another suggested adding a second crisis center (in addition to the existing center at Crozer-Chester), stating *"maybe we could have one [crisis center] for adolescents and one for adults, separating the two."* Children and youth should not be grouped alongside adults with psychiatric issues, such as in clinic waiting rooms or emergency departments, because doing so may cause further distress to youth who are in crisis, one participant said.

Train all levels of hospital staff and other healthcare providers, including outpatient service providers, on *"non-biased, culturally appropriate, trauma-informed care,"* advised one participant.

They added:

"Making sure that the nursing staff … [and] the point of entry when you're registering – when you get to the hospital that everyone is treating everyone appropriately."

Increase the number of trained mental health professionals who speak Spanish.

"For mental health hiring, more Spanish speaking staff [are needed] in Delaware County. That's always been a barrier for Spanish-speaking individuals. Imagine going for a therapy session and having to use Language Line."

Embed social workers in primary care practices, such as in family medicine, pediatrics, and OB/GYN offices.

These professionals could help to assess, refer, and enroll individuals and families in other needed health and social services.

Expand the number of community health centers *"so that everyone has access to care within a walking distance, much like we want to see food resources within walking distance of everyone."*

This participant, from a community focus group, envisioned comprehensive health centers that would *"break down the silos between mental health, dental health, physical health. There should be more one-stop shops, so to speak, where people can go in and have their physical, mental, dental care taken care of in one facility. In a culturally competent way as well."*

BEHAVIORAL HEALTH AND SUBSTANCE USE

ALL FIVE COUNTIES

To better understand needs and opportunities to improve the prevention and treatment of behavioral health issues (including mental health and substance use) in southeastern Pennsylvania, focus groups were convened for each of the five counties with representatives from area organizations addressing these issues. In Philadelphia and Delaware Counties, both behavioral health and substance use topics were discussed in a single extended focus group. In Chester, Bucks, and Montgomery Counties, each topic was discussed in separate focus groups. Additionally, addressing behavioral health issues was identified as a major priority in focus groups conducted with community residents in all five counties; where relevant, comments from those discussions are included below.

OVERVIEW

The terms mental and behavioral health are often used interchangeably. According to the Centers for Medicare and Medicaid Services, behavioral health is defined as the emotional, psychological, and social facets of overall health; it encompasses traditional mental health and substance use disorders, as well as overall psychological well-being. This definition of behavioral health is used throughout this summary.

Substance use can include the use of illegal drugs; improper use of prescription and over-the- counter drugs; unhealthy use of alcohol, tobacco and vaping; and the continued use of drugs to alter mood, relieve stress and/or avoid reality. Many people will use substances at some point in their lives without any issues; substance use only becomes a problem when it starts to have harmful effects on someone's life. Substance use disorder (SUD) is the recurring use of a substance (legal or illegal) to the point that it interferes with the user's physical health and/or responsibilities at home, work, or school.

At some point during their lifetime, almost half of all people in the U.S. will be diagnosed with a mental health disorder.

According to the National Institute of Mental Health:

- Nationally, nearly 1 in 5 adults live with a mental illness, but less than half (46.2%) received care for their condition in the past year.
- About five percent of U.S. adults reported having a serious mental illness (schizophrenia, bipolar disorder, or major depression); 64.5 percent reported receiving care for their condition in the past year.

In 2019, 7.7 percent of people 18 or older had an SUD per the 2019 National Survey on Drug Use and Health. Of those, 38.5 percent struggled with illicit drugs, 73.1 percent with alcohol use, and 11.5 percent with both illicit drugs and alcohol. Among people aged 12-17, 4.5 percent had an SUD in the past year. Only 10.3 percent of people over age 12 with an SUD in the past year received needed SUD treatment.

According to the National Institute on Drug Abuse, people with a mental health disorder, such as anxiety, depression, or post-traumatic stress disorder, may use drugs or alcohol as a form of self-medication. **Multiple national population surveys have found that about half of individuals who experience an SUD during their lives will also experience a co-occurring mental health disorder and vice versa.** Similarly, research suggests that adolescents with SUD also have high rates of mental health conditions.

Behavioral health issues among youth have risen over the past decade.

Even before the pandemic, behavioral health issues were the leading cause of disability and poor life outcomes in young people, affecting up to one in five aged 3 to 17 in the U.S., according to a recent report from the U.S. Surgeon General.This report cites data showing one in three high school students reported persistent feelings of sadness or hopelessness in 2019—an overall increase of 40 percent from 2009. According to the Center for Disease Control's Youth Risk Behavior Surveillance Data Summary and Trends Report for 2009-2019, one in six youth reported making a suicide plan in the past year, a 44 percent increase from 2009. These data show that almost half of youth identifying as LGBTQ+ had seriously considered suicide, and the number of Black students reporting a suicide attempt increased by almost 50 percent.

Many adolescents with depression or other behavioral health challenges do not always get necessary treatment. According to the National Survey on Drug Use and Health and the National Health Interview Survey, 26.7 percent with mental health problems (aged 4 to 17 years) did not receive treatment. Among adolescents with a diagnosis of depression (aged 12-17 years), 58.6 percent had not received treatment.

One in four older adults (aged 65 and older) are socially isolated, according to the CDC. Lack of social connectedness (arising from social isolation and leading to feelings of loneliness) has been linked to depression, anxiety, cognitive decline, Alzheimer's disease, and higher rates of chronic diseases like high blood pressure, heart disease, and obesity. While drug overdose rates across the U.S. have been declining, rates of substance-related hospitalizations and overdoses have increased among older adults.

Access to care for behavioral health services was lacking prior to the pandemic and remains extremely problematic.

In a recent national survey of mental health professionals conducted by the New York Times, nine out of 10 therapists said the number of clients seeking care is on the rise, leading to a surge in calls for appointments, longer waiting lists, and difficulty meeting patient demand. This trend has also been seen in southeastern Pennsylvania.

Focusing particularly on the five-county region, selected behavioral health indicators for adults and youth that compare less favorably to state or national rates are highlighted below. (For more granular data on behavioral health indicators at the geographic community or county level, please see the geographic profiles.)

According to data on adults from County Health Rankings 2021:

- As compared to Pennsylvania rates, Philadelphia County has higher rates of smoking, poor mental health days in the past 30 days, and more frequent mental distress.
- The drug overdose rate in Bucks, Delaware, and Philadelphia Counties exceeds the rate in Pennsylvania.
- Excessive drinking and alcohol-impaired driving deaths are higher in Bucks and Chester Counties in comparison to the rest of Pennsylvania.

Behavioral Health Indicators for Youth

Relevant behavioral health indicators for youth are collected through the Youth Risk Behavior Surveillance System (grades 9-12, collected in Philadelphia only) and the Pennsylvania Youth Survey (grades 6, 8, 10, 12, administered in Bucks, Chester, Delaware, and Montgomery Counties). Based on 2019 data from both data collection efforts, a selection of indicators in which rates in the five counties compare less favorably to state-level data are presented below:

- Philadelphia youth reported feeling sad or hopeless two or more weeks in the past year at a higher rate than the national rate (40.3% compared to 36.7%). The rate among those identifying as LGBTQ+ was considerably higher (59%).
- Compared to a national rate of 8.9 percent, 14.6 percent of Philadelphia students had attempted suicide. Among those identifying as LGBTQ+, this rate was 25.7 percent.
- Use of substances in the past 30 days was highest for marijuana (21%), followed by alcohol use (17.2%), and vaping (7.1%) among Philadelphia students.
- Bucks County youth had higher rates of reporting alcohol (17.8%) and marijuana (11.2%) use, as compared to Pennsylvania (16.8% and 9.6%, respectively). Of those who reported vaping, youth in Montgomery (37.2%), Chester (36.3%), Bucks (37.8%), and Delaware (29.7%) Counties had higher rates of marijuana vaping than the state rate (26.6%).
- Youth across the four counties reported getting alcohol from friends, siblings, and parents, but the majority reported taking the alcohol without permission or giving money to someone to buy it for them. They also shared that prescription drugs are given to them by a family member or friend (32%-41%) or taken from a family member living in their home (41%- 44.6%). Seven to 13 percent of youth indicated that they purchased drugs on the internet.

IMPACTS OF SOCIAL DETERMINANTS OF HEALTH ON BEHAVIORAL HEALTH

Social determinants of health impact the risk of developing behavioral health disorders, access to care for these conditions, and, ultimately, health outcomes.	Given the importance of these determinants, focus group participants agreed that basic human needs should be addressed as part of care. "A lot of these families are focused on just their basic needs, and if we can help with the basic needs … so paying rent bill. Those are probably the biggest ones; it's the financial, employment, and shelter."
The effects of trauma on behavioral health, particularly since the pandemic, were highlighted across most groups.	According to a provider: "100% of our patients experience some type of trauma." Another participant said: "More people that have experienced trauma, more people who have experienced isolation … we do see that there's been an increase in the number of people who are seeking medical assistance."
Violence affects behavioral health and access to care.	"In addition to the shutdown which isolated families, there has been an uptick in gun violence across the city causing more trauma." Another participant noted that face-to-face counseling in some communities has been limited by violence "Clinicians are afraid to come into the community because of gun violence … because [they] heard on the news that there was this shooting down the street."
Racism impacts behavioral health services and resources.	"Racial disparities, and the racial upheaval that went on was not just stressful, it was traumatic, and it still is, it has always been for Black people. And on top of the pandemic, on top of every layer of racism, systemically that we have to deal with. is [that] mental health is not accessible. … I can't stress enough that there is a high need for more mental health professionals who have cultural competency, and who look like the people they serve."

SUBSTANCE USE: TOP ISSUES

Across counties, participants highlighted opioid and alcohol use as priority concerns.

Participants also shared concerns about rising use of methamphetamines, fentanyl, marijuana, vaping, and other substances. (Note: marijuana and vaping are discussed in the Children and Youth section of this summary). In addition, participants stressed the need to expand medication disposal and overdose prevention programs, as well as increase funding for non-opioid related addiction.

Prescription drug misuse.

"*Most people don't start shooting up heroin or snorting heroin*," said a participant. "*They start with prescription drugs. … People become dependent upon them, and then go to the street because they can't get them anymore. And here we are. In the middle of an opioid epidemic taking lives every single day*." Another participant cited the need to address prescription drug misuse as a preventive measure: "*I think prescription drugs just across the board are affecting everyone at every age. Even unintentionally*."

Fentanyl use.

Concerns about increased fentanyl use, increasingly present in street drugs, were raised. A participant noted: "*We don't even see heroin in Montgomery County anymore; it's all fentanyl*." Another from the same group added: "*Now there are so many what we classify as 'user-dealers' in Montgomery County, people who are supporting their own habit by selling fentanyl, that the people with abuse disorders don't even have to go to Philadelphia to get it anymore. Fentanyl has been around for so long now it's just in everything. We are starting to see fentanyl in cocaine and crack.*"

Related concerns include the use of fentanyl in "*fake drugs*," the corresponding increase in juvenile overdose, and the need to educate youth about drugs that are made to look like oxycodone but are really fentanyl. "*The third biggest problem we have in Montgomery County is the fake fentanyl pills. We have seen an increase in juvenile overdoses with these pills, because the quality of them is so good that they can't tell. They look like the 30-milligram oxycodone pills, they're stamped with the M, and it's just a fake pill laced with fentanyl.*"

Methamphetamines.

Participants highlighted increasing availability and use of methamphetamines. According to an individual in law enforcement, "*We have seen an influx of methamphetamine in the last about a year. … Everybody sells methamphetamine now, and everyone unfortunately is using it. We've seen a seismic shift of opioid users now self-medicating with methamphetamine*."

While participants agreed on the need to sustain funding for opioid use disorders, they expressed concern about insufficient funding to prevent and treat other addictions.

"*There's been a huge push relating to opioid use disorders and for good reason… But because all of the funding seems to be at the opioid use level, … a lot of the other addictions have fallen to the wayside to some extent, and it could potentially be harder to connect people to resources because the funding is tied directly to [having] an opioid use disorder.*"

Alcohol use.

Across counties, participants noted more alcohol than opiate misuse. Practitioners from several counties described high levels of alcohol misuse as a major concern and discussed its impact on families and older adults. "*[There are] greater numbers of people with alcohol use issues. … And I'm not talking about alcohol poisoning, I'm talking about people with long term alcohol use issues that are dying from that. But because opioid use disorder is so much more visible and imminent than for a person who's dying from alcohol issues, that's generally more long term, alcohol doesn't get the same traction and attention*," said a participant who works in the field. Another, in private practice, cited the impact on families: "*I see the effects of alcohol abuse on families. It's devastating, it affects every member of the family. I think that we can't ever lose sight of the dangers of alcohol abuse.*"

Kratom.

Participants from one county discussed the use of kratom, particularly among young adults. Concerns include easy access to the drug, lack of understanding about the drug and potential side effects, including addiction, and lack of knowledge about treatment. "*It's something that you can buy on Amazon, get at 711. … It's advertised online as a safe alternative to opioids…But the problem with kratom is at a low dose, it's kind of a stimulant. So, people who want it for the opioid effect don't tend to take it as a low dose because it doesn't have the opioid effect. And it's completely unregulated. So, when you're buying it on these websites, and most of them are out of China or Russia, people don't know what's in it beyond kratom.*"

KEY CHALLENGES

Access to behavioral health care in southeastern Pennsylvania is complex and difficult to navigate, multiple participants emphasized. Factors such as stigma, lack of health system capacity, including too few culturally and linguistically competent providers, and difficulty with navigating the system are delaying care for many.

Stigma: Stigma related to behavioral health can be due to personal and familial attitudes or cultural beliefs, as well as negative perceptions held by the public. Stigma can delay or prevent people from seeking treatment, resulting in worsening symptoms and poorer outcomes. In addition, participants raised the need for providers to recognize the stigma they may bring to counseling patients with addiction.

- **"Stigma is really what keeps people from reaching out and can even keep people from helping their kids to get help too. I think more awareness is needed."**
- A person who perceives community stigma about substance use may be more reluctant to seek care or participate in support groups.

  "Having meetings in a place where you're going to see a lot of other members of your community, is definitely a hard thing for people in that position to do."
- Even when practitioners and families successfully address stigma, barriers to care remain.

  "And so by the time we do all that background work regarding the stigma, and engaging the family, and convincing the family that this would benefit them, and then we send them somewhere, and they don't get what they need. That by the time we convince them to make that move … there's going to be a very long waiting list or a lot of other barriers."
- Stigma held by providers about patients presenting with substance use is a potential barrier to treatment.

  "There's a lot of stigma that influences providers, our provider capacity to connect well with a person, our level of motivation to push for resources, and that certainly affects the outcome and success to see a person connected to a resource."

Bed capacity for inpatient and crisis care is limited in most counties, resulting in extended stays in emergency rooms and patients not receiving the level of care needed at times.

- **"The hospitals are suffering from not enough staff, and there weren't enough beds to begin with. We're running into difficulties where people are coming to the emergency room, they're getting approved for a hospital stay, and then we can't find any hospital who will take them."**
- **"It's a lack of beds even beyond the lack of staffing. It's a lack sometimes of the specific needed bed. If you've got a 15-year-old female, you need something that's for both females and adolescents. So there might be a bed somewhere but it's not a bed you can send this one to."**
- **"Sometimes people need to go across the state for what is the right treatment for them and then that creates other barriers because their natural supports aren't there with them."**

Lack of behavioral health professionals is leading to delayed care. Staffing shortages were cited across all counties, particularly for professionals serving youth and immigrants. Retention of staff, even more problematic since the pandemic, also was noted, due to low pay and professional burnout.	• "Even prior to COVID, our system experienced staffing issues across the provider system that impacted access to care for individuals. During the pandemic and more currently, I would classify the system being in a staffing crisis … to the point where it has impacted access to care much more dramatically than I've seen in my career." • "There are extraordinary waiting lists for every type of mental health treatment. A lot of private practitioners will not even accept a referral from a new client, psychiatrists are completely unavailable." • "It's not just direct support workers that are leaving the field, but it's professionally trained licensed professionals that are leaving the field as well for a whole host of reasons. … They are looking for benefits, they're looking for stable and full-time work, and … in addition (since COVID) a lot of people have reassessed how they want to live their lives, and have chosen to move on to something different." • "In my 34-year history I never remember telling people that we didn't have availability. It is painful to have to tell people we don't have availability. … We're seeing mass exits of employees leaving…not just their position with a particular provider, but in a lot of cases leaving the field and just burned-out from the field. We have hospitals that don't even have all their beds available open, because they don't have the staffing to support their beds." • "Not being able to hire enough staff, not enough funding, low rates of pay which make it hard to retain staff. … So, you know, not enough hospital beds, not enough outpatient capacity, not enough residential, not enough case managers, not enough."
The need for culturally and linguistically prepared behavioral health providers who reflect the communities they serve was identified as a priority in all counties.	• "In Upper Darby, there's like 100 different dialects that are spoken. There's a big Asian population, so that's just a huge issue and like a barrier for those individuals to access care." • "I can't echo enough the language barrier, and the lack of bilingual providers …Behavioral health issues are not best done through a translator, you know, for psychiatry or counseling - folks who are able to speak the language are needed."
Participants from all counties noted the need for cultural competence and cultural sensitivity among behavioral health providers and health systems, as well as greater diversity among behavioral health professionals.	• "You have people coming in who are not white who feel like there's nobody here that looks like them. … Being able to hire a more diverse staff is an issue." • "There is a sense of distrust in the healthcare system…We have to take ownership of that and be able to connect with the communities we're serving as providers."

Training that builds skills of providers to help patients commit to substance use treatment is needed. Providers need to be able to adequately assess and address substance use treatment with patients at critical points in time that may be short-lived.

- "Maybe when people decide, 'hey, this is the sweet spot of time that I want to access treatment,' that moment, that special moment when people make that decision. It may be when they're on a medical floor in kidney failure. The clinical staff may not be the best folks to be intervening at that point. A nephrologist may not have motivational interviewing training to be able to really get that person committed to treatment. So, I think there's maybe a disconnect with the medical side of things, maybe not fully understanding, SUD treatment, and what's entailed."
- "We don't have the training to engage that [SUD] patient. If they're not ready, then you know we don't have the skills to kind of talk them into what may be the best path for them."

Providing a "whole patient approach" to the treatment of SUD, that includes medication-assisted treatment (MAT), is being promoted across counties by encouraging primary care physicians to incorporate it into their practices. As part of this process, X-Waiver Training (which allows physicians who meet certain qualifications to treat opioid use disorder with buprenorphine in clinic offices) is needed, as is increasing awareness among providers about available resources:

- "Primary care doctors can help with this and refer to resources. But they don't necessarily know what all those resources are."

Trauma-informed care training for health professionals, school personnel, and other community organizations was noted as an essential need in most counties. Other trainings, such as Mental Health First Aid and integrated health care, also are needed.

- "Providers need to be able to fully understand what trauma is, and how trauma presents in the populations that we're providing services to. … They need to receive … training for trauma, and fully immerse themselves to understand … the symptoms of trauma, how the symptoms of trauma present and come out in the forms of behavior."

FOCUS: SYSTEM NAVIGATION CHALLENGES

Across all counties, participants cited multiple challenges with navigating the complexity of behavioral health systems. Obtaining a timely, appropriate level of care depends on many factors: insurance regulations, transportation, care coordination, awareness of available resources and services, and technology. Equity issues in accessing SUD treatment based on income also were noted: *"People with unlimited funds to fund this themselves have lots more options."*

One participant summed up many of these issues:

"The drug and alcohol system actually has a lot of potential resources, but there's a particular path to accessing most of them and if you don't know the path or where the entry points are, or in many cases, what your insurance allows, then it feels like there's nowhere to turn. So, the biggest issue, aside from getting people to the point where they truly want to engage with this kind of treatment, is breaking down the barriers. So, when they are ready, they can engage. There's a very short window in this field, like 48 hours, when a person decides they want treatment and needs to be engaged before that passes, and an opportunity is missed. … A lot of people just think that they call up and say I'm ready for drug and alcohol treatment and then they go there, and that's not exactly how it works."

Participants from all counties cited insurance barriers to accessing behavioral health care.

Providers may limit which patients they treat based on whether the patient is uninsured or has an insurance type, such as Medicaid, that pays less for SUD treatment.	• "Many of these patients have Medicaid insurance, which doesn't really reimburse for services very well. And so most providers either have a limited number of Medicaid patients that they'll accept or they won't accept Medicaid at all. So, a lot of times patients don't have commercial insurance that will reimburse for services adequately. … I think that's one of the big limitations as to why providers don't take this on."
Insurance issues may arise for those with SUD and possible co-occurring mental health issues.	• "What do we do with an individual when we can't identify whether their primary issue is a drug and alcohol addiction related issue, or a mental health issue? And then we think we're going one path in terms of treatment, and they don't have insurance [that covers it]. … I think most of us would agree that in a lot of cases, it's usually both."
Information about services for those who are uninsured or underinsured needs to be more widely known in the community.	• A participant from an organization that provides coverage for underinsured or insured individuals seeking care for SUD said: "A priority specifically for our office is making our services more known to everyone in the county, residents, school districts. The main function of our office is to help people fund treatments for drug and alcohol. That's for uninsured or underinsured, including adolescents who have to pay co-pays for their treatment multiple times a week."

Negotiating service limitations can be frustrating.	• "If the moment that the individual is looking for help is outside of business hours, it [creates] an added layer of challenge to accessing those services." Another participant shared: "Finding outpatient services after a rehab or detox is absolutely a challenge as well. … Everybody's got their own procedures, everybody's got different requirements. If it's a dual diagnosis -if they have multiple co-occurring disorders -then we won't take a patient that has this, but we might take a patient sometimes that might have this, but we don't really do amphetamines … we'll do opioids, but not that. So, it's frustrating."
Across counties, challenges related to transportation were raised	• Inadequate provider networks result in long wait times, requiring some to travel great distances to see in-network providers. A participant noted about Bucks County: "In some areas people don't have transportation. There's not public transportation in the upper part of the county for sure, very little in the middle, some in the lower, but people can't even get to services."
The need for a holistic, coordinated, and collaborative community-driven approach to care was seen as a priority in most counties.	• **A culture shift that sees physical and behavioral health as components of a person's overall health is needed:** "If a hospital is to serve the health and wellness needs of the community … I think some sort of cultural or perspective shift is needed everywhere. Mental health is a thread through everything that you do. Integrated health is really, really important. … When health organizations start to separate physical and mental health it adds to the stigma. … It's this is your physical health, and then your mental health is something that you need to worry about somewhere else … and not here. It needs to all happen in the same place, and people need to understand it, and need to be educated across board not just in primary care, but everywhere." • **A collaborative, coordinated system of care that includes integration with community services and resources is also needed:** "The idea of integrating behavioral health within the communities, either a community setting, a hospital setting, whatever team you're working with - stigma is significantly reduced, and folks have more access. It's about breaking down the silos that our systems have created, for us to work together towards our common goals. … I wish more institutions, especially healthcare institutions would go to community-based organizations and reach out and initiate collaboration with support. Very often our voices or voices from particular communities … are not taken into consideration in terms of the design and the programming [from the very beginning]."

The need to reduce system fragmentation through greater awareness of available resources, and improved communication throughout the treatment process, was described as vital to improving care, especially for those with SUD. Successfully coordinating and navigating post-discharge treatment can be challenging.

- **Some providers may be reluctant to start treatment if patients are not able to get needed post-discharge services:**

  "One of the biggest challenges we face is connecting patients when they leave the hospital to an outpatient provider. We've done a lot of work to address … how to treat their withdrawal and potentially start them on medication for opioid use disorder, but they are only with us for a very short period of time. So, then what? We want to make sure we're handing them off to someone that can help them."

- **Better communication between community-based services and primary care providers is needed:**

  A participant who works in behavioral health said:

  "Our patients come in through primary care, and so we're often the first line for patients and they trust us. Shopping for services is really difficult. There is no Amazon that sells all of the services at once. There's a lot of work involved. Once we do find a place for a person to go, we don't know what happens next, and they [community service providers] don't have a reciprocal kind of a communication with us. … We're only be able to rely on what that patient tells us about how it went. A collaborative situation would be so much better."

- **Greater awareness is needed to help people and organizations navigate services and resources for behavioral health conditions.**

  "I think the systems are so complex with all the different insurers and levels of care, it's really hard for people to figure out where to start, and it can become overwhelming. Once you get into the navigation, from my perspective, there's a complete lack of available resources, which has just become even more apparent. Before it used to be a struggle for folks who were uninsured or had Medicaid products, now we're even seeing it for folks that have commercial insurance or private pay."

  A participant from a community organization shared:

  "We could use some help as an organization to really understand where to direct people, whether that's numbers to call or resources or partners we could have."

Warm handoffs to promote treatment goals and facilitate access to other needed services should be included in integrated care, said participants in most counties.

- "More can be done with discharge planning, and facilitating a more successful warm handoff, getting other organizations inside, you know, before discharge to make that connection, so that there's more likelihood to follow through in the community."
- "We offer services such as helping people fill out government assistance, people getting evicted, people losing their income, people filing for unemployment, and we observed so much distress. So, we started bringing in MSW interns to just talk to them while they're waiting for their services. There are a lot of opportunities about how we can deliver mental health services in very creative ways in nontraditional settings, and in community settings," said a participant from a community organization that provides behavioral health services.

Trained individuals with lived experience, such as Certified Peer Specialists (CPS) and Certified Recovery Specialists (CRS), are needed to provide culturally competent community outreach and support for post-discharge patients. Having access to peers who have gone through the recovery process is essential, especially given the shortage of providers.

- **CRSs should be able to follow clients for extended periods to provide post-discharge support**, a behavioral health professional said:

  "What seems to be lacking is being able to continue to follow that individual from beginning to whatever is considered the end point. So, it seems like once we get them into the initial phase of treatment, the CRS is backed off because they're established with a provider. But … the road to recovery is not an easy one and there's frequently relapses and other issues … during the treatment process. So, I would love to see the CRS … have the capacity to follow (a client) for an extended period of time."

- **Helping people connect to services and engage with their health care providers are important CRS and CPS roles:**

  "We're relying on CPSs to use their lived experience to help someone engage in the services that they already have or connect them to services that they're eligible for. Knowing the resources is definitely a huge benefit for all of the providers. But especially for the person who is saying 'I need help, but … I don't know what to do' … Having somebody who can say, 'you don't have to be the expert in this, let's walk through it together,' has been really helpful."

- A participant who works in behavioral health commented:

  "Our biggest issue has been staffing peer supports. It's low pay, and it's Medicaid rates, the government pretty much pays what it pays. So, we're competing with jobs that pay higher in the private sector."

Overall, use of technology to provide behavioral services was mostly seen as positive across counties. Participants generally agreed that telehealth has improved some access issues, such as reducing transportation barriers, increasing flexibility in appointment scheduling, and enabling those fearing exposure to COVID-19 to receive services in their homes.

- "Telehealth is the one thing that is helping the most, it helps with the transportation problem, it helps with the access problem, because we're finding … that the no show rate is so much lower. When you don't have to get a ride, you don't have to get childcare, it doesn't matter if you have a stomachache, you know, you can still keep your appointment. The vast majority of our clients are saying we like this better; it works better."
- "Using behavioral health services and telehealth has been a lifesaver for many of our patients during the pandemic, because they face transportation challenges and missing work, so we're much more flexible about getting them appointment times and they keep them."
- "There are still a lot of people that are afraid to come out into the community…a lot of people for whom transportation is an issue, or for whom their anxiety doesn't allow them to be able to leave their home to access those services."
- "On a positive note for telehealth, at least for drug and alcohol, we've seen an uptick in compliance in regards to individuals following their treatment plans. Just being able to go to IOP [intensive outpatient programs] or OP [outpatient programs] every single time you're scheduled and go for the entire time."

Challenges cited for the use of telehealth include lack of access to technology (noted across counties), telehealth fatigue, privacy concerns, and perceived differences in the quality of therapy online.

- "There is push in the county [Bucks County] to determine where the internet deserts are in this county, where there isn't access to internet. And hopefully that will help some, but even so, people don't … all have the devices."
- "I think a barrier is that there's so much of the virtual and online connection, right, that people are tired of it."
- "There's less privacy when we're talking about communicating with people in their home; we have to be aware of their surroundings and ours … that could be difficult at times."
- "Telehealth, just by design of what telehealth can and can't do, reduced the overall intensity [of therapy]. We have some family therapy programs that are provided in the home. Sometimes we do this under telehealth and hear responses like 'I'm not comfortable my mom, kids, grandma lives upstairs and she's compromised physically' and so we really are being more careful around the home … that's one of the limitations."

CHILDREN AND YOUTH

Participants across all counties spoke of the pandemic's impact on youth. Pandemic-related stress also has affected the behavioral health of parents and, often as a result, their children.

With virtual schooling, school counselors, teachers, and others have had fewer opportunities to monitor youth for warning signs of behavioral health concerns.

- "When you think about kids it's been almost three years since they've had a normal school year. They have experienced so much disconnection, lack of accessibility to resources … families and children haven't had the supports in place that they had had before."
- A mental health provider who works with school-aged youth said:

  "Over the course of the last couple years … [we have] had a lot more parents suffering with addictions, we've had a lot more parents suffering through COVID, loss of job, depression, all those things. We've had a lot more parents dying, to be honest, whether it be suicide, drug overdoses, COVID itself. All the things related to the pandemic have really impacted adult mental health, and the trickle down of that with the children in schools is astronomical. And school aged children's' mental health is also directly impacted by their parent's mental health."

Pandemic-related social isolation, as well as grief and loss, have worsened behavioral health for children and youth.	• A behavioral health professional who works with schools stated: "There is an increased number of youth that have lost caregivers, whether it's a parent or a grandparent through this pandemic. We are really trying to keep a close eye on them, because grief may have traumatic effects. A needs assessment done in the greater Philadelphia area … [is] projecting that 73,000 plus youth will have lost a parent or sibling by the time they're 18 years old, and in Montgomery County, specifically, [that's] about 11,000, and that's pre-pandemic predictions."
Increased rates of depression, anxiety, self-harm, and suicide were reported across counties:	• "In the emergency department, we are definitely seeing increased volumes in general of pediatrics and adolescents, and I think that's across the county, probably the country." • "Our young folks are struggling, and more of them are struggling now with mental health issues. I have a private practice, and I see a lot of adolescents. And the rate of anxiety, goes hand in hand with depression, is just soaring, and again, there was not enough services to serve that need. And then the youngsters, the little ones can't even verbalize their anxiety, so they act out. And then we don't know what to do with them. Sometimes they end up in inpatient, and it's not really the most advantageous place for their treatment sometimes, but there's no other options." • "We have a psychologist in our district specifically just to do crisis assessments for kids with suicidal ideation and more and more are younger and younger … as young as first grade." • A participant who provides group therapy to youth offered: "Our goal is to transition our kiddos back to school, and I think because of the pandemic, I'm having more school avoidance than ever before of getting back into that building. Instead of going, they refuse, and then they'll either engage in self harm or have a suicide attempt and that's definitely increased." • "We're seeing a lot of the trauma related to more generalized fear and anxiety probably related to COVID. I think the return to school, I think overall is positive for kids, but I think it's also brought with it a lot of challenges and a lot of increased transitional challenges."

Aggressive behavior among youth was also noted across all counties:	• "Children with behavioral needs act out. What we see are outbursts of behavior. Our crisis services are way overworked, they can't be there in two minutes, and that's what schools think they need with kids throwing desks across the room." • "I can say in schools, across the board, we're seeing a big uptick in aggressive behaviors with kids... just overwhelmed children trying to run from the building or come at teachers or go at other kids in a much bigger way than we've ever seen before. Usually, in some of our emotional support classrooms we'd see a lot of those behaviors, but now it's ... in regular education settings as well." • "We are seeing an increase in violence in Montgomery County especially amongst, kids like 15, 16-year-old, 17-year-olds. The violence is increasing, and it seems to be younger kids." • "We're really concerned about gun violence. Safety and personal safety is an issue and it's a constant stressor. ... [Also] general ambient violence, but also gang involvement."
While alcohol was identified across the board as the substance used most by adolescents, marijuana and vaping were also recognized as priorities to address in all five counties. Youth self-medication as a means to deal with unaddressed behavioral health issues also is an ongoing concern.	• "I would say that the biggest youth issues are unaddressed mental health issues. We have a lot a lot a lot of self-medicating youth." • "We're definitely seeing more of the vaping, and drinking, and those sorts of things among middle and high school kids, but the young elementary kids that I deal with, it's just acting out and shutting down behaviors." • "What the Single County Authority in Montgomery County is focusing on at the county level with our partnering school districts is youth using alcohol, marijuana, vaping, vaping marijuana, and just mental health and how that leads to their decisions to use substances."
Changes in the legal status of marijuana in the past few years are increasing its use among youth. Perceptions of harm have decreased, increasing acceptability of its use.	• "There's been a dramatic increase in the use of marijuana with vaping. Kids are vaping THC all the time now. For many years, the perception of harm of marijuana had been fairly high. We were educating kids about the potential dangers of using marijuana. And then medical marijuana came, legalized recreational marijuana came, and kids being kids with a not fully developed cortex, said, 'Oh, it's medicine, so it's safe.'" • "There's just no conception or understanding of the fact that marijuana can be addicting and high rates of usage can be problematic and long-term usage can create situations that mimic depression. We're also seeing parents that have a medical marijuana card that are passing that knowledge and permission on to kids."

While vaping of marijuana is a key concern, youth vaping of any kind was noted as an *"enormous issue, regardless of what's actually in their vape,"* said a participant who works in behavioral health.	• "We're even seeing it as young as elementary school, but middle school definitely. ... Some students were reporting at one of the high schools that at lunchtime kids would actually bring it into the bathroom and sit on the floor and vape. ... So the problem is kids really become addicted to this. ... There are certain stores that sell to minors and kids know that. But they'll also get things from peers ... or they'll get people to buy it for them. A lot of them get it online, including the marijuana."
Access to needed services and resources has not kept up with rising demand, resulting in long wait lists and, in some instances, a level of care that may not be appropriate for the child and family.	• "There is a huge need for children's inpatient mental health beds," said one participant. For some children, such as youth who are housing insecure but do not meet criteria for homelessness or youth in transition, this can be even more problematic.
Schools and afterschool programs provide opportunities to monitor youth for signs of behavioral health issues and provide counseling. However, remote schooling and closure of many afterschool programs has limited earlier detection and intervention.	• "I think that's why we're seeing the increase in behaviors, too, because we're not able to be proactive, we're not able to get to these kids, when, you know, the behaviors just start happening." • "In the schools I see tremendous needs of young people that are just being met with a Band-Aid. We do what we can, but it never seems like it's enough." • "There are not sufficient supports out there for family members. Children that are living with someone with alcoholism, or drug addiction - those kids struggle, they act out, and often the reason isn't even identified. And those kids don't get the support that would help them cope with that situation." • "We work across five different school districts in the southern Chester County [and] there's not always consistent programming for counseling across the different districts, so there's some disparities within the different districts as to what the schools are able to offer."

FOCUS: ACCESS TO BEHAVIORAL HEALTH CARE FOR CHILDREN AND YOUTH

Access to services is often delayed due to lack of behavioral health providers with pediatric or specialty expertise, creating difficulty in obtaining appropriate care.	• "We've had kids stuck in the emergency room for over a week. They're living in the crisis center or they're living in the emergency room, and they often will need staffing one-to-one with them the entire time that they're there. ... And then ... a week has gone by and maybe the person's doing a little bit better, maybe we've been able to stabilize them a little with the doctor who's covering crisis, and then they're stepping down to a lower level of care than they really should have had." • "We have seen an incredible uptick in the needs of kids who have significant behavioral issues, and a lack of providers that can support those kids effectively and safely. It also has to do with kids who have multiple diagnoses, and multiple needs, and across multiple systems. Those kids have always fallen through the cracks, but they're falling through the cracks more now, because there just seems to be more of those kids in need right now. We are constantly having multiple system case reviews for some of these kids to try to figure out what the best supports and services are for them."
Behavioral health professionals from several counties noted that treatment services for youth have decreased and finding resources is challenging everywhere.	• "The county [Chester County] itself has limited resources for youth. But I think that goes beyond the county. I think that's the state [and] probably the country. If I have a youth that needs a detox level of care, it would be almost impossible for me to find it, unless they have private pay and go to someplace like California or Florida. Which is obviously not possible for the majority of them." Another shared: "So, if kids are really in trouble with substances, their families are looking to go to Pittsburgh or New Jersey, or places like that to get their child care. And people aren't willing to do it quite honestly. So that is a huge, huge problem." • "One of the biggest voids that I am seeing, especially for elementary aged kids, is partial hospitalization programs and inpatient programs for younger kids." • "It is really, really difficult to find psychiatrists. We'll have instances of students coming back from inpatient treatment and not being able to get psychiatry services to monitor their medication going forward, much less get therapy."

Better post-discharge support services also are needed. For example, a warm hand-off would help schools follow through with personal and treatment goals of students after discharge from behavioral health treatment facilities. Another issue: youth returning home from treatment facilities may face challenges related to returning to a home environment where there is ongoing substance use.	• "The warm handoff — as far as schools go — kids coming out of hospitalizations ... or even a more intensive outpatient or a partial program and back into schools - How can we help support them? What are their goals? What are their discharge goals? How can we help families make the connections they need to make upon discharge?" • "Even if we do successfully get them through some kind of treatment path, we are often returning them to environments that are not remotely supportive in maintaining a clean and sober lifestyle. If you have parents that are using, whether medically allowed or not, it's really hard should you manage to get yourself clean and sober to return to that environment and remain so."
Finding correct information about in-network providers for health insurance plans can be difficult and delay care or disengage patients.	• "They may only have one therapist in an organization that works with kids, but they're not taking that insurance right now. So, there's a lot of movement right now, especially in commercial insurances, about who's taking what insurances. And, providers are always dropping in and out of accepting certain insurances and participating in certain plans. We have to find out what agencies are taking what insurance, and then find out which ones that take that insurance are also taking children. It could take, you know, a month to whittle down a list of providers to someone who's taking children of that age with that insurance, and how long the waiting list is, and then by then, a lot of times we've lost the family's engagement."
Using telehealth for mental and behavioral health services with children and youth was seen as having both positives and negatives. On the positive side, according to one provider, telehealth allows youth to access services without having their friends know and the quality of the online therapy is better.	• "With the telehealth, the kids don't have to come to the lobby and run into the kid who sits behind them in math class. And it's just a totally different atmosphere. The kids are more open, they're going deeper, it's just a much better quality of therapy." • On the other hand, "Telehealth has been challenging for the kiddos. If they're elementary school age it's kind of hard to keep their attention or keep them engaged over a telehealth platform. So, as soon as we could our children's advocate was seeing the kids in person again, just because she was having a much better impact that way, and it was safer for families who were still in an abusive situation." • Telehealth also limits providers' ability to monitor youth who may be engaging in self harm. "If they're engaging in self harm or substance use, we weren't really able to track that because they were at home."
Youth with multiple diagnoses, such as autism, can have difficulty obtaining appropriate care, including behavioral health providers, inpatient care for a behavioral health diagnosis, and psychiatry services.	• "If there's a diagnosis of autism, getting services or resources for those individuals, whether an inpatient level or outpatient wraparound services, has huge waitlists. And it's a similar situation in terms of inpatient, where we frequently are unable to locate a bed, because there are very few facilities that are working with autism."

Transitional-age youth experiencing homelessness may face particular challenges in accessing behavioral health services. Policy definitions of "homelessness" that enable access to mental health services often do not apply to transitional-aged youth, who may technically have shelter.

- "Kids that are couch surfing or living in their cars, kids that are kind of bouncing from house to house or have been kicked out of their home ... those transitional-age youth are sometimes not eligible for services through the homeless system, because they're not technically homeless. ... Those kids fall through the cracks."
- "There's a segment of our young folks 18 to 24 that we've been focusing on a lot across the board...This transition age group are kind of left in between having the services from birth to 18, and then the adult services that don't always fit their needs. So, that segment of our young population I think is a particularly needy one right now."

OLDER ADULTS

Across all five counties, participants highlighted that older adults were particularly hard hit by the pandemic.

- "Our seniors have been so isolated. ... They haven't been able to visit with family, haven't been able to go to the grocery store and it's just been so isolating for them. And then to compound on top of that, that access to care for them, they might not be able to access technology as savvy as other people, and even the lack of providers in the outpatient setting is very typical to or limited, for seniors. In some respects, I feel like they've suffered more than our kids and adolescents."

The pandemic has had an impact on physical health as well as behavioral health, noted a participant from the faith-based community. Lack of mobility, transportation, and awareness of programs during the pandemic were cited as barriers to maintaining physical activity and health.

- "It was lack of them being able to exercise, a lot of them gained a lot of weight, and it caused a different attitude in their behavior. And the seniors are used to going out and walking together in the park and now not being able to do those walks with any freedom. They're not physically mobile, it's lack of transportation or they haven't gotten the information [about program services] that they need. A lot of people were depressed and locked in, but the seniors really had it harder."

Several participants noted increased substance use for self-medication and overdoses among older adults during the pandemic, linked to social isolation and depression.

- "Hearing from partners that, because of the isolation during the pandemic and the limitation on gathering or seeing friends or going to a senior center ... it led to depression, and to self-medication. There are people in the older population not only abusing illegal substances, but abusing all sorts of substances, drinking way too much in the house."
- "We've seen, since the pandemic began, an increase in the age of fatal overdose victims in Montgomery County. Prior to the COVID, most overdoses were in the 20 to 30 age group. Now we're seeing higher overdose deaths in people ages 50 to 60 which we have never seen before. My thought would be that people are depressed, lonely, and turning to drugs that they probably haven't used in years. And they're not used to the purity and strength of those drugs, and they're dying."

Grief and loss among older adults have increased during the pandemic, due to loss of loved ones and limited connections with family and friends.	• A participant noted that older adults experienced: "increased grief and loss due to higher COVID fatalities in older populations and were more likely to have lost friends and family members." Another shared: "There's also the loss of connection to family not seeing grandkids, not having the holidays, not having the same kind of experiences and just the layers of that degree."
Fear and trauma have increased isolation particularly for older adults in Asian communities. Isolation has impacted family dynamics as well. Fear of getting COVID-19 by being in public is common for older adults, but the increase of anti-Asian hate incidents during the pandemic has been an added stressor.	• A participant from an organization serving Asian older adults said: "The pandemic comes in a time with anti-Asian hate incidents being increased. … We hear a lot of stories of senior citizens afraid to go out to even buy groceries, to even take a walk. So for the last year, a lot of Asian senior citizens were just stuck at home. They didn't want to go out, they were so scared. So, then they depend on their adult children, to buy things for them to do the most basic things for them, and now we're hearing more abuse against senior citizens by their adult children, because of this imbalance in power dynamics."
Senior centers and other community venues for physical activity and socialization play a key role in preventing isolation and monitoring the mental and physical health of members.	• "Senior centers in [Montgomery] County [that] had been serving low-income seniors on a daily basis have seen a severe drop-off in attendance since the pandemic. These were essential connection points for seniors and provided an opportunity for observation of mental health [and physical health] conditions. The increased isolation since the pandemic has had a profound impact on seniors' mental and physical health." • A participant cited the influx of older adults returning to the YMCA: "What we saw is a return of the active adults of the senior population more than any other population…because of the connectivity, the community that they built, and just to avoid the isolation."
Another issue for some older adults: grandparents taking on the responsibility of raising grandchildren and their need for assistance, which was discussed in most counties. Participants noted that the number of grandparents raising grandchildren, including those with behavioral health needs, increased during the pandemic.	• "There have always been grandparents raising grandchildren, but, … now it's just at a different proportion, and maybe more people who are already struggling with mental health, and now they're taking on this extra stress. It's just a different level of stress, and worry. … There has been an influx of grandparents and great grandparents raising children with behavioral health needs especially during the pandemic."

FOCUS: ACCESS TO BEHAVIORAL HEALTH CARE FOR OLDER ADULTS

Issues related to older adults with co-morbidities were discussed in most counties. People with serious mental illness are living longer, often with ongoing chronic diseases. During the pandemic, more older adults delayed care for medical problems and accessing services. Patient health assessments, whether for primary care or for behavioral health, need to include both physical and behavioral health assessment to ensure appropriate care is provided.

- "We've noticed that a lot of our older patients are not taking care of their medical needs. … We need to be more aware of looking at medical concerns and making that a part of our assessments. We need to retrain the staff to not just look at the mental health side, but to look at the whole wellness."
- "We're seeing people live longer and longer. We have a mental health system that does not feel comfortable supporting a patient with high physical health needs, maybe somebody who just needs nursing home level of care or just below it. But then we have an elder physical needs system that does not feel comfortable supporting somebody who may still be very actively symptomatic (with a mental health condition). And there are rules and regulations within each system that preclude serving somebody with high needs in both areas."
- "One of the biggest problems with elders is they don't use the services available until it's almost too late. They don't use hotlines, we run into them at the point where we're dealing with compound issues. So, whether its nursing homes, other, long-term care of people living in the community I think there has to be some focus on earlier intervention."

Medicare coverage for behavioral health conditions, including SUD, is complex and difficult to navigate. Payment for services depends on many factors, such as whether a facility or provider is a participating Medicare provider, the type of the Medicare plan, and the level of treatment needed.

In addition, there are treatment limits for certain inpatient and outpatient services. Medicare does not cover or has lower reimbursement rates for certain behavioral health services, which can prevent individuals from seeking needed treatment.

- One participant described Medicare as a *"convoluted process"* and another said,

  "Anytime we say hold on, we're going to need to contact Medicare … it's quite an ordeal."

Other Medicare challenges for older adults with behavioral health issues are a lack of credentialed providers and difficulty accessing care for those with co-morbid medical conditions.

- "It's really hard to find therapists and practitioners that are qualified and credentialed under Medicare that can offer services."
- "We have a number of assisted living [facilities] that take a lot of folks into their dementia units. And then frequently what happens, if there's behavior problems, they end up in emergency departments, and we're being told that they have to go to an inpatient psych facility. But based on Medicare guidelines, the psych facilities can't treat dementia, because it's not a psychiatric diagnosis. That is a huge disservice to the patient, but it also creates a huge burden on the families."

Some patients are fearful of in-person appointments during the pandemic.

- "A lot of them only have phone access, and just not getting eyeballs on folks is really challenging. We offer the ability for them to come in and have support and video access, but we're seeing a really significant fear of them wanting to come in, so that's definitely been a real barrier for us."

Use of technology poses challenges for older adults in terms of connectivity and usability and does not replace the desire for in-person social connectedness.

- "A lot of seniors don't have access to computer, don't know how to access the telemedicine sites, and all those things that are being done now through the pandemic. … We need to make sure that our seniors are aware of how to access those technologies and use them."
- "Telehealth is difficult for them because they struggle with technology, and so they usually need some support from family members or younger children."
- "They might be able to manage talking on the phone, but that's not as good as being able to see someone."

OTHER GROUPS

Expectant and perinatal families. A behavioral health professional serving pregnant and perinatal women reported an increase in anxiety and depression in this population. During the pandemic, *"Domestic abuse has also seen a bit of an increase, moms are isolated, lack of communication with friends, not much of the outside world. I would just like to add that, depressed mom's depression is contagious. So, a depressed mom, the likelihood of her child being depressed is very likely."*

Challenges for expectant or new mothers with behavioral health concerns include a lack of specialized providers and insurance barriers.

- "Having access to a psychiatrist who specializes in perinatal mental health. I'm not aware of any psychiatrist that has that specialization, and the few that might be available they don't take Medicaid."

Also noted: the need for centralized information about services for pregnant women and families as well as the importance of including fathers, as well as mothers, in behavioral health services:

- "Right now, there's not one point of entry for a family or a mom who is pregnant where she can reach out to one number and be referred to multiple places."
- "Really prioritizing parent's behavioral health, because that's really what affects the children, and not leaving out dad. … We talk about mom and her mental health or substance use, but dad is there too, and dad has also mental health issues and substance use issues. There's not a lot of services available for fathers in the community at all."

People experiencing homelessness and housing insecurity. Access to behavioral health services for those experiencing homelessness, especially adolescents, was identified as an issue in multiple counties.

- A behavioral health professional cited the lack of mental health resources for these individuals and the need for training for street outreach teams:

  "There's not enough mental health support for those experiencing homelessness. If they are experiencing mental health issues on the street, what we find is there's not enough access. They go to the hospital and the hospitals put them back out on the street. But often there's nowhere to take them, it's just 'go to the hospital.' They do a few things, and then they don't have any place to put you, and so you leave. I'd like to see some more support for our street outreach team around mental health issues and behavioral health issues, because sometimes our hands are tied, and there's not a lot of resources for these folks on the street."

People leaving incarceration.	• **"Individuals coming out of incarceration tend to be pretty transient when they get out. There's a lot of housing instability, so they may start in one catchment area for a community behavior health center, and they may very quickly transition to another."** As a result, behavioral health services may be initiated in one area and then, depending on an individual's new location, the behavioral health assessment process may need to be repeated—an often-challenging process that can delay care. Older adults in the re-entry process may face other obstacles, such as needing care at a behavioral residential facility but being denied due to their criminal record.
Immigrant communities. Participants in all counties raised concern about the difficulty language barriers pose to accessing behavioral health care, including SUD services.	Comments included: • **"There's not a lot of bilingual options"** • **"There's a lack of interpreter services and other language barriers in trying to access care."** A goal of the Single County Authority in Delaware County is • **"to get better access to language and interpreter services within the county within the next five years."** Stigma and insurance issues were cited as other challenges for immigrant communities: • **"Finding those who are bilingual, those who can serve immigrants is very, very hard to find, let alone insurance. … There is stigma, and also, it is hard to find someone who understands the cultures."** • **"A lot of our clients are undocumented, and so that means the places where they can get service across the board for health, especially for behavioral health are very few, so the wait times are really long. And a lot of practitioners don't take uninsured clients."** • **"That's a really rough combo, to not be insured and not speak English so, to find resources for that is really, really difficult. We have all these struggles with commercial insurances and Medicaid, and we have a very large number of uninsured patients in Montgomery County and many don't speak English – one of our biggest challenges is finding resources for this group."**
LGBTQ+ communities. Participants in several counties shared the need for behavioral health care providers with expertise in working with those identifying as LGBTQ+.	• **"The issue becomes finding providers that have the sensitivity and understanding of, what does it mean to be transgendered? What does it mean to be queer? What does it mean for people who identify differently? So, I think, there are some providers in Delaware County that do focus on that on that group, but again, wait lists are long."**

SUGGESTED ACTIONS

CARE COORDINATION

What's working:

All publicly funded schools in Pennsylvania are required to provide Student Assistance Programs (SAPs), which are school-based services to address students' behavioral health, including drug and alcohol use: *"The SAP team receives referrals from anyone in that building who might have concerns about a student, including drug and alcohol. The program is in place to identify kids in the very early stages of use or experimentation."* Some school districts contract with organizations to provide ancillary counseling services in schools for individual students.

What's needed:

Calls for an integrated behavioral health system with a population health approach are supported by national organizations such as SAMHSA, American Psychological Association, and American Academy of Pediatrics-American Academy of Child and Adolescent Psychiatry-Children's Hospital Association. In addition, Pennsylvania commissioned the *Behavioral Health Care System Capacity in Pennsylvania and Its Impact on Hospital Emergency Departments and Patient Health* report, whose recommendations support these approaches.

In all counties, participants called for an **integrated care model** that assesses the whole person, addresses both physical and behavioral health, and coordinates care across hospitals and community-based service providers.

- **Improve service capacity:** Address bed capacity, emergency room (ER) boarding, and staffing shortages to reduce wait times and improve access to the appropriate level of care. Improve youth access to timely, appropriate care, including inpatient services available locally.
- **Improve care coordination:**
  - Expand warm handoffs between hospitals, ERs, primary care practices, community behavioral health service providers and community-based organizations.
  - Improve communication and coordination between community-based service providers and patients' primary care physicians. Also, encourage use of CRSs and CPSs in warm handoffs for drug overdose and other behavioral health issues.
  - Develop coordinated Crisis Response Systems available 24/7, 365 days a year.
- **Increase awareness of behavioral health resources and services:** Hospitals can promote internal awareness and community knowledge about behavioral health services and how to access them: *"Most hospitals put out regular distributions of what's happening in their hospital system. It's a great opportunity to focus on behavioral health. It's something they could work on with their county partners … promoting awareness of behavioral supports available in their communities and knowing where to go if they have a challenge."*
- **Streamline system navigation for providers and the population at large.** *"Finding outpatient services after a rehab or detox is absolutely a challenge. If it's a dual diagnosis, if they have multiple co-occurring disorders … everybody's got their own procedures, everybody's got different requirements. It's frustrating."* Create a "*linear system, like a depot of services, that can be easily accessed."*

PREVENTION PROGRAMMING

What's working:

Prevention programs range from school-based educational programs to community drug take-back programs and programs to reduce opioid overdose. Participants across counties stressed the need for more prevention programs: *"Sandy Bloom [a prominent expert on trauma] often says, we're not going to be able to treat our way out of this … we have to start thinking more about prevention … about how we can intervene at the community level."*

Prevention programs are seen as essential to reduce risks of substance use among youth: *"When you asked about what's working, prevention is working, prevention is a science, we utilize evidence-based programs. We offer those services in schools, to parents, and in the community."*

School-based programs that are working well:

Most counties offer drug and alcohol prevention programs for youth and the community and deem these efforts effective. *"I think our county does a good job on topics related to prevention and education and de-stigmatization talks. I think that's one thing that we do fairly well."* The Single County Authorities in Montgomery and Delaware Counties are working with school districts to provide prevention programs focused on alcohol, marijuana and vaping. They also are looking to improve access to bilingual programs. In Delaware County, a local organization received funding received from the state to provide digital devices for schools for families to engage in an eight-week virtual drug and alcohol prevention program.

Community-based programs that are working well:

- **Project Meds** is offered by the Bucks County Area Agency on Aging to "*educate the senior population on taking medication as prescribed, the dangers of over medication, and safely disposing of unused medication*."
- Bucks County's successful **drug take-back program** was the first of its kind in Pennsylvania. "*Someone at the state level called Bucks County the Cadillac of drug take back. We have drug take back boxes in the lobby of almost every local police station. You don't have to identify yourself or interact with anyone*."
- **Delaware County Department of Human Services gives funding to many organizations in the county for evidence-based drug and alcohol prevention programs in schools** and one-time speaking engagements for parent groups and other community organizations.
- The **Strengthening Families program run by the Child Guidance Resource Center in Delaware County** is a supportive substance use prevention program for children aged 6 to 12, parents and grandparents.
- **Narcan training and distribution: Montgomery County Mobile Crisis program** provided by **Access Services** is an effective intervention that should be expanded throughout the County, a participant said. Training more professionals, including police, to provide these services could help lower overdoses. *"Overdose deaths in Montgomery County are down this year. Access Services became more involved in Norristown and started going out when someone overdoses. I think … we should try to expand that to the entire County."*

What's needed:

- **Increase access to safe, structured afterschool activities for youth** available on weekends and in the evening.
- **Co-locate prevention and behavioral health services in community settings ("one stop shop") where families live, work, and socialize.** For example, in partnership with community-based organizations, provide co-located substance use and behavioral health prevention programs, treatment and other intervention services in schools. *"We're trying to advocate for a substance abuse unit in our wellness curriculum in the schools, so kids get real information, not what they're hearing on social media or from their peers."*
- **Increase access to support groups** to address mental health and substance use issues.
- **Develop texting support services that address underlying issues of substance use**, provided by trained peers or qualified therapists to individual clients. *"It's private, which helps with the stigma. … People are on their phones, texting with people all the time, so, whether you're texting with your peer support or a therapist, … that's not something that's gonna stand out, the way going to a twelve step meeting might feel."*
- **Expand effective prevention and crisis intervention models**, as noted above.

WORKFORCE DEVELOPMENT AND TRAINING

What's needed:

- **Increase training for healthcare providers, community-based organizations, schools, law enforcement, and others** in Mental Health First Aid, trauma-informed care, and cultural competence/sensitivity. Also provide Narcan training for health and social service professionals and law enforcement.
- **Increase awareness among healthcare providers and community-based behavioral health service providers** about behavioral health and substance use services and resources.
- **Increase behavioral health workforce capacity and diversity** (e.g., language, racial and ethnic diversity). Increase behavioral health professionals who represent the racially and culturally diverse populations they are serving. Also, develop and use "inclusive (culturally competent) curricula" in workforce development and training (e.g., for therapists, social workers, psychologists, etc.).
- **Develop strategies to encourage young people to pursue careers in behavioral health.** Work with colleges and universities to recruit students interested in these careers by offering tuition reimbursement and scholarships.
- **Increase individuals with lived experience in the behavioral health workforce**, such as CPS, CRS, and community health workers.
- **Provide programming to prevent mental and behavioral health "burn-out" among behavioral health staff.**

FUNDING

What's needed:

- **Support efforts to increase funding** to ensure that all families and children can access evidence-based mental health screening, diagnosis, and treatment to appropriately address mental health needs, school-based mental health care, and community-based systems of care that provide evidence based behavioral health intervention and support in homes, communities, and schools, as advocated by the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, and Children's Hospital Association.
- **Advocate to increase and sustain funding for drug and alcohol prevention programs in schools and other programs.** *"Unfortunately, prevention doesn't get the funding that treatment gets because it's hard to prove the effects. But I think it's definitely effective. If you look at tobacco over the last 40 years, we've been pretty successful in educating our young people about the dangers of tobacco, not that some kids don't still smoke, but they know that if they smoke, they're more likely to have heart disease and lung cancer. We need to have the same push in marijuana and THC … to try to curb this trend."*
- **Advocate for competitive salaries for behavioral health service providers** to increase retention in the profession. To sustain *"quality service year after year and have good client continuity of care,"* pay rates need to be competitive.
- **Advocate for higher Medicaid and Medicare reimbursement for behavioral health services.** Advocate for Parity Act standards to be applied to Medicare to protect beneficiaries with SUDs from discriminatory and other treatment limitations.
- **Advocate to increase funding for services not covered by insurance.** *"Mental health- based dollars have not received a cost-of-living increase since 2007… When you think about what those dollars pay for … things like portions of mobile crisis for people who are uninsured, it supports our student assistance programs for kids in schools, and any kind of awareness or prevention. … So, a good place to start is to create awareness of legislators."*

CHRONIC DISEASE

ALL FIVE COUNTIES

OVERVIEW

Chronic diseases are a leading cause of disability and death nationwide and statewide.

In Pennsylvania, five of the ten leading causes of death are chronic diseases, including heart disease, cancer, stroke, chronic lower respiratory disease, and diabetes. As Pennsylvania's aging population grows and longevity increases, the burden of chronic diseases and associated costs are expected to rise.

Numerous chronic disease indicators show how the impact of chronic disease varies across the five counties of southeastern Pennsylvania. For example, the age-adjusted rate of diabetes hospitalizations in Philadelphia in 2019 was 331.1 per 100,000 -- more than triple the rate in Chester County and roughly double that in Montgomery, Bucks, and Delaware Counties. In that same year, age-adjusted heart disease mortality rates were lowest in Bucks and Chester Counties (135.5 and 141.2 per 100,000, respectively), followed by Montgomery County (150.7), Delaware County (168.9), and Philadelphia County (198.5).

Across the five counties and within them, striking inequities in chronic disease burden correlate with poverty, a key determinant of poor health outcomes, which disproportionately affects communities of color. In Philadelphia, for example, Hispanic/Latino communities have some of the highest rates of chronic conditions, such as asthma and obesity, and the city's non-Hispanic Black population has disproportionately high rates of chronic conditions such as hypertension and diabetes.

To understand the impacts of chronic disease on health needs in the five-county southeastern Pennsylvania region, focus groups were convened for each county with representatives of local organizations who address chronic disease prevention and management and related risk factors. Chronic disease was also discussed in focus groups conducted with community residents in all five counties; where relevant, comments from those discussions are included below.

KEY CHALLENGES FOR CHRONIC DISEASE PREVENTION AND MANAGEMENT

Participants discussed multiple challenges to reducing rates of chronic disease, including issues related to healthcare cost and access, as well as lack of public awareness and education:

Difficulty affording health insurance and out-of-pocket expenses are common challenges.

- "We see people that no longer go and get certain services because there's high co-pays with their insurances."

Several mentioned that fear of incurring healthcare expenses can itself be a barrier to seeking care. A participant from a health clinic serving patients with low incomes commented:

- "All of the population that we serve, they don't want to be in debt or have bills that they owe to hospitals. They're very worried about that. They don't want to be in that position, so they forego [care]."

Another added:

- "for people with insurance, fear of co-payments, and thinking it's going to be too much [and] they can't afford it, so not even making appointments."

Lack of information and stigma surrounding chronic diseases can lead to fear and avoidance of getting screened or seeking treatment.

A participant who managed a cancer screening program said:

- "One of the things that I saw was fear, fear of getting that diagnosis, and kind of putting your head in the sand. There seems to be a 'Don't ask, don't tell, don't know, and I'll be okay' kind of mentality.'"
- "We have overwhelming diabetes in this city, and we have overwhelming high blood pressure in the city, and a lot of heart disease. Those things are fearful for a number of people, which makes them afraid to find out the information."
- "I will add a lack of … knowledge of family medical history. Oh, and stigmas and, avoidance of any kind of stigma. Like I work in colorectal cancer, and there's a ton of stigma, male breast cancer, prostate cancer, all of it."

Mental health conditions, such as depression or anxiety, can complicate or worsen chronic disease care, if not addressed.

- "I think that comorbid mental health issues, and the broken mental health system definitely compound and accentuate all the problems faced by people with chronic diseases."
- "People with chronic disease are at higher risk for depression and anxiety, but also those difficulties can also precipitate more physical health problems. I don't think that there is enough integrative programming … I think any family that's dealing with a family member with chronic disease, there is a need for additional support beyond just addressing the physical illness."

Stress management and social support are important to optimize care.

A participant who works with people in cancer recovery said:

- "General stress management is a huge barrier, not only through it, but even after treatment. One of the things we also hear is sort of once everything stops, so treatment is done, surgery's done, okay, your doctor's like 'You're good, I'll see you in three months,' or whatever. It's like 'Holy moly, what just happened?' It's like post-traumatic, 'Now what do I do?'"

Some patients also experience "scanxiety" after treatment for cancer—that is, fear and anxiety before follow-up visits to check for cancer recurrence. After a diagnosis of cancer,

- "Number one is just feeling they have the support in their life, whether it comes from friends or family, or just support of others that understand what they're going through."

IMPACT OF THE PANDEMIC ON CHRONIC DISEASE PREVENTION AND MANAGEMENT

Participants discussed additional challenges to chronic disease care resulting from the pandemic, especially delays in seeking care due to patients' fear of contracting COVID and a lack of provider capacity, causing long waits for many appointments.

With care delayed for some patients, several participants said **cancer and other conditions are more often diagnosed in later, more advanced stages.**

- "During COVID, … people are experiencing increased isolation, and everything that goes along with that, and may not feel comfortable going to see the doctor, going in for screenings, or even going to the grocery store."
- "Because of the pandemic, many [people] have been diagnosed later in their cancer stages. So, that's really been an obstacle, too, because everything was kind of pushed back because of the pandemic with everybody, with everything basically. But, you know, for our cancer patients it's been really tough in that respect."
- "The fear of going for those screenings during COVID. A lot of people that typically got yearly colonoscopies or blood work or whatever they're like, 'No, we're going to wait.' And then things exacerbated in that time, so a lot of people are being diagnosed later, in more advanced stages."
- "[People are] having difficulty getting medical appointments … [For example,] diabetics who were struggling with control and not being able to see an endocrinologist for several months."
- "We constantly have people telling us that they're having problems with access to health care. For example, if they have to go to the ER, they have to wait, oh, like, seven, eight, nine or more hours just to be seen, where pre-COVID, that was not the case."

Staffing shortages at hospitals, coupled with staff redeployment to pandemic-related care, are further challenges.	• "Finding some of the supportive services, the social workers, the nurse navigators, if they [patients] need financial assistance– those have been a lot harder to come by." Another participant who works at a health clinic added: • "We are currently in major catch-up mode when it comes to the cancer screenings, and then availability of getting folks in … can be months waiting."
With many people working remotely during the pandemic, fewer workplace wellness programs that offer screening and education are being offered.	• "With the emphasis on the pandemic, there may be a lack of awareness even in workplaces about doing screening as part of work and offering it as part of work. Think about that: a lot of people are working remotely, and that's where these things used to be in the office, or that people could gather to a bus [providing mobile health services] that is on office property, the access to that is reduced because of people working remotely."
One participant raised concern about the amount of **misinformation being disseminated about COVID treatments and vaccines**, with broader implications for following recommended prevention and health screening recommendations.	• "Because of all the media hype about the vaccines … and the lying, and false lies and false news and stuff, I think it's become more acceptable to say doctors and science don't know what they're doing. And people feel justified to reject services as a civil liberty right. Which they do, but I don't think it's an educated choice; I think they're starting to just rebel against being told what they should do."
Participants said **the growing transition of many health services to virtual platforms was a mixed blessing—convenient for some people but depriving others of needed care due to the digital divide.**	• "It's not for everyone. Certain appointments lend themselves much better to a telehealth or a digital appointment, but not everyone has the same connectivity and technology. We find many of our patients are able to use their cell phone to connect, but not necessarily through a computer. Some have concerns about use of minutes and things on their phones. So, it's just not available equally across the board." • "There are a lot of people who don't know how to use the technology, so [that is] a main barrier. And … the language of the technology is in English, so it is a problem also." • "There's also an almost paranoia fear, definitely, about technology, and who will see my records, and where will it go, and how are people using it. … And it's like, you know, just not understanding how all that happens and not trusting it even slightly." • "I think today the digital divide is real and created almost two different worlds, in some ways, when we're talking about chronic disease."

SOCIAL DETERMINANTS OF HEALTH

Participants in all groups emphasized the need to address social determinants of health to improve prevention and management of chronic diseases. With poverty cited as the single most important social determinant of health, participants discussed a range of closely related determinants that contribute to chronic disease:

Food and nutrition. Because of the importance of a healthy diet for preventing and managing many chronic diseases, multiple participants cited the need to improve food security as well as access to healthy, affordable food and nutrition education.

- "We know that diet plays such a huge role in managing and preventing chronic disease, so that is top of mind for me."
- "I work in diabetes education, and I see it over and over, where people think that their diabetes is being managed, yet they're on so many different medications. If they just tweak their diet a little bit, they're able to manage without a plethora of medications."
- "We are seeing that parents and grandparents that are helping to raise children [will] often, when there's food insecurity in the family, have the children eat before them. … So, I think food insecurity is a major issue. Anybody who's dealing with chronic disease or maybe trying to prevent it … would not be eating healthy if they're dealing with food insecurity. So, that's a major, major issue, I think."

Transportation. Participants in rural, urban, and suburban areas cited lack of affordable and convenient transportation options as a barrier to accessing health care and other resources needed to prevent or manage chronic disease.

- "Geographically, Chester County is enormous, and public transportation doesn't get you everywhere. So, even if you have access or have insurance, being able to get around [to] make appointments is a huge challenge."
- "I would definitely second the [need for] transportation. Our organization is not only inside Philadelphia County, but also up into Bucks, Montgomery [Counties] … and transportation gets even harder."
- "When it comes to access to health care, transportation is a huge issue … whether it's the cost of affording an Uber or not feeling well enough to be able to do the travel and to drive yourself. It's always been a struggle to find transportation for treatment, but COVID really escalated that because people who were willing to, were able to pay for Uber or take public transportation were no longer comfortable or [it] was no longer available. So, I think that's definitely been a barrier for healthcare access."

Violence. Fear of violence and other threats to personal safety were mentioned as barriers to physical activity or access to care by several Philadelphia participants.

- **"You know, there's not as many places to walk or walk safely, so that's definitely kind of at risk."**

Another participant said:

- **"We have a lot of gun violence in our city. And it could be treated as a public health issue, but it isn't. … That has impact on transportation, whether people are really not fearful coming out of their houses to go to a screening, and how far do they have to go to get screened."**

Lack of awareness and knowledge. Participants in all counties cited a common lack of awareness about chronic disease risk factors, prevention, and management.

Greater awareness also is needed about available resources to help prevent or manage chronic disease, such as community-based programs to access health insurance, nutritious food, or physical activity programs, as well as websites that provide education and help for those in need. As one participant put it, the issue is

- **"where are we finding those pieces of information to help make decisions on our own health?"**

Environmental exposures. Indoor and outdoor pollutants were mentioned as risk factors for asthma, cancer, and other chronic diseases by several participants in Philadelphia and Delaware Counties.

A Delaware County participant said:

- **"In the southern part of the county, where we've got a huge industrial corridor, we have a lot of anecdotal evidence of high rates of cancer, asthma, lung conditions, and we're even seeing things like children with chronic nosebleeds, and that shouldn't be happening. … So people are facing chronic illness, but physicians are not necessarily aware of the environmental hazards in the community."**

Another Delaware County participant added:

- **"We do have the cancer corridor down 95, which has been there for a million years, all the things that [were] mentioned with regards to asthma and cancer. … I'm old, and it's just some of the same things are still persisting."**

A Philadelphia participant commented on indoor exposures:

- **"I think 90% of Philly homes are very old, and that could lead to [exposure to] lead levels and asbestos, which could lead to a lot of respiratory problems for a lot of citizens in Philly."**

CHILDREN AND YOUTH

Childhood obesity, which has increased during the pandemic, was cited as a key concern across the region, contributing to type 2 diabetes and other chronic conditions, participants said. They focused on barriers to healthy eating and physical activity as root causes of the obesity epidemic.

- "Childhood obesity is still there, it's still present. It's not discussed and brought to the forefront really as much as it was ... but I think that need is still there."
- "I've noticed that when kids came back [to school], they gained a lot of weight, a lot of weight. ... I mean, childhood obesity has always been a concern in this country, but even more so now – you know, some people use food to cope with the pandemic, and all the stress."
- "It's not just in communities experiencing food insecurity--we're seeing that in all communities, that children just don't have that awareness, even their families, about what healthy eating actually is."
- "The amount of screen time children and youth are getting every single day. You know, it's taking from physical activity, which is resulting in bad behaviors."
- "The obesity is starting at a very young age, and that's part of the chronic disease and if we can get our children more active, and get them involved in more activities that are available to them to join that can help."

Opportunities for physical activity have been reduced during the pandemic, due to virtual schooling, closure of many afterschool and extracurricular programs, and increased use of social media and other forms of screen time.

Several participants also cited high costs to join local sports leagues as barriers to physical activity for children and youth. As one parent (a participant in a community focus group) shared:

- "I'm a single parent, and I can't afford to pay for my son to be doing sports, like that's not something that's going to happen in my household."

In several counties, an "***epidemic of vaping***" among youth was cited as another top concern, one that increases the risk of a host of serious chronic conditions over the long term, such as heart and lung disease.

- "As we get closer to high school, not necessarily the young kids, vaping is definitely one that it is extremely concerning to us, and flavored tobacco in general."

Childhood asthma and lead poisoning, stemming from environmental exposures, were raised as additional concerns by participants in Delaware and Philadelphia Counties. Specific concerns are lead dust from paint in older homes, causing lead poisoning, and indoor pollutants such as mold and dust that can worsen asthma and allergies.

With children and youth spending more time indoors during the pandemic, their risk of exposure to indoor pollutants has increased, one participant noted. This participant stated:

- **"Delaware County is the fifth highest– in Pennsylvania – in terms of the number of kids who are poisoned each year by lead, primarily because of peeling lead paint in older homes."**

Participants in every county brought up an **increase in mental health issues among children and youth during the pandemic**, along with insufficient behavioral health services to meet the demand for care. Mental health issues among youth can adversely affect their physical health, participants noted, as well as increase unhealthy behaviors, such as vaping or overeating, that contribute to chronic disease or interfere with a young person's ability to manage conditions like asthma or diabetes.

OLDER ADULTS

Increased social isolation during the pandemic has had a range of adverse effects on older adults' ability to prevent or manage chronic diseases, such as delays in accessing care, barriers to good nutrition and physical activity, and an uptick in mental health issues, such as depression and anxiety, that can interfere with self-care and disease management.

Participants who work with older adults across the region commented:

- **"We've done everything we can to make it safe for our members but there is still some hesitation, especially amongst a lot of the seniors who we used to see coming in."**
- **"Something what the people we serve have been facing long before the pandemic is isolation, and … that has such a profound effect on chronic disease, and also the mitigation of it."**
- **"We've seen a decrease in their function level. There's been an increase in falls and, you know, it is notable that during the pandemic when they were less active, they did lose some ground as far as their balance, and flexibility, and strength."**
- **"We're seeing a lot of need to break depression and just a lot of mental angst and anxiety from COVID and as these new variants pop-up, the anxiety rises again."**

Several participants said they have observed a **decline in the overall health and well-being of older adults during the pandemic**, especially among those who have not resumed visiting senior centers or reengaging in other healthy activities.

- **"When they come in for their COVID boosters or things like that, their COVID shots, flu shots, we definitely are seeing the health effects of that isolation and that is major for those that are not coming back. For those that are coming back, we're offering as much as we can but … they can't just jump right in and do everything that they did before. So, it has been a progression."**

In addition to longer wait times for many medical appointments during the pandemic, the growing shift to telehealth has been challenging for many older adults.

- "Some who are even tech savvy who just don't wanna spend a ton of time or feel a little awkward doing the Zoom calls."
- "For seniors, it's been for some of them challenging with the computer technology. I think a lot of seniors have had help through the senior centers and other organizations to learn technology. But it has taken them a while. Many seniors that I've spoken to have continued to keep in touch with their healthcare providers through the phone, probably more than the computer themselves."
- "Some seniors can't afford to have the internet services, things like that, so that's been challenging for the senior population. Or just feeling comfortable enough. … I'm amazed at how we get them on programming virtually, and the success that they have. But it's just being familiar with that use."

On a positive note, as older adults learn new technology skills, some are sharing their knowledge to help their peers learn to navigate virtual services.

- "You do see a lot of support from the seniors to the seniors, so I think that's really been great. I think sometimes that peer guidance and acceptance is really huge for them, to know they're not alone out there."

Participants discussed **other barriers to healthcare access** for older adults, including

- **Lack of care coordination, especially for those with multiple health issues.**

  "Many people with dementia are not getting diagnosed, and then once there is that diagnosis, once again, that care coordination is so important, because many of them have more than one chronic condition, and the dementia impacts their ability to manage that chronic condition such as diabetes."
- **Reluctance to travel more than a short distance from home for medical appointments, even if care is available.**

  "We have found that seniors who are still driving tend to want to stay in their immediate kind of neighborhood. They're not, as you know, not as willing to go further … they kind of follow their routines."
- **Lack of awareness and knowledge about their health conditions and resources,** especially among those who are homebound with little or no digital capability.

  "A lot of times older adults, they're not going to hop on Google and see what resources are available to them. So, you know, just the unknown of not knowing what questions to ask, because you don't know what's out there."

For older adults living on fixed or limited incomes, **affording prescription medications, co-pays, and other healthcare expenses can be further barriers to managing chronic diseases.**

- "Not everyone [with Medicare] qualifies to have a Medicaid managed care program. You know, trying to get enough to eat because of limited incomes. Being able to afford medications, which could cost them thousands – I mean, just ask a diabetic what their medications cost, for example, or a cancer patient, or anyone else. Medications are extremely high cost, and there's a [point] where they are out of luck."

Several participants remarked that self-care for chronic disease is hard work, requiring individuals to use motivation, planning, and organizational skills for disease self-management. **Many older adults need—but often lack—support people in their lives**, such as family members or home health aides to help them manage these tasks.

- **"A real difficulty is staying on task and dealing with the skillsets and the behaviors that you have to do in order to maintain your chronic illness, and to keep that going for the long haul. It's very difficult to stay on track, and people slip, and they need to find [and] have supports to get back on track."**

One bright spot, mentioned by several participants, is **the pleasure that many older adults experience when they are able to reconnect socially with others and reengage in activities**, such as at senior centers, YMCAs, and other social venues.

One participant commented on

- **"the support that the seniors are giving each other, and how they can really help each other. And they don't have to actually have the exact same chronic disease, but they kind of use the same tools, and they share them with each other, and I think sometimes that peer guidance and acceptance is really huge for them to know they're not alone out there."**

Another added

- **"I think that's why our senior centers are so crucial, because of the interactions that they have with one another. … We just see that when they came back, they're just so alive again."**

OTHER GROUPS

Participants briefly discussed other populations who are at risk of poor outcomes associated with chronic disease:

Immigrant and refugee communities. Language barriers are key issues among those who lack proficiency in English.

A participant who works with immigrant communities said:

- **"Most of them, they go to these health centers, and they don't find a lot of help, because of the language barrier. And they also don't understand a lot of things also, just because of the language barrier."**

Several participants mentioned that members of these communities often are afraid to seek care, especially if they are undocumented.

- **"In the population that we deal with, many have a lot of false information about applying for assistance and being deported or their status as an impairment, even if it's not necessarily true, it impedes their desire to access care."**

The need for healthcare providers to understand different cultural customs and traditions also was discussed. For example, in some cultures, *"they value obesity as something good,"* said one participant, who explained that in some cultures, *"people see it as prosperity,"* and they may therefore encourage their children to gain weight. In Hispanic/Latino communities, lack of access to affordable fresh food in many neighborhoods, including culturally preferred healthy foods, can increase the risk of obesity, type 2 diabetes, and heart disease.

Caregivers. Participants in several counties commented on **the need to provide support for family members and others who provide care for individuals with chronic diseases.**

- **"Caregiving responsibilities can keep older adults from taking care of themselves. Caregivers often have chronic conditions themselves they're dealing with, and providing, and connecting them with support resources is going to help them better support the patient with their chronic condition as well as help them manage their own chronic condition as a caregiver."**

During the pandemic, some families took their older adult parents out of nursing homes to avoid COVID exposure and restrictions on visiting residents during the pandemic.

- **"That's impacting the family now the adult daughter or son is [now] taking a long leave of absence from work to stay home and take care of that person--you know, changing family dynamics, that's for sure a COVID-specific impact."**

One participant mentioned the **challenges for caregivers in the "sandwich generation,"** that is, those who are raising children while caring for elderly parents or grandparents.

- **"There's an expectation sometimes that family members will rally and that they will participate, but there's also a reality that sometimes that doesn't happen. So, a person who is doing the caregiving may be stuck and not only caring for a person who has a chronic disease or has cancer, but also dealing with children, or re-parenting."**

On a related note, the closure of many adult daycare centers during the pandemic has placed new burdens on some caregivers.

- **"People who used to be able to work and … have their people [elderly family members] cared for at adult day service now have to reconfigure their lives … to think about what to do with older adults who need a lot more structure."**

People with disabilities. People living with disabilities who have comorbid chronic diseases often experience fragmented health care.

These individuals need "*help with coordination of care,*" said one participant.

- **"Once you get multiple different medical care teams involved … it gets really overwhelming for people."**

Also important are accommodations to address the needs of people with disabilities, such as hearing aids, use of a wheelchair, and Braille resources.

LGBTQ+ community. Several participants cited the need for more outreach to individuals who identify as LGBTQ+.

- **"Service providers at large [do not have] a great understanding of the LGBTQ+ community."**

Another participant, a physician, emphasized the need for more education for health professionals and screening of patients to increase use of pre-exposure prophylaxis (PrEP), a medicine prescribed to prevent HIV among people at risk due to sex or injection drug use.

SUGGESTED ACTIONS

For many community organizations, the pandemic has spurred a range of successful innovations to existing services that could be further expanded, such as virtual wellness programs.

For example, regional YMCAs now offer online exercise classes, taught by YMCA instructors. A participant from a regional YMCA said:

- **"It's something that we were actually looking to develop right before the pandemic started, so it happened at a very good time for us, and it's grown a lot."**

Depending on the branch, members can now choose to participate in person or online in a variety of disease management programs, such as group sessions to prevent type 2 diabetes, support cancer recovery, and promote heart health.

Participants suggested a range of other strategies to improve chronic disease prevention and management, such as by starting new initiatives or scaling up model programs that are working well elsewhere. Their recommendations:

Before patients leave a hospital or clinic, provide screening, referrals, and "warm hand-offs" to community-based health and social services. Multiple participants in all five counties emphasized the need for hospitals and other clinical care settings to provide "*better referral to both social service resources and health resources to support people to live independently, to manage their chronic diseases.*"

Others added:

- **"I think it would be important for hospital systems to ensure that they are integrating some kind of social determinants of health screening tool, and then providing referrals. So, that could include food access, transportation needs, mental health services, and then partnering with local organizations who are focusing on those specific areas, and then referring out."**
- **"That warm hand-off from being in a clinical environment going back to your home is a really critical time for people. … Community-based resources, like Meals on Wheels, like senior centers, they reduce recidivism, they keep people out of the hospital, and they save healthcare dollars."**
- **"One of the important things the hospitals could help us with the chronic conditions, especially with seniors, is letting them know that there's tools [in the community] they can use to manage their conditions."**
- **"If we can get those referrals from physicians in the healthcare system, when people present with chronic disease, like how they can get some help to manage it. … I think that would be a great system."**

Several participants pointed out that achieving this strategy likely "*will involve educating the hospital staff about what's available in the community. …. I think sometimes it's just that they're not aware that those services are there for [their patients].*"

Bring more health and social services directly to underserved communities to increase access to care and address social determinants of health.

Suggestions, which came from participants in all five counties, included opening health clinics in schools (*"a great place to connect to the whole family"*), offering mobile medical clinics (*"you got to meet people where they are"*), and starting pop-up produce markets or community gardens in urban areas with fewer healthy food access options. More affordable and convenient transportation options also are needed to bring people who cannot drive or take public transit to needed health and social services.

Others suggested bringing health and social services to faith-based institutions or where people shop, recreate, or work. In Philadelphia, for example, a participant cited an existing program that offers "*blood pressure screenings at [grocery] stores, and then the providers are referring the individuals if they don't have a primary care doctor already to clinical care to make that linkage.*" Another participant mentioned an innovative program that bundles several preventive services conveniently together, such as FluFIT, which provides a take home stool-based screening test for colorectal cancer when people receive their annual flu shot.

Increase networking and collaboration among community organizations and health system partners to improve resource sharing and coordination of services. The need for greater collaboration and information sharing was raised by participants from every county.

One participant envisioned "*a vast network of organizations, nonprofits, healthcare providers, social service agencies all sharing and educating the community on the services available and how to access.*" Another noted that collaboration "*helps to not only kind of maximize services, but it also lessens the duplication of efforts, as there are some folks that are [already] doing things really, really well.*" Another participant, a health professional, suggested creating "*an app where you could put in food insecurity and a zip code, and get some options to give to the patient immediately, and you could text it to them.*"

Coalition building was cited as a strategy that has been working well, especially during the pandemic, to meet the growing need for emergency food and other essential services. To cite a few of many examples, the Montco Anti-Hunger Network worked to equip food pantries and soup kitchens in Montgomery County with funding and food donations, while helping them to reconfigure their operations for safe social distancing amid supply chain disruptions, shortages of personal protective equipment, and loss of volunteers.

Broaden and intensify efforts to reduce vaping among youth.

Participants pointed to the need for better data to understand vaping trends among youth and for school districts to shift toward policies that provide "*more supportive and restorative disciplinary actions*" for students who are disciplined for vaping, such as referral to cessation programs and other support.

Better inform, educate, and engage the public regarding chronic disease prevention and management.	Limited knowledge about chronic diseases, ranging from not knowing one's family medical history to being unaware of screening guidelines and resources, was a frequently mentioned problem. More virtual health promotion programs are needed as well. A participant said: • "We have to try to figure out how to share information with our community in a way that is not using our jargon in our field, that's just general language. … Sending out the reports is not going to do it. You have to go to the communities, you have to find people [in the] places they go to share that information."
Integrate mental health services into overall care management for people with chronic diseases.	• "Mental health is an aspect of everything. If somebody is diagnosed with cancer, they're going to have some depression, some anger, so mental health comes into everything. So, [we need] to have like an umbrella of mental health that goes across the board."
Strengthen efforts to close the digital divide.	Several model programs are working well to improve digital access, but more needs to be done. The Bucks County Area Agency on Aging has created a pilot program to provide new computer tablets to older adults, along with internet connection if needed and training on how to use technology: • "We've been providing tablets to seniors to help them connect. It's not an easy process because many seniors have not had the technology, but everything now has moved [online]. You cannot do in-person anymore. It's almost, you know, almost impossible to do many things in-person."
Improve access to quality language services, along with culturally competent care for the region's immigrant and refugee communities.	• "A proper interpretation is very important," including "an interpreter that has some understanding of medical language so that they can provide good information for the patient." Another spoke to the need for • "having providers or medical professionals that can communicate in the same [language]– just to better educate."
Mobilize people and organizations to work toward system-level changes on pressing public health issues.	• "I don't think behavior changes are necessarily what the focus should be on. It should be focused on making the healthy choice the easy choice." The same individual noted that hospitals can be a powerful voice in partnered advocacy campaigns. • "Healthcare provider voices can really play a big role. Patient stories can help tell that to a legislator in a very important way, and help to really – kind of a swipe of a pen, if you will, to really see what we can do to influence behaviors in a better way."

FOOD INSECURITY

DELAWARE, CHESTER & MONTGOMERY COUNTIES

To better understand needs and opportunities to improve regional food security and access to healthy food, focus groups with representatives from local organizations addressing these issues were held in Delaware, Chester, and Montgomery Counties. Information was also gathered from geographic community discussions in these counties; where relevant, comments from those discussions are included below.

OVERVIEW

Due to the COVID-19 pandemic, rates of food insecurity have been rising nationally and regionally.

In 2019, before the pandemic, food insecurity nationally was the lowest in more than two decades, according to Feeding America, and 35.2 million people were food insecure. The pandemic is likely to have reversed this improvement, with more than 42 million people who likely experienced food insecurity in 2021. Considerable racial and ethnic disparities exist in food insecurity, with Black and Hispanic/Latino communities facing hunger at higher rates than whites.

In southeastern Pennsylvania, food insecurity remains highest in Philadelphia County, where the rate is projected to reach 17 percent in 2021, up from 14.4 percent in 2019 before the pandemic, according to Feeding America. Surrounding counties also have seen sharply rising demand for emergency food assistance during the pandemic, along with increased food insecurity. In Chester County, Pennsylvania's wealthiest county, Feeding America projects food insecurity will rise to 7.4 percent in 2021, up from 6.3 percent in 2019. In Delaware County, about one in 10 residents are projected to be food insecure in 2021, up from 8.5 percent in 2019. In Montgomery County, the rate is expected to rise from 6.9 percent to 8.3 percent over the same period, and in Bucks County, from 7.2 percent to 8.6 percent

As is true nationally, emergency food providers in southeastern Pennsylvania have substantially stepped up their efforts to meet the growing need for food assistance. For example, Philabundance, which partners with 350 emergency food agencies, distributed 55 million pounds of food in 2020, a record for the organization and a 60% increase from 2019. The Share Food Program, the largest hunger-relief agency in the area, has been distributing 4 million pounds of food every month since the start of the pandemic.

REGIONAL EMERGENCY FOOD PROVIDERS: PANDEMIC RESPONSE

During the pandemic, food banks, food pantries, schools, and other food providers had to gear up quickly and creatively to meet the rising need for food.

Many clients were first-time users of a food pantry or other emergency food provider. Participants from organizations that distributed food during the pandemic commented on the dramatic uptick in need. A participant who works for a school district shared:

- **"My opinion is it [the pandemic] pretty much just exacerbated the needs that were already there. ... I mean, I was out daily, giving meals out every day when we were shut in. I just, I saw the lines and [it was] just really tough, really tough."**
- **"I can definitely comment on the increased incidence of food insecurity in Montgomery County as a result of the pandemic. We have served close to 25,000 additional individuals in the last year than we had previously. And that equates to about 9,494 additional households that had been impacted by the pandemic, that are in need of food assistance. And many of those folks are using our food pantry network for the very first time, and they've never needed food support before. So, the impact has been really quite substantial."**
- **"Since the pandemic started, I myself as a community outreach person can testify to the fact that there are more food pantries that have opened since March of 2020, because of the pandemic. And that's throughout Delaware County, but definitely in the City of Chester itself."**
- **"[Our organization is] distributing about 300% more meals in our soup kitchen than we had previously, pre-COVID. We had to go from our warm meal that's served in our dining room to to-go meals for safety, but we were distributing a lot of meals. People were coming in and getting meals for their family and they were allowed to take as many meals as they needed. We were distributing about 200% more groceries; ... And so, we went from twice a month to once a week, that people could come and get groceries."**

While the introduction of emergency Supplemental Nutrition Assistance Program (SNAP) benefits (Pandemic Electronic Benefit Transfer program: P-EBT) and increased services of other food assistance programs have had a positive impact on food security, overall demand for emergency food has remained substantial, participants said.

- **"We have seen a dip in the numbers since public assistance benefits had become available, but our numbers are still higher than they were before the pandemic in 2019"**

Emergency food providers, schools, and other organizations that distribute emergency food had to quickly and creatively devise new COVID-safe ways of operating. For example, senior centers that had offered on-site congregate meals before the pandemic developed new processes to safely pack and distribute to-go food. A participant whose organization serves meals to older adults said:

- **"We went to a completely no-contact [process, with] everybody wearing gloves, everything's wrapped in a brand new bag and [it's a] basically drop and run type of situation."**

SOCIAL DETERMINANTS OF HEALTH AND REGIONAL FOOD SECURITY

Job losses and other financial hardship stemming from the pandemic are key drivers of hunger in the region, along with lack of transportation, affordable housing, and language or cultural barriers, participants said. Social determinants of health that contribute to regional food insecurity include:

Poverty, exacerbated by job loss.

- "To me, it's all about poverty. [People are] having to make these difficult choices about how to spend the limited resources that they do have," said a participant. Another added: "I think it's the choice of 'am I gonna feed my children or myself or am I gonna pay my utility bill or my food?' I think it's all very interrelated."

In focus groups with community members, concerns also were expressed about **rising food prices due to recent inflation**, which has made it even harder to afford food.

- "The price of gas, the price of food, the price of everything has increased so much that it has put a strain on families, and it definitely has impacted the aging population."

Housing costs. The escalating costs of housing across the region have further tightened food budgets for many. Some households also lack working kitchen equipment or a home altogether.

- "One of the things that we see is the relation [of food insecurity] to the high cost of housing that exists within the southern Chester County area. ... Higher living expenses really impact the ability of people to get those foods."

In Montgomery County, a participant spoke of the "Main Line bubble," where

- "there are folks who are house poor ... but aren't willing to ask for help."

Transportation.

In rural areas, such as southern Chester County or northwestern Bucks County, *"just being able to get to where that food's available"* is a challenge, noted a participant. Some residents do not have easy access to a grocery store or a food pantry, especially if they lack a car or other affordable transportation. Transportation barriers also affect low-income urban communities, such as in areas of Coatesville, Norristown, and Chester, where many residents lack walkable access to a grocery store, which is especially challenging for those with mobility limitations, such as many older adults.

Language and cultural barriers.

For people who do not speak English as their primary language, accessing the emergency food system can be difficult, participants said, especially for those who do not have a family member or someone else to help with navigating services and interpretation. Moreover, food provided by local pantries may not reflect the cultural food preferences of immigrant households. One participant cited the need for healthy food *"that's culturally relevant"* for local populations.

Lack of knowledge and awareness.

- "There are folks out there who aren't connected to any organizations. And so, they may be eligible for programs, but they don't know about them and they're not connected with anybody that can tell them about those programs."

ACCESS TO HEALTHY FOOD

Participants commented on the need, especially, for affordable healthy food, such as fresh fruits and vegetables, both in the emergency food system and in accessible food markets in communities.

As one participant put it:

- **"It's not just about having food, but it's about having the right foods that people need."**

In many of the region's cities, some urban neighborhoods—often, where communities of color live—lack supermarkets and instead have many corner stores or bodegas selling mostly low-nutrition snacks and processed food, with little or no fresh produce. A Chester County participant said:

- **"There is no grocery store in Coatesville. It's all the small convenience stores that have a tendency not to sell nutritious food [and] that often sell expired food. I [am also] concerned about the number of dollar stores that are popping up, specifically, in neighborhoods [with] low-income people of color. Of course, no nutritious foods, you know, sold at those dollar stores."**

Participants emphasized that access to healthy food is vital for maintaining health and preventing common chronic diseases. Affordable healthy food also is crucial for those who are trying to manage chronic conditions such as type 2 diabetes or heart disease, or in treatment or recovery from illnesses such as cancer. *"A lot of people that we see, particularly within the Latino community, have [type 2 diabetes] which has some basis in food choices and food availability,"* said one participant.

The minister of a Black congregation, whose church has a community garden that gives away fresh produce and works with a local hospital to provide nutrition and health education, observed:

- **"What works really well is to bring the healthy food to the people, because access is a challenge. But if you can find innovative ways so that it's easy for people to get [healthy food], that's when you can really help to solve the problem."**

USE OF FOOD ASSISTANCE PROGRAMS

Stigma remains a major barrier to using food assistance programs, both for enrolling in SNAP or other government programs, and for using food pantries and other emergency food services.

- **"Some of the families I've worked with, there is almost like a stigma attached, where there's that, 'I don't wanna go stand in line and have people know that I'm there to get food.' I don't know what the solution is to fix that. But that's what I've come across with some families when I say: 'You know, you can go here and get meals and they're free.' There is almost that like embarrassment to go or 'who might see me there' kind of thing. ... Even when there are resources available, [for] things like SNAP, sometimes it's the need to demystify it. It's the need to destigmatize it."**

Another participant similarly commented that, because of stigma, *"certain folks won't ask for help or [won't] get their support from here—they will travel to other places."*

Participants discussed the need to address other **barriers to enrolling eligible people in SNAP, WIC, and other food assistance programs.**

These challenges include lack of awareness, difficulty understanding and navigating the application process, and, among immigrants, fear of exposing their legal status to others or being ineligible for some forms of government assistance.

A participant from a regional food bank commented on barriers to WIC participation during the pandemic. To have their WIC benefits reloaded every three months, mothers had to travel to WIC offices, because their benefit cards cannot be reloaded virtually.

- **"WIC participation is way down and that was [due to] the barriers of having to go to the actual office [and] the barriers that go with the cards that Pennsylvania is currently using for WIC administration. So, that's certainly another program that could be a really vital resource to folks that's being underutilized here in Pennsylvania."**

Participants discussed the need to improve access to food assistance programs for other groups, including:

People who are undocumented and may be fearful of using the emergency food system or applying for food assistance programs.

A participant whose organization provides health and social services to immigrants and other clients said:

- **"People who are working toward becoming citizens, wherever they are in that process, one of the things that they get concerned about [is] signing up for any sort of public benefit, just becoming a public charge and having that impact their ability to become citizens later on. … Even with school feeding programs or things like that, oftentimes families are nervous to sign up for those programs, because they get concerned that it may impact their ability to become citizens later on."**

People with limited or fixed incomes, including the "near poor."

Concern was cited for people whose incomes are too high to qualify for government food assistance programs, but not enough to adequately feed themselves and their families.

- **"For some, if they make $1 too much, you know, they make $40,000, [but] you need $72,000 to live sustainably in Chester County."**

Lack of understanding about income eligibility for SNAP and other programs can further worsen this barrier.

CHILDREN AND YOUTH

During the pandemic, **school districts across the region geared up to distribute healthy meals to students and their families during remote learning.**

Several participants praised the efforts by many local school districts to address the nutritional needs of students and families during the pandemic.

- **"I hope that all the school districts continue the really great work that they did during COVID to get out there with the families, it was really heroic what they did," said a participant.**

Another participant commented:

- **"Some of the schools stepped up in a magnificent way to the point that they ended up doing seven-day-a-week feeding programs because there were some waivers in place."**

As the pandemic continues, however, **schools are facing new challenges to their food service operations, including staffing shortages and supply chain issues,** similar to problems that other businesses and organizations have encountered.

A representative from a public school district stated:

- **"Our biggest challenges are sort of the global challenges of staffing, transportation, and supply chain issues. The meals that we're providing, although nutritionally sound, are not really up to the quality levels that our nutritional services team would like to provide, because the supply chain has been unreliable. ... [for example,] we don't get apple slices, and the next week we don't get carrot sticks. And then we're having a lot of trouble staffing our school cafeterias, it's one of several areas where we're experiencing real staffing issues."**

Schools also face **new challenges feeding students whose family situations have changed due to pandemic hardships.**

For example, more high school students are working during the regular school day to supplement their family's income and therefore may not be on site for school breakfast and lunch. To accommodate these students, a participant commented on how the public school district where she works had implemented an after-hours lunch program.

- **"We're just trying to be creative with how we can still educate our kids while they're having to work. For example, some students work during the day and attend school from 3 pm to 7 pm. We're trying to figure out how to still provide them a lunch when it's off-hours. So, it has caused another stressor onto our cafeteria staff, because they [students] are entitled to that."**

During the pandemic, several participants mentioned that **more young people are under the care of their grandparents**, because their parents are unable to provide care for various reasons.

When grandparents assume caregiving duties, new barriers to family food security may arise. For example, grandparents who do not have formal legal custody of their grandchildren may have difficulty accessing some types of emergency food assistance. And those with limited incomes or age-related health impairments may not be able to procure or prepare food for other family members. A participant who works with students and families shared:

- **"A lot of grandparents are raising their [grand] kids, second time generation. Parents either are in facilities, institutions, or MIA [missing in action] and grandparents don't either have the transportation or the custodial paperwork ... to get eligible to go to food banks."**

Participants also raised **concern about the nutritional needs of children and youth during out-of-school time periods, such as weekends, holidays, and summer break.**

Concern was expressed about young children, such as infants and preschoolers, who do not receive school meals, as well as young adults (17-24 years), who may fall through the cracks of available feeding programs. The need to address hunger among college students with low incomes was highlighted. Already an issue for these young people before the pandemic, one participant said:

- **"COVID made it worse, because they [college students] were at home trying to access courses, not really accessing good nutrition as well, and not knowing where resources were."**

OLDER ADULTS

Older adults, already at higher risk of food insecurity pre-pandemic, have faced new challenges during the pandemic.

- **"During the pandemic, seniors were in the highest risk group [for COVID-19], and food pantry shopping was not an ideal scenario for them."**
- **"So, they really had a double whammy as a group that was at higher risk to begin with, and then they were unable to access their food supports."**

Fear of COVID-19 exposure also was a barrier to food shopping.

- **"People were fearful to go to the grocery stores."**

Senior centers that provided congregate meal programs before the pandemic transitioned to contactless methods of providing food, such as grab-and-go meals.

Some also used volunteers or staff to deliver meals to homes, which provided a brief opportunity to check in and socialize with isolated older adults. *"Meals-on-Wheels does do a lot more than just provide food. It provides that social connection,"* noted a participant. Others commented:

- **"The senior centers actually delivered meals as well to folks who weren't capable of carrying five frozen meals from the senior center to their homes. Partnering with the food banks, all of our senior centers received senior food boxes through the food bank. ... So, our seniors were very, very resourceful during the pandemic, just figuring out how to navigate."**
- **"We had to really be resourceful in getting those seniors connected to groceries. Manna on Main Street has had a program where they deliver groceries directly to senior living facilities, and that's just really an outside-of-the-box, innovative way to be connecting people who are eligible for food support."**

For older adults in poor health and those living in or near poverty, **lack of working kitchen equipment and health impairments, such as loss of manual dexterity or cognitive decline, can make it difficult to prepare food.**

- **"It's one thing to give somebody a 35-pound box of produce, but if they go home and don't have a refrigerator, what have you really accomplished? You can say, 'Yes, we gave them healthy food.' But [if] they have no way to store it, if they have no way to safely prepare it. If they have no way, you know, no place to eat it. You know, [with] COVID, it was grab and go, but the question for those without housing, grab and go where?"**

With more home deliveries to people in need during the pandemic, these issues are frequently coming to light, the participant said.

SUGGESTED ACTIONS

Several participants emphasized that the emergency food system is a temporary solution to addressing hunger, and more long-term, sustainable solutions are needed to lift people out of poverty and food insecurity. Their suggestions include:

Work to ensure more equitable access to food assistance programs and resources throughout the region.

- **"What we're really concerned about is, where are those high-need communities with low resources and how [can we serve them] better?" Are there communities and … individuals who have no access at all?"**

Hospitals could partner with local organizations to collect and share data to assess and address food access disparities in different communities. Data collection tools also are needed to measure progress toward food security goals. To ensure equitable access to resources, people from under-resourced communities also need a voice at the table.

Before patients are discharged from the hospital, provide "warm handoffs" to connect them with community health and social service organizations that address hunger and other needs.

Hospitals need to "*make sure that folks are connected to benefits,*" and *"get signed up [for] those resources that they're eligible for, to make sure that they're getting appropriate nutrition and other kinds of assistance they might need,"* one participant said. Another said: *"I would like to see the hospitals actually enroll people in benefit programs rather than doing referrals,"* including enrolling eligible individuals in SNAP and public health insurance programs, such as Medicaid and Medicare.

Increase collaboration and resource-sharing between hospitals and community groups that are working to increase healthy food access.

"Food is important to our operation as a church," said the pastor of a Black congregation, which already collaborates with a local health system that provides free nutrition education workshops and other health programs at the church. More such efforts are needed, the participant advised:

- **"How can hospitals with their collective power and resources be able to make it [so that healthy foods] drop very, very easily into people's hands?"**

Build the evidence base to document the clinical benefits and cost savings of a nutritionally sound diet to prevent or manage common diseases.

- One participant noted the groundbreaking work of MANNA in Philadelphia, whose research has shown the positive impacts of a medically tailored meal program for people with serious illnesses: *"As health systems are thinking about how to improve health and prevention efforts, … being able to tap into some of that research might be helpful in the long run."* Such research also could encourage more insurers to help cover the cost of healthy food for at-risk individuals.
- Another model partnership that was cited: Geisinger health system's partnership with the Central Pennsylvania Food Bank, which distributes fresh food to patients with diabetes and their households.
- Another participant called for hospitals to share relevant data with community groups to better inform local efforts to increase healthy food resources; for example, demographic data and information on local trends related to food insecurity and diet-related conditions, such as childhood obesity.

Increase outreach to raise awareness and utilization of food assistance programs.

Many participants noted that while the region has a tremendous number of emergency food agencies and other food system resources, helping people find and connect to what they need is often a challenge. Also, because many people lack online access or digital skills, several recommended developing communications that do not rely exclusively on technology. As one participant put it: the *"good old fashion way, going back to the basics of communicating with people rather than relying on them accessing technology."* She suggested, for example, printed cards listing food pantries and other resources that churches could distribute to members. Of note, the MontCo Anti-Hunger Network recently completed its "Build Back Better" strategic planning process, with an important goal being the creation of a communications platform to better connect consumers and service providers with available resources, a representative said.

Provide services that distribute food directly to people where they live, especially in neighborhoods with limited or no access to healthy food.

- **"Food trucks are the biggest new thing now. Why can't we have food trucks that go around the neighborhoods to give out fruits and vegetables and give out … all the canned goods that are sitting in food banks that people aren't able to access? … We have Uber Eats. Why can't we have, like, Uber Helps? You know … just call your local food pantry and ask what you need, what you like and they'll bring it to you."**

Donating healthy food in community settings that already bring people together, such as churches, can help remove the stigma of seeking food assistance. "*When there are non-stigmatized ways of being able to get the help, folks respond*," said a participant. Speaking about her church's community garden, which gives away fresh produce, she added:

- **"With the gardening program we have, it's removed the stigma, because everybody grows—poor, rich, middle—it's for everybody."**

Increase affordable transportation options for people who cannot drive or get rides to emergency food or other needed resources.

Participants pointed to the need for better transportation options for people in both rural and urban areas of southeastern Pennsylvania.

HOUSING AND HOMELESSNESS

PHILADELPHIA COUNTY

To assess needs and opportunities to address housing issues in Philadelphia, focus groups were conducted with representatives from area organizations that address housing and related social services. Information was also gathered from geographic community discussions in Philadelphia; where relevant, comments from those discussions are included below. Across groups, participants discussed a range of issues related to housing insecurity (the risk of losing one's home), habitability (encompassing environmental exposures to mold, lead, or other unsafe housing conditions that pose a risk to health), and homelessness.

OVERVIEW

Safe, stable housing is important to both physical and mental health and well-being. The average life expectancy for a person without stable housing is 27.3 years less than one with a stable home. Health issues associated with housing instability include behavioral health issues (e.g., mental distress, depression, developmental delays in children), chronic medical conditions such as asthma, decreased access to or delayed care, and increased use of the emergency department, according to an American Hospital Association report. Healthy People 2030 highlights objectives for housing instability and habitability related to cost, exposure to lead or secondhand smoke, accessibility, and safety for older adults and people with disabilities, as well as access to mental health services for adults experiencing homelessness.

One of Philadelphia's greatest housing challenges is the age of its housing: 90 percent of all housing is more than 30 years old and often in need of repairs, exposing occupants to myriad potential health and safety hazards. According to Philadelphia's Healthy Rowhouse Project, "Nearly half of the homes in Philadelphia with health-related repair needs have children or seniors living in them." It cites research that shows that more than a quarter of older adults in Philadelphia live in a home with damage to the roof, plumbing system, or heating system. Older adults in homes with health-related repair needs are far more likely to have chronic conditions, visit the emergency room, or experience falls. Moreover, about 40 percent of asthma diagnoses in children can be attributed to risk factors in the home.

Lack of affordable housing is a major driver of homelessness in the city. According to the Pew Charitable Trusts' report *The State of Housing Affordability in Philadelphia* (released 2020; based on a 2019 survey), 40 percent of residents said they had some difficulty in making their mortgage or rent payments. Citywide, 54 percent of renters are cost-burdened (meaning they spend more than 30 percent of their income on housing); for those earning less than $30,000 per year, that figure jumps to 88 percent. Geographically, West, Southwest, and North Philadelphia have higher rates of housing cost burden.

According to the Philadelphia Office of Homeless Services, about 15,000 people access the city's homeless services each year and thousands more are at risk of homelessness. A third of the beds available in Philadelphia's homeless assistance system are temporary shelter, 20 percent are transitional and rapid rehousing, and 44 percent are permanent housing for households with someone who has a disability. Of those served in fiscal year 2021, 23 percent were under the age of 18 and 22 percent were age 55 or older (the latter group is expected to increase as the population ages). Of those served, 78 percent were Black and 58 percent were male. In the 2021 Point in Time survey, 45 percent of individuals experiencing homelessness who were surveyed reported having a mental illness and one-third reported chronic substance use.

SOCIAL DETERMINANTS LEADING TO HOUSING INSECURITY AND POOR HABITABILITY

In Philadelphia, lack of affordable housing, widespread poverty, and high rates of community violence are obstacles for adults seeking safe and sustainable long-term living situations.

Participants identified the need for more affordable housing, both subsidized and unsubsidized, as a priority. As one participant shared:

- **"There is a dire shortage of affordable housing so even if someone has a plan, there may be a lack of units available."**

Another participant remarked that:

- **"Preservation of publicly assisted affordable housing" is essential.**

Participants cited the need for more rental assistance programs to help those with low incomes pay for housing and other basic needs to prevent homelessness. (Note: The largest form of public subsidy for affordable housing is the Low Income Housing Tax Credit Program, which guarantees affordability for at least 15 years. Many of these developments are approaching the end of their affordability period, allowing them to potentially move to market rate rents.)

To support long-term neighborhood stability, equitable community acquisition fund programs also are needed, participants said. With these fund programs, a local jurisdiction (e.g., a state or nonprofit) creates a pool of capital to provide low-cost financing to secure sites for development or preservation of affordable and mixed income housing.

According to several participants, **individuals at risk of homelessness and others in need of stable housing may not be receiving services for which they are entitled and that are critical to *"keeping them healthy and housed."***

Obtaining assistance with these services can help people with low incomes stretch their budgets to cover rent, utilities, food, health care, and other basic needs.

- **"Most people experiencing homelessness, and many of the people who are renting but not yet homeless, are living on less than $20,000 a year... if your income is really $800 a month, plus food stamps, that is not enough money to live on."**

Managed care organizations often help pay for home delivered meals and transportation to health care for eligible patients. However, people are often unaware of *"where to go to get help."* Access to technology, such as phone, internet, and computer devices, also is needed to connect those in need of health care (including telehealth) and other services.

Participants cited the importance of Rapid Re-housing Programs, which work with landlords across the city to increase access to affordable housing, helping individuals and families to quickly exit homelessness and return to permanent housing. Many are *"everyday people, down on luck or in the midst of poverty and now getting a chance."*

HABITABILITY

The city's aging housing stock, combined with blight and vacancy, all lead to a lack of safe, affordable and habitable housing. Persistent poverty for both homeowners and private landlords can lead to deferred maintenance.

Lack of habitability was highlighted by participants as a range of concerns, such as lack of kitchen equipment (working stove or refrigerator) and leaky roofs. In addition, poor quality of housing renovations and repairs may result in future environmental health exposures, such as high lead levels found in children, due to lead dust contamination after improper scraping or removal of old lead paint.

Barriers to improving habitability include the cost of repairs, the ability to get financing, and, in some cases, confusion over a home's legal ownership title (tangled title), making it difficult to apply for public assistance for repairs.

- **"Many people need to have their homes repaired but there is also a lot of tangled title issues, which prevent people from accessing resources to repair their homes."**

Private landlords may themselves be impoverished or lack resources due to non-payment of rents and need assistance to make repairs. Or they may have the capacity to make the repairs but are negligent, in which case legal intervention may be necessary.

The COVID-19 pandemic has created supply chain issues and labor shortages that also have deferred home maintenance and repairs.

During the pandemic, fewer homeowners have received repairs through the city's Basic Systems Repair Program (BSRP), which provides free repairs to correct electrical, plumbing, heating, limited structural and carpentry, and roofing emergencies in eligible owner-occupied homes.

- **"There's been about an 80% drop between 2019 [before the pandemic] and 2020 for the BSRP home repairs, primarily due to COVID. The longer maintenance is deferred on a home, the more housing-insecure the household becomes."**

Another repair-related challenge is controlling infestation

Lack of community cleanliness, such as garbage near housing, and vacant properties encourages rodents or other infestations. Also, multiple landlords can own properties in a single block, making pest control difficult – for example, a home that is treated for pests can easily become reinfested if neighboring homes remain untreated. In many cases, identifying all property owners and landlords for a residential block or area with infestation problems can be problematic.

- **"No matter how much you are cleaning up … and the landlord comes in and sprays, there are still the rats and mice. They go to the other houses, but then they come back … so that's the struggle."**

Small landlords who are unable to maintain their properties or pay their mortgages may sell to outside investors, which can result in higher rents and less available affordable housing. Especially during the pandemic, *"Small landlords have been unable to maintain their properties [and] stay up on their mortgages,"* a participant said. In addition to reducing habitability, *"we're losing affordable housing there, which leads to additional housing insecurity."*

HOMELESSNESS

The Office of Homeless Services uses a crisis response system that includes a centralized intake system that prioritizes housing based on an individual's vulnerability. Application is done by phone, online, and through homeless outreach in the community. *"There is shelter, and we will move heaven and earth to get people into some place,"* one participant emphasized.

However, preventing homelessness "*at the front end*" is key.

As one participant stressed:

- **"While a crisis response system is necessary — it's life or death — we never want to drive solutions towards shelter, we want to drive solutions to putting shelters out of business, because everybody has a place to live."**

Another participant stated:

- **"We will do everything we can to try and prevent and divert people from coming into shelter."**

According to participants, shelters in the city are safe, clean, and provide housing case management and other services purchased mostly from other nonprofits. A participant shared that during the pandemic, the need for shelter beds decreased, attributed in part to emergency rental assistance programs and other pandemic-related relief funding. *"We also have enough shelter beds, one of those silver linings of COVID…a little money [such as from emergency assistance programs] goes a long way when you're a family living on a shoestring."* However, the pandemic also created challenges for shelters, such as the need for COVID-19 testing as well as isolation and quarantine sites.

Lack of funding for the Office of Homeless Services (decreased by $6 million in the fiscal year 2022 city budget) **was cited as a barrier to providing services.**

The need for resource investment was stressed. One participant said:

- **"You have programs in place that work … What we lack is the investment to expand those programs to scale so we can get out of the shelter business and give people what they really need to prosper."**

CHILDREN AND YOUTH

Participants identified family and youth homelessness as major concerns.

One participant said:

- **"Children and youth are a priority population, because they are still growing and you can interrupt generational poverty and alter their future by investing early."**

Youth who are aging out of the child welfare system, in particular, need assistance to be connected to supportive housing resources and other services to meet their needs.

Homelessness among children and families is often missed.

More assessment by health providers is needed to help identify the issue and make timely referrals to services. Often, families may be

- **"doubled-up in really precarious situations. ... If children's health needs aren't taken care of, you're going to see an increase in using the health care system as well."**

The pandemic has made it difficult for youth and others in abusive households to reach out for help to access shelter or other services.

- **"The pandemic and virtual schooling took away that safe place for kids and survivors to access resources. ... I think it diminished the likelihood of people coming into the shelter... it's hard to make a call from a bathroom ... if you can't go to the library, if you can't go to a friend's house, if you can't get to the school to find a safe place to make the call, then you don't leave."**

Women and children dealing with domestic violence may need to seek shelter or transitional housing for safety reasons, several participants noted.

Pregnant or postpartum women who enter shelters to escape abusive relationships are an especially high-risk group.

- **"We have a lot of people coming in with children ... we also have a lot of health issues related to prenatal care ... in many cases not having received medical care because of the abuse. ... They come into the shelter in late-stage pregnancy or having just had their child and very likely suffering from postpartum depression, may not be providing early childhood or infant care."**

OLDER ADULTS

"We are seeing a graying of the homeless population," said a participant involved in addressing homelessness. *"The population's getting older and there are very limited, dedicated resources [for older people who are homeless]. [There] used to be more [resources for older adults], but not as much anymore."* For many older adults living on social security, *"that is not enough money to live on,"* increasing the risk of homelessness, one participant said.

Many older adults live in aging homes in disrepair, posing risks to their mental and physical health. Older adults living on fixed or limited incomes may not be able to afford these needed repairs.

Community residents shared:

- "We have so many elders that are living in unsafe homes. There's been a lot of deferred maintenance because of poverty, but the basic systems repair program doesn't do as much as it needs to, and … [the repair program] doesn't have enough money to really service even a quarter of the actual need."
- "In our older neighborhoods, elderly neighborhoods…their houses are in disrepair, they don't have the finances to get them fixed, and in a lot of these old wooden houses, there are a lot of problems with mold. Toxic mold that is not being addressed [is] affecting their health through asthma, through just breathing, breathing in the toxic air, and the effects that comes along with mold."
- "They don't have any way to address all these repairs … and they're like stuck in a cycle. Because if they fix the mold, now they can't pay the electricity, and they can't pay the gas, and that then does nothing but – it adds to their stress."

In addition, **home modifications**, such as grab bars in bathrooms and stair lifts, **may be needed to prevent falls and allow older adults to age safely in place**. Programs such as the city's Adaptive Modifications Program provide funding to assist older adults with these necessary changes.

OTHER GROUPS

Individuals in reentry after incarceration and those with a criminal justice record need assistance and support to overcome obstacles to obtaining housing, multiple participants said.

- "It's a bigger population than I think we want to acknowledge exists out there."
- "Part of my business is to work with folks from the criminal justice system who are reentering back into the community. It's not just for 55 and older, it's also for those who are younger, who also face challenges with obtaining housing. … We will accommodate emergency shelter, which is far from ideal for someone coming from incarceration in prison, and then they're in another institutional setting. So, this has been a frustration, that there is not enough housing resources for participants exiting incarceration settings."

Master leasing programs, in which a nonprofit organization leases a number of rental units, then subleases them at affordable rates to eligible tenants, are one approach to help people in reentry obtain stable housing. For example, Philadelphia Health Management Corporation has a program that provides housing and wrap-around services for individuals in reentry who also have opioid use disorder. However, *"there needs to be more organizations willing to take the risk to do this type of housing support for individuals,"* said a participant.

SUGGESTED ACTIONS

Drive solutions that prevent homelessness.

- **"Get out of the shelter business and give people what they need to prosper."**

Hospitals can advocate for livable wages, more affordable housing, and services that support aging in place. To prevent homelessness due to fire, participants also pointed to the need to continue to provide fire safety programs in schools and raise awareness about the availability of smoke detectors through the Fire Department. Some organizations, such as Resources for Human Development (RHD), assist with technology needs, which can help people access resources, such as rent and utility assistance to improve housing security.

Increase investments by hospitals, managed care organizations, and others in programs known to be effective in reducing housing insecurity and preventing homelessness.

Given that hospital inpatient and emergency room utilization costs are driven in part by homelessness, encourage hospitals and health insurers to invest in evidence-based supportive housing programs. These programs, which have been shown to reduce healthcare costs, provide housing and rent subsidies along with wrap-around services to prevent homelessness and re-incarceration. In Philadelphia, examples include programs offered by the People's Emergency Center, Impact Services, ACHIEVEability, Pathways to Housing, Project HOME, Broad Street Ministry, Philadelphia Health Management Corporation, RHD, and the Philadelphia Department of Behavioral Health and Intellectual disAbility Services.

- **"RHD operates the pilot Housing Smart with Temple, Keystone, and Health Partners Plans. We've seen a 70% reduction in ER use for the participants we've housed."**

Explore strategies that aggregate funds to support rental assistance, such as Chicago's flexible housing voucher model. Encourage health systems and health insurance providers to invest in rental assistance.

Hospital systems, along with others, can explore development of an equitable acquisition fund to preserve and create affordable housing.

Evaluate existing hospital housing investment programs, such as those offered by Temple and Children's Hospital of Philadelphia, **for potential expansion.**

Expand programs that support habitability to enable aging in place, such as Habitat for Humanity and the CAPABLE (Communities Aging in Place—Advancing Better Living for Elders) program, Philadelphia Corporation for Aging's Senior Housing Assistance Repair Program (SHARP), Rebuilding Together Philadelphia, and the Healthy Rowhouse Project.

Increase Rapid Re-housing Programs. These programs help individuals and families to quickly return to permanent housing, while also building community and landlord relationships to increase affordable housing.

Train and encourage health care providers, including primary care physicians, to conduct regular housing insecurity assessments for patients, particularly families, and make referrals as appropriate. "*A lot of time, family homelessness is hidden*," noted one participant. Screening for housing insecurity is vital to help connect those at risk to services and resources. Also train health professionals and social service providers to use a trauma-informed approach when caring for individuals who are experiencing homelessness or housing insecurity.

OLDER ADULTS AND CARE

BUCKS COUNTY

OVERVIEW

According to the 2019 American Community Survey, older adults make up 19 percent of Bucks County residents (120,628 older adults). This population, which is predominantly white (93%), is growing as baby boomers age and people live longer. Nearly 40% of older adults in the county live alone and 27 percent have a disability. Almost a quarter (22%) are employed and 42 percent have an educational attainment of high school or less. About one in ten has an income below 150 percent of the poverty line. Among older adult renters, nearly two thirds (61.2%) pay more than 30 percent of household income on rent.

To assess needs and opportunities to improve the health of older adults (age 65 and older) in Bucks County, a focus group was conducted with representatives of area organizations serving older adults. The needs of older adults were also discussed in geographic community discussions with Bucks County residents; where relevant, comments from these discussions are included below. [Please see the summary of Bucks County geographic community discussions for further details.]

SOCIAL DETERMINANTS OF HEALTH

For older adults with fixed or limited incomes, meeting basic needs for housing, transportation, and food is difficult, increasing their risk of mental and physical health problems. *"Anything extra that comes up, they have to start making choices between food and other necessities. … We see a lot more seniors needing assistance with anything extra that may come up in their lives."* Challenges meeting basic needs, cited by multiple participants, are detailed below.

Lack of affordable housing and support for aging in place.

- While many older adults want to age in place, obtaining home health care and other home services is often difficult. Many older adults cannot afford to make home repairs and programs to assist with repairs are insufficient. Many also cannot afford senior living communities, while for others, rising rents threaten housing security.

  "All these fancy developments that … are popping up. Most of our population and [our] clients cannot afford them."

- **To enter subsidized housing in the county, wait lists are long.**

  "Hundreds and hundreds of people," often wait a year or longer. "It's definitely a burden for anybody looking into subsidized housing."

- A participant from a social services organization commented on a **growing number of referrals for older adults who are experiencing homelessness**, with some living in their cars or outside.

  "We have definitely seen an increase in seniors in referrals that are coming in. … I think seniors are particularly vulnerable if they're living in their cars or outside. More services [need to] be available specifically for seniors who are homeless."

Transportation barriers.

For those who don't drive, getting to healthcare providers or other services is a major barrier, particularly in rural areas.

- "If someone's living in Upper Bucks, there's not a lot of opportunity to get to different places unless you have your own vehicle or a friend or somebody that can drive for you."

While some local organizations have volunteers who drive older adults to services, *"there's not really the bandwidth here in the county that we need."* Ride services (e.g., Lyft, Uber) are available, but the cost of these services is a barrier for some, as is access to and ability to use technology to schedule rides. Several participants noted that some older adults also have difficulty using Bucks County Transport (a nonprofit organization that provides shared rides for residents) for needed services, such as getting to medical appointments.

Food insecurity.

Local organizations have stepped up food donations during the pandemic, but more efforts are needed to provide nutritious food for older adults, especially those who are homebound.

- "We do luckily have some programs available to provide healthy food to seniors [on a] limited basis. … More widespread opportunity to provide healthy food to seniors that don't have the ability to leave their homes [is needed]."

HEALTH CARE ACCESS

Participants discussed a range of barriers that limit access to health care for older adults, including:

Lack of understanding about Medicare and other insurance barriers.

- "Seniors are overwhelmed with Medicare information, scam calls, internet scams and they are fearful and paralyzed and do not know who to trust."

Older adults may not realize that hearing aids, vision, and dental care may not be covered by their Medicare plan. Delays in reimbursement or lack of coverage for home health services may prevent some older adults from aging in place.

Need for care coordination and support.

Older adults often need help from an advocate or companion to make medical appointments or navigate other health care.

- "Many of them just don't have anybody to help them through this process, so if they can't do it on their own, it's gonna be a struggle. Many of the seniors that we see live in their apartments by themselves. Unless somebody can come in and help them with that, they're not gonna be able to figure it out themselves."

Lack of trained and affordable providers.

Participants mentioned a shortage of home health workers; a lack of medical providers trained in geriatrics (including geriatric psychiatrists); and the need for more providers to focus on the whole person, not each separate diagnosis. A participant also commented:

- "It's been hard for agencies to keep a full staff of CNAs [certified nursing assistants]."

Lack of power of attorney or legal guardianship documents.

For older adults who become incapacitated and refuse care for a behavioral or physical health issue, the ability of family members and healthcare providers to help is limited if power of attorney or legal guardianship is not established.

- "Sometimes, we will get referrals from physicians' offices or hospitals [to provide care], but if there's not any natural supports in place [e.g., a family member or trusted friend] or guardian or power of attorney, they still … have free will. We can't force anybody [to receive care] unless it's a mental health crisis, where it would be an involuntary [commitment]."

IMPACT OF THE COVID-19 PANDEMIC

The pandemic has worsened many existing barriers to care and created new challenges for older adults, including:

Increased social isolation and loneliness, exacerbating mental and behavioral health issues, were a top concern for all participants.

- **"Some seniors in our county, and some seniors everywhere, just do not have enough social connections. And the pandemic has certainly made that worse for a lot of folks."**

For older adults who have long been coping on their own with mental health challenges, the added stress of prolonged isolation may be overwhelming, prompting some to finally seek help.

- **"We've had some say to us, 'you know, I thought it was okay dealing with this and then I was stuck in my apartment house.'"**

On a positive note: As COVID restrictions have eased, YMCAs in Bucks County are seeing older adults returning "*in droves*" to stay active and socialize.

- **"Coming out of the pandemic as an organization, we [were] expecting seniors to be very hesitant to come back and be around others, because of the health risks. And they ended up being like the first group and the largest group of people coming back to our facilities, and still are. So, the value of socialization for them is huge."**

Delays in or avoidance of care.

Many older adults who put off medical care earlier in the pandemic are again seeking care as restrictions have eased. As a result, *"appointments piled up,"* overwhelming system capacity in many cases and further delaying care. Others are continuing to delay care because they "*still have a lot of fear and trepidation about going out.*" Stigma associated with mental illness leads some to avoid care. Others are hesitant to let service providers visit their homes, due to fear of exposing an unsafe home environment or other conditions that might threaten their ability to age in place. Especially for older adults with dementia or hoarding issues, *"they're fearful if somebody comes in and it [their home] is really in poor condition that they will be removed, or somebody will take their home away."*

Use of telehealth.

The shift to telehealth during the pandemic has been an obstacle for the many who lack computer technology, digital knowledge, or both.

- **"We've seen a shift to telehealth, and yet we know that all of our seniors aren't equipped either with the hardware or [having] the understanding or learning how to navigate. So, I think that shift has left some of them behind."**

Using online portals to sign up for COVID-19 vaccines also has been challenge for many.

- **"Signing up for their vaccine and such, and other appointments — their capability was just not there."**

SUGGESTED ACTIONS

Participants noted several initiatives that are working well to support older adults and should be sustained or expanded. For example: *"Some of the local senior centers are super coordinated with reaching out and checking on some of their members [such as] during the lockdown, as well as the vaccine rollout -- keeping their members and members of the health community informed of what they were able to offer."*

Several participants also cited the benefit of increased collaboration among community organizations working to address food security and other services for people in need, including older adults. *"I think some organizations working together … have really, over the last several years, improved access to healthy foods. We still have certainly a way to go, but I've seen a lot of movement in a positive direction in the last several years."*

Participants offered additional suggestions to improve the health and well-being of older adults in the county:

Increase services to help older adults age in place.	These needs include affordable home health care and programs to assist older adults with critical home repairs and other basic needs, such as food delivery for homebound older adults and utility payment assistance. • "Particularly for the seniors that can't leave their homes, more opportunities for healthy foods [are needed]."
Expand access to safe, affordable housing, including subsidized housing.	• "I would underscore the lack of available low-income housing. It just has so many impacts across the board. I don't know that's a problem that a healthcare system can solve, but it is one that I think is just cross-cutting for many residents and seniors who are on fixed incomes in particular." Resources to prevent and address homelessness among older adults also are needed.
Train community health workers to check on and support vulnerable residents, such as older adults who want to age in place.	These providers could • "work along with social workers … to be the eyes and ears in the community and feet on the ground … and connect with people who are vulnerable."
Create more opportunities for older adults to have social interaction in homes, community sites, and through technology.	• "Just any kind of interaction -- it's being craved right now by everyone, specifically the seniors that have been so isolated. … Even ones who have family, they didn't get to see them for so long. Anyone living alone is, you know, extremely isolated and missing … one-on-one interaction."
Create intergenerational opportunities to address community needs, such as through mentoring, intergenerational service provision, and education.	• "Seniors need more IT training and youth can benefit from life experiences. Seniors are also lonely and would welcome the company."

RACISM AND DISCRIMINATION in HEALTH CARE

PHILADELPHIA COUNTY

OVERVIEW

Increasingly, racism is recognized as an ongoing national public health crisis that needs urgent attention. The COVID-19 pandemic, especially, has unmasked and amplified longstanding health and economic disparities related to race and ethnicity. For example, Black residents experienced the highest COVID-19 infection, hospitalization, and death rates in Philadelphia, according to the Philadelphia Department of Public Health. Health inequities, driven by poverty and other social needs, persist across racial and ethnic groups. In the 2020 *Health of the City* report, Black and Hispanic/Latino communities were more likely to describe their health as "fair" or "poor" than their white counterparts.

In the aftermath of George Floyd's killing in May 2020, many area hospitals and local organizations have intensified efforts to address inequities that have long been ignored. For example, a collective of 13 southeastern Pennsylvania hospitals announced a shared commitment to combat racism, inequality, and discrimination in all its forms. The Philadelphia Board of Health also declared racism a public health crisis, stating that: "African-Americans suffer higher rates of nearly every adverse outcome – from heart disease to cancer to violence and even the recent epidemic of COVID-19 infection – owing to the impact of racism on social disadvantage through inadequate education, discrimination in employment and housing, poverty, mass incarceration, residential segregation, and racial trauma."

To understand the impacts of racism and discrimination on health care, and to identify community-driven solutions to address health disparities based on race and ethnicity, a focus group was convened with community leaders in Philadelphia who serve and advocate on behalf of Black residents and other historically under-represented groups, including immigrant communities.

IMPACTS OF RACISM AND DISCRIMINATION ON ACCESS TO CARE

Participants discussed a wide range of negative impacts of racism and discrimination on healthcare access and delivery in Philadelphia:

Fear and distrust of health care.

As one participant noted:

- **"there's a long history of why Black folks distrust medical care in this country, given the way that Black folks have been treated by the institutionalized health system in America."**

For example, one participant talked about racial inequities in pregnancy-related deaths, which disproportionately affect Black women—a fact that has instilled fear of seeking maternal health care among some women, she said. (Note: According to city data, non-Hispanic Black women accounted for 58% of pregnancy-associated deaths from 2013 to 2018, even though they accounted for approximately 43% of Philadelphia births during this time.) As one participant recounted:

- **"Being a Black woman in Philadelphia, ... the Black maternal mortality rate is really traumatizing, is horrific, it's disgusting. That we have to go through that personally, I have gone through that fear of not wanting to deal with doctors or [not] wanting to--and I'm going to keep it very real here--get pregnant because I might die ... in giving childbirth. ... We've seen it too much, it's just like it's a pandemic within in [and] of itself."**

Implicit bias among providers.

One participant commented that providers are less likely to prescribe pain medication to Black patients than others.

- **"They ... think we have a high pain tolerance; we're denied pain medications and maybe they think we're drug abusers. So, the implicit bias is rampant and explicit bias."**

In the participant's experience, doctors too often are likely to recommend hysterectomy to treat uterine fibroids in Black women, instead of discussing other treatment options that would preserve fertility.

- **"The stories that I've heard from friends, from my sisters, from cousins, from coworkers, is that when they go into the doctor's office, and they want to talk about the fibroids, and they want to get them removed, doctors want to do a hysterectomy, they want to take everything out."**

Lack of empathy and respect.

As one participant noted:

- **"I have personally experienced racism--poor bedside manner, just lack of attention to care, tests I was supposed to receive that weren't given,"**

Another participant, who works with many Black and Hispanic/Latino families, added:

- **"What I've seen amongst families is that people [providers] don't know how to talk to them, they're rude, they're quick, because insurance companies telling doctors and healthcare professionals, you can only spend a certain amount of time per patient, they don't understand the information that's been explained to them."**

Others shared negative encounters with healthcare employees who were dismissive, inattentive, or rude:

- **"The assumption that if you're Black, you're uninsured or otherwise less worthy of care. I have, in the past, [not had] care been given to me until they saw my medical insurance. And then they realize, 'oh, you're employed,' and then I have to school them on not only my employer, but I'm educated, and I live in a certain zip code, look at that zip code. And I should not have to do that."**

CULTURAL AND LANGUAGE BARRIERS

Participants who work with immigrant populations described similar barriers to health care stemming from bias and discrimination.

- **"I am dealing with immigrants and refugees every day. And the stories and the experience that they have is really sad, that gives you a feeling that ... nobody is caring about people anymore. I have heard that immigrants have [been] denied medical care, ... because they were Muslim. They're not giving them the proper health care, which is very sad."**

Another participant whose organization works with immigrants shared that:

- **"Our clients, many have low English proficiency and making phone call appointments or telehealth has been really hard, for a lot of [them]. We'll have phone operators who just hang up on our clients, because they don't want to navigate the conversation and spending the time to communicate clearly. And we have a lot of clients who will come back to us, [after] we've set them up with an appointment, ... and they come back and like, none of their questions have been answered and follow up care, they have no idea what the next steps are."**

Language services are often inadequate for people who lack proficiency in English.

As one participant noted:

- **"It's just really clear that the communication barrier is really hurting them in terms of follow up care and access."**

Another emphasized the need to improve the selection and training of language interpreters.

- **"I think just the screening of interpreters--and just even the way the interpreters treat the client--is important … I use Language Line frequently. And sometimes I always take down [the translator's] ID number, because there's many times when I'll have to report that there was poor treatment, or they just glossed over what the person was saying, and they weren't specific enough."**

Cultural competence is often lacking in health care, starting with the basic need to treat all patients with dignity, kindness, and respect:

- **"It's just not about language, but it's about just how you actually treat someone, as a human being with kindness and dignity, and I think that needs to be foundational."**

Another agreed, saying: it's about

- **"approaching people … with dignity and making sure people feel included. And that's a universal thing. I understand everybody is stressed at their job, but we've had some very difficult experiences with impatient staff, and that's really dehumanizing and inappropriate."**
- **"Sometimes just the simple act of kindness--just the way someone is spoken to -- can make a difference from the moment they walk into a facility."**

Participants stressed that all healthcare workers who interact with patients, not just doctors and nurses, need to practice cultural competence, starting with showing basic compassion and empathy for others.

- **"I think the way a person enters a facility, and their first contact is extremely important, and the importance of that front desk person, being welcoming and kind, and careful to listen and not impatient, so many times I've seen them, as soon as they find out [that a patient] can't speak a language, they huff, or they like roll their eyes."**

Participants noted that cultural competence needs to extend beyond providing interpretation services to understanding others' customs and cultural practices, including food preferences. *"A lot of food that people are giving [in hospitals] is not culturally appropriate or may not be respectful to one's culture. And that can make a person feel uncomfortable, not at ease."* Another suggested that emergency food *"contain foods reflective of the communities"* where food donations are provided.

More trauma-informed care is needed, especially for people of color, immigrants, and others who have borne the brunt of health and social inequities:

- "Many patients get re-traumatized by the healthcare system, because healthcare workers aren't trauma-informed."
- "I think that staff need to know about trauma to understand what people might have gone through or what they're going through, and how trauma affects them. I visited … clients many times in the hospital, and especially clients who've been in the hospital a long time, and I can see how they're treated, where staff they just get kind of weary, they don't understand why the person is so upset, why they won't eat the food when you're sick."

SOCIAL DETERMINANTS OF HEALTH

Participants discussed how **long-standing disparities in health are rooted in social determinants of health, especially generational poverty, which must be addressed to achieve equity.**

- "We need to talk about racism as violence, poverty as violence, all this stuff as violence. These things are interconnected."

Several cited the **need for more racial and ethnic diversity among healthcare providers and leaders** – while noting that **inequities in education** need to be addressed to build the pipeline of more practitioners of color.

- "If you're not addressing a child's education, how do you anticipate them to complete elementary, middle school, high school go onto college and be able to do medical rounds or behavioral rounds or any job?"

Other barriers, such as **lack of transportation and resources within the community,** further amplify health disparities in marginalized communities.

- "A big issue for some people in the communities [is] where they have to kind of travel outside to get the proper care and help. I don't see their needs being met within our communities."

Another example: insufficient resources to support people who are experiencing homelessness, including those who have mental health issues or physical disabilities. Failure to address their housing needs leads to a *"revolving door for some participants, where hospitalization is looked [at] as if it's a resource for living space."*

SUGGESTED ACTIONS

Train and hire people with lived experience, such as community health workers and community peer specialists, to work in communities that have been historically marginalized.

These workers, who could be embedded in local community organizations, would be paid a fair wage to connect people to care, help them navigate services, and assist as their advocates within the health system. Several participants supported this strategy, commenting:

- "Pay the community peer specialists a proper wage!" and "community peer specialists ... would be grassroots and can advocate for people."

Increase hospital investment in grassroots community organizations that are working to address social determinants of health and related needs.

A participant suggested that when hospitals apply for federal grants, some funds could be allocated to small community organizations as seed money to enable them to start needed programs or support data collection. Another participant commented:

- "Sustainable funding is needed, too. So many good programs die when funding runs out."

Expand and improve the training of healthcare providers around diversity awareness, cultural competence, and trauma-informed care.

- "Doctors [are] going through medical school program without having direct experience with community. So I'd suggest healthcare workers having regular and mandatory training about social issues, cultural humility, trauma sensitive training. Diversity trainers need to be paid if hospitals and these institutions are really serious about this diversity training."

Increase the number of people of color in healthcare leadership positions.

- Especially "those who have experience [working] with those on the ground and folks from various communities."

Create and fund ongoing forums for community leaders to work with health system partners to address issues of racism and discrimination in health care.

Health system partners also need to recognize that asking people who are directly affected by these issues to continually recount their experiences with racism is re-traumatizing. Compensating people for their time and expertise also is needed.

- "People can't just show up here and there to do this work. People need full time sustainable wages with benefits. This is hard work!" Another participant stressed that "people need to get paid to do these trainings. ... Pay the people who are doing the labor. Just because we live in the reality doesn't mean that we want to share it every day and talk about it every day with people. It's re-traumatizing to talk about our traumatic experience, and to educate white folks about what our experience is with racism."

Given that systemic racism has been embedded in American society for several centuries, participants also called for longer-term, bigger picture solutions to creating an equitable system of health care.

Several stated the need for a radical shift in how health care is structured, with a shift away from a capitalistic system to a *"health care for all"* approach. Several envision changing the fundamental delivery of health care to provide universal health care, through "*de-commercializing of the healthcare system*" and *"destroying capitalism and getting universal health care for all."*

VIOLENCE

PHILADELPHIA COUNTY

OVERVIEW

According to Healthy People 2020, violence is a "neighborhood and built environment" social determinant of health that impacts people who are direct victims of violence, as well as those who are exposed to violence and experience resultant trauma. The many types of violence include adult or child physical, psychological and/or sexual abuse, elder abuse, sexual violence, as well as gun and other types of interpersonal violence. Violence can impact the brain, neuroendocrine system, and immune response, resulting in higher rates of depression, anxiety, posttraumatic stress disorder, suicide, and Adverse Childhood Events (ACEs). Violence also increases the risk of cardiovascular disease and premature mortality. The health consequences of violence vary based on the form of violence and victim characteristics, such as age and gender.

In 2021, there were 15,013 violent crimes in Philadelphia, including homicide, rape, robbery, and assault. According to the Philadelphia Police Department and the Office of the Controller, homicides increased 13 percent from 499 in 2020 to 562 in 2021. With 447 deaths, 2020 saw the. most gun-related homicides in Philadelphia in 30 years.

Among victims of gun violence in Philadelphia:

- 21% were fatal
- 88% were male
- 84% were Black (non-Hispanic) and 9% were Hispanic.
- A majority were between the ages of 18-30 (52%) and 31-45 (28%).

According to Philadelphia's Roadmap to Safer Communities (2019): "Gun violence in Philadelphia is largely concentrated in communities that also experience structural violence. Structural violence refers to harm that individuals, families, and communities experience from economic and social structures (economic, political, medical, and legal systems) that prevents them from meeting basic needs; this includes social institutions, relations of power, privilege, and inequality, and inequity." The *Roadmap* provides an overview of, and progress toward, violence-focused strategies and interventions that are initiated before, during and after violence occurs. Its goal: to reduce gun shootings and homicide by 30% by 2023.

To understand the impacts of violence on community health and identify suggested actions to prevent and reduce violence, a focus group was conducted with representatives from area organizations addressing this issue in Philadelphia. Information was also gathered from geographic community discussions in Philadelphia; where relevant, comments from those discussions are included below.

SOCIAL DETERMINANTS OF VIOLENCE

Poverty and the neighborhood built environment were identified as examples of structural violence in Philadelphia. Most participants shared that poverty, food insecurity, and loss of employment during the pandemic were inherent to violence in the community.

- "Poverty is violent, and economic violence is a thing that doesn't get named in Philly. … It's violent to have a society that cannot meet the literal clinical needs. At a certain point, something in the design has to shift, to continue along that route is just violent, when you know that you cannot meet the need."
- "I often think about all of the factors that are leading to violence, and I definitely agree on the fact that poverty is a huge issue … and all of the other things that we know go along with lack of employment and food insecurity, all of these things are impacting what we're seeing right now."
- "Because of the shutdown, we saw a loss of employment for a lot of families and even for younger people. And so I think, already experiencing poverty and then not being able to work on top of that are all added pressures for people and I think helps to contribute to what we're seeing in Philadelphia now."

Gun violence and substance use were cited as particular concerns.

One participant described community gun violence as a battleground:

- "Rampant gun violence that's going on, I feel like it's kind of a warzone out here. And then working in Kensington, just seeing the amount of people that are killed or shot constantly, mothers' children being caught in a crossfire, it's disturbing. I think about Gratz High School - you can go in as a freshman in Gratz, and you will probably lose 30 friends by the time you're 18. That's wild. That's unacceptable. That's violent across every level of being."

Substance use, specifically the opioid epidemic, contributes to unsafe neighborhoods.

In the words of two community residents:

- "There's no place for the kids … there's a park but they fenced it up because of all the drugs and things that are going on, all of the homelessness. People are practically pushing their needles in front of your face, and you have to tell them to stop when you are walking with the children."
- "99% of problems related to drugs would vanish overnight were they not criminalized … there'd be no need for turf wars, there'd be no need for gun violence. … How long are we going to do this dance?"

ACCESS TO HEALTH SERVICES FOR PEOPLE AFFECTED BY VIOLENCE

For people who have been direct victims of violence and those exposed to violence with resulting trauma, access to appropriate health and social services is needed. However, participants cited a range of barriers to access needed services, such as dealing with other life stressors, lack of culturally competent care, and stigma associated with seeking care.

Amid the ongoing trauma that many individuals and families face in their neighborhoods, seeking health care may not be a priority in light of other daily challenges.

- "When there's trauma happening, there are a lot of other things that our families are dealing with … and supporting your physical health and mental health does not become a priority. … I'm trying to put food on my table, so it's not even necessarily an access issue, but sometimes it can just be that's not my top priority in my life right now."

Another shared about challenges faced by parents:

- "A mom recently that I was working with here, she lost her job, because she had to take her student, to the psychologist to get evaluated, right. … And then that caused her to lose her home. So now her priority is, I don't have a job and finding a home for her children. … So, she can't really focus on maybe the behavioral health issues that her child has."

Culturally appropriate, trauma-informed behavioral health services are needed in community locations where people can safely talk with trusted providers about their experiences.

An individual who works with schools shared:

- "Working with the families … they are like, sorry, I don't have anybody to talk to about what I'm going through. And it makes me realize, where can our families go to talk about the violence that they experience? … Distrust of the healthcare system, that's another barrier, but I think providing safe spaces for people to talk about the violence that they experience is huge. … Sometimes it's just talking about it, and not holding it in, that's a huge win for some people."

Stigma around mental health, reluctance to seek care, and parental lack of knowledge about mental health diagnoses and services are further barriers to care.	• "There's just a lot of a stigma around mental health and needing that type of service. … And when we say to people, you should go seek out therapy - because of the stigma they're like, oh, I don't need therapy- nothing is wrong with me, I'm not crazy. … And so not using those words, but instead having those opportunities where people can feel safe to speak up." A participant, speaking about a young man he worked with, said: • "He got shot. I said to him, who are you talking to? He's like, 'I'm not going to talk to anybody.' He's not gonna talk to anybody, so you may rush in there to send the therapist in there, he's not gonna talk to them." A participant who works with parents stated: • "There's a lack of understanding for parents about, like mental health procedures, and how students are diagnosed, and things of that nature. So, I think there's an understanding issue, I think there's a lack of communication issue, constantly seeing that and having to fight in systems… families absolutely need advocates, and advocates that they trust, to be able to fight for them."
Lack of clinician diversity and mistrust of the healthcare system also are barriers to care, especially for those who are uninsured, undocumented, or have limited English proficiency.	• "We're working with immigrants, asylees, and refugees. And we're seeing that there's no trust for the healthcare system, some of them are undocumented, and they don't have access to the healthcare system. And so, what we do is we partner with clinics and health centers, and other hospitals to give them access to the health care that they need. … I'm talking about families, not only the boys and the children, but the families, as a whole need access to health care, but they don't have it because of their situations." • "We don't have enough clinicians to meet the need, we don't have enough clinicians that speak Spanish, we don't have enough clinics … we don't have enough Black clinicians."

CHILDREN AND YOUTH

Pandemic-related social isolation, coupled with gun violence, substance use, and other issues, have worsened mental health for children and youth.

- "We are in an ongoing health pandemic, but we're also in the middle of an epidemic of gun violence across the city. The need for mental health is dire."

As discussed previously, **youth and their families need access to mental health services provided by trusted individuals in accessible, safe community locations, such as schools.**

Parents need education and support to discuss stressful and traumatic events with their children.

- "A lot of times, we just think the child is affected by their friend [dying] but it's the whole family [that's affected], because they bring it home."
- "Many of our young people do rely on the services provided by the schools. ...We know that a lot of resources are provided by schools and that teachers many times are a form of support, counselors are a form of support. And I think not having those resources and supports that are wrapping around our young people have contributed to violence."
- "Schools provide a necessary safety net for youth dealing with abuse in their homes."

On the other hand, for some youth, isolation during the pandemic provided a sense of security, while returning to school has raised fears about their personal safety.

A participant who coaches youth shared that, when she asked her players about the impact of pandemic isolation, she was surprised to learn:

- "They felt safer, being at home, some of them ... it didn't affect them in a way where it was that negative. Now going to school, they're afraid [and they say], 'Now I'm watching my back going to school, now I'm not sure what's gonna happen to me when I step out the door.'"

Youth need access to educational and recreational opportunities to reduce their exposure to violence and increase access to support systems. A participant who works with young men in gangs said that **gangs are forming due to poverty and lack of programs that meet their needs.**

- "They're forming these gangs due to poverty, yes. They're also forming gangs due to not having enough programs that are relevant to their needs, it could be educational programs, afterschool programs. The fighting that's going on, it's so common ... and these young boys are being killed, and people are being caught in crossfire as we've lost some students."

During the pandemic, recreational opportunities were lacking. Strategies are needed to increase youth awareness of and participation in activities that help prevent violence.

- "There are many violence prevention programs; any program that provides opportunities for our youth can be deemed violence prevention. The issue is that we live in a city of the "haves" and "have nots." The majority don't have access to these programs."

According to a coach:

- "Our football program, that's a violence prevention program, because it's an opportunity for youth to be involved in an extracurricular activity that's allowing them to know what it means to make team connections, and work with their peers and have trusted adults in their lives, that's violence prevention. ... We have many violence prevention programs in our city, it's a matter of who has access to them. How are we providing more and more opportunities for young people to participate in these types of activities? ... How are we making sure that they see it as something that they really want to participate in and then getting their peers to do it?"

Social media is affecting mental health and suicide rates among youth through peer pressure and bullying.

A participant who is the parent of a teenager shared:

- "How I talk to them about that sort of peer pressure and bullying is much different than what I had to deal with, because we didn't have social media ... when you think about violence and even some of the videos where they show fights and record fights ... it's constantly people seeing it and re-traumatizing that event. So, that's another large piece to this violence."

Social media can also "fuel retaliation" among youth.

- "When we think about retaliation as a main issue, of fueling the cycle, we know some of that is coming from feedback that they're getting both online. ... A lot of the issue is also online now, which is why understanding youth culture is really, really important."

OLDER ADULTS

Violence affects older adults' sense of safety, increasing social isolation for many.

- "The last Elder Circle we had was on violence, and we brought in the police department to talk to them about what their experiences are, and the conversations that we were hearing was that they are afraid to leave home, they are afraid of the police, they don't feel safe in their homes, they don't feel safe going down the street. They're just caught up in this fear that makes them stay enclosed, and when they stay in, they are bottling up everything, they're taking everything by themselves, and they're not able to express themselves to other people, so it's creating other issues for them."

A participant who is an older resident with mobility issues said:

- "I've walked these streets almost 14 ... years without a thought of being harmed, and now I'm very fretful when I walk the streets, particularly if the sun goes down."

Safety concerns using public transportation were noted by community residents as a barrier to accessing health and social services.

- "I've heard from several seniors that need to use the Frankford El to go to the doctors, and they are too terrified because of what's happening, they're afraid to use buses because people are sleeping on them and we just heard about that woman who was sadly, raped. They [older adults] aren't getting the help they need to get to the doctors for their health care."

SUGGESTED ACTIONS

Increase awareness and availability of youth programs to prevent violence, including educational programs, sports, and other recreational activities.

Communication strategies that encompass youth culture and include youth input are needed, as is more funding. A participant who works with students and parents said:

- "I think that having social services in schools would greatly impact and make them (students) feel safer. I think my families feel safer, because they see that you're there to help them, because they send their kids here, and there's a level of trust there."

A participant who coaches youth cited the benefits of a recreational program.

- "We rented a 13-acre field, and we did a COVID protocol, we remained open so that they could come and have that outlet. And what we saw with those young men in that time was nobody was hurt, nobody had been shot, there was a better mental health among them. And I mean, young men would bike all the way from West Philly, to North Philly to be on that field with us."

Integrate social and mental health services into existing youth activities.

Also provide training for individuals who are trusted by and work with youth (e.g., teaching artists, coaches, teachers, parents) in addressing trauma and other violence-related issues. Help parents advocate for needed mental health services. A participant who serves as a youth coach shared plans to integrate mental health into sports programs.

- "I'm just going to bring somebody in who is a therapist, and create a natural scene of mental health, because they're not talking to anybody."

A participant with expertise in the arts said:

- "Working with young people and their families using art and media... particularly with boys, when you use what they know ... like hip hop ... within 20 minutes, people are talking about getting shot what they've seen, I mean, it just all comes out. ... And I realized that there's a kind of a cultural liberty that they recognize to be that honest in the music or to talk about it. It's an opportunity to train teaching artists and art centers that are in neighborhoods."

Create more safe spaces for people to talk about the violence they experience.

- "We need to provide opportunities and safe spaces for people to be vulnerable and not necessarily calling that support "therapy" or "mental health support." Lots of stigma around those words. Language is important and building trust so that people can be vulnerable is key."

Address structural violence issues that impact youth and families in ways that consider biological, psychological, social, and spiritual factors and take into account policy, advocacy, infrastructure, and funding.

- "Making sure that the family has everything they need [such as] food, healthcare services, therapy, making sure that their bills are paid or like light, heat. Offer them the services that they need, so they can have the resources to get things done."

Increase accountability and coordinated action in addressing community violence from the city, schools, health systems, higher education, neighborhood civic association groups, and community-based organizations. As an integral part of these efforts, hospitals can:

- **Increase advocacy on policies to prevent or reduce violence**, including initiatives to address poverty and other social determinants that contribute to violence.

  "Shouldn't the health community and researchers be the ones advocating for health in all policies at a local level in Philadelphia? They are equipped to do that, they have the resources and the research and the tools, and policy advocacy from a think tank kind of perspective that we know drives policy, but they've got to want to step up and do that."

- **Partner with community-based organizations to build on each other's strengths and increase funding opportunities.**

  "There's an opportunity for hospitals to really partner together and really lead the charge of working hand in hand with our community organizations that are on the ground, doing the work, who know and have built that trust from the community, because we know that in some instances, there's not trust of the hospital systems. ... So, having that coordinated approach, where hospitals are helping to lead the charge in a way that we're not all in competition, instead, we're working together and really having a very strategic plan to address this large issue."

FOCUS AREAS AND COMMUNITIES

This section features primary and secondary data focused on health needs associated with particular conditions requiring specialized care (cancer and disability), as well as communities whose needs have historically been less understood or adequately addressed (immigrant, refugee, and heritage communities; youth; and LGBTQ+ communities).

CANCER

Cancer is one of the leading causes of death in southeastern Pennsylvania (SEPA).

County-level data for several cancer-related quantitative indicators previously presented in the geographic community profile tables are shown below for ease of reference:

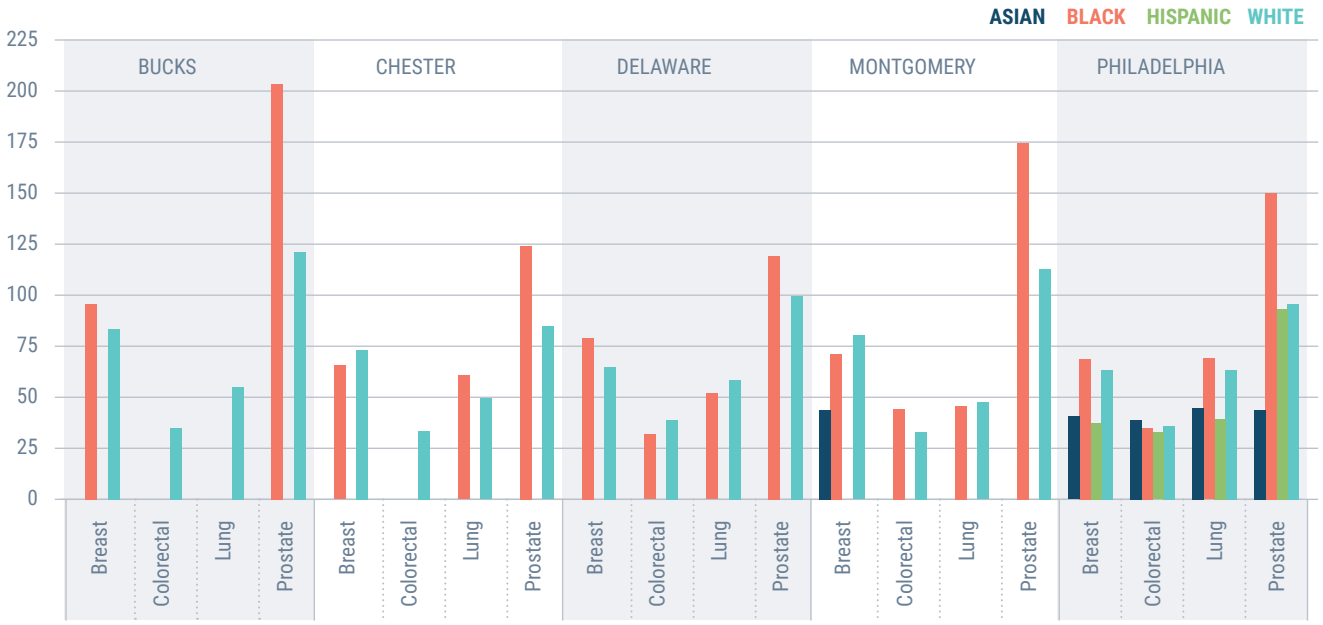
	Bucks	Chester	Delaware	Montgomery	Philadelphia
Major cancer incidence rate (per 100,000)*	308.7	242.9	262.9	286.1	242.5
Major cancer mortality rate (per 100,000)*	91.4	72.8	88.9	85.2	80.3
Colorectal cancer screening**	68.6%	69.5%	65.1%	71.3%	63.5%
Mammography screening**	76.6%	77.6%	77.4%	77.4%	78.3%

* Prostate, breast, lung, colorectal cancers; crude rate per 100,000; 2019 Vital Statistics (PA Department of Health)

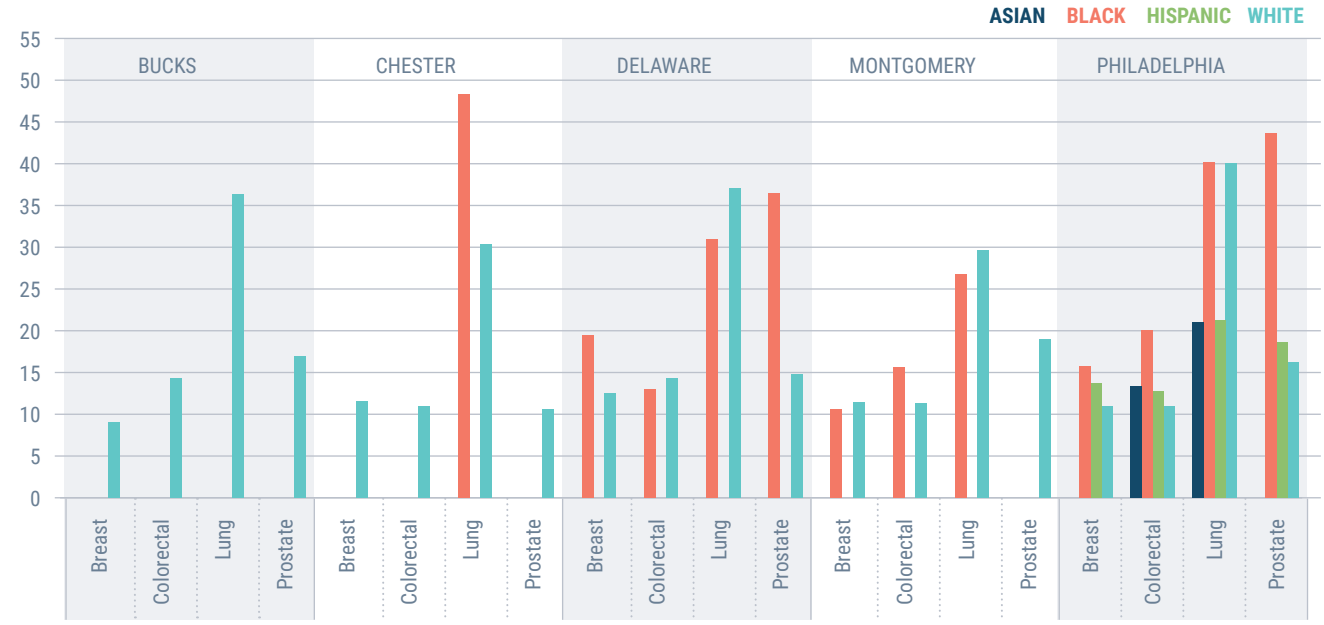
** 2018 Behavioral Risk Factor Surveillance System

Age-adjusted incidence and mortality rates by race for the four most common cancers in each of the five counties, according to 2018 data from the Pennsylvania Cancer Registry on the Cancer Statistics Dashboard, are presented below:

Age-Adjusted Major Cancer Incidence by Race, 2018



Age-Adjusted Major Cancer Mortality by Race, 2018



NOTE: No bar indicates estimate that is unreliable due to low numbers.

These data show not only the extent of cancer's impact on SEPA communities, but also the variation and scope of racial/ethnic disparities in each of the five counties.

In addition to quantitative data, qualitative data about community needs related to cancer were collected through focus group discussions on spotlight topics, including chronic disease, with representatives of community organizations and government agencies serving each of the counties (see Spotlight Topics section for more details). Key insights related to cancer from those discussions include:

- **Lack of information and stigma surrounding chronic diseases can lead to fear and avoidance of getting screened or seeking treatment.** *"One of the things that I saw was fear, fear of getting that diagnosis, and kind of putting your head in the sand,"* said a participant who managed a cancer screening program. *"There seems to be a 'Don't ask, don't tell, don't know, and I'll be okay' kind of mentality."*
- **Stress management and social support are important to optimize care.** *"General stress management is a huge barrier, not only through it, but even after treatment,"* said a participant who works with people in cancer recovery. *"One of the things we also hear is sort of once everything stops, so treatment is done, surgery's done, okay, your doctor's like 'You're good, I'll see you in three months,' or whatever. It's like 'Holy moly, what just happened?' It's like post-traumatic, 'Now what do I do?' "* Some patients also experience "scanxiety" after treatment for cancer—that is, fear and anxiety before follow-up visits to check for cancer recurrence. After a diagnosis of cancer, *"Number one is just feeling they have the support in their life, whether it comes from friends or family, or just support of others that understand what they're going through."*
- With care delayed for some patients due to the COVID-19 pandemic, several participants said **cancer and other conditions are more often diagnosed in later, more advanced stages**. *"The fear of going for those screenings during COVID. A lot of people that typically got yearly colonoscopies or blood work or whatever they're like, 'No, we're going to wait.' And then things exacerbated in that time, so a lot of people are being diagnosed later, in more advanced stages."*
- **Staffing shortages at hospitals, coupled with staff redeployment to pandemic-related care, are further challenges.** Another participant who works at a health clinic added: *"We are currently in major catch-up mode when it comes to the cancer screenings, and then availability of getting folks in … can be months waiting."*
- **With many people working remotely during the pandemic, fewer workplace wellness programs that offer screening and education are being offered.** *"With the emphasis on the pandemic, there may be a lack of awareness even in workplaces about doing screening as part of work and offering it as part of work. Think about that: a lot of people are working remotely, and that's where these things used to be in the office, or that people could gather to a bus [providing mobile health services] that is on office property, the access to that is reduced because of people working remotely."*
- **Environmental exposures.** Indoor and outdoor pollutants were mentioned as risk factors for asthma, cancer, and other chronic diseases by several participants in Philadelphia and Delaware Counties. A Delaware County participant said: *"In the southern part of the county, where we've got a huge industrial corridor, we have a lot of anecdotal evidence of high rates of cancer, asthma, lung conditions, and we're even seeing things like children with chronic nosebleeds, and that shouldn't be happening. … So people are facing chronic illness, but physicians are not necessarily aware of the environmental hazards in the community."*
- **The need to integrate mental health services into overall care management for people with chronic diseases**. *"Mental health is an aspect of everything. If somebody is diagnosed with cancer, they're going to have some depression, some anger, so mental health comes into everything. So, [we need] to have like an umbrella of mental health that goes across the board."*

A final important source of qualitative data to inform the rCHNA process were collected by three cancer centers affiliated with participating health systems:

- Abramson Cancer Center (ACC) at University of Pennsylvania (Penn Medicine)
- Fox Chase Cancer Center (FCCC) (Temple Health)
- Sidney Kimmel Cancer Center (SKMC) (Jefferson Health)

Representatives from each of these cancer centers conducted focus group discussions with community advisory board (CAB) members January – February 2022, based on a standardized discussion guide developed jointly. There was a great deal of agreement across all discussions, with common points that resonate with items raised by the spotlight topic discussion groups above. Full summaries of each of the discussions developed by each team are presented below.

ABRAMSON CANCER CENTER AT UNIVERSITY OF PENNSYLVANIA

To solicit feedback about cancer awareness, concerns, and ideas for addressing cancer control, the Community Outreach and Engagement (COE) program of the Abramson Cancer Center (ACC) convened two meetings of its Community Advisory Board (CAB). There were 19 attendees at the two meetings at ACC. The meetings were held on Zoom, audio recorded, and the recordings were transcribed. The COE lead team created summaries of the meeting along with selected verbatim quotations, and combined both summaries from both meetings into this summary.

In your community (or in the community you serve): Is cancer seen as a health concern?

- It is seen as a concern because it is so **prevalent**. It comes up even in general community discussions about health. *"So many people have family members, if not themselves, who have cancer or have died of cancer or are being treated for cancer. So it's definitely seen as a health concern in the community."*
- There are a lot of **misunderstandings about cancer**, especially related to family history, the different types, the role of the environment, treatment options, and the variety of prognoses/outcomes (i.e., people think there is nothing that can be done if someone is diagnosed with cancer).
  - *"Our people in the community don't think there's any connection between the environment and cancer… that's an area which we really have to start educating a lotta communities about the connection."*
  - *"There's… sometimes a fear about what happens if I do end up with a diagnosis, what will happen then?"*

Do people in your community talk about cancer? If so, what do you typically hear about? If not, why not?

- People often **do not know their family history** or if they know someone in their family had cancer, they often do not know what kind of cancer their family member had. This can sometimes be because medical professionals do not share with patients where the cancer started after it has metastasized.
  - *"I use my cousin as an example. She died before 50 from colon cancer but did not know that there was a family history because nobody in the family shared it. And so she kept being misdiagnosed for something like bronchitis. By the time it was staged, it was end stage."*
  - *"The health system does not do a good job, especially for brown and black people, to explain what was the original point of origin. It's kinda like they have – it's all over….Where did it start? And oftentimes family members never even get that information in order to share with family if they so choose to do so."*
- **Diverging opinions regarding cancer's stigma:** on the one hand, some saw cancer as having less stigma than other diseases/illnesses (COVID/AIDS), but for others, it is harder to talk about cancer than sex/sexuality.
- People are most likely to talk about cancer if it **affects someone close to them**, but it is not top of mind otherwise. *"The people in the community talk about cancer. Not, till they get it and/or somebody close has it because for many people, it's associated – without the education about cancer, it's associated with fatality, and who wants to talk about that?"*
- **Groups where there is general conversation about health** are usually more comfortable talking about cancer. It also might **be easier to talk about cancer when it's discussed alongside other health concerns** rather than on its own. *"Where there is strong advocacy, strong support groups, where you have a lotta survivors, there is a lot of conversation. … Until it hits home, it may not come up as a general conversation."*
- When there is discussion about cancer, the **mental health aspect is often neglected**, which it shouldn't be. *"It was tougher for me to learn how to be a cancer survivor than when I was actually in treatment. I would notice these cycles of anxiety around my appointments, and the weeks leading up, I was just – I would experience things that I never experienced in my entire life with respect to anxiety and just irritability and fear."*

Are there cultural nuances about cancer in your community that should be noted? Are there cultural beliefs or behaviors among your community that make cancer prevention and access to cancer care more challenging?

- Sometimes **religion** plays a role (e.g., "*Can't do anything about it. This is His will*").
- There are potentially **cultural factors** that affect misinformation about cancer and screening and other preventive measures, which could have many long-term negative consequences. For example, cultural ideas about sex prevent people from getting their children the HPV vaccine.
- Other **perceptions in different cultural groups** related to treatment include:
  - There is a myth in the Black community that when someone with cancer has surgery, the cancer spreads throughout the body.
  - When someone must go to the hospital, it is seen as a death sentence—there is not much knowledge around treatment and how people could get better. People do not understand the different between a comprehensive cancer center and a community hospital.
- **Trusted messengers (especially survivors)** are an important factor to consider when addressing cultural factors.
  - Speakers' bureaus would be a great asset to Philadelphia, as only one cancer center currently has one. The speaker could be a physician, health educator, or nurse, depending on the audience.
  - Highlighting survivors' stories and good outcomes of treatment could help: *"Highlight survivor stories, highlight good outcomes in there, and I mean, I think a lotta this is educational, and a lot of it is you're dealing with folks, they don't wanna talk about – they got enough stuff going on, they don't wanna talk about more bad news."*
  - Messages need to be tailored to the group/community, and trusted messengers are key. Organizations can come in and fill this role, too, in some cases. It is especially effective when they have a health and wellness committee/group within the organization.
- Having **resources in both Spanish and English** is important, as well as making sure the materials are written at a level most people can access/understand: "*…we have bilingual staff that can have those conversations, but I think about people walking into other establishments that may not get that in their native language, in a way that they can relate to.*"

Do you think there is good/adequate awareness or knowledge of cancer? Do people seem aware of particular cancers, and if so, which ones? Which cancers do you believe there should be better awareness of?

- Many people do not know about the different kinds of cancer and just see it as one thing. There are varying **degrees of knowledge** related to different types of cancer. For example, there is not enough awareness of blood cancers, lung cancer, or connection between HPV and head/neck cancer. While there is agreement that there is strong awareness of breast cancer, opinions differ about prostate cancer wherein some think there is a lot of awareness and others do not. There is also a lack of knowledge about the **different degrees of cancer** (precision medicine can help with this).
- It takes a **great deal of effort to have sustained interest** in the topic. It can also feel overwhelming to think about and look out for the signs of all possible cancers.
- The **patient-provider relationship** is key, and providers need to not dismiss the concerns that patients bring to them: *"you'll have people going in really trying to advocate for themselves, and you have a healthcare provider that isn't listening…A savvy person may walk out that door an into another healthcare provider door, and sometimes they won't walk into any healthcare provider, period."*
- Communities that need special attention include the **LGBTQ community and people who are pregnant**.
- **Advertising for specific cancer treatments can be confusing** for people. *"The pharmaceuticals have new commercials on TV about various different medications for cancer. If you've seen that come out, there's a slew of 'em out there now, and folks are confused."*

Do you think people in your community know about cancer screening? Do you think some cancer screenings are more well-known than others?

- There is more awareness of breast cancer screening and colorectal cancer screening, less awareness of lung cancer screening. *"There are certainly some others like lung cancer screenings still a lotta people are not aware of. We need to do a better job with that one."*
- Many people don't become proactive about being screened until they know someone personally with cancer.
- It would be great to piggyback off of COVID testing/screening to get more people screened for cancer.
- There has been some success in a drive-by Flu-FIT campaign at Abramson.

If someone wanted to know more about cancer, where do you think they would go? What health information (cancer information) do you think they would trust the most?

- **People in their circles** (family nurse, friends and family, someone close to them, people from their church)
- **Someone who looks like them** is more trusted than someone of another race: *"I've heard directly from survivors and the ambassadors that they want to talk to people that look like them."*
- **People generally trust their doctors and team**, including navigators or social workers at cancer centers: *"…we've done surveys of our community members, and they all say they wanna hear about trials from their doctors."*
- At the same time, people do not always trust that the healthcare system is supporting them, in part because of the huge costs: *"…I know we still have high copays for a lotta different things, but a lotta people don't necessarily feel like the health system is there for them."*
- People may seek out information from the **internet or organizations like the American Cancer Society**.
- For older adults, **partnering with a group like the Philadelphia Corporation for Aging** would be a good idea.
- It is important to **consider the whole person** when educating them about cancer. **Funding** is necessary to take ideas and put them into action.

What could we do better to get the word out to your community about the importance of cancer screening? Where would we place/put them? Who should our collaborators be? What would those messages sound like?

- **Neighborhood, local, ethnic newspapers/magazines.** These are the magazines in their neighborhoods, stores, businesses, and they read them regularly. "*They read the Philadelphia Tribune. They read the Philadelphia Sun. They read the Westside Weekly. They read the Leader."*
- Young people get cancer too, so **social media** is an important outlet for that age group (Instagram, Facebook, Twitter, TikTok), especially with greater use due to the pandemic and not being able to get outside.
- Other important sources include the sometimes overlooked outlet of the **radio, leaders at trusted community organizations, and documents** like infographics with QR codes to websites for further information. A specific resource suggested was a **one-pager** that lists the cancers you can screen for, the age at which you are supposed to be screened, and a phone number for someone within Penn who can help a patient schedule the screening.
- **Variety in messaging** is important—things are not one-size-fits-all. People need to hear that cancer can be treated and you can be a survivor—people do not hear that message often.
- Having **health care in unexpected places** was suggested. Bringing it to where people are, like libraries, churches, mosques, synagogues, supermarkets, parking lots, buses, laundromats, donut shops, and food pantry lines. This ensures that they do not have to worry about transportation or babysitting.

How could we make it easier or more likely that people in your community would be screened for cancer? What are the biggest barriers they face in getting cancer screenings?

- It is important to remember the **social determinants of health**. Some people are just trying to survive, so cancer screening is not top of mind. There are barriers, like the cost of prep for colorectal cancer screening and getting to/from the screening, even when people get signed up/scheduled to be screened.
  - *"Well, if you have a car or you have someone that can drop you off and pick you back up who has the luxury to take off work, who can pay for the parking, all of those things, that they didn't have to come on a bus, there are so many things that we don't consider when we're talking about communities who every day are trying to just figure out how to survive."*

  - *"We don't think about the fact that I could go to the CVS and purchase the stuff for the prep, but everybody doesn't have the resources to go and plop down $20 to $25 to buy the Miralax, the Dulcolax, the – what is that, the Gatorade and those kinda things."*

- **Self-advocacy** is important, too, including empowering people to get a second opinion if they want.

FOX CHASE CANCER CENTER

Fox Chase Cancer Center (FCCC) conducted a focus group with five members of their Community Advisory Board (CAB). For all questions, participants were asked to answer as a voice for the community they serve. The participants are representatives of the following community organizations with whom FCCC closely partners:

- A Hug Saved My Life
- Bethel Deliverance International Church
- FCCC Patient and Family Advisory
- Sista's Daughters Inc.
- Delaware Valley Community Health (FQHC)

Awareness and Knowledge of Cancer

Cancer is seen as a health concern in all the communities represented in the group. Specific concerns include: **access to treatment and screenings, high rates of diagnosis and death, and fear of screenings and cancer itself**. There is also a concern about l**ate-stage diagnosis of cancer** which is occurring more as cancer screenings and doctor's visits have decreased since the start of the pandemic.

Several members stated that many community members **do not talk about cancer and find it taboo** to even discuss their own experiences with cancer. This crosses generations, where many in older and younger generations have been taught not to talk about cancer. Several participants said this was mainly among the African American community. As one participant explained: *"Even my generation, because they were raised by that generation of quietness and so we are trying to break that cycle, but still no one's talking about it, and if they talk about it it's in a whisper."*

Another participant explained that while **breast cancer and others such as thyroid cancer are typically discussed, there are others that are more taboo, such as gynecological cancer**. This is a topic that no one talks about. There are also **superstitions among many cultures**, including the Russian population she works with, that if you talk about cancer you will bring it in to your life. There are also beliefs among many in the community that they will not get cancer and therefore do not need to get screened. As one participant stated: *"Why do I want to do these things to my body, you know I'm not going to get cancer, it's not going to happen to me."* This participant also mentioned that from a male perspective, many men think they are invincible and do not need screening.

Participants stated that there is a lot of knowledge about breast cancer, but there are other cancer types that people are not as familiar, such as kidney cancer. Consistent with the point above, gynecological cancers are often not discussed, and many women feel they may be too old to have these types of cancers.

Cancer Screening

There is both a **lack of knowledge about cancer screening and a fear of the screening** and possible resultant cancer diagnosis among the community. Individuals may also be more likely to receive common cancer screenings, such as breast and prostate cancer, but may be more reluctant to obtain colon cancer screening. Skin cancer screening also seems to be underperformed.

The group felt that there needs to be **more information among general practitioners about the importance of screening**. There are some who do not prescribe it among adults they consider to be too old for screening.

One barrier for screening is **distrust of the medical community**. This is also a large barrier for research as well. **Wait times** in medical offices are another barrier. Additionally, a barrier for members of the **LGBTQ+ community is worry about if the healthcare facility will be an affirming healthcare location** (will they be gendered correctly, is there access to appropriate restrooms, etc.?)

Methods for decreasing screening barriers include any screening tests that can be **conducted at home**, such as the at home colorectal cancer tests. Similarly, a **mobile screening** unit to bring screening to the community can reduce barriers for some populations. However, others, such as those that live in senior housing communities, may not like this option because they don't want everyone that lives in their building to know when they obtain a screening.

Several suggestions were made for **how to increase awareness of screening**:

- **Working with providers to make sure they recommend screening** to all adults of an appropriate age.
- Outreach can also be conducted at **social clubs**.
- Providing reading material is also a useful tool. *"Provide information to take home that is presented in a certain way and would engage them from the standpoint of saying yes here is the stage of life this pertains to you, and you know, things are not over, in that sense, meaning you're not past the risk of cancer."*

Personal testimonials are also important: *"The best message also is testimonial and word of mouth in the faith based community, because they are going to believe testimony of those that have partaken of your services."* It is also important that the people that go into the community to tell them about their screening options are relatable and *"look like the community I'm talking to."*

It was also suggested that when conducting community outreach events, **focus should be on wellness, not sickness or medical issues**. For example, perhaps instead of calling events health fairs, calling them a wellness fair or community day, in order to bring in more people. Using educational tools, such as the inflatable colon, are also great learning options.

Health Information Resources

Participants were asked where they thought members of their community would go for cancer information. Several participants stated that people in the community talk to their **friends and family** for information. This includes individuals such as **adult children that are physicians or cancer survivors that might be a friend or acquaintance** who are willing to have a conversation about their experience.

Common websites that community members utilize are the American Cancer Society and National Cancer Institute's websites. Additionally, NCI-Designated Cancer Centers are useful resources.

SIDNEY KIMMEL CANCER CENTER

Representatives from the following organizations participated in the discussion: African Family Health Organization (AFAHO), American Cancer Society, Bucks County Health Improvement Partnership, Chamber of Commerce for Greater Montgomery County, Chinatown Clinic, For Pete's Sake Foundation, Hepatitis B Foundation, Philadelphia Chamber of Commerce, Philadelphia Corporation for Aging, Philadelphia Department of Public Health, and SEAMAAC.

Cancer is a concern in the community but not always discussed or acted on:

- *"I believe there is a concern as there is awareness about it, however, too often people are not doing the wellness preventative steps."*
- *"It is a concern, but I don't hear people talk about it until they or someone they know is diagnosed with cancer."*

Discussions about cancer include a focus on:

- **Diagnosis.** *"A lot of what I hear is around people being diagnosed with cancer. From a prevention standpoint, it is common to hear people talk about what habits to avoid that may cause cancer such as smoking." "There is no general discussion about the importance or availability of screenings. Most discussion is around positive diagnoses."*
- **Role of traditional medicine.** *"I hear people say that if you take this medicine, you know, this certain traditional medicine, you will be cured of cancer. So sometimes there are these rumors that go around. Eat this certain food and it'll take your cancer away or keep you from getting cancer."*

The community does NOT talk about cancer openly, because:

- **Fear. Cancer is like the death penalty.** *"I think one of the challenges is that people still see cancer as being fatal. It's not seen as a chronic disease where prevention, early screening really can make a difference." "…a lot of fear around a diagnosis, and that cancer means death is kind of how it's simply thought about in the community."*
- **Cultural beliefs such as if it is not talked about, it will not happen:** *"…because in many cultures it's like foretelling, right? You don't want to talk about it because you may make it happen. This was something that came up in the African immigrant communities, and also the Pacific Islander communities, that some things that are too scary, that are related to death particularly, they just don't want to hear."*
- **Stigma also plays a role:** *"I also think that is where some of the misperceptions are. That cancer is hereditary, and that often stigmatizes the families who have cancer diagnoses, which further limits discussion - people often don't want their community to know if they have cancer. I think it can be overwhelming, too — so many different cancers, so many different messages!"*
- **Gender differences** around willingness to talk about cancer, with men seen as being less willing to engage.

Cultural nuances about cancer include:

- **Fatalism.** *"…because they don't think of screening traditionally as something that they do, and because you know, there's a lot of other cultural issues. Like fatalism, and like other things that fate, why would I bother?"*
- **Taboo.** *"To some Chinese or Asians, there's a taboo, you know? Something's wrong with you when you have cancer. Something you have done. Not necessarily it's a natural cause or something happened."*
- Undocumented immigrants without **health insurance** are concerned about a positive diagnosis and cost of care: *"A lot of our clients are undocumented, and a cancer diagnosis and screenings are often avoided, because if I test positive or if I have a positive screening, it's overwhelming too, like how am I supposed to pay for this? And can I get care? I'm not sure if I'm allowed to get care because I'm undocumented."*
- **Other barriers to screenings:**
  - *"People are resistant to getting screened, because ignorance is bliss, and it's not a problem if I don't know."*
  - *"Many of our clients live in the moment and so they don't think much about prevention. Some are afraid of getting screenings or just don't want to take off work."* (representative of immigrant serving organization)
  - Cervical cancer is an issue for women in some communities (for example, African immigrant communities) because clients are not comfortable with pelvic exams.

Many are aware of cancer, but there are varying degrees of knowledge, especially related to different types of cancer, and the knowledge is not always accurate:

- **Greater awareness of breast cancer, especially among women, and some awareness of lung, cervical, colon, and liver cancer.** But not much knowledge of other forms of cancer. *"In the African immigrant community, people are mainly aware of breast, cervical, and liver cancer. But some steps are being taken to raise awareness around other kind of cancers as well through our health programs."*
- **Greater awareness of breast cancer screening**, but less information on lung cancer screening or prostate cancer screening. *"Lung cancer screening and eligibility needs to be made more clear, especially with the high death rates seen nationally (not sure what it looks like locally)."*
- **Prevention:** *"I think is greater awareness that cancer kind of runs in the family. …There's really very little information around prevention, what you can do to minimize your risk."*
- **Accuracy:**
  - *"I also think there is a difference between awareness and knowledge. Many are aware, but the knowledge is not always accurate - there are many misperceptions."*
  - *"In the local focus groups we have done in the AA and AI communities, they mention breast, lung, colon cancer. In the Chinese communities, they also are aware of liver cancer (many know someone who has had liver cancer), but there are many misperceptions about it. In the AI communities locally, we have heard that people confuse liver cancer with cirrhosis and hepatitis."*

When it comes to cancer, the messenger matters:

- **Trusted messengers** include:
  - Community-based organizations: *"So we have found that we are the trusted party, also because we can accommodate languages and people who are not literate and just from a practical standpoint. We're able to communicate and reach people. And so it feels like a lot of the burden has fallen on community organizations for this kind of general public health messaging. Which, to a point, makes sense. And if we have a relationship with people, then that's fine." "With regard to our clients, they come first to their cultural health navigator because of their trust, then we send them to health centers."*
  - American Cancer Society website: *"When my family members were diagnosed we utilized ACS resources"*
  - *"Community and religious leaders. A lot of the time, the messenger is more important than the message."*
- **Places where people are thinking about their health** would be a good promotion site, such as health clinics. *"But so many of my clients that go to the health center, and you know, I don't, I'm not familiar really what kind of care they would get at a health center. Are they getting information in their own languages about screenings? …just places where they're thinking about their health would be a good place." "Our patients at the clinic would most likely come to our physicians at the clinic to get the information."*

Messages about Cancer

- Make sure information is offered in **languages that communities speak**.
- **Change the narrative of cancer as a chronic disease.** *"It's not seen as a chronic disease where prevention, early screening really can make a difference. So I think once we do a better job changing that narrative, you'll have more people being proactive…"*
- **Focus on preventative care** including healthy lifestyles to minimize the risk of cancer: *"Another area of messaging that gets neglected is like preventative care. …the conversation around cancer is really restricted to like what happens when you have a diagnosis, and when you're already sick. …connecting diet, nutrition, exercise, regular screenings, dental care. You know, these little day-to-day choices, there's not really a clear line drawn between those decisions and avoiding a cancer diagnosis."*
- **Marketing that explains how to prevent or live with cancer:** *"…there's so much messaging from pharmaceutical companies about the medications that treat all these different forms of cancer, which then plays into this society factor of fear, where there isn't the PSA's explaining about how do you prevent it or how do you live with cancer... So if we could flip the communication or marketing trend to be more educational, PSA format...why can't we do that for cancers, you know? Make it trendy and make it stick with people. That lasts a long time."*
- **Imagining the impact of cancer:** *"In the past whenever I did some workshops on screenings, I noticed that I had a better effect when I focused on people imagining what would happen to their lives if they did get cancer."*
- **Engage men around screening:** *"…agree that men's engagement around managing personal health seems to lag behind women's engagement. More dialogue and comfort discussing prostate cancer would be welcome."*
- **Consider the context** of people's lives: *"It is also important to consider how the messaging of prevention in ways that are reaching the audience if they are too busy working and making ends meet day to day."*
- It is also important to include information on the **availability of treatment and resources**.

Suggestions for Cancer Screening

- Addressing lack of time and transportation as barriers through **flexible hours and increased accessibility**:
  - *"(Senior) caregivers who are caring for someone who may be homebound or have some difficulties at home oftentimes don't have the time to get these screenings. So, maybe find flexible timing and outreach efforts that these caregivers can take some time to get these screenings that would be helpful."*
  - *"People's time is a barrier. Making it easier to get screened. Offering screening where people frequently visit, such as community organizations and at work."*
  - *"Continue to partner with specific communities, bring the screening to where the people are presently: businesses/ companies, churches, schools, etc."*
- An example of a successful intervention is the **screening bus**: "
  - *We loved the screening bus. We loved it. It was a huge hit. It was great, because it was coming to where the community was. People know where our office is, they feel comfortable here. Our case managers were able to vouch for the bus, and we were there in person to explain everything. It was convenient and really efficient and effective. We loved, loved, loved the bus. More busses, please."*
  - *"We have the bus come to the Wyss Wellness Center and that is great!"*
- **Providing support at every step:**

– *"...if you look at the whole picture, there are challenges at every step, right? Individual, personal, systemic. I think bringing the screenings to where people are is really important, and knowing that your community may have access issues, transportation issues, issues with, you know, flexible work hours. I also think linkage to care is something that I think people are concerned that they're going to be diagnosed with something that they won't be able to follow up on."*

– *"Most of our people are undocumented...they would need assurance to get the appropriate and free cost treatment after diagnosis."*

DISABILITY

According to the Centers for Disease Control and Prevention, "a disability is any condition of the body or mind that makes it more difficult for the person with the condition to do certain activities and interact with the world around them."

One in four adults (61 million) in the U.S. live with some type of disability. In 2019, approximately 13 percent of residents of the five-county southeastern Pennsylvania (SEPA) region were living with a disability. People with disabilities have a wide range of diverse needs that may require particular forms of health and social support, but understanding of their population-level needs is limited due to underrepresentation in population-based surveys or qualitative studies and a lack of targeted data collection efforts.

Survey Development & Administration

A survey was developed to assess the health needs of people living with disabilities in the SEPA region (see online Appendix). The questions were adapted from a survey developed by Magee Rehabilitation Hospital for their 2019 community health needs assessment. The questions addressed respondents' disability, general health status, health care access, health behaviors, non-medical needs, employment status, use of technology and assistive devices, community participation and resource needs, and demographic characteristics. A committee composed of representatives from Bryn Mawr Rehab Hospital, Good Shepherd Penn Partners, Magee Rehabilitation Hospital, MossRehab, and St. Mary Rehabilitation Hospital reviewed and approved the final survey.

The survey was fielded as an online survey October – November 2021. The link to the survey was distributed to a list of contacts generated by committee members, which included partner organizations, community programs, and support groups across the region. Committee members also sent links to their own networks of current and former patients. All who completed the survey and provided an email address were entered in a gift card drawing.

Frequency analysis was conducted on 341 unique submissions. Where appropriate, free response items were coded for key themes by the project team. Frequencies for multiple choice and coded free response items are reported below. For items that were "check all that apply," percentages may add up to greater than 100 percent.

Survey Results

Respondent Characteristics

The table below summarizes the demographic characteristics of respondents. Respondents who are over 40, white, or had earned bachelor or graduate degrees made up a majority of the sample. Given this sample profile, it is important to note that the findings may not generalize to the larger community of adults with disabilities when interpreting survey results.

		N	%
Gender	Female	163	47.8
	Male	173	50.7
	Other	3	0.9
	Blank	2	0.6
Age	<18	1	0.3
	18-39	33	9.7
	40-59	111	32.6
	60-70	102	29.9
	>70	92	27.0
	Blank	2	0.6
Race	American-Indian/Alaskan Native	3	0.9
	Asian	8	2.3
	Black/African-American	66	19.4
	Native Hawaiian/Pacific Islander	0	0
	White	256	75.1
	Some other race	4	1.2
	Blank	8	2.3
Ethnicity	Hispanic, Latinx, or of Spanish origin	9	2.6
	Not of Hispanic, Latinx, or of Spanish origin	324	95.0
	Blank	8	2.3
Education	Less than high school degree	7	2.1
	High school degree or equivalent	56	16.4
	Some college	57	16.7
	Associate degree	31	9.1
	Bachelor degree	77	22.6
	Graduate degree	111	32.6
	Blank	2	0.6

Additionally:

- Over half of respondents reported being **married or living with a partner**.
- Almost half of the sample are **retired (48%), 29 percent are not currently working, and 11 percent are working full-time**. For those not currently working, the most frequently cited barriers included physical or functional limitations, potential loss of benefits, and needing support on the job.
- **About 77 percent are residents of the five-county SEPA region (Bucks: 11%, Chester: 5%, Delaware: 7%, Montgomery: 12%, Philadelphia: 41%)**, with an additional 2 percent from other parts of Pennsylvania. The remainder are largely from New Jersey, New York, Delaware, and Maryland.

Disabilities and Limitations

- Most respondents **(79%) reported their disability as permanent**.
- While **78 percent described their disability or limitation as physical**, 30 percent described it as cognitive and 27 percent as characterized by chronic pain.
- Approximately half of respondents **(49%) reported having their disability or condition for over five years**.
- A large majority **(78%) indicated that their mobility is impacted** by their condition. **Forty-one percent reported impacts on self-care** and 32 percent on remembering and/or concentrating.
- Of those respondents who indicated that they **require personal assistance for life activities (57% of the total sample)**, 67 percent indicated that unpaid family and friends provide this care.
- **22 percent of the sample reported needing help for certain activities but not being able to get it.** These included daily activities such as self-care, mobility-related or physical activity, social interactions, and therapy or other health care.

Current Health

- Most prevalent **health conditions** were as follows:
  - **46 percent of respondents reported falling** within the past 12 months.
  - **42 percent had been diagnosed with high blood pressure or hypertension.**
  - **25 percent reported being diagnosed with a mental health condition.** Of these respondents, 70 percent indicated that they are currently receiving treatment for it.
- **A majority of the sample reported good (41%) or very good health (22%).** An additional 26 percent reported fair health.

Accessing Health Services

- When asked about health services that had been utilized in the past 12 months, the most frequently selected options were **primary care (82%) and dental care (43%)**. Roughly one-third of respondents reported using emergency care (36%) and nearly a quarter used psychological and/or counseling services (21%).
- Of the 30 percent of respondents who indicated that they could not get the medical care that they needed in the past 12 months, the most frequently selected barriers were: **concern about COVID-19 exposure at the health care setting, inability to get an appointment, and inability to find a provider who understood their condition.**
- A large majority **(81%) reported that they have used telehealth services** in the past 12 months, and a majority of these respondents found **services beneficial (74%)**.
  - Those who had not used telehealth services indicated that they either did not have a need for such services or preferred in-person care.
  - While many found the services **convenient** (especially for particular types of appointments), others expressed **preference for in-person appointments or cited challenges related to technology and limitations of what could be done virtually**.

Disability-Related Resources

- **24 percent of respondents reported needing special equipment or assistive device(s)**, with factors such as cost, insurance-related issues, and lack of knowledge posing barriers to acquisition. Needed equipment included:
  - Lifts, chairs, or other mechanized assists (11%)
  - Ramp for their home (11%)
  - Railings, bars, or other non-mechanized assists (9%)
  - Motorized wheelchair, cart, or scooter (8%).
- About a third **(29%) reported that they currently participate in support groups**, with an additional 21 percent indicating that they are not currently participating but would be interested. A variety of resources were not widely used, but some respondents indicated interest in using:
  - Complementary therapy (33%)
  - Adaptive sports programs (22%)
  - Support for caregivers (relief support or respite) (22%)
  - Transportation support (21%)
  - Peer mentors (19%).

Non-Medical Needs

- With respect to housing, the biggest challenges were related to home access and safety:
  - **About a quarter of respondents (26%) with a physical disability indicated that they cannot enter or leave their home without assistance from someone else.**
  - **One in five indicated that their current housing does not meet their needs.** Most commonly shared issues included those related to accessibility, safety, need for repairs, and cost.
- **Fourteen percent of respondents shared that their primary means of transportation does not meet their current needs.** Most cited reasons included cost, need for assistance or equipment, and lack of reliability or convenience of transportation mode.
- **A small, but consistent, subset of the sample expressed significant financial needs:**
  - Eleven percent reported that there was a time in the last 12 months when they were **not able to pay mortgage, rent, or utility bills**.
  - Approximately 12 percent **experienced food insecurity**.
  - Eleven percent needed the **services of an attorney but were not being able to afford one**. Most common legal needs pertained to planning documents (e.g., will, power of attorney), public benefits (e.g., SSI/SSDI), and domestic relations (e.g., divorce, custody).

Lifestyle

- While 36 percent of respondents shared that they exercise at least 30 minutes three or more days per week, **27 percent indicated that they never participate in such activity**. Most frequent barriers to physical activity were: lack of knowledge of exercises appropriate for their condition, lack of interest, and not having the physical capability to participate in exercise.
- **A majority of respondents (71%) reported eating at least one serving of fruits and vegetables in a typical day.**
- **Substance use was not prevalent in the sample:** 93 percent indicated that they do not currently use tobacco, and 87 percent stated that they do not feel that drug or alcohol use impacts their daily life.
- The survey asked about **typical social interactions and activities**:
  - A majority of respondents indicated that they **socialize with close friends, relatives, or neighbors (82%) and feel there are people they are close to (88%)**.
  - **Over a third (36%) indicated that they do not feel that their daily life is full of things that are interesting to them.**

IMMIGRANT, REFUGEE, AND HERITAGE COMMUNITIES

The five-county southeastern Pennsylvania (SEPA) region is home to a diverse mix of communities representing a wide range of racial and ethnic backgrounds. These communities consist of foreign-born immigrants and refugees, as well as those native-born to the U.S. with cultural and heritage ties to diasporic communities.

A critical point to underscore about such communities is their heterogeneity in terms of demographic makeup, experiences, and needs. Not only is this section premised on the understanding that no community is a monolith, there is recognition that, under the scope of the current assessment, the ability to fully represent the breadth of the diversity in the region is limited. Insights from primary and secondary data presented in this section therefore seek to illuminate experiences of a subset of communities in the region. Inclusion is based on availability of recent local data for these communities. In addition to using publicly available secondary information on specific communities, support and funding were provided to organizations across the region with both the interest and capacity to collect primary data about health needs from the communities they serve or share relevant secondary data. Data collected from surveys, focus groups, and case management intake records are presented below.

Background

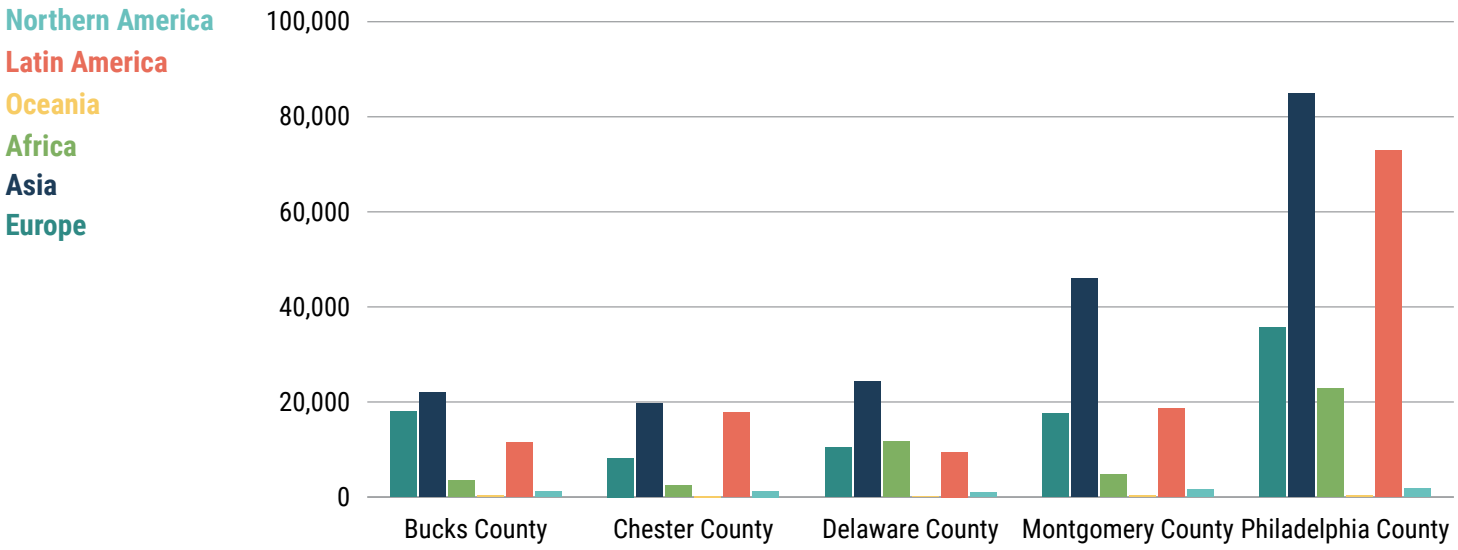
According to 2019 data, approximately 12 percent of residents in the region are foreign-born, with county-level estimates as below:

Foreign-Born Residents

Bucks	Chester	Delaware	Montgomery	Philadelphia
9.7%	**9.8%**	**10.3%**	**10.7%**	**14.1%**

As shown in the graph below, based on 2018 5-year estimates, places of birth for foreign-born residents varied across SEPA five counties. Those born in Asian or Latin American countries made up a significant share of the foreign-born population in each of the five counties. Also of note is the large share of foreign-born residents in Bucks County hailing from European countries, as well as those born in African countries in Delaware County.

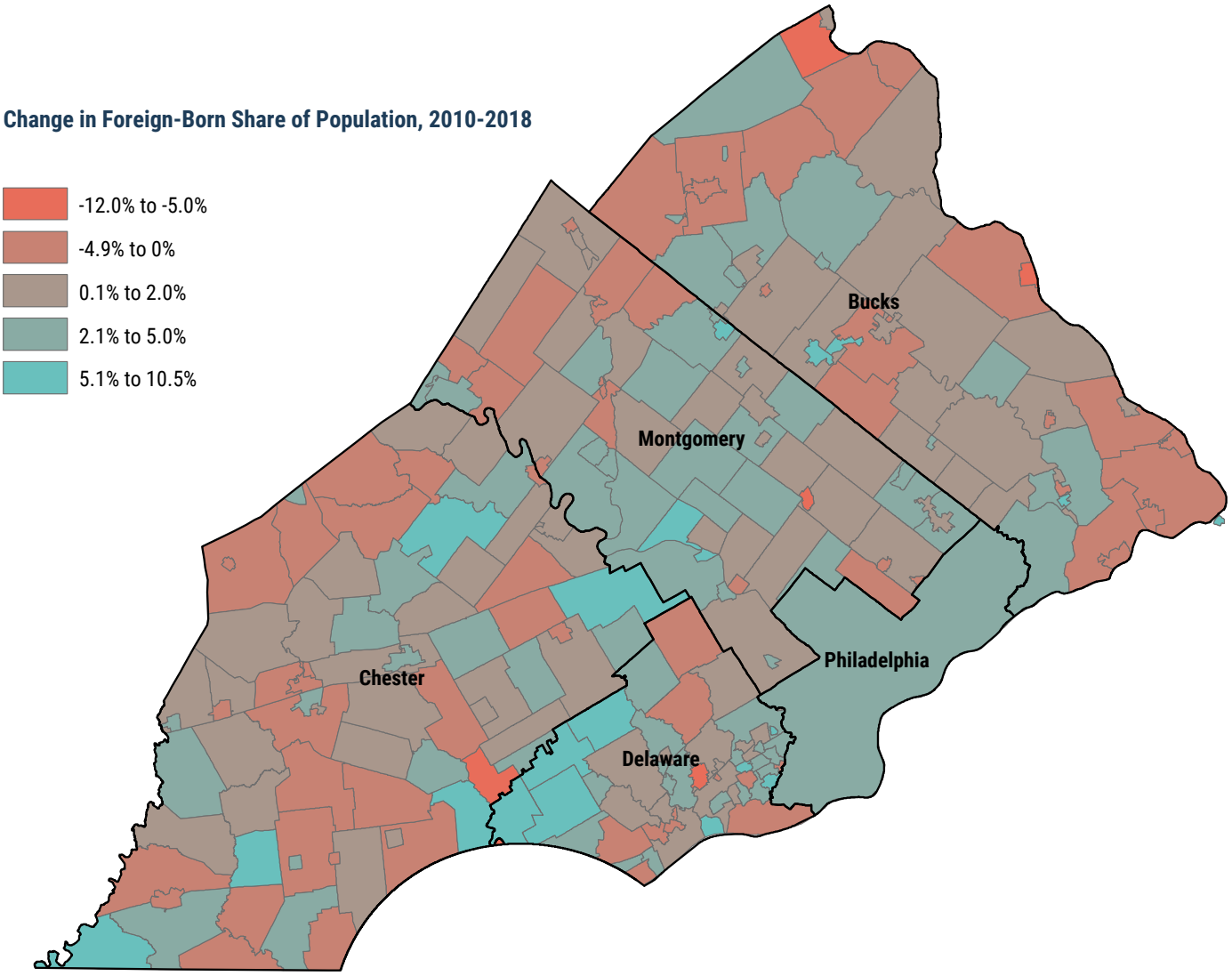
Foreign-Born Population Place of Birth by Country, 2018



Source: ACS 5-Year Estimates (2014-2018)

During that same period, municipalities with the greatest number of foreign-born residents were Philadelphia (218,489 or 13.9% of the population), Upper Darby Township in Delaware County (16,988 or 20.5% of the population), and Bensalem Township in Bucks County (11,454 or 19.0% of the population). The map below, adapted from this report developed by the Delaware Valley Regional Planning Commission, illustrates the changes in foreign-born share of the population by municipality between 2010 and 2018.

Relative to the native population in SEPA counties, foreign-born residents were more likely to have a higher median age, lower rates of homeownership, and bifurcation in educational attainment (i.e., higher rates of those with less than a high school education, as well as those with graduate degrees). Foreign-born residents were more likely to be self-employed and overrepresented in industries such as Services, Natural Resources/Construction/Maintenance, and Production/Transportation/Material Moving.



Source: U.S. Census ACS 5-year Estimates (2006–2010, 2014–2018)

General Health Needs

The rCHNA qualitative data collection (see summaries of community conversations, spotlight discussions, and data collected for focus areas and communities) revealed consistent themes of barriers to health faced by local immigrant and refugee communities. These include:

Language and cultural barriers.
Many foreign-born residents are English language learners (ELL) with varying levels of English proficiency. Discussion participants raised the need for language services encompassing qualified interpreters and widely available translated materials to ensure equitable access to health care and other services for ELL. This need is particularly acute for certain types of health care (for example, treatment for mental health conditions), where having high quality interpretation or a language concordant provider is critical for optimal effectiveness. The need for providers and health care systems to provide culturally responsive care that takes into account cultural norms and is grounded in cultural humility was underscored, as was the value of community members seeing and working with providers who "look like them."

Anxiety and safety concerns

- The political and societal climate of the past several years have contributed to an atmosphere of anxiety and fear among some communities, particularly among those who fear deportation and family separation, that adversely affects health. For example, the recent discourse on public charge deterred many, including those who were eligible, from applying for public benefits or programs that provide necessities, such as health care and food, due to fears that the application process will divulge information to federal immigration officials about who they are and where they are living. (A recent survey conducted by the Pennsylvania Immigrant and Citizenship Coalition found that these fears were shared by youth, with two-thirds of respondents expressing that they do not feel safe in school and a third sharing specific concerns related to U.S. Immigration and Customs Enforcement presence in schools.)
- Anti-Asian violence during the pandemic has led to fear among Asian elders that prevent them from leaving their homes, resulting in social isolation and delayed access to care and other services or resources that support health. This exacerbates issues arising from the need to manage multiple chronic conditions, low health literacy, and difficulties navigating complex health care systems.

Impacts of the COVID-19 pandemic on economic stability.
Diverse immigrant communities were disproportionately affected by stay-at-home orders that shut down businesses and resulted in widespread job losses for the large proportion of immigrants working in retail, service, and hospitality industries. The financial hardships and economic instability have hit these communities hard, leading to increased rates of food insecurity, housing instability, anxiety, and depression.

Refugee Communities

Though not specifically discussed during the qualitative data collection, it is important to note the specific needs of refugees, especially in light of recent world events that have led to the arrival of Afghan and Ukrainian refugees to the region. While data specific to these communities have yet to be fully available, those seeking asylum often arrive with significant medical conditions including injuries from war, infectious diseases, and unmanaged chronic health conditions. Refugees also experience emotional trauma resulting from war, displacement, and loss of loved ones, and are frequently diagnosed with posttraumatic stress disorder (PTSD) and other mental health conditions.

Data from January 2020 to December 2021 collected by Nationalities Service Center (NSC) provide a snapshot of recent arrivals to the region. As one of three refugee resettlement agencies in the area, NSC case managers conduct an intake needs assessment for any client enrolling in programs such as medical case management; legal support; services for survivors of human trafficking, torture, domestic violence and other crimes; and employment readiness assistance.

Among the 446 clients interviewed for intake, 51.1 percent were male, 48.0 percent female, and 0.9 percent endorsed other gender identities. The median age was 35 years, with the largest share of the group (64.1%) ages 25 to 44 years. Clients' countries of origin were diverse, with particularly significant representation of African and South Asian countries.

Countries, Nations and Territories *(most frequent in **bold**)*	Count	Percent
Methodology Note: Data capture of clients' country, nation, and/or territory of origin was retrieved from client immigration documentation, or via client self report.		
Africa *29 Countries, Nations and Territories: Algeria, Angola, Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Congo (Democratic Republic of), **Congo (Republic of the)**, **Cote d'Ivoire,** Egypt, Equatorial Guinea, Eritrea, Ghana, Guinea, Kenya, **Liberia**, Mali, Mauritania, Morocco, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, **Sudan**, Togo, Uganda, Zimbabwe*	116	26.0%
South Asia *3 Countries, Nations and Territories: Bangladesh, India, **Pakistan***	78	17.5%
Central America *5 Countries, Nations and Territories: Costa Rica, El Salvador, **Guatemala**, **Honduras**, Nicaragua*	57	12.8%
Middle East *8 Countries, Nations and Territories: **Afghanistan**, Iran, Iraq, Jordan, Palestine, **Syria**, Turkey, Yemen*	51	11.4%
North America *2 Countries, Nations and Territories: **Mexico**, U.S.*	39	8.7%
Europe *4 Countries, Nations and Territories: Czech Republic, Poland, Russia, **Ukraine***	32	7.2%
Caribbean *6 Countries, Nations and Territories: The Bahamas, Cuba, Dominican Republic, **Haiti**, **Jamaica**, Trinidad & Tobago*	30	6.7%
South America *9 Countries, Nations and Territories: Argentina, Belize, Brazil, Chile, Colombia, Ecuador, Guyana, Peru, Venezuela*	23	5.2%
Southeast Asia *3 Countries, Nations and Territories: Myanmar (Burma), Malaysia, Thailand*	10	2.2%
Asia *3 Countries, Nations and Territories: China, Kazakhstan, Philippines*	7	1.6%
Other or Unknown *1 Countries, Nations and Territories: Papua New Guinea*	3	0.7%

Clients' health-related needs were assessed in the following domains:

- **Food access.** 23.5 percent expressed either not having enough food for the week or being unsure. Regardless of this response, a large majority (72.0%) indicated using multiple sources to obtain the food they ate, including some form of assistance. This assistance was most frequently in the form of SNAP/ food stamps, friends or family members, or food banks or other resources.
- **Health conditions.** Slightly over a third (34.8%) of clients had an urgent medical condition.
- **Health care access.** Half of clients did not have health insurance (with half of those due to not being currently eligible), and 43.7 percent did not have a regular doctor or clinic they visited. A third expressed needing help with accessing dental care and 21.5 percent help with accessing vision care.

Based on feedback gathered on health education materials, NSC also identified needs for information about how to access language interpretation services, dental care, and Medicaid among their client population.

African and Caribbean Communities

As indicated by data in the overview and refugee discussions in this section, African and Caribbean communities are a large and growing segment of the immigrant population in the region. This is consistent with a larger national trend of immigrants from African and Caribbean nations comprising a larger share of the Black population in the U.S., as the current population of 4.6 million Black immigrants is projected to double to 9.5 million by 2060. One in five Black people in the U.S. are either immigrants of children of immigrants. Between 2010 and 2019, Philadelphia saw a 121 percent increase in the Black immigrant population.

Despite this growth, there is a relative dearth of targeted data collection efforts about these communities in the region. Examining the NSC dataset with a focus only on those clients from African or Caribbean countries of origin (N = 146), there are some indications of higher need relative to other populations served by NSC:

- Nearly 38 percent of clients were either not sure or did not have enough food for the week.
- Approximately 40 percent had an urgent medical condition.

Health care access needs for this group were comparable to the full dataset with all clients.

A recent survey of COVID-19-related needs among African and Caribbean communities conducted by the Coalition of African and Caribbean Communities (AFRICOM) identified top needs among respondents as employment, housing, food, and access to the internet. Suggestions for resources to help with these needs included cash assistance, as well as assistance with employment, community resource navigation, supports for youth learning, immigration and legal needs, housing and utility needs, health care and insurance, and food and clothing.

In addition to AFRICOM, nonprofit organizations like African Cultural Alliance of North America (ACANA), African Family Health Organization (AFAHO), and Multicultural Community Family Services, play a critical role in supporting these communities. Recognizing this role, the Office of Immigrant Affairs and the Mayor's Commission on African and Caribbean Immigrant Affairs in Philadelphia conducted an assessment of these nonprofits to better understand their capabilities and needs, as well as identify potential areas of support. Of the 24 organizations who participated in the survey, over half have operating budgets of $20,000 or less. Consistent with that, high priority areas for support involved assisting with fundraising/development and revenue generation and access to systems of support and capacity-building. This suggests opportunities for local government and health care organizations to ensure the continued growth and financial health of largely grassroots organizations providing essential services to underserved communities.

Asian Communities

Asians represented 6.5 percent of the population in the five-county SEPA region in 2019, with highest concentrations in Philadelphia and Montgomery Counties. As shown above, Asian immigrants account for a large proportion of the foreign-born population in both of these counties. Similar to African and Caribbean immigrant communities, there is limited up-to-date information about the health needs of Asian communities in the region owing to a lack of recent, specific, and systematic data collection efforts. The information presented below draw upon data collected and provided by organizations serving Asian communities in Montgomery and Philadelphia Counties.

The Asian American Coalition for Health and Human Services (AAC) in Montgomery County reflects the diversity of Asian communities in Montgomery and Bucks Counties, with representation from Bangladeshi American, Chinese American, Filipino American, Indian American, Korean American, Nepalese American, Taiwanese American, and Vietnamese American communities. With leadership from the Philip Jaisohn Memorial Foundation (Jaisohn Center), much of the recent efforts of the AAC have been focused on COVID-19 response, significantly increasing COVID-19 vaccination rates among the communities served by member organizations.

In December 2021, HCIF conducted a 90-minute focus group discussion with 12 members of the AAC to learn about community assets and needs related to health. Questions were adapted from discussion guides developed for other rCHNA qualitative data collection. Key insights from this discussion are described below.

- **Community assets**
  - Across all communities, **social connections** between community members was cited as a source of strength, enabling support for members who may not know each other. For elders in these communities, connections through communities like apartment complexes facilitate sharing of information about resources and events by **word of mouth**. Large church networks providing social service support, availability of daycare for elders, and communication tools like KakaoTalk and WeChat were also raised. **Support within families**, particularly intergenerational family support, was noted as a particularly important form of social connection. One participant raised the downsides of reliance on family support for things like health care access, as waiting for the availability of adult children to accompany elders to healthcare appointments can delay care.
  - The value placed on **preventive care and health awareness**—with a focus on harmony between healthy eating, exercise, and medicine—was shared as a particular source of strength for some communities.
  - Past successful community engagement efforts around health for Asian American communities across the Delaware Valley (for example, with the American Cancer Society) underscore the importance of **engaging health leaders from Asian communities** (e.g., doctors, priests) who can provide health information in different languages.

- **Challenges and barriers to health**
  - **Mental health and substance use issues** were a prevailing concern among AAC members. Stigma associated with mental health conditions, drug use, and suicide prevents communities from talking about it. The lack of culturally sensitive resources and facilities, as well as mental health care providers who speak community members' languages, pose barriers for seeking treatment for these issues. One participant noted that a belief that prayer can solve mental health issues in strong Christian communities can also be a challenge to seeking care, suggesting a need for particular outreach to spiritual leaders in communities.
  - **Language barriers** were top of mind for all communities, with several citing limitations around interpretation due to a lack of face-to-face interpreters. These barriers were noted as being particularly problematic for elders.
  - Several members raised the impact of **attitudes towards health and health care** on seeking care. Some communities may perceive no need to seek preventive care if they do not feel ill, especially if they distrust the health care system or feel shame for seeking help. Some may avoid talking about health conditions within the family, leading to family members not having a complete understanding of their family history. Other communities shared the "tunnel vision" that exist among members that prevent them from paying much attention to health, telling themselves to work "work through it."
  - Challenges **accessing specialists**, especially those who are language concordant and not an hour's drive away, were also shared.
  - For smaller communities, it can be difficult to get attention and health resources directed at them, leading to a **lack of awareness** of what is available for help.
- **Issues specific to youth**
  - Concerns about the **mental health** of teens were prevalent, especially in light of the COVID-19 pandemic impacts on being able to interact with others and build friendships with peers. The need for therapy in schools, as well as therapy provided by bilingual or Asian therapists who understand teens' cultural contexts and barriers, was noted.
  - Several AAC members discussed the **generation gap** between youth and parents. The lack of communication between parents and children, especially around issues like relationships, drugs, alcohol, and sex, may lead to parents not being aware of issues their children may be experiencing until they become serious or reach a stage of crisis.
  - **Identity issues** for Asian American youth were also raised, which were connected to academic pressure and high parental expectations, as well as racism and threat of anti-Asian hate crimes.
- **Issues specific to elders**
  - Challenges with **technology and internet access** were noted among elders, posing barriers to telehealth. To address this, some noted successful models of intergenerational teaching to increase digital literacy among older adults.
  - Issues with **depression and anxiety** among elders arising from lack of social connection and communication with family members were raised. Most "just accept and not deal with it."
  - Navigating **aging in place and family dynamics** is complex. Elders prefer to live with family, but adult children may find it difficult to care for parents as they age and have more serious needs. These children need respite, but it may be difficult to get an adult sitter to provide support. Elders, for their part, are afraid to be a burden on family members, leading them to try to be as independent as possible and therefore not asking for help when they need it.
  - Other issues discussed were **lack of transportation and worsened physical conditions** due to delayed care.

- **Ideas for potential solutions**
  - Seminars with psychologists to talk to parents and kids about mental health
  - Youth center to give youth an outlet where they can feel they belong and build their self-confidence
  - Directory of health care providers by ethnic community
  - Engaging ambassadors within communities to share their stories of resources and benefits—as one member put it, "*we trust our own people*."
  - Immigrant groups with longer histories in the community sharing information with and supporting newer immigrant communities

Themes related to mental health noted in by AAC member are corroborated by a recent survey conducted by the Philadelphia Chinatown Development Corporation (PCDC), as part of the Chinese Immigrant Families Wellness Initiative (CIFWI). The 2020 Wellness Leadership Program Impact Report summarizes survey findings (N = 78), reporting that 46 percent of youth respondents (aged 15 to 23) and 100 percent of parent respondents indicated COVID-19 had an impact on their mental health. The most common adverse experiences among youth were family pressure, racism, poverty, and sexual abuse, while parents identified family pressure, death, unemployment, and illness. The Wellness Leadership Program, one component of CIFWI's strategies to promote mental health wellness, seeks to "raise mental health awareness, develop leadership skills, and promote healthy communication with family" among high school and college students. The 3-month program led to positive effects among the 2020 cohort of youth participants, including lowered anxiety and increased self-compassion and functional health.

One major source of stress and anxiety for Asian communities are increased incidents of anti-Asian hate during the pandemic. PCDC collected data from 315 respondents in March 2021 to explore this further. According to PCDC's Anti-Asian Racism Incident Survey Report, one in seven had personally experienced an anti-Asian racism incident, with 39 percent of the incidents taking place in public settings. The most common form of incident was racial slurs/name calling (63%), followed by physical intimidation (34%). Over three quarters of respondents did not report the incident to police or any agency due to language barriers and distrust. Such findings bear further widespread and systematic examination to better understand and respond to the ongoing implications of such racial trauma on mental health for local Asian communities.

The health needs of Southeast Asian immigrant and refugee communities in Philadelphia, as revealed by data provided by SEAMAAC, share commonalities with findings already discussed. SEAMAAC has served South Philadelphia communities for nearly 40 years, supporting as many as 18 distinct linguistic communities with a wide array of programming, including education programs for youth, health and social services, and community development initiatives. During the COVID-19 pandemic, SEAMAAC expanded its programming to encompass robust hunger relief efforts.

The following sources of data collected by SEAMAAC were reviewed and analyzed for this report:

1. **Focus groups** conducted with Cambodian, Chinese, Burmese, Bhutanese, Laotian, and Vietnamese client groups in 2019 to discuss community health needs to inform the development of services for a new health center.
2. **Philadelphia Immigrant and Refugee Experiences (PIRE) survey** of clients (N = 78), many of whom were completing their initial intake for case management services from September – November 2021.
3. **Interviews** with SEAMAAC staff about physical health and social determinants of health conducted in December 2021.

1. **Across all client focus groups**, the following were expressed as common needs related to health and therefore important features for the new health center:
   - Providing language services, particularly on-site interpreters
   - Ensuring health care is affordable
   - Minimizing wait times
   - Addressing transportation barriers
   - Providing easily understood health education material in diverse languages
   - Ensuring that staff are welcoming and respectful
   - Providing a wide array of services (including specialties) at one site
   - Offering mental health treatment and education
   - Facilitating the passing down of cultural norms such as respect for elders to youth

2. **Survey results include:**

   - A majority of respondents are female (65.4%) and residents of South Philadelphia (84.6%), with a median age of 47 years. Those identifying as Indonesian, Chinese, or Burmese made up over 65 percent of the respondents.
   - A large majority express difficulties with speaking, reading, and writing in English.
   - Nearly 60 percent are renters, with about half able to pay rent each month (20.5 percent indicated that they do not pay, perhaps reflecting older adults living with family members). Similar patterns were seen with paying for utilities.
   - When paying for required expenses, 19.2 percent express needing help from a government agency or other agency/organization, with an additional 9.0 percent indicating that they do not have enough money and do not have anyone who can help and a further 3.8 percent receiving help from family or friends.
   - Approximately 30 percent report feeling unsafe sometimes or all or most of the time in their neighborhoods.
   - Nearly half are in poor (15.4%) or fair (26.9%) health.
   - A majority are able to do the following themselves or with the help of an adult family member:
     - Make a medical appointment
     - Seek emergency care
     - Use transportation to complete everyday tasks
     - Attend regular and new appointments
   - Of the 55 respondents who shared what they were most worried about (responses were coded into categories; since respondents provided multiple answers, percentages add up to more than 100%), most common concerns were related to:
     - Their health (45.5%)
     - Finances (41.8%)
     - COVID-19 pandemic (20.0%)
     - Their family (18.2%)
     - Lack of employment (18.2%)
     - Immigration status (10.9%)
     - Housing (9.1%)
   - Of the 47 respondents who shared what they are proud of accomplishing in the U.S., the most frequently cited were:
     - Raising their children, providing them an education, and feeling pride in their accomplishments (36.2%)
     - Being employed (14.9%)
     - Making a life for themselves in the U.S. (10.6%)

3. **Staff interviews** revealed themes common to other data collection efforts described above:

   - Behavioral health
     - Across the Southeast Asian communities that SEAMAAC staff support, behavioral/mental health is not considered to be a part of health; health is considered to be purely physical. Many clients express that their intake conversation is the first time anyone has asked about their mental health.
     - Mentioning behavioral/mental health is extremely taboo, and stigma can make it offensive to ask about mental health. The closest thing that clients will acknowledge is stress, which is seen as normal, not a big deal, and something that can be overcome.
     - The connection between behavioral health issues like addiction and physical health is not often understood. Addiction is sometimes understood related to drugs, not gambling or drinking.
   - Priority health needs
     - Chronic diseases such as diabetes, hypertension, high cholesterol, heart disease
     - Health care access and affordability, medication management, health literacy
     - Addiction (gambling and/or drinking)
     - Elder care
   - Priority social needs
     - Poverty and its cascading effects such as food and housing insecurity, which contribute to health problems
     - Lack of transportation contributes to loneliness, especially for elders who may be unable to socialize with others other than their family members
     - Depression and loneliness resulting from lack of social contact (e.g., when factory workers whose main source of socializing is through the workplace are unable to work due to illness)

- Prioritizing of work before health due to lack of safety nets like savings and concerns about job loss
- Barriers to addressing health concerns
  - Lack of language access in healthcare settings, as well as in interactions with landlords and schools
  - Immigration status
  - Lack of transportation and accompaniment
  - Long wait times at health clinics
  - Complexities around accepting public benefits, immigration status, and employment
  - Trauma, which affects ability to plan and prioritize needs
  - Internalized feelings of being undeserving of assistance
  - Discrimination based on language, race, or ethnicity
  - Lack of education for clients about navigating systems AND lack of education for providers around barriers that client face
- Attitudes and beliefs about preventive care
  - There is a prevailing lack of urgency around it for many communities, as it is regarded as not necessary or a luxury most are unable to afford.
  - Strategies to increase willingness to seek preventive care include framing in terms of potential negative future financial impacts and impacts on loved ones.
- Impacts of COVID-19
  - Widespread loss of family and friends, especially in the first 6 months of the pandemic. Cambodian and Indonesian communities were particularly hard hit.
  - Job loss, ranging from factory jobs to closing down of small businesses; women lost jobs due to daycare and childcare centers closures.
  - Digital divide, compounded with language barriers, made it difficult for parents to help their children with online learning.
  - Disparities in access to federal financial assistance like stimulus checks, resulting in financial hardship that put people's housing at risk.
  - Early reluctance to seek health care has led to even more delays in health care currently, as clients face long waits for appointments (especially for specialists).
- Needed resources
  - Safe, affordable, quality housing
  - Decent paying jobs
  - More access to culturally appropriate foods (e.g., halal food markets)
  - Benefits that can be accessed by undocumented clients (including transportation assistance)
  - Employment/work readiness programs (high school and adult)
  - Workshops addressing topics such as nutrition/healthy diet, tenants' rights and responsibilities, and bills (medical, utility)
  - Time! Healthcare providers do not have or give enough time with clients. Sustained changes require investment in every case and a holistic approach that takes into account social determinants of health, education about resources, and a person-in-environment (PIE) approach.

Hispanic/Latino Communities

Hispanic/Latino communities made up 8.9 percent of the population across all five SEPA counties according to 2019 estimates. Chester and Philadelphia counties are home to large Hispanic/Latino communities. An analysis provides a snapshot of Philadelphia's Hispanic/Latino population, which nearly doubled between 2000 and 2018. A large majority hail from Puerto Rico, followed by residents originally from the Dominican Republic, Mexico, and Central America. One in five are foreign-born. Local Hispanic/Latino populations have contended with significant systemic barriers to employment and housing that have contributed to the highest proportion of residents living in poverty (37.3%) than any other racial/ethnic group in the city. This has driven poorer health outcomes, such as higher rates of chronic disease and mental health conditions than other racial demographic groups. Compounding these issues is an array of barriers to health care access, including language barriers, greater likelihood of lacking health insurance coverage than other groups, and higher unemployment rates that contribute to lower incomes and inability to afford health care. Fears related to immigration status and immigration law enforcement have been exacerbated in recent years, posing further barriers to seeking out health care.

These vulnerabilities have translated to communities that have been disproportionately impacted by the COVID-19 pandemic. A recent data brief catalogues the toll on Philadelphia Hispanic/Latino communities and the factors contributing to the highest age-adjusted rates of COVID-19 incidence, hospitalization, and mortality, and lowest testing rates of racial/ethnic groups in the city. These factors include greater likelihood of being employed in essential occupations, living in overcrowded conditions that are often multigenerational, and lacking a private vehicle (and consequent reliance on public transit or other means that increase the risk of transmission and reduced access to testing and health care services. The digital divide is particularly acute for this group.

The 2019 rCHNA incorporated insights about health needs for Hispanic/Latino communities collected for the assessment, as well as an assessment focused on the health needs of communities in North Philadelphia conducted in 2018. The current report provides summaries of primary data collection conducted in partnership with organizations serving Hispanic/Latino communities in Montgomery County.

ACLAMO is an organization based in Montgomery County that "provides educational programs, social services, and access to health and wellness programs to Latinos and other community members to empower them to fully achieve their life potential." ACLAMO developed a survey to assess the health and well-being of Spanish-speaking communities in Montgomery County, with some focus on the impacts of the COVID-19 pandemic on these communities. HCIF provided assistance with questions and administered funding to support staff time on this project and provide gift cards to respondents. ACLAMO translated the survey into Spanish and conducted the survey with program participants in Lansdale, Norristown, and Pottstown from January – February 2022. The survey was administered as a structured interview with ACLAMO staff asking questions and recording responses. Frequencies for multiple choice and coded free response items are reported below. For items that were "check all that apply," percentages may add up to greater than 100 percent.

The 126 responses collected were distributed across the three sites as follows:

County	Count	%
Lansdale	26	21%
Norristown	47	37%
Pottstown	53	42%
TOTAL	126	

Respondent Characteristics

Respondents were primarily female, between the ages of 30 and 49, and Hispanic/Latino/a. A large majority were Central American or Mexican American/Chicano. Most of the sample were married or living with a partner.

		N	%
Gender	Female	115	91%
	Male	8	6%
	Blank	2	2%
Age	20-29	15	12%
	30-39	52	41%
	40-49	42	33%
	≥ 50	17	14%
Race	Hispanic/Latino/a	124	98%
	Indian	1	1%
	White	1	1%
Ethnicity	Central American*	41	33%
	Dominican	5	4%
	Indian	1	1%
	Mexican American/Chicano	58	46%
	Puerto Rican	9	7%
	South American*	9	7%
	Blank	3	2%
Marital Status	Single	24	19%
	Legally married	65	52%
	Living together with a partner	26	21%
	Divorced	5	5%
	Widowed	4	3%
	Blank	2	2%

* If respondents indicated that they were Central or South American, they were asked to name their home country. Most common responses were Honduras, El Salvador, Guatemala, and Ecuador. Other countries represented with only one or two responses included Colombia, Costa Rica, Nicaragua, Peru, and Venezuela.

Household Characteristics

- Ninety-four percent of respondents indicated that they lived with others. Of those, over half (57%) said they lived with two other adults, while 16 percent lived with one other adult and 15 percent with three other adults.
- A majority of the sample had at least three children under the age of 18 at home: one (12%), two (32%), or three (26%).
- In the household, 98 percent of respondents reported being either a parent or grandparent.
- The language most spoken in households was Spanish (90%).

Health Status

- A majority of the sample reported fair (21%) or good (52%) health.
- In terms of diagnosed physical health conditions, responses were as follows:
  - Diabetes: 17% (with an additional 10% not sure)
  - Asthma: 13% (with an additional 7% not sure)
  - Hypertension: 16% (with an additional 6% not sure)
- Eight percent of respondents shared that they had been diagnosed with a mental health condition. Of those 10 respondents, 60 percent were receiving treatment for that condition.

Health Service Use

- Seventy-seven percent of the sample had used health services in the past 12 months. Those respondents indicated using the following health services (in order of frequency):
  - Primary care: 68%
  - Dental care: 58%
  - Emergency or urgent care: 29%
  - Sexual or reproductive health care: 23%
  - Hospital inpatient care: 12%
  - Psychological counseling: 12%
  - Home health care: 7%
- Thirteen percent of respondents shared that there was a time when they needed medical care in the past 12 months but did not get it. The reasons for not receiving this care by these respondents (n=16) were given as follows:
  - Difficulty scheduling an appointment: 81%
  - Difficulty affording medical care: 75%
  - Difficulty communicating with a provider: 69%
  - Not knowing where to go: 44%

Health Status

- Respondents indicated significant impacts of the COVID-19 pandemic on their lives, including childcare center/school closure (84%), work hour reduction (84%), income reduction (81%), and job loss (51%). Twenty-seven percent reported that a family member had to continue working outside the home as an essential worker, and 13 percent shared that they had to move out of their home.
- When asked about other impacts on their lives and health, respondents provided free responses, which were coded for themes. Of the 54 responses given, the most frequently reported negative impacts were related to:
  - General emotional and mental health: 46%
  - Finances and anxiety related to finances: 37%
  - Physical health: 9%
  - Family and friends: 7%

Health Barriers

- Survey participants were asked about potential barriers to health they may experience.
  - The biggest barriers to health expressed were related to finances: 46 percent reported being stressed about employment or money, and 41 percent said they could not afford what they needed to be healthy (with an additional 10 percent indicating that they were not sure). Twenty-nine percent shared that they experience racism and/or discrimination.
  - The sample reported having healthy food available near their homes (93%), feeling safe in their neighborhoods (90%), having the transportation needed to get to the doctor (82%), having reliable internet service (80%), and being able to access health care when they need it (79%).
  - When asked about problems not mentioned, 20 responses were gathered. Most frequently mentioned were lack of resources and help (30%), emotional or mental health issues (25%), physical health issues (20%), challenges with family (20%), and changes to life and routines (5%).
- Of the barriers to health presented, the top priorities for respondents (who selected up to four) were related to (in order of frequency of selection):
  - Availability of healthy food near their homes
  - Employment and money concerns
  - Having transportation to go to the doctor
  - Feeling safe in their neighborhoods
  - Having access to health care when they need it
  - Being able to afford what they need to be healthy

Food Security

- Three questions were asked to assess food security in the last 12 months:
  - Over a quarter of respondents (27%) reported skipping a meal because there was not enough money or resources to get food.
  - Seventeen percent shared that their household had run out of food because of a lack of money or other resources.
  - Five percent indicated that they had gone without eating for a whole day due to lack of money or other resources to get food.
- Sixty-five percent of the sample reported that they had received food from a food pantry or other organization in the past 12 months.

Family Priorities

Respondents selected up to four community services that were the most important for helping to keep them and their families healthy. In order of frequency, the most important services were:

- Housing or housing case management (e.g., tenant/landlord disputes, eviction)
- Immigration services
- Rental or utilities assistance
- Youth programs (afterschool) or childcare

Communication

When asked how they get information about health services and issues in their community, respondents selected up to four options. The most commonly selected option by far was one-on-one peer discussion/word of mouth. Other sources (in order of frequency) were:

- Facebook Live
- School or church
- Video or TV programs or commercials
- Pamphlets/brochures
- Billboards/public transportation advertisements

Centro Cultural Latinos Unidos (CCLU) supports Latino children, youth, and parents in Pottstown with educational, recreational, legal, and health services. CCLU convened a focus group composed of 13 clients and their children in November 2021. CCLU conducted the focus group in Spanish; the discussion was recorded, transcribed, and translated into English for coding and analysis. Key themes from the discussion include:

- **Lack of information or communication** about health resources, including where to go or what to do to stay healthy.
- **Lack of health insurance** prevents people from going to see a doctor or going to a clinic "*without being rejected because we don't have it*." This lack of insurance also leads to high medical bills: *"I got sick and I had to pay tons of bills, and now they are sending me more. All because I don't have health insurance.They said, 'But, you don't have insurance?', and they said, 'Unfortunately, you have to pay. You can pay cash, or you can use your credit card.' It was harder because I was scared, because I didn't have that amount…."*
- Other barriers to health care access include **difficulty getting access to a physician, transportation barriers, and long waits for care** (*"over an hour, even if the pain is killing you"*), which can be due to a variety of causes: *"Well, you need to get a translator, they need to check you have health insurance, what's covered by the insurance… it's a long wait. And one is ill."*
- Others elaborated on issues with **language access**, including lack of interpreters. In some cases, children are asked to interpret: *"For example, when my son took ill, it was 1 a.m. I explained his symptoms to his doctors, and they said, 'I didn't understand you; we are going to refer you to X, it's the only place with Spanish speakers. I can't understand what you say.' They were upset at me….They would tell my son, who was in pain, "'You need to translate what your mother said.' I was angry. How could he translate when the pain was killing him?"*
- **Inequitable treatment:** *"When we go to the hospital, they don't treat us as they should." "They make you wait. If you don't speak English, they don't treat you, or they treat you in the hall, while standing."*
- **Impacts of the COVID-19 pandemic** were felt by adults and youth alike.
  - A participant shared that illness prevented her from working and consequently she didn't have the money to pay rent, while a youth participant expressed her fear that missing so much school due to illness would mean that she would not be able to pass the eighth grade.
  - Others shared challenges with **access to vaccines**: *"Yes, for the vaccines, you had to wait a while, and they didn't have many Spanish-speakers for the appointments. They made you phone a line, there, they referred you to another line, and no one could really tell you the time and day of your appointment. So, that took a long time. Then, when you had to go back for a check-up, there was no one there to provide the proper assistance. They didn't do their job."*
  - Referencing a clinic that was set up to facilitate vaccine access, one participant shared, *"It helped, but there's more information needed on the status of the vaccination process, where they need to go, if it's appropriate or not."* The need for more accessible, reliable sources of information was widely endorsed: *"Something that would make us feel safer would be having more information. Maybe a fixed hotline we could call to get reliable information."*
- Potential solutions include **offering affordable transportation to care, "pro bono" doctors** (those who can treat people without asking for their medical insurance, their social security information: *"They shouldn't ask where you come from, if you have insurance or not. They just should accept you."*), and doctors (including specialists) and doctors who are Hispanic or speak Spanish.

YOUTH VOICE

Children and youth represent a population with diverse health needs and unique vulnerabilities that require urgent attention in order to prevent lifelong negative repercussions and maximize the potential for growth and thriving.

Unfortunately, the barriers to well-being for all children and youth in the region are significant, as many families across the five counties struggle with economic stability to support their children, and racial and ethnic inequities related to education and health outcomes persist. The negative impacts of the COVID-19 pandemic and response on youth learning and development and a wide array of issues like housing and health are increasingly being documented

Against this backdrop, to facilitate understanding of health issues specific to children and youth, several types of inputs are represented in the report, including:

- Quantitative data on youth (middle and high school student) behavior related to mental health and substance use presented in the county profiles
- Qualitative information about the needs of children and youth from birth to age 18 gathered in each geographic community conversation and spotlight discussion (see individual summaries throughout the report).

In addition, the Steering Committee sought to hear directly from youth (ages 11-25) to ensure robust inclusion of youth voice in the rCHNA. A subset of participating health systems (Children's Hospital of Philadelphia, Einstein Healthcare Network, Main Line Health, Penn Medicine, and Trinity Health Mid-Atlantic) formed a committee to guide the development of this data collection process, which centered on the engagement of youth-serving organizations and programs based in the five-county region. Specifically, program leads were presented with an opportunity to facilitate discussions with youth participants about youths' perceptions of community assets and barriers to health, health needs specific to youth, and ideas for potential solutions. All organizations received funding to hold these discussions, and youth participants received gift cards for their time.

From an initial list generated by subcommittee members, additional outreach was conducted through existing networks (e.g., Greater Philadelphia Extracurricular Collaborative, Philadelphia Youth Sports Collaborative). Twenty-five organizations were engaged to participate in this data collection, representing youth in Bucks, Chester, Delaware, Montgomery, and Philadelphia counties:

Falcons 215
After School Activities Partnerships (ASAP)
Black Women in Sport Foundation
Born With Purpose
Caring People Alliance
Children's Hospital of Philadelphia Adolescent Initiative
Focused Athletics
Ivy Hill Youth Association
La Liga del Barrio
Liberty Youth Athletic Association
Lutheran Settlement House
Mercy Neighborhood Ministries
National Network for Youth / Valley Youth House (Montgomery County)
Open Door Abuse Awareness Prevention
Parent Power
Philadelphia Chinatown Development Corporation
Philadelphia City Rowing
Philadelphia Robotics Coalition
Philly Teen VAXX Ambassadors
Starfinder Foundation
Sunrise of Philadelphia
The Common Place
United Philly Soccer
University of Pennsylvania Netter Center for Community Partnerships
Youth Mentoring Partnership

About a third of organizations offer sports programming to youth, in addition to other educational and enrichment support, including mentoring and coaching. Others provide out-of-school-time programs, offering a variety of arts-based, educational/tutoring, and youth leadership development programming.

A total of 354 youth participated in 34 discussions held in November 2021 – February 2022. These discussions were conducted both virtually and in-person, at the discretion of the organization, and facilitated by trusted program leaders and staff. Discussions ranged from 30 to 129 minutes, with an average length of approximately 60 minutes. The age distribution of participants is as shown below:

Age	Count	%
<13	33	9.3%
13-15	170	48.0%
16-18	117	33.1%
19-22	24	6.8%
>22	6	1.7%
Missing	4	1.1%
Total	354	

Geographic representation was as follows:

County	# of groups
Bucks	1
Chester	3
Delaware	2
Montgomery	2
Philadelphia	29

NOTE: The number of groups does not add up to 34, as some groups included representatives from multiple counties.

Within Philadelphia, most groups represented either North or West Philadelphia. Residents of Southwest Philadelphia, Center City (including Chinatown), South Philadelphia, Northeast Philadelphia, and Northwest Philadelphia were also represented across the groups. One group included representatives from South New Jersey as well.

Facilitators were given a discussion guide with six questions and suggested prompts (see online Appendix) and provided additional guidance as requested. Facilitators were supported by note takers and, in some instances, opted to record the discussion to capture specific quotes from participants. Organizations summarized the discussion using a report-back form that was provided to them and, where appropriate, submitted additional materials such as notes or sign-in sheets. Based on the report-back form submissions and additional materials, responses were coded for key themes. Frequency of mention across discussions was calculated as a percentage based on 30 submitted reports (some organizations opted to combine multiple discussions into a single report). Since multiple themes were discussed in each group, percentages total over 100%. The themes, percentages, and, where appropriate, illustrative quotes from the discussions are presented on the following pages.

Community Assets

Youth identified the following as key resources and assets that make their communities healthier:

Theme	%	Description and Examples
Connections/mutual support	47%	Participants cited the importance of **cohesive, community bonds/relationships and support networks** for health. These connections enable community members to be **accountable** to one another, as several groups valued being able to "watch out" for and check in on one another. Those "**willing to take the journey with you**" and who "**you can count on**" are sources of **motivation, inspiration, and "cheerleading."** By confiding in one other and acknowledging shared struggles, these strong networks provide **mutual care**, and foster a sense of **belonging and inclusion**.
Community spaces/ organizations	33%	Youth frequently noted the importance of spaces like **recreation centers** and **outdoor greenspace** (e.g., parks, running trails) in promoting health. These represent not only a space for physical activity and sports, but as important, **safe places for community gathering**. Participants also noted the need for **spaces for creative exploration and expression**, as well as the critical role played by local non-profit organizations, faith-based organizations, and businesses in creating a thriving community.
Shared values/mindset	30%	Youth participants underscored the value of shared values and positive mindset for community health. They repeatedly mentioned values related to **diversity, unity, freedom, voice, acceptance, inclusion, respect, and collaboration** as essential.
Supports for healthy eating	30%	Quite a few group discussions had a strong emphasis on the need for supports for healthy eating. Though youth noted a few existing supports (e.g., school lunches, grocery stores), they also noted the need for support through the growth of resources like **farmers markets and produce trucks**.
Health resources	27%	Youth recognized the contributions of facilities like **pharmacies** (especially in light of the COVID-19 pandemic) and **health care professionals** (including mental health care providers and dentists) in fostering health. **Mental health supports** were of particularly interest for participants.
Leaders and role models	27%	Participants cited the crucial role of trusted community leaders and adults in their lives who can serve as positive role models and **mentors**. These include **teachers, coaches, counselors, and community police officers** who demonstrate that "they care."
Community activities	27%	Opportunities to connect as a community through **community clean ups, donation drives, and cookouts** were mentioned by youth participants as positive influences on community health.
School and extracurricular programs	23%	Participants strongly endorsed the role of school-based and extracurricular programs in supporting health. These programs included **sports and other afterschool programs** that provide opportunities for **building connections** between youth, fostering **social emotional learning**, and enabling **creative expression**.
Supports for physical activity	17%	Participants discussed the importance of fostering opportunities for physical activity more generally, beyond the mention of specific facilities like recreation centers, gyms, or outdoor spaces.
Clean, safe environments	13%	Several groups noted the need to ensure neighborhood and school environments are **clean and safe**. Safety encompassed protection from air **pollution or mold/asbestos in schools**, as well as more generally from **physical, emotional, or psychological harm**.

Community Needs

Participants were asked to share the biggest challenges and barriers to health in their communities:

Theme	%	Description and Examples	Illustrative Quotes
Violence and safety	**67%**	A predominant concern for youth was the rampant violence in their communities. This is largely in the form of **gun violence**, but participants also cited instances of **interpersonal violence**. Youth mentioned **fights in schools, police brutality, and gangs** in association with violence. For youth of Asian descent, fear of **anti-Asian hate crimes** was significant. This threat of violence had cascading impacts on youth, both direct and indirect, resulting in **not feeling safe enough to go to parks or work out outside**. This fear also has a strong negative impact on mental health through experience of **toxic stress**.	*"Gun violence…We all know that we were on track to break the record for the most homicides in a year, and I know that it was a lot of killing going on and I know a lot of people affected by it. And I just wanted to say that's a big problem because…we're losing people and people are losing their lives all over dumb stuff like a simple argument or even things that people shouldn't be doing like drug deals, stuff like that."* *"There needs to be better gun control. Like everyone – anybody can handle a gun at this point. There's some crazy people out there that just go straight to the killing and not really any solutions."* *"And it makes me even more feel some type of way because I cannot wait to move out of Philly and I grew up here. And things, when I was growing up, wasn't like this at all. They do have violence here and there but nothing like this."*
Food	**50%**	Participants were concerned about the **lack of access to healthy foods** in their communities and **food insecurity**. Many noted the easy access to cheaper fast food and unhealthy foods in corner stores, with supermarkets being further away and less accessible without a car. Youth were interested in increasing access to fresh produce and *"good-tasting, nutritious food that will fuel kids for the day."*	*"A lot of people don't have access to healthy food. And so a change I think should be made is one that promotes access to healthy food. Because food insecurity is not only access to food at all but access to food that is healthy and benefits you rather than harms you."* *"I think changes, like really big changes such as Pennsylvania has a P-EBT, like all of those benefits have helped my family at least, because during the pandemic one of my parents actually lost their job. And my other parent was affected significantly, because her job involves like, a more person-to-person thing. And she was unable to do that obviously because the COVID-19, which caused us to be in a weird financial situation, so benefits such as P-EBT and Pennsylvania's support has been really helpful. Those changes, I think, were like some of the biggest ones in my family."*

Mental health	**50%**	Mental health is a pressing issue for youth. Participants shared the multiple factors influencing mental health in their communities, including concerns about **violence and safety** as mentioned above and the impact of **COVID-19 pandemic** stay-at-home orders. Youth frequently mentioned their experience of stress. For example, some cited **generational trauma and toxic stress** associated with directly experiencing AND living in communities contending with **racism, poverty, violence, or substance use**. Others cited the challenges of **balancing competing demands** of schoolwork and parental expectations. Compounding these factors are issues related to **stigma** associated with mental health concerns in some communities of color and **challenges with accessing mental health supports** and treatment (lack of awareness of available resources, not being able to get timely appointments, affordability). There is a sense that youth mental health concerns are **not taken seriously** by adults in their lives, with some telling themselves that *"it's not that bad"* and getting the message that they should "*keep going, you will be alright, get over it.*"	*"For physical health, people are a lot more willing to go to doctors and learn about their challenges but with their mental health there is a certain stigma, and they don't want to talk about their issues."* *"In the community, trauma builds up. That's why they reflect also the trauma…."* *"Even though resources are available for mental health support, there is a stigma, especially in the Asian community where one can go for help and not feel judged. People may not get help because of the stigma."* *"The Black community does not think that mental health is a thing."*
Substance use	**33%**	Participants shared the impact of substance use in their communities, including **drug addiction and overdose** and **peer pressure** related to smoking and alcohol use. For several groups, drugs were mentioned in association with violence in their communities.	*"I wanna throw in instead of like the strengths, I would say the weakness like drugs especially in Philly like in Kensington areas are horrible."*
Environment	**30%**	Youth noted the negative impacts of **pollution and lack of trees and greenspace** in their communities. Several groups were particularly concerned about the presence of **trash in public areas and illegal dumping** in their communities.	*"A challenge that we face is people taking advantage of the community and littering and putting trash everywhere basically."*

Racism and inequity	**27%**	Racism and resulting inequities in health, as well as inequity arising from discrimination based on **other identities** (e.g., gender, sexual orientation, ability, intersectional), were of great concern to youth participants. **Disparities in COVID-19 outcomes, differing levels of investment** in certain communities, associated **socioeconomic disparities**, and **hate crimes** were raised in these discussions.	*"Within health care, there's a lot of discrimination based on color and sexual orientation, which is crazy, because that affects a person's health. Also one thing for individuals who are part of LGBTQ, doesn't really trust…doesn't receive the right medical care. And within the Black community, 37 percent of Black women don't really trust the health community. So I think that ties into being a part of the Black community and being part of the LGBTQ+ community."* *"Looking back to the past few years, as a young person going through taken out of school, no vaccine to begin with, seeing Black people that look like you getting murdered, seeing an uprising on TV and try to focus on academics, trying to work, go to college - going through these things and not enough time to process and trying to push through saying 'it's not that bad.' Then thinking about 'Even with access to vaccines and mental health resources it's still very hard to keep going and go get the vaccine and mental health.'"*
Housing/ neighborhoods	**23%**	Several groups discussed **lack of affordable housing** in communities, **housing insecurity**, **homelessness**, the impact of gentrification, and the **lack of sustained investment** in neighborhoods. One group discussed the interrelationship between lack of housing and mental health concerns.	*"Homeless people being out on the street 24/7."* *"I'd like to change the gentrification of the neighborhoods."*
Resource information and navigation	**23%**	Youth shared challenges related to getting information about available health resources and navigating systems to obtain these resources. They expressed a desire for **clear communication and education** about these resources. They advised potentially using **social media** and adopting **positive, youth-focused approaches** to reach youth with health information and messages.	*"Maybe more of like advertising things that aren't bad. Like, for example, everywhere I go…we see a lot of posters everywhere but it's all advertising parties and nothing is really advertising like yoga classes or meetings like this that we can actually put our input in. I feel like it's very limited to…this information to who we can extend it to. I'm pretty sure there are parents who would love to join and give their input…Being more vocal about the good things and the little things."*

COVID-related concerns	**17%**	The COVID-19 pandemic had and continues to have a significant impact on youth and their communities. The stay-at-home orders associated with the pandemic negatively impacted youth mental and physical health. In addition, the challenges associated with **vaccines and masking in schools** persist, leading to a great deal of confusion with **changing rules and eroding trust in adults**.	*"…the thing is that with the pandemic, especially during like the more harsh periods of the pandemic, I don't think anyone can learn during virtual learning at all. Like the majority of students who are more hands on or like who are definitely more used to in-person learning definitely had a hard time, and now they're having an even harder time adapting to school that's going back in person and it just feels like we're all behind. And it's very easy to feel overwhelmed, especially for those with a lot of responsibilities at home as well."* *"My mental health and emotional health were affected because of fear of getting sick and being angry that people would not get vaccinated and might inconvenience them but do good for the community's health."* *"I used to not talk to people and now I do because I needed to because of being lonely and I got more comfortable with new people. But now I get highly anxious by the lack of people but also having people around, because I am concerned for my family's health and I am concerned about people's view on the vaccine. I am afraid of saying something if I say I support the vaccine. Will that turn people against me?"*

Interpersonal dynamics and communication	**23%**	Several groups were concerned with negative interpersonal dynamics and communication in their communities. Some cited the detrimental effects of **"toxic" attitudes, disrespect, comments that impact body image, and making assumptions**. Some of these negative dynamics can play out on **social media**. Other youth shared that sometimes they experienced language barriers and that there were **no spaces to express themselves and foster meaningful, deep connections** among community members.	*"…Most of the issues is basically people not communicating with each other as much as they should be or like not understanding where the other person is coming from in order for them to help…."* *"People not being able to understand someone else's opinion…it's like when you don't understand it creates conflicts. It will not be a healthy community."* *"…people don't want to change what they've been doing for periods of time, it's what they're used to. So if you have like something new or you want to change what's going on, it's like an issue and then it becomes like a big problem. And they tend to go on… people aren't getting heard, no one's understanding what others are saying….down to it is people who undermine others and don't try to listen on other people's issues."*
Transportation	**17%**	Some participants shared barriers to accessing transportation, even with critical needs like attending school and going to medical appointments. The main issues include **lack of available, affordable options**.	*"I would use Transnet [a program by Medicaid] but you need to schedule in advance. If you have something urgent it's hard to get there. For example, when I was pregnant and going into labor, I called and couldn't get a ride."*
Health care access	**17%**	Youth brought up challenges with **accessibility and affordability of health care**. The lack of free clinics, the significant distance needed to be traveled for some facilities (or, put differently, few options close by), low appointment availability, long wait times, lack of insurance, and high costs of deductibles were particularly noted. Related to other needs raised, **lack of knowledge of available resources where they can go without parents and are free** was shared.	*"Yeah, like, my dad, he works for himself. He has his own business and he doesn't have insurance and he got hurt working 'cause he's a construction worker and like, he's been – his back is like really bad and I'm like, 'Are you going to the doctor?' 'No, it's too much. I'm gonna have to tough it out.' And I think that's kind of messed up 'cause he's doing all this work and he can't even – he can't afford insurance 'cause he has three daughters, so, it's just a lot."* *"…so, with difficulty accessing mental health, I think that mental health resources, like I think it's hard to find providers, and like to pay for it too. I have personal experience with this, like I was trying to find with my mom, but a lot of places are either just like - there wasn't like enough staff. And some of them just didn't pick up - they had like a waitlist. So, it was just very hard to find like - to get access to help. So, I think that should be improved."* *"I have been to the emergency a few times and each time it was more than a 2-hour wait."*

Youth Needs

The main issues for health for youth (with particular prompts related to health care) were shared as follows:

Theme	%	Description and Examples	Illustrative Quotes
Mental health	**60%**	Similar to what was expressed related to mental health needs in their communities, youth shared with greater intensity their own experiences with **stress, pressure, and burnout. Depression, anxiety, and trauma** due to the COVID-19 pandemic and community violence were widely shared across groups. A theme of **balancing** between school, parental expectations, other responsibilities, and social life was consistent across several groups. Other sources of stress and toxicity include **expectations around physical appearance and beauty**, often exacerbated by social media. Challenges of not talking about mental health issues due to **stigma and accessing mental health resources** like therapy (long wait times for appointments, limited number of therapists within insurance networks, difficulty finding information, need for parental consent, lack of affordable options) were also raised by participants.	*"I said the most important issues when it comes to youth nowadays, was mental health. Although COVID-19 does affect our physical health quite a bit I feel like mental issues right now are more prevalent, because as we're starting to like go back and forth between the COVID restrictions. I feel like…it's a lot easier for everyone, especially the youth, to feel overwhelmed. Especially how like earlier, she talked about how her friend was getting overwhelmed with schoolwork. I feel like the pandemic and the two years of completely virtual school has like really made it hard for us to get used to our pace when it comes to schoolwork, and academics, and extracurriculars now that we're like starting to uplift those restrictions. It's really hard to keep up with everything when you haven't done it at all for like two years, and it's like quite abrupt as well."* *"On the subject of mental health, a lot of the times people my age will joke about it… it's become such a…maybe convenient or casual topic that you can't ever really tell when someone's serious about something. Like it's just hard to determine who actually needs help."* *"I have heard people call our generation the generation of mental health. Some people in the older generation don't take it as seriously as it's supposed to be. They think that it's just 'oh, you're sad…go to church, go pray, go read the Bible'—it's always the same answer. So I think our biggest issue is mental health as the younger generation."* *"How things are portrayed toward youth. I feel like we see a lot of things, pick up on a lot of things that we shouldn't, like body health or people trying to be things that they're not and it'll turn out bad for them…like anorexia or especially with the oversized community. Because I feel like people equal health as in you're not bigger but in all actuality, you can be healthy in any size, and I feel like that targets children more than it should."* *"It's not always easy to talk to people, like actually have a conversation about your mental health with everybody because not everybody's gonna care….it's been times where I've actually tried to talk to somebody about my mental health and they just like 'I don't care.' So with that, you shut down and you don't wanna talk to anybody because you feel like you can't talk to anybody."* *"Doctors prescribing [psychiatric] medication to kids rather than looking deeper into a situation. In school, teachers suspending kids rather than talking to them."*

Violence and safety	**40%**	Like the discussion of violence and safety in their communities, youth brought up the impact of widespread gun violence/ easy access to guns on their feelings of safety. They shared that they want to have **safer options for being outside and active. Trauma and concerns that "they will die either by the virus or gun violence"** were expressed. Some youth expressed a desire to find out how to respond to racist violence without resorting to violence themselves. **Cyberbullying** was also raised as another form of violence experienced by youth.	*"There's something traumatizing about exiting a train station and seeing someone being carjacked at knifepoint does something to you and having to walk past things like that on your way to school is super problematic."* *"And it's like, when I was younger, back in like middle school and elementary school days, it was not like that. Like, I could go to a park and it's a lot of people there. I don't have to worry about running into a gang or seeing a group of kids with black hoodies on, walking around, messing with people or starting stuff. It's like, I don't have to worry about that. I went to the park, played and went home safely. And now, it's like, 'cause I walk home, you know, from school but I change my route every single time going home. Like I can take three different routes in walking home to get to my house just so I make sure that I'm not being followed or no one's coming from behind me. Like, I'm very aware, especially now that I'm further away, like, walking from West Philly to Southwest, I'm just more aware of my surroundings."* *"A while back when I was sitting with some people that I called friends, people started driving up slowly in black cars with tinted windows. I told them we should leave. They were like no its fine. I left. They rolled down the windows and started shooting. Two to three people died at that party. Everyone started running but I had a head start. You can't even sit at a park anymore."*
Health care access	**30%**	The major points across discussions related to health care access emphasized challenges with getting the right information about available health care resources and how to access them, **understanding and navigating confusing systems**, and managing insurance (and related cost issues, to be discussed below). Participants raised challenges with not getting navigational support from providers, as well as quality issues stemming potentially from **bias/ stereotyping and lack of staffing**. The issue of a local hospital closing was also mentioned.	*"I think that for the Black community, it's very hard to see a doctor, especially given the…current and past racial discrimination within the medical field. It's very hard for Black people to say, 'oh I'm gonna go to the doctor to get a checkup' or 'oh I'm gonna go to the doctor because I have X, Y, and Z medical condition.' 'I'll figure it out on my own, I'll be fine, I'll use these natural resources'….I'm going to go to a hospital that's not gonna give me the same care because of my skin color?–absolutely not! Just not being able to see doctors in that position that look like us, it discourages you from going."* *"It's hard to get myself to get meds."*
Social needs	**30%**	The most commonly cited social needs raised were related to **food (access to healthy foods), housing, financial instability, and transportation**.	*"I know a lot of people who…had to hurt other people to make sure their family was ok. So when I think about health in my community, I think like financially, making sure everyone is cool so they don't have to hurt other people so that their family can eat and can have food for the household…"*

Substance use	**27%**	**Ready access** to drugs, alcohol, cigarettes, and vapes was raised by several groups, leading to problems with addiction. One group raised that use of such substances was a **coping mechanism** for stress and pressure.	*"And I feel like anybody could get vape. It's like so easy. It's not like they need to make the like age limit to where you can smoke or a little bit higher so that people can – no kids can buy it and have more education in schools about that type of stuff. Like nobody knows that vaping is way worse than cigarettes and it's like killing your lungs faster than cigarettes did to the organs, that we all see people dying from lung cancer and having like cold and then burns."*
Need: Supportive adults	**23%**	The need for supportive adults in youths' lives was mentioned several times across groups. The important role of these adults as **volunteer mentors, positive and responsible role models, and "trusted people that they can go to in order to discuss things"** was emphasized by youth, especially to provide support and a sense of safety for difficult or uncomfortable issues they may be experiencing. Youth shared a sense of feeling "**let down**" by adults at school due to lack of nurses and medical staff; lack of timely and supportive response from security personnel, teachers, and police to violence and bullying; and a lack of mentorship.	*"I would say that something we're missing in our community is responsible role models or good role models for the youth, you know. Because it's easy to go out there and just be out and doing whatever you want to do, but when you go out and all you see, you know, is people doing the wrong thing, you know, it's hard to see people doing the wrong thing and not do it yourself 'cause it's even more difficult to know what you're supposed to be doing…"* *"Probably like more encouragement for youth to stand up for themselves, and just like encouragement from their parents, encouragement from teachers, because a lot of times when they don't say anything or like they just let it slide by, it's like you're kind of like giving up on a child…"* *"Counselors mainly just help you get into college, but don't wanna talk about your feelings."*
Physical health	**20%**	In contrast to their responses to questions about community needs, youth did raise a few points about physical health issues experienced by youth. Several pointed out **obesity and lack of sleep** being prevalent across youth. One group shared the importance of greater awareness of **chronic conditions** affecting youth and increasing support for such conditions.	*"I think physical health is also important. Many of my peers don't sleep much because of too much school work."*
Need: Communication/ connection	**20%**	Several groups noted the importance of efforts related to increased and improved communication between peers and with adults. Youth across groups shared challenges with **socializing (including experiencing anxiety), communicating with new friends, and feeling lonely and disconnected** as a result. The negative impact of communicating through **social media** was also mentioned.	*"And then like just a lot of face-to-face interaction, and also like text each other, I guess, but not as much as right now. But then right now, because of how advanced technology is, there's so many social media apps that you can use to communicate with each other. And also, because of COVID, you kind of like - I see some youth be kind of like lost the way of…just like being able to communicate with others."*

Need: Wellness supports for youth	**13%**	A number of discussions mentioned the need for more general resources for youth mental and physical wellness. These could include **informational resources, social or emotional wellness resources, or creation of spaces or activities** where they can be free, safe, and have fun.	*"I think it's habits, like we - like young people…are like learning about stuff they need to do - they can do better to help themselves keep themselves healthy. But…like once you have bad habits over time, and it's really hard to change those."* *"I think I'd say especially rec centers. 'cause one thing I know that makes me stressed is my work so I want tutoring but I want affordable tutoring or even free, 'cause in my area everything is so expensive and I don't get that because a majority of minorities can't afford that."*
Cost of health care	**13%**	In addition to issues with health care access noted above, several groups discussed the impact of **insurance coverage limitations and high costs associated with specialty care and therapy.**	*"I was at the doctors and somebody was just talking about like trying to get on birth control and I overheard the doctor say, 'Well, your insurance doesn't cover this, so, you can't get on it.' And they was like just telling her, like, 'Just keep using condoms.' And stuff like that. And I just feel like, and for females, like, that's just like us having to pay for – pay for pads. Why should we have to pay for something that we can't control our period? So, I just feel like pads should be free and if somebody wants to get on birth control, they need birth control, they should just get it for free."*
Youth autonomy, decision-making, and voice	**10%**	The importance of youth voice and autonomy for health-related decision-making was emphasized by a few groups. Instead of telling them what to do, **providing relevant information so that they can make informed decisions** was preferred by youth.	*"When you bring to them [elder people] your problems, they're gonna try to tell you things that the way they see it. I'm telling you that I see it this way and you're trying to tell me to see it that way, so we're not going to get like the solution. When I bring to you the problem, you should sit down with me and we should discuss it, like what can we do to solve it. The elder people sometime they think that they know everything and they don't want to listen to us and our own opinion."*
Sexual health	**10%**	A few groups raised that issues of sexual health were specific to youth, especially as they are experiencing puberty.	*"In terms of the female community, with like both mental health and physical health, I think that like better sex education in schools is something that's really important. And sex education that is updated to like our modern perceptions of gender and sexuality. I think that's something that's really important for improving both the mental and physical sexual health of especially teenagers, and especially women and people in the LGBTQ community. Because good education can sort of combat stereotypes which can be very harmful like both mentally and physically to people in those communities."*

Potential Solutions

Participants contributed ideas for potential solutions for improving health for youth and their communities:

Theme	%	Description and Examples	Illustrative Quotes
Social needs	**53%**	Youth shared ideas for improving **food access** (e.g., food delivery/car services to increase accessibility for those particularly in need), **building affordable housing** and providing more resources to those experiencing homelessness, making **transportation options more accessibl**e, and **providing workforce development** and employment opportunities.	*"Housing… definitely housing because there's many buildings that could be rebuilt that's in Philly that aren't used and that could be used for housing. But also equity within housing. Equity in jobs. And education."*
Mental health supports	**50%**	Participants offered many creative ideas for providing mental health supports in the community and in schools. Increased **access to mental health professionals** (counselors, therapists) in community settings, as well as in schools was raised. **Peer advocates and teen mentors** supporting mental health were also suggested. Youth had ideas for **creating spaces for openly talking about mental health** (including as a student-led club), as well as **measures schools could adopt** (periodic anonymous mental health check ins, mental health periods, mini-breaks, or wellness days, mental health days off, de-stressing equipment like weighted blankets in a room focused on wellness). Other ideas included providing **workshops on self-care** that offer tools such as meditation, as well as **campaigns** with messages to raise awareness of the body neutrality movement. Youth viewed these efforts as all serving to **normalize and destigmatize** mental health issues, with some noting the importance of educating parents. It was also emphasized that mental health supports should be **free or low cost** to increase accessibility.	*"I said this before, but just like getting more access to mental health resources. I guess, maybe, like giving schools - having schools have more counselors so that students can talk to them."* *"A lot of our youth and even the young adults and adults period have gone through a traumatic experience so just having that trauma-informed care…"* *"Certain groups where you can just sit and listen to someone talk. Because a lot of the times people treat their disorders so casually that if you just let them speak they'll go to rambling on and start revealing things that they would have never said if they were actually paying attention. So you should sit and listen to people sometimes…and you never know what they're gonna say, as long as you're just quiet you listen they can talk on and on and you'll actually find something out that you can see if you could help them with."* *"I would try to like "casualize" therapy because it seems like therapy is such a taboo. Like everybody's like, oh, if you go to therapy you're crazy or therapy is not for you, you don't need it…I would try to normalize therapy, casualize it, casualize talking about mental health in a positive way…. And to make group therapy sessions and things like that and have communication, instead of having like someone says something and it doesn't get heard by someone else, things like that."*

Safety	**43%**	Youth noted several strategies to potentially **increase safety in play areas and neighborhoods** (e.g., cameras, officials and other monitoring of playgrounds). To stop gun violence, participants mentioned **gun control** to get guns off streets. Others suggested building capacity for **healthy conflict resolution** and creating **positive outlets for arguments or anger**. Youth discussed the **role of police** (increasing numbers, having more officers who "look like me") and strengthening **community policing**.	*"Better gun protection laws…who's accessing this type of stuff? How they're getting their hands on it and how can we make it safer for those communities so that people who may not be in the right state having access to this type of stuff, or children getting access to it. What we can do to protect ourselves and others, along with the children in the neighborhood getting access to this type of stuff. Better safety measures."* *"I think definitely fixing up Germantown but not pushing out people that lived in Germantown. But fixing it up to a point that it feels like a stable environment. I don't want to say more police around Germantown because that wouldn't help but doing something that would help prevent violence."* *"Our police are a major part of this community and they have a lot to do with the interactions between the community and them and so trying to strengthen those community relations and realize that every single cop that you see is not necessarily a bad cop….Just strengthening community policing would be major for communities in general."*
Community activities/facilities	**43%**	Participants felt that increasing community activities like **clean ups and social events**, as well as facilities like **recreation centers or skating rinks**, would improve health in their communities. In particular, they emphasized creating **safe spaces for youth**, such as community gardens, or events like sports tournaments. Such gathering places could offer health-related programming. One group discussed a **one-stop-shop for youth** to get services and assistance with navigating complex systems, as well as connect with other youth.	*"I will like kind of say what you said, like community service. And I feel like our biggest issue may be …the many homeless people that you see out there, there's probably like, as I came here today I probably seen like 10 homeless there, I always see every day. And I feel like we as community could do… what is it like donation to give out food and stuff and clothes since there's also COVID so it's like obviously, they're affected by all this COVID and stuff. And like me and my friends during COVID we actually planned out and made food, and then we surprised homeless people, we drove around South Philly or North Philly and stuff, we just gave out food. So, I feel like if our community do that, I feel like we could get more people, more homeless out the streets and stuff."* *"I would say like more recreation centers around the community to like keep kids off the street, stuff like that."* *"I want somewhere where I can feel safe….I want somewhere where everybody's gonna accept me for who I am and not just look at me for, she has an accent, she's from that place. I want them to see me for who I am and not from where I'm from or how I'm different. I just want them to see me for me."*

School and extracurricular programs	**43%**	The potential to create and offer **more clubs to cultivate hobbies**, programs to encourage self-development, **classes to build life skills**, and **sports activities to foster social emotional learning** was very appealing to youth participants. They emphasized that it was important that the programs be **fun and foster connection** with others.	*"I feel like afterschool programs, like, [name] said, she said, not all kids like school but at least, if they know that they could go to basketball practice once the school day is out, they'll give them a motivation or a reason to come to school and to do their schoolwork and do good so that they can stay on their basketball team."* *"A lot more programs and stuff but more specifically free programs because the poverty in Philadelphia is like really high and so a lot of people can't afford a lot of things. And so I would say a lot more free programs that people can join because I've noticed that when youth aren't a part of a program or a job or just like not doing anything with themselves, they more so get in a lot more violence and more drama, gun violence and all that type stuff that they could avoid. But since they're not a part of anything they're more so to be in it. And so if there's more free programs for them to join they have more opportunities to find something that they like to do or something that like interests them or something like makes them happy to do."* *"Youth in developmental workshops, getting your own sense of identity, just to know that there are things out there, putting youth on different podcasts, different things like that… to just see what out's there in the world."*
Supportive adults	**33%**	As raised in responses to an earlier question, the importance of supportive adults in youths' lives cannot be overstated. Again, participants expressed a strong desire for **strong community leaders, community volunteers, positive role models, and mentors to help keep them "safe and off the streets."** In addition to "teachers who care" (ideally hired from the community), youth offered an idea for building connections with police in schools, as well as thoughts around providing training to adults working with youth on social emotional learning. In addition, one group discussed educating parents on conversations about race and gender.	*"I guess like in my school community, like once I talked to one of my counselors, it took me a long time. It was like after I went through a really hard time, I didn't talk to her during that hard time. But then it was like after with college applications, which I'm doing right now. And then I started talking to her about problems that I had in the past, and then she was - it was like really helpful and she really made me feel a lot better. And so, I guess, just like counselors in schools, like in school communities work really well."* *"Definitely partnering up with schools and being more vocal about females…about our body parts, menstrual cycles, what can we take including herbal things, that could be brought into health. Having the nurses not be in the nurse office and to come check. 'Cause I'm pretty sure there's a lot of students that I knew I grew up would not just really care about themselves because they were suffering from depression from home and their parents didn't check up on them…. So I feel like…the way that you take care of yourself root from childhood."*

Health care access and affordability	**30%**	Consistent with responses to earlier questions, youth shared the need for **financial and navigational supports** when seeking to access health care. The need for **more affordable and accessible health care facilities**, such as neighborhood clinics, was emphasized. The **qualities of health care providers** are also important – increasing representation of people of color and diverse gender identities, as well as hiring/training providers who are committed to providing equitable care, was suggested by participants.	*"Uniformly having providers accessible especially those who are people of color, and/or Queer."*
Support systems and resources	**23%**	From a general perspective, youth are in need of support systems that are **integrated and help them connect to needed resources**. Similar to health care, youth need help finding out about available resources for other needs and ultimately connecting with them. This was particularly noted for immigrant communities who may be contending with language barriers and fear/anxiety related to asking for help. Some suggested **school-based support systems**, while others discussed **community-based systems that seek to ensure services provided are widely known, accessible, and effective**. Some youth suggested culturally relevant **public education and awareness campaigns** to spread the word about these systems and resources.	*"For me, I guess like if I could design my own community, I would put in like a lot of support systems, and just build like a friendly environment where everyone can depend on each other, and just help each other out."* *"The youth don't want the resources that are provided…the youth need more help. They need people to actually go to them with the resources."* *"Resources on different types of topics. So like family issues, on an individual basis as well relationships, how to form integral, intimate, intentional relationships…. You want to have a joyful road in life. You don't want to just do anything just for the sake of doing it. I think resources, education, self-development are things that our communities could use."*
Environment	**20%**	Suggestions for improving local environments included community **clean ups**, planting **more trees and more plant life**, putting up more **murals**, providing more **garbage cans**, and preventing **illegal dumping**.	*"I would say… getting together and cleaning yards around the neighborhood because seeing trash every day because it doesn't bring a good image in your mind."* *"Why do you have to clean up a neighborhood just to kick people out? Why can't all people be allowed to live in their neighborhood? A clean equitable neighborhood, so that they don't have to go to a white neighborhood to get good produce."*

Community connections and collaboration	**17%**	Participants discussed the importance of building connections and **trust with communities**, especially for the medical community. This could be achieved by working with **trusted messengers** and **sustaining initiatives** in communities (participants noted programs that end when funding ends). Youth also emphasized the need to build connections and collaboration within communities, **being supportive of one another and fostering diversity and equality**. By building stronger connections and collaborations, these youth feel that advocacy efforts would be that much more effective.	*"The problems within our community are here by design. Since they are man-made, man/woman can fix them."* *"Have more activities and programs for people of different ages and different ethnicity to join. This can bring people out of their house and educate each other so there's less misunderstanding or miscommunication."* *"I would have people from different backgrounds, ethnically, race, etc. People of different ages… basically people who are different from each other… so they can all share their ideas and their beliefs and they can also like come to understandings for each other. Which is something that could help people in the real world, like meeting new people from different places, from different backgrounds, with different histories…it could help people understand those people better. I honestly feel that would make the world a little bit better so there's not so much fighting and disagreement."* *"Having that somebody that cares about you, that really want to see you grow, it helps….In the Philadelphia community, we have a lot of violence and you know, and having somebody that constantly asks you 'are you ok? Are you having a good day? If you really like the equipment, how it feels and whatnot?' It really makes me feel like somebody values my opinion and for them to value my opinion says a lot."*
Physical activity	**13%**	Youth shared the importance of increasing access to opportunities for physical activity that are **safe and ideally outdoors**.	*"I would like to see a recess in the schools. I know high schools may not do that but I really miss recess. Since I graduated from 8th grade I had recess, but 9th, 10th, I did virtual in 11th but that don't count, and now I'm in 12th and still no recess. I really miss recess. I like to go outside, get fresh air, run around. I feel like kids, even older kids like us teenagers, we still need it."*
Youth voice	**13%**	Several groups prioritized the need for youth leadership and voice related to health improvement in their communities. They expressed wanting to be **taken seriously, taking a "seat at the table," "speaking out," and crossing generational divides** by sharing their ideas and working alongside adults to improve health.	*"Our generation is very defensive…and we also feel like we know it all. But we forget that these people have lived through hard times. And they might actually have some insight in a way to help us better. In the moment you may not see it as it's gonna help me… but as a younger generation I feel like we don't know how to take things with a grain of salt…Open-minded. And this can also go for our older generation, too, to be open-minded to us. But I feel like it's a two-way street. Because I've talked to like a bunch of older people, and I have to say that it's one of the best things that I've done. When you want to get somewhere in life, when you want to do something, you look at those people who are doing what you want to do because at the end of the day, they've done it, they've done it."* *"Solutions in the community is giving your youth a voice, not only in their towns but bigger!"*

Substance use	**13%**	A number of groups noted the importance of programs to address **addiction, including increasing services provided in communities, and reducing access to substances** by preventing them from being sold to youth.	*"…all those people that are on the streets, there should be facilities like rehabs specifically for them to get back on their feet because they always go to locking them up. But in reality, it's not that you control, it's a mental illness – so we shouldn't be putting people in jail for something that they can't control like addiction."*
Social media	**13%**	Youth acknowledged the power of social media as a major form of communication in their lives. Some suggested **harnessing the power to spread** important health messages, while others suggested the need to **ensure that it isn't being used to spread misinformation**. Participants offered the idea of **education campaigns** to share the impacts of cyberbullying and trolling.	*"Social media is like a cup—you know, it depends on what you fill it with. You can fill it with poison, or you can fill it with water, you can fill it with juice. What are you consuming on social media? When you go on Youtube, what are you watching? What are you putting your mind, what are you using your brain for?"*

LGBTQ+ COMMUNITIES

One of the goals of Healthy People 2030 is to improve the health, safety, and well-being of lesbian, gay, bisexual, and transgender people.

In recognition of the challenges posed by limited and inconsistent collection of sexual orientation or gender identity information, several Healthy People 2030 objectives are focused on increasing the collection of such information in national surveys, including the Behavioral Risk Factor Surveillance System. Such information is critical for identifying and gaining a more comprehensive understanding of the unique health needs of lesbian, gay, bisexual, transgender, queer/questioning, and other identity (LGBTQ+) communities.

Available data underscore the need for urgency not only in understanding, but action. Targeted data collection efforts amply demonstrate the increased risk of poor physical and mental health outcomes among those identifying as LGBTQ+. These stem from intersecting challenges related to societal stigma, interpersonal and institutional discrimination, heightened threat of violence, and lack of access to culturally-affirming and informed health care. The greater likelihood of risky health behaviors, such as higher rates of substance use, found among members of LGBTQ+ communities must be examined in light of these significant stressors. Inclusive, responsive systems of care are necessary to mitigate these increased risks and establish the conditions for sustained well-being for LQBTQ+ communities.

Since 2015, the Pennsylvania Department of Health (PA DOH) has sought to systematically assess the health needs of LGBTQ communities throughout the Commonwealth with what is now the biannual Pennsylvania LGBTQ Health Needs Assessment. For the 2020 assessment, PA DOH partnered with Bradbury-Sullivan LGBT Community Center and the Research & Evaluation Group at Public Health Management Corporation to administer an online survey to LGBTQ-identified Pennsylvania residents. A total of 6,582 respondents participated in the survey, which was available in English and Spanish. Most respondents identified as gay (34.7%), bisexual or pansexual (29.8%), lesbian (18.3%), or queer (10.4%). One in six identified as non-binary (9.2%), genderqueer (2.7%), genderfluid (2.6%) or another gender (2.0%). Nearly half the sample was between the ages of 25 and 49 years and nearly a third under 25. A large majority (83.8%) identified as white, with the remaining identifying as Black or African American (4.6%), another race (4.5%), multi-racial (4.5%) or Asian (2.0%); seven percent identified as Hispanic or Latinx. The sample was highly educated, with 86 percent having greater than high school levels of educational attainment.

Across the entire sample, key findings demonstrate:

- Interest in incorporating healthy living strategies into their lives among nearly all respondents.
- Widespread experience of respect for their LGBTQ identity by their friends and household members.
- Lack of trust of health care providers, as a quarter of respondents have not disclosed their LGBTQ identity with any of their health care providers and over a third fear seeking health care services because of past or potential negative reactions.
- Significant barriers to health care, with over 40 percent experiencing at least one barrier to health care, such as inaccessibility of LGBTQ-affirming providers (too far away, not covered by their health insurance) or inability to afford costs.
- High prevalence of mental health concerns, as nearly three quarters of the sample experienced a mental health challenge in the past year; of those, less than half received counseling or mental health treatment. In their lifetimes, over half have had thoughts of suicide or self-harm.
- Widespread lifetime experience of discrimination based on LGBTQ status.
- Nearly 40 percent have experienced violence from a family member, partner, or spouse. Nearly a quarter report experiencing violence based on their LGBTQ status, with greater likelihood among respondents of color or those who identify as transgender, non-binary, or genderqueer.
- Financial challenges, with nearly a third experiencing food insecurity and more than one in four reporting that they do not have any money left over at the end of the month.
- About a fifth of the sample reporting experiencing homelessness in their lifetime. Nearly a third of respondents of color, as well as nearly a third of transgender, non-binary, or genderqueer respondents, report experiencing homelessness.

Philadelphia residents comprised 13.6 percent of the sample, while residents of Berks, Bucks, Chester, Delaware, Lancaster, Montgomery, and Schuylkill Counties made up the 21.8 percent of respondents designated as a separate Southeastern Pennsylvania (SEPA) region.

Results specific to these areas include:

	Philadelphia	Southeastern PA	PA BRFSS Comparison
Smoking	25%	26%	17%
Binge drinking	38%	31%	17%
Having at least one primary risk factor for HIV	42%	34%	7%

Highest priorities to address in each area include:

- **Philadelphia:** Depression, alcohol/drug addiction, and loneliness/isolation
- **SEPA:** Depression, suicide, and bullying

From a health care perspective, findings from Philadelphia respondents shed light on gaps in care, as:

- Nearly 22 percent do not have a personal doctor or healthcare provider
- Nearly a quarter have not visited a doctor for a routine checkup in the past 12 months
- Almost a third have experienced a negative reaction from a healthcare provider upon learning their LGBTQ status
- A third do not believe most of their healthcare providers have the medical expertise related to their health needs as an LGBTQ person.

To address the needs revealed by this assessment, the following actions are recommended:

- Support connections to LGBTQ-competent providers;
- Support initiatives that address social determinants of health;
- Identify community-wide mental health supports;
- Support chronic disease prevention;
- Promote tobacco cessation opportunities;
- Encourage health screening discussions and health education;
- Bolster community supports for black, indigenous, and people of color;
- Prioritize the health needs of transgender, non-binary, genderqueer, and individuals born intersex;
- Continue and enhance data collection; and
- Partner with LGBT community-based organizations.

Respondents were asked, **"What is one thing you would like to tell healthcare providers to be more welcoming?"** Here are some of their messages:

If you claim competence, I should not be put in a position of educating you on basic care. If you do not claim competence, at least be prepared for an LGBTQ person to walk through your door.

Don't assume everyone is cisgender.

Accept and understand that identity often doesn't change how you need to do your job.

Be honest with us.

Train staff on transgender interactions and appropriate usage of pronouns and communication skills. We are a population highly vulnerable to mistreatment by medical staff, and most likely do not trust that we will be treated fairly from person to person, as many assumptions are made by our appearance. It is exhausting.

Just because we don't 'look gay' doesn't mean we are not gay.

Ask if I'm lonely or depressed.

Take 'first, do no harm' seriously. That's not just physical, but also intellectual and emotional.

Ask everyone their pronouns.

Please be mindful of body language and facial expressions when someone confides that they are LGBTQ+.

Educate yourself.

I know that 'sex' on the intake form is needed for medical reasons, but it would be great if you could also include 'gender' and 'pronouns' on the forms.

A rainbow flag goes a long way.

Be more welcoming to the trans community.

Source: 2020 Pennsylvania LGBTQ Health Needs Assessment

Findings from the 2019 Youth Risk Behavior Surveillance System provide information about the experiences of youth in Philadelphia (a comparable dataset is not available for other counties in the five-county region). More than 1,200 9th to 12th grade high school students from 25 randomly selected Philadelphia public high schools completed the anonymous, self-administered survey in spring 2019. Nearly a quarter of respondents identified as lesbian, gay, bisexual, or unsure.

Among those students:

- Nearly half seriously considered suicide in the prior 12 months (almost three times the rate of heterosexual students) and were over three times more likely to be treated for a suicide attempt than their heterosexual peers.
- Relative to their heterosexual counterparts, LGB students were more likely to report that their mental health was not good (80.3% vs. 55.6% of heterosexual students) and that they felt sad or hopeless for 2 or more weeks in the past year (64.9% vs. 35.3%).
- Compared to 14.3 percent of heterosexual youth, 33.7 percent of LGB youth report drinking in the past 30 days. Binge drinking is also more prevalent among LGB youth relative to heterosexual peers (13.7% vs. 3.8%).
- LGB youth also experienced being physically forced to have sex, sexual dating or physical dating violence, and electronic bullying at much higher rates than their heterosexual peers.
- Thirty percent of LGB youth report experiencing homelessness.

COMMUNITY HEALTH NEEDS

All quantitative and qualitative inputs were organized into 12 community health needs that were categorized across three domains:

Health Issues	Access and Quality of Healthcare and Health Resources	Community Factors
Physical and behavioral health issues significantly impacting the overall health and well-being of the region	*Availability, accessibility, and quality of healthcare systems and other resources to address issues that impact health in communities across the region*	*Social and economic drivers of health as well as environmental and structural factors that influence opportunity and daily life*
• Chronic Disease Prevention and Management • Mental Health Conditions • Substance Use and Related Disorders	• Access to Care (Primary and Specialty) • Food Access • Healthcare and Health Resources Navigation (Including Transportation) • Culturally and Linguistically Appropriate Services • Racism and Discrimination in Health Care	• Community Violence • Housing • Neighborhood Conditions (e.g., Blight, Greenspace, Air and Water Quality, etc.) • Socioeconomic Disadvantage (e.g., Poverty, Unemployment)

Participating institutions' ratings of the community health needs were aggregated and are listed below in order of priority (please see "Our Collaborative Approach" for details on the prioritization process):

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

Potential solutions for each of the community health needs, based on all qualitative data collection efforts, are also included.

PRIORITY
#1 Mental Health Conditions

- Youth and adult community members and community partners prioritize mental health as their top health need.
- Significant mental health needs across the region are indicated by:
  - High rates of depression among youth and adults (1 in 5 adults report diagnosed depressive disorders, and many more are undiagnosed)
  - Across the 5 counties, 15 percent of residents report frequent mental distress.
  - Suicide mortality and suicide attempts/ideation rates among youth (particularly among those who identify as LGBTQ+) that persist and are likely to show increases when more recent data is made available.
- These concerning trends were exacerbated by the social isolation, stress, and fear experienced due to the COVID-19 pandemic.
- Pandemic-related trauma is particularly compounded for those communities also contending with trauma associated with high levels of poverty, community violence, and racism.
- If left undiagnosed or untreated, there is increased likelihood of serious issues that result in increased health care (especially emergency department) utilization and co-occurring substance use disorders.
- Populations particularly affected include youth, older adults, immigrant communities, LGBTQ+ communities, those experiencing homelessness and housing insecurity.
- There continues to be a significant lack of community-based, integrated mental health treatment options and a particular dearth of resources for youth with mental health needs and their families.

Potential Solutions

- **Improve care coordination as part of an integrated care model** that assesses the whole person, addresses both physical and behavioral health, and coordinates care across hospitals and community-based service providers:
  - Expand warm handoffs between hospitals, emergency departments, primary care practices, community behavioral health service providers and community-based organizations.
  - Develop coordinated Crisis Response Systems available 24/7, 365 days a year.
- **Increase awareness of behavioral health resources and services**. Hospitals can promote internal awareness and community knowledge about behavioral health services and how to access them.
- **Increase access to safe, structured afterschool activities for youth** available on weekends and in the evening.
- **Create spaces for openly discussing mental health for youth** to normalize/destigmatize mental health issues.
- **Co-locate prevention and behavioral health services in community settings ("one stop shop") where families live, work, learn, and socialize.** For example, in partnership with community-based organizations, provide co-located behavioral health prevention programs, treatment, and other intervention services in schools.
- **Increase access to support groups** to address mental health and substance use.
- **Increase training for healthcare providers, community-based organizations, schools, law enforcement, and others in Mental Health First Aid, trauma-informed care, and cultural competence/sensitivity.**
- **Increase behavioral health workforce capacity and diversity** (e.g., language, racial, and ethnic). Increase number of professionals who represent the racially and culturally diverse populations they serve.
- **Increase individuals with lived experience in the behavioral health workforce.** Peer advocates and teen mentors may be particularly effective sources of support for youth.
- **Provide programming to prevent "burn-out" among behavioral health staff.**
- **Support efforts to increase funding** to ensure that all families and children can access evidence-based mental health screening, diagnosis, and treatment, as advocated by the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, and Children's Hospital Association.

PRIORITY
#2 Access to Care
(Primary and Specialty)

- The supply of primary care providers across the region compares favorably to national data and trends with uninsured rates are improving regionally, but challenges remain with increasing provider acceptance of new patients with Medicaid coverage.
- Barriers to access to primary care for communities are due to:
  - Lack of providers in neighborhoods (especially in NE/SW Philadelphia, rural areas in suburban counties)
  - Affordability (particularly among those who are uninsured, those with lower incomes unable to afford co-payments/ deductibles)
  - Language/cultural barriers (notably among immigrant communities and English language learners)
- The above issues are exacerbated with specialty care, with added challenges posed by even more limited availability of appointments, high cost, and lack of care coordination/linkage with primary care.
- Impacts of the COVID-19 pandemic include:
  - Increased enrollment in Medicaid (increases ranging from 11% to 20% in 5 counties, 2020-2021)
  - Longer wait times for appointments, especially for specialty care
  - Gaps in access to preventive services, including immunizations for children/youth, health screenings/ diagnostic testing for adults (e.g., chronic diseases, breast/ colon/prostate cancer)

Potential Solutions

- **Provide education and information about Medicaid (e.g., eligibility, coverage) and assist with enrollment.**
- **Create high quality free or low-cost health care options** to serve those who may be uninsured or underinsured.
- **Establish comprehensive health centers** that would address not only physical health, but also mental health and dental care. (It is worth noting that though not the highest priority, there was consistent mention of the need for improved access to dental care across different communities, suggesting a potential opportunity to explore improved linkage to dental care providers.)
- **Bring more health and social services directly to underserved communities through health clinics in schools or mobile medical clinics.**
- **Embed social workers in primary care practices, such as family medicine, pediatrics, and OB/GYN offices.** These professionals could help to assess, refer, and enroll individuals and families in other needed health and social services.
- **Train all levels of hospital staff and other healthcare providers on delivering "non-biased, culturally appropriate, trauma-informed care."** Community members expressed the need to ensure that all staff are welcoming and respectful.
- **Provide on-site language interpreters and health education materials in diverse languages.**
- **Increase the racial, ethnic, and language diversity of staff and providers** to better reflect the communities they serve.
- **Increase transportation assistance**, including adding options for those not eligible for certain benefits.
- **Expand appointment availability and hours in low access areas.**
- **Address barriers to telehealth (e.g., related to internet or device access or digital literacy)** and provide necessary support to ensure high quality telehealth experiences.

PRIORITY
#3 Chronic Disease Prevention and Management

- Conditions like heart disease, cancer, stroke, and chronic lower respiratory diseases continue to constitute the majority of the top 5 leading causes of death for all counties.
- Notable differences between counties in southeastern Pennsylvania:
  - Rate of premature cardiovascular deaths significantly higher in Philadelphia County
  - Cancer mortality rates highest in Delaware and Philadelphia Counties
  - Hypertension-related hospitalization rates highest in Bucks, Delaware, and Philadelphia Counties
- Across and within 5 counties, disparities in burden of chronic disease correlate with poverty, which disproportionately affects communities of color. In Philadelphia, for example, Hispanic/Latino communities have some of the highest rates of chronic conditions, such as asthma and obesity, and the city's non-Hispanic Black population has disproportionately high rates of chronic conditions such as hypertension and diabetes.
- The COVID-19 pandemic has negatively impacted chronic disease prevention and management. Notably, there have been delays in seeking care, as found in qualitative reports and indicated by lower health care utilization in 2020 as compared to previous years. The full impacts will be clearer with data from 2021 and beyond.

Potential Solutions

- **Better inform, educate, and engage the public regarding chronic disease prevention and management**. Address limited knowledge about chronic disease screening guidelines and resources through engaging campaigns on varied platforms, including virtual health promotion programming.
- **Engage trusted community leaders to help spread important messages** (for example, promoting cancer screening). Men sharing their stories around personal health and screening may serve as particularly effective examples for other men.
- **Expand successful innovations from the pandemic, such as virtual wellness programs.**
- **Bring screenings and health education to faith-based institutions or where people shop, recreate, or work.** Provide flexible times.
- **Integrate mental health services into overall care management for people with chronic diseases.**
- **Before patients leave a hospital or clinic, provide screening, referrals, and "warm hand-offs"** to community-based health and social services, as well as resources that assist with lifestyle changes for people managing chronic conditions.
- **Increase networking and collaboration among community organizations and health system partners** to improve resource sharing and coordination of services.

PRIORITY

#4 Substance Use and Related Disorders

- Substance use disorders often co-occur with mental health conditions.
- Substance use is associated with community violence and homelessness.
- Drug overdose rates continue to be high due to the opioid epidemic. The drug overdose rates in Bucks, Delaware, and Philadelphia Counties exceed the overall Pennsylvania rate. It is the leading cause of death for young adults.
- The opioid epidemic is associated with increases in other health conditions including HIV, Hepatitis C, and Neonatal Abstinence Syndrome (NAS).
- Use of other substances, especially during the COVID-19 pandemic, was of pressing concern to community members and partners. Binge drinking among adults and youth, as well as cigarette, marijuana, and vape use among youth, were raised as increasingly prevalent. High rates of marijuana vaping among youth in the four suburban counties.

Potential Solutions

- **Sustain and expand prevention programs**, ranging from school-based educational programs to community drug take-back programs.
- **Advocate to increase and sustain funding for drug and alcohol prevention programs in schools and other programs.**
- **Expand school-based services** that address students' behavioral health, including drug and alcohol use.
- **Broaden and intensify efforts to reduce vaping among youth.** Collect better data to understand vaping trends among youth and encourage school districts to shift toward policies that provide "*more supportive and restorative disciplinary actions*" for students who are disciplined for vaping, such as referral to cessation programs and other support.
- **Reduce youth access to substances** by preventing their purchase by youth (e.g., drugs purchased on the internet).
- **Expand Narcan training and distribution.** Training more professionals, including police, to provide these services could help lower overdoses.
- **Increase medical outreach and care for individuals** living with homelessness and substance use disorders.
- **Encourage use of Certified Recovery Specialists and Certified Peer Specialists in warm handoffs** for drug overdose and other behavioral health issues.
- **Develop texting support services that address underlying issues of substance use**, provided by trained peers or qualified therapists to individual clients.
- **Streamline system navigation for providers and the population at large** to facilitate access to outpatient services after discharge from inpatient facilities.

PRIORITY
#5 Healthcare and Health Resources Navigation

- Community members and partners widely viewed navigating healthcare services and other health resources, like enrollment in public benefits and programs, as a challenge due to general lack of awareness, fragmented systems, and resource constraints.
- Healthcare providers, particularly in the primary and acute care setting, can play an integral role in linking patients directly to health resources or to community health workers or care coordinators.
- Navigation includes information as well as transportation. Many individuals, especially older adults, face significant challenges securing transportation to healthcare and health resources. Lack of accessible, affordable transportation options was raised in a large majority (70%) of qualitative meetings, with the need spanning urban and suburban counties. Financial and logistical issues associated with travel can be a barrier to accessing healthcare and health resources.

Potential Solutions

- **Increase public awareness of community resource directories** that local health systems have invested in and support community members with using them.
- **Increase the capacity of healthcare staff** to assist community members with navigation by regular education on available resources.
- **Grow the numbers of professionals serving as community resource or healthcare navigators.**
- **Create permanent social service hubs** that serve as "one-stop-shops" for commonly needed resources.
- **Expand low-cost transportation options** available for those in most need (e.g., older adults, some immigrant communities).

PRIORITY
#6 Racism and Discrimination in Health Care

- Racism is recognized as an ongoing public health crisis in need of urgent, collective attention.
- The COVID-19 pandemic has unmasked and amplified longstanding health and economic disparities experienced by communities of color. Higher rates of COVID-19 infection, hospitalization, and mortality experienced by Black communities are further examples of inequities stemming from structural racism.
- Representatives of communities of color shared their mistrust of healthcare providers and institutions arising from seeing such disparities and personally experiencing discriminatory treatment in health care settings.
- Such experiences can lead to forgoing of needed care, resulting in increased morbidity and mortality.
- Anti-Asian hate crimes have increased during the COVID-19 pandemic. Fear of violence among Asian older adults has led to reluctance in leaving their homes, resulting in increased social isolation and adversely affecting mental and physical health.

Potential Solutions

- **Train and hire people with lived experience, such as community health workers and community peer specialists, to work in communities that have been historically marginalized.** These workers, who could be embedded in local community organizations, would be paid a fair wage to connect people to care, help them navigate services, and assist as their advocates within the health system.
- **Increase hospital investment in grassroots community organizations that are working to address social determinants of health and related needs.**
- **Expand and improve the training of healthcare providers around anti-racism, structural racism, implicit bias, diversity awareness, cultural competence, and trauma-informed care.**
- **Increase the number of people of color in healthcare leadership positions.**
- **Ensure diversity, equity, and inclusion efforts and plans within healthcare institutions include an explicit focus on racism and discrimination, with focus on policies, care practices, and ongoing measurement.**
- **Create and fund ongoing forums for community leaders to work with health system partners to address issues of racism and discrimination in health care.**

PRIORITY
#7 Food Access

- Issues of food access focus primarily on food security, defined as having reliable access to a sufficient quantity of affordable, nutritious food. Many community members experience challenges with obtaining sufficient food of any kind, as well as report issues with accessing healthy food more specifically.
- The financial challenges brought on by the COVID-19 pandemic has led to an increase in rates of food insecurity across all counties and sharply rising demand for emergency food assistance. Nearly a quarter of Philadelphia households are receiving Supplemental Nutrition Assistance Program (SNAP) benefits.
- Black and Hispanic/Latino communities are disproportionately impacted by food insecurity, as are older adults and immigrant communities.

Potential Solutions

- **Ensure more equitable access to food assistance programs and resources throughout the region.** Hospitals could partner with local organizations to collect and share data to assess and address food access disparities in different communities. Data collection tools also are needed to measure progress toward food security goals. To ensure equitable access to resources, people from under-resourced communities also need a voice at the table.
- **Before patients are discharged from the hospital, provide "warm handoffs" to connect them with community health and social service organizations that address hunger and other needs.** Ensure that patients are connected to public benefits for which they are eligible.
- **Increase collaboration and resource-sharing between hospitals and community groups that are working to increase healthy food access.**
- **Build the evidence base to document the clinical benefits and cost savings of a nutritionally sound diet to prevent or manage common diseases.**
- **Increase outreach to raise awareness and utilization of food assistance programs.** The sheer number of food resources and agencies in the region requires consistent outreach efforts to help people find and connect to what they need. Such assistance should use a wide range of formats and media to reach diverse audiences.
- **Provide services that distribute food directly to people where they live, especially in neighborhoods with limited or no access to healthy food.** Possible ideas for exploration include food trucks or produce distribution from local community gardens.
- **Increase affordable transportation options for people who cannot drive or get rides to emergency food or other needed resources** for people in rural and urban areas of southeastern Pennsylvania.

PRIORITY
#8 Culturally and Linguistically Appropriate Services

- About 12 percent of the population across the 5 counties were not born in the U.S. As much as 45 percent of residents of some geographic communities report speaking English less than very well.
- The need for culturally concordant providers and resources to address language barriers was raised in over 50 percent of qualitative meetings.
- Provision of high quality language services (oral interpretation and written translation) is critical for providing equitable care to these communities.
- Beyond language access, cultural and religious norms influence individual beliefs about health. Providers and systems equipped to engage patients about these beliefs and integrate them into care is needed.

Potential Solutions

- **Increase the racial, ethnic, and language diversity of staff and providers** to better reflect the communities they serve.
- **Develop organizational language access plans that outline protocols for identifying and responding to language needs.**
- **Explore the development of formalized programs to train and credential bilingual staff (employed for other roles) to serve as medical interpreters.**
- **Provide on-site language interpreters and health education materials in diverse languages.**
- **Develop strong partnerships with community organizations serving diverse communities that involves providing financial support.** This could mean sharing funding with community organizations for providing consultative support based on their linguistic or cultural expertise or healthcare navigation support to patients.
- **Train all levels of hospital staff and other healthcare providers on delivering *"non-biased, culturally appropriate, trauma-informed care."***

PRIORITY
#9 Community Violence

- Violent crime and homicide rates are 8-10 times higher in Philadelphia compared to suburban counties.
- In 2020, Philadelphia lost 447 people to gun violence, the most gun-related homicides in 30 years. It is the leading cause of death for Black men ages 15-43 and Hispanic/Latino men ages 15-31.
- Community violence driven by community disadvantage disproportionately impacts N, NW, and SW communities in Philadelphia.
- The trauma associated with exposure to gun violence is widely felt in communities, especially among youth. However, they report experiencing significant challenges in accessing the necessary mental health supports to address the negative impacts of such exposure.
- Women, youth from immigrant communities, and LGBTQ+ communities are at higher risk of interpersonal violence, including intimate partner violence (IPV), sexual assault, and sex trafficking. Reports of increased risk of IPV associated with COVID-19 stay-at-home orders have been shared by local advocates.
- Negative social media engagement, including cyberbullying, among youth can be a source of community violence.

Potential Solutions

- **Increase awareness and availability of youth programs to prevent violence, including educational programs, sports, and other recreational activities.** Communication strategies that encompass youth culture and include youth input are needed, as is more funding.
- **Integrate social and mental health services into existing youth activities.** Also provide training for individuals who are trusted by and work with youth (e.g., teaching artists, coaches, teachers, parents) in addressing trauma and other violence-related issues. Help parents advocate for needed mental health services.
- **Build youth capacity for healthy conflict resolution and create positive outlets for arguments or anger.**
- **Create more safe spaces for people to talk about the violence they experience.**
- **Train all levels of hospital staff and other healthcare providers on delivering *"non-biased, culturally appropriate, trauma-informed care."***
- **Increase accountability and coordinated action in addressing community violence from the city, schools, health systems, higher education, neighborhood civic association groups, and community-based organizations.** As an integral part of these efforts, hospitals can:
  - **Increase advocacy for policies to prevent or reduce violence**, including initiatives to address poverty and other social determinants that contribute to violence.
  - **Partner with community-based organizations to build on each other's strengths and increase funding opportunities.**

PRIORITY

#10 Housing

- Safe, stable housing is critical for physical and mental health and well-being. Lack of stable housing is associated with 27.3 fewer years of life expectancy.
- Health issues associated with housing instability include behavioral health issues (mental distress, depression, developmental delays in children, falls among older adults) and medical conditions such as asthma and lead poisoning. Households may forgo needed health care due to financial strain.
- In 2018, 40 percent of Philadelphia households were cost-burdened (when a household spends 30 percent or more of its income on housing costs, including rent, mortgage payments, utilities, insurance, and property taxes). This figure is expected to be higher as a result of the COVID-19 pandemic.
- Poor housing conditions like old lead paint, asbestos, infestations, lack of running water or HVAC, and damaged infrastructure disproportionately impact communities with low incomes.
- Lack of affordable housing is a major driver of homelessness.
- Although point-in-time counts of individuals experiencing homelessness indicate decreases in overall numbers in all five counties over the past several years, continued focus on addressing homelessness is critical, especially when the moratorium on evictions ends.
- People experiencing homelessness are at increased risk of mental health and substance use disorders and experiencing discrimination and bias in healthcare settings.
- Homelessness experienced by youth and older adults are of particular concern for local advocates.

Potential Solutions

- **Drive solutions that prevent homelessness**, including advocating for livable wages, more affordable housing, and services that support aging in place.
- **Advocate for and implement responsible and equitable neighborhood development that avoids displacement and segregation.**
- **Increase investments by hospitals, managed care organizations, and others in supportive housing programs known to be effective in reducing housing insecurity and preventing homelessness.** These programs, which have been shown to reduce healthcare costs, provide housing and rent subsidies along with wrap-around services to prevent homelessness and re-incarceration.
- **Explore strategies that aggregate funds to support rental assistance.** Encourage health systems and health insurance providers to invest in rental assistance.
- **Explore development of an equitable acquisition fund** to preserve and create affordable housing.
- **Expand programs that support habitability and raise awareness of available resources for housing repair assistance.** Such programs can help older adults age in place.
- **Evaluate existing hospital housing programs for potential expansion**, including those that provide home repairs and remediation for high risk youth (e.g., with asthma) and older adults.
- **Train and encourage health care providers, including primary care physicians, to conduct regular housing insecurity assessments for patients, particularly families, and make referrals as appropriate.** Also train health professionals and social service providers to use a trauma-informed approach when caring for individuals experiencing homelessness or housing insecurity.
- **Increase Rapid Re-housing Programs.** These programs help individuals and families to quickly return to permanent housing, while also building community and landlord relationships to increase affordable housing.
- **Invest in respite housing for individuals in urgent need of transitional housing.**

PRIORITY

#11 Socioeconomic Disadvantage (e.g., poverty, unemployment)

- Individuals living at or near poverty levels have higher rates of adverse health behaviors and outcomes; poverty resulting from structural racism is the underlying determinant for many racial/ethnic health disparities.
- Inadequate education, limited opportunities, and unemployment are key drivers of poverty.
- Poverty among children and adults tends to cluster in communities; these communities collectively experience trauma and toxic stress, lower life expectancy, limited access to healthcare and health resources, and greater exposure to unhealthy living environments.
- Poverty rates are nearly 4 times higher in Philadelphia compared to suburban counties overall, but pockets of high poverty clusters are seen in suburban counties.

Potential Solutions

- **Screen for socioeconomic disadvantage and establish systems for linkage to community resources to address needs.**
- **Partner with local community-based organizations who provide public benefits enrollment assistance** to ensure that residents receive all the benefits (e.g., SNAP, Earned Income Tax Credit) for which they are eligible.
- **Collaborate with community colleges and universities to develop and expand programs** focused on skills training and development to increase access to family-sustaining careers.
- **Train and employ returning citizens.**
- **Advocate for improvements to the disability system** to ensure that people with disabilities are able to work without losing attendant care services.
- **Provide workforce development/pipeline programs with schools.**
- **Increase access to Science, Technology, Engineering, Arts, and Mathematics (STEAM) education for youth.**

PRIORITY

#12 Neighborhood Conditions

(e.g., blight, greenspace, air/water quality, etc.)

- Greater neighborhood blight (e.g., abandoned homes, vacant lots, trash) is more likely in high poverty areas and is associated with increased community violence. This has a negative impact on physical activity, as youth expressed avoiding going outside to exercise due to fears of violence.
- Lack of maintenance of public spaces, like schools, libraries and recreational facilities create additional health hazards. Communities often brought up community clean ups as important community-building activities.
- Access to outdoor greenspaces and recreation areas like parks and trails are lower in these neighborhoods. The negative impact of such lack of spaces on mental and physical health was shared by community members.
- Communities expressed concerns about air pollution and climate change, particularly in S Philadelphia, Delaware County, and flood-prone SW Philadelphia.
- Rapid gentrification of some historically low-income neighborhoods creates risk of displacement and housing insecurity, and further racial segregation.

Potential Solutions

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

RESOURCES

Local Health Resources and Services

Many health resources and services are available to address the needs of SEPA communities. A list of organizations serving Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties was developed based on those included in the 2019 rCHNA report, as well as community organizations identified by Steering Committee members as partners. Organizations were coded into categories based on types of services provided, and contact information was verified in April 2022 for all included organizations. Descriptions of the categories are below, and a searchable list of organizations with contact information, organized by category and county, is included in the online Appendix.

Category	Description
Behavioral Health Services	Services, including treatment, to address mental health or substance use issues
Benefits & Financial Assistance	Assistance with enrollment in public benefits or provision of emergency cash assistance
Disability Services	Services for individuals with disabilities
Food	Food pantries or cupboards, as well as assistance with Supplemental Nutrition Assistance Program (SNAP) benefits
Housing/Shelter	Assistance with emergency shelter, rental payment, or support services for individuals experiencing homelessness
Income Support, Education, & Employment	Support for tax assistance, adult education, and employment
Material Goods	Material goods including clothing, diapers, furniture
Senior Services	Services for seniors
Substance Use Disorder Services	Treatment for substance use disorders
Utilities	Assistance with utility payment
Veterans Services	Services for veterans

References and Data Sources

The participating hospitals and health systems would like to acknowledge the following organizations for access to data and reports to inform the rCHNA.

Organization	Resource
Bucks County Housing Link	• Point-in-Time Count Data
Centers for Disease Control and Prevention	• Behavioral Risk Factor Surveillance System Data (PLACES) • CDC/ATSDR Social Vulnerability Index • Youth Risk Behavior Surveillance System Data
Chester County Department of Community Development	• Point-in-Time Count Data
Children First (formerly Public Citizens for Children and Youth)	• No More Dreams Deferred: Building an Education System that Works for Black and Hispanic Students in the Philadelphia Suburbs (Mar 2021) • Underwater: 2019 Regional Reports on Child Well-Being (Mar 2019 – Feb 2020)
City of Philadelphia	• A Digital Equity Plan for the City of Philadelphia (Jan 2022) • Connecting Philadelphia: 2021 Household Internet Assessment Survey (Oct 2021) • Language Access Plans • Nonprofit Assessment Survey Report for African and Caribbean Immigrant/ Refugee-led Organizations (Spring 2021)
Coalition of African & Caribbean Communities (AFRICOM)	• COVID-19: Needs and Recommendations Among African and Caribbean Immigrants (Mar 2021)

Community Legal Services of Philadelphia (Youth Action Board)	• How the Pandemic Response Has Failed Young People & What We Need to Thrive (Aug 2021)
Delaware County Council	• Examination of Health and Public Health Service Delivery in Delaware County, Pennsylvania (Jul 2020)
Delaware Valley Regional Planning Commission	• Broadband: Understanding the Digital Divide (Oct 2020) • Immigration in Greater Philadelphia: FY 2021 Update (Jul 2021)
Drexel University Urban Health Collaborative	• COVID-19 in Context: Racism, Segregation and Racial Inequities in Philadelphia (Jun 2020) • The Impact of COVID-19 in Latino Communities in Philadelphia (Jun 2021)
Feeding America	• Map the Meal Gap Data
HealthShare Exchange	• COVID-19-related Emergency Department Utilization • Emergency Department Utilization • Emergency Department High-Utilizers • Gun-related Emergency Department Utilization
HUD Exchange	• Point-in-Time Count Data (Continuum of Care Programs in Delaware County and Montgomery County)
Pennsylvania Department of Health	• Pennsylvania 2020 LGBTQ Health Needs Assessment (Jan 2021) • Vital Statistics (Birth and Death Records)
Pennsylvania Office of the Attorney General	• Pennsylvania Uniform Crime Reporting System
Pennsylvania Health Care Cost Containment Council	• Hospital Inpatient Discharge Data
Philadelphia Chinatown Development Corporation	• PCDC's Anti-Asian Racism Incident Survey Report (Mar 2021) • Wellness Leadership Program 2020 Impact Report (Chinese Immigrant Families Wellness Initiative) (Sep 2021)
Philadelphia Department of Public Health	• 2020 Health of the City Report (Dec 2020) • Growing Up Philly: The Health and Well-being of Philadelphia's Children (Mar 2020)
Philadelphia Office of Homeless Services	• Point-in-Time Count Data
Pennsylvania Commission on Crime and Delinquency, Pennsylvania Department of Drug and Alcohol Programs, and Pennsylvania Department of Education	• Pennsylvania Youth Survey Data
U.S. Census Bureau	• American Community Survey Data

Notes

- Vital statistics data were supplied by the Bureau of Health Statistics and Registries, Pennsylvania Department of Health, Harrisburg, PA. The Pennsylvania Department of Health specifically disclaims responsibility for any analyses, interpretations or conclusions.
- The Pennsylvania Health Care Cost Containment Council (PHC4) is an independent state agency responsible for addressing the problems of escalating health costs, ensuring the quality of health care, and increasing access to health care for all citizens regardless of ability to pay. PHC4 has provided data to this entity in an effort to further PHC4's mission of educating the public and containing health care costs in Pennsylvania. PHC4, its agents and staff have made no representation, guarantee, or warranty, express or implied, that the data – financial, patient, payor and physician specific information—provided to this entity, are error free, or that the use of data will avoid difference of opinion or interpretation. This analysis was not prepared by PHC4. This analysis was done by PDPH. PHC4, its agents and staff bear no responsibility or liability for the results of this analysis, which are solely the opinion of this entity.

Online Appendix

An online appendix of resources used to inform and produce this CHNA is available at:
https://www.phila.gov/documents/regional-community-health-needs-assessment/